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Gender Stereotypes and Women's Health in Buea Municipality

Dorothy Forsac-Tata[1], Lisette Sui[2]

[1,2]Department of Woman and Gender Studies, University of Buea, Cameroon

ABSTRACT: Women's health is not only critical for women but for their families and communities at large. The importance of and focus on women's health is reflected on the different national and international development agendas. However, the social construction of gender and the eventual development of gender stereotypes directly and/or indirectly affects the health of women. This paper focuses on gender stereotypes and women's health in the Buea Municipality of the South West Region of Cameroon. Through a stratified convenient sampling prsscedure to select 108 women, the paper uses the Harvard Analytical Framework and Leveque's Conceptual Framework of Access to Health to interrogate the theme and with the help of a questionnaire. Different gender stereotypes were identified that put the woman as responsible for care and family well-being no matter her condition. This proved to affect their health through stress, ill health, self-medication, mental health challenges etc.

KEYWORDS: Gender stereotype, health, effects, women's health

INTRODUCTION

Health care is unquestionably a major global development issue (UN Women, 2020). This is made evident in the Sustainable Development Goal (SDG), which is the global development agenda. Goal 3 of the SDG strives 'to ensures healthy lives and promote well-being for all at all ages'. Promoting healthy lives and well-being for all at all ages literarily means making sure that women, men, girls and boys live healthy lives by preventing needless suffering and premature death. It is very evident that women and men have different health-care needs, but have equal right to live healthily. However, for many women and girls, gender stereotype systematically undermines their health, for reasons that include fewer financial resources and constraints on mobility. This is compounded by other issues such as long hours spent on domestic work, unsafe work environments and gender-based violence (UN Women, 2020).

Gender stereotypes are over simplified and widely held beliefs or expectations about the characteristics, roles, behaviours and abilities of women and men. They are widely acceptable judgments or biases about a person or group based on socially constructed norms, practices and believes and are often cultural, religion- based and reflect underlying power relations. These stereotypes are often oversimplified and can lead to unfair and inaccurate assumptions about individuals based on gender construction (www.apa.org/topics/gender-stereotypes). Gender stereotypes dictate how individuals should behave, dress and speak, and this can be harmful because they limit people's potential and can lead to prejudice and discrimination. They are both a root cause and consequence of discrimination, and a contributing factor to a broad range of human rights violations including healthcare. These stereotypes, are often internalized by men and women and thus influence how they perceive themselves and how others perceive them (Koening and Eagly, 2014).

Due to gender stereotypes, men are considered to be more suitable for particular tasks considered to be masculine and women are considered more suitable for tasks considered to be feminine, leading to gender segregation in paid employment. These are perpetuated and reinforced by family members, teachers, and other members of the society who encourage boys to take career choices which are regarded as masculine (science, engineering, mathematics and technology), while girls are encouraged to take career options which are regarded as feminine such as health care, home economics etc. The gender stereotypes of men being assertive and ambitious and women as submissive, nurturers, has shaped what is expected of women in any sphere of life where they find themselves (Stangor, 2016).

Women face pervasive and persistent harmful gender stereotyping as a result of strong religious, social, and cultural beliefs and ideas about sexuality, pregnancy, and motherhood (O'Connell & Zampas, 2018). Women are often expected to be accommodating and emotional, while men are expected to be self-confident and aggressive. In general, personality traits are perceived as productivity-related attributes. A personality trait has the capacity to influence wage, preferences, which can in turn, affect education and occupation, resulting either to positive or negative workplace biases. Heilman (2012) reveals that not only do men and women differ, but they also tend to act like polar opposites, with women appearing to lack the qualities which are most

prevalent in men, and vice versa. For instance, dominance is an acceptable trait in men, but is socially unacceptable in women. In contrast, women are permitted to display weakness, whereas this trait is unacceptable for men (Rudman et al., 2008).

In the health systems, gender stereotypes surrounding women's health care impede women's access to essential reproductive healthcare and contribute to inequality more generally. Stereotyping in healthcare settings impedes women's access to contraceptive information, services, family planning, abortion etc. Gender stereotypes are multidimensional and affect women's access to health care in many ways. In many African countries, women undergoing pregnancy and childbirth are often unable to access maternal health care due to systematic discriminations rooted in gender stereotype within the society (Namasivayam, Osuorah, Syed and Antai. 2012). Whereby, pregnant woman is forced to bear the depression coming with physical and hormonal changes because of the desire to maintain the concept of a good wife and mother. The type of society (patriarchal or traditional) that a woman lives in reflects the gender norms and roles abiding in the society which determines her status within the community and household. Gender stereotype thus enhance gender inequality and promote gender discrimination in healthcare accessibility for women.

RESEARCH PROBLEM

It is widely accepted that access to health care is a basic human need and right. As such, the issue of women access to health care is relevant and topical within development discourses. Thus improvements in access to health care amongst men and women will contribute to ensuring the wellbeing and better health for all. Accessibility to healthcare, which is not only seen as affordability nor accessibility but most importantly, acceptability to seek health care, is the main concern of women who turn to continually put others needs first before theirs.

Gender stereotyping, enforced by socialization plays a role in the access to and use of healthcare for women, because it affects the opportunities women have regarding education, income and occupation, control over earning and participation in decision making in the household (Namasivayam, Osuorah, Syed and Antai, 2012). Within the society, the family as a foremost socialization agency transmits simplistic labels and deep-rooted messages considered specific for a feminine woman and a masculine man. These differences are assigned to women and men according to what is traditionally attributed to them through the socialization process (Hussain, Naz, Khan, Draz & Khan, 2015).

However, the practice of stereotypes has left women with the unpaid, physically demanding and exhausting tasks of household work, constantly sleeping late and getting up early, constantly putting children, husband and family before themselves in everything including healthcare. Gender stereotypes is thus descriptive and prescriptive in relation to domestic behaviour encouraging women to nurture, take care of children, clean, cook and meet communal needs. Women are supposed to be warm, sensitive and cooperative and avoid any dominance traits (aggressive, intimidating and arrogance), while men are expected to take care of finances, take care of home repairs and be assertive, competitive, independent, and avoid any demonstration of weakness (Lindsey, 2016). This gives women a general feeling of total dependence and lack of autonomy.

The feeling of lack of autonomy and control over one's life is known to be associated with depression. Furthermore, socially determined gender roles and responsibilities place women in situations where they have little control over important decisions concerning their lives including decision to access healthcare services. This paper investigates the role played by gender stereotyping in women's healthcare accessibility in the Buea Municipality.

Research questions

1. What is the profile of respondents?
2. What are the different types of gender stereotypes experienced by women?
3. How does gender stereotyping affect women's healthcare accessibility?
4. How do women cope with the challenges of the effects of gender stereotype on their health?

LITERATURE REVIEW

Gender Stereotype

Gender stereotype refers to widely held beliefs about the personal attribute of females and males, which can be untrue or partly true. They are mainly as a result of the socialization process, facilitated by various sociocultural and relational factors like family, school, peer groups and tradition. These institutions play significant roles in the development of gender, gender stereotypes, gender roles and gender division of labour (Gleitman, Fridlund, & Reisberg, 2000). In the domestic sphere women are expected to perform the majority of routine domestic work and play the major caretaker role. In the workplace, women are tended to be employed in people-oriented, service occupations rather than things-oriented, competitive occupations, which are traditionally for men (Lippa et al., 2014). This contrasting distribution of men and women into social roles, and the inferences about what women and men should be, gives rise to gender stereotypical conceptions (Koenig and Eagly, 2014)

The process of gender stereotyping influences people's identities as they are internalized and become part of a person's gender identity (Wood and Eagly, 2015). Young boys and girls learn about gender stereotypes from their immediate environment and the

media, and they learn how to behave in gender-appropriate ways. These socialization experiences no doubt continue to exert influence later in life. Stereotypes are deeply engraved in cultures, societies, and human consciousness.

Stereotypes induces faulty assessments of people based on generalization from beliefs about a group that do not correspond to a person's unique qualities. These faulty assessments can negatively or positively affect expectations about performance, and bias consequent decisions that impact opportunities and work outcomes for both men and women (Hentschel et al., 2019). Stereotypes about gender are especially influential because gender is an aspect of a person that is readily noticed and remembered. MacNaughton (2000) explains that the idea of gender is a social construction and its developmental process begins at birth and then expands and develops with time.

Gender stereotype patterns is recognized in how women and men respectively tend to be, how they tend to behave and the roles they occupy in society and this generally leads to gender discrimination as people are usually unjustly treated because of the influence of gender stereotype (Kite, Deaux, & Haines, 2008). In order to be able to recognize such gender-based discrimination, as well as to avoid it, it is important to be aware of the existence of gender stereotypes, their content, the areas of everyday life, where they come into play and the mechanisms in which it influence choices and decisions and of how precisely they lead to discrimination.

Types of Gender Stereotypes

Gender stereotypes have both descriptive components (how males and females typically act), and prescriptive components (how males and females should act). They are both descriptive and prescriptive in nature. This happens from childhood to adulthood. For example, as children girls are expected to play with dolls while boys play with cars or trucks; during youth girls are well behaved, good in math, and not interested in STEM subjects while boys are the opposite of that (Gender Equality Law (2015). Further gender stereotypes in adulthood includes: there is something wrong with a woman who doesn't want children; assertive women are unfeminine and are "bossy," "bitches" or "whores"; women are natural nurturers while men are natural leaders; women don't need equal pay because they are supported by their husbands; women with children are less devoted to their jobs; men who spend time with family are less masculine and poor breadwinners etc. (Gender Equality Law, 2015). These assumed characteristics or behavior of women and men turn to affect them either directly or indirectly in every aspect of their life and this in turn influences their sense of rational thinking thus being bias in decision making which leads to discrimination.

Effects of Gender Stereotypes on Women's Health

Gender stereotype has a significant impact on the mental and physical health of people worldwide. This is because it creates an arena of gender discrimination and inequity that limit people's access to healthcare, increase rates of ill health, and lower life expectancy. This situation tends to affect more women than men. According to Burcu (2015), women's subjective health is worse than men's in any age and socioeconomic group as they have more illnesses and disabilities than men even if the life expectancy of women is higher. Gender division of labour and gender roles which are distribution of functions according to belief of masculinity and femininity, results to gender stereotyping and are part of the causes of this distinction.

Women are assigned more responsibilities for household tasks and childcare, regardless of their educational level or employment status. This means that women spend more time in household work and childcare and less time in employment and leisure and this takes a huge toll on their mental health. According to WHO (2002), depression is almost twice as prevalent in women compared to men and female patients are twice as likely to be diagnosed as depressed than men. During adolescence, girls have a much higher prevalence of depression and eating disorders, and engage more in suicidal ideation and suicide attempts than boys. Boys experience more problems with anger, engage in high risk behaviors and commit suicide more frequently than girls. In general, adolescent girls are more prone to symptoms that are directed inwardly, while adolescent boys are more prone to act out. In adulthood, the prevalence of depression and anxiety is much higher in women, while substance use disorders and antisocial behaviors are higher in men.

Gender stereotypes surrounding women's reproductive health impede women's access to essential reproductive healthcare and contribute to inequality in healthcare accessibility. Stereotyping in healthcare settings makes it difficult for women to access information on contraception and other reproductive health services (O'Connell and Zampas, 2016). In most of sub Saharan Africa, women and girls shy away from accessing reproductive health for fear of being seen as sexually loose. One pervasive stereotype is that because women are seen as being emotionally weak and unstable, they are not considered capable of making sensible decisions about their health. Therefore, they are seen as persons that need to be controlled and not persons that can make healthy and informed decisions. Stereotyping thus shift this decision making to male family members, doctors etc. as being in better positions to make decisions for women (ibid).

Gender stereotyping also leads to gender discrimination which directly affects women's mental health. Depending on the situation, facing discrimination can also result in anxiety and psychological trauma. Experiencing any type of abuse or assault can lead to a mental health condition, as well as further complications that are traumatic in themselves. (Villines, 2021).

Gender Stereotyping and Women's Access to Healthcare

Accepting gender stereotypes does have long-term negative influence on women's beliefs, attitudes and health conditions. Although the life expectancy rate for women is greater than men's, they have lower health measure and higher morbidity rates. According to Africa Health organization (www.aho.fact-sheets), gender inequality does not only limit access to quality health services but also contributes to morbidity and mortality rates in women and men throughout their lives. One of the major reasons for this is the attribution of gender roles which leads to gender division of labour and the stereotyping of women with reproductive chores. The lesser involvement of men in household chores and greater transfer of stress from work to family causes increased domestic workload on women. The social construction of gender leads to stereotypes and has implications for women's health, their exposure to diseases and their access to healthcare (WHO, 2021).

The vicious cycle of poverty and poor health especially affects women and is perpetuated by gender roles which is a result of gender stereotypes. Most women turn to work in the lowest-paid and informal sectors and carry the heaviest burden of unpaid housework and home care which only does not give them less time to take care of their health but also less time to generate income (Hentchel, Heilman &Peus, 2019). For majority of women, the low-paid employment is less likely to provide health insurance, requiring to access healthcare from out of pocket, meanwhile their reproductive role requires more total health care all through their lives to manage childbearing and chronic conditions. These obligations negatively affect women's ability to afford medications and reduces their access to healthcare (Hentschel, ed al. 2019).

Also, gender stereotypes lead to delayed diagnoses and inadequate symptom management in women especially when doctors do not believe the patients. Many times, gender stereotyping make doctors to dismiss the severity of chronic pain for women and would not prescribe medication. Furthermore, the stereotypical idea that heart attacks only occur in males exposes women to neglect and risk of dying.

THEORETICAL FRAMING

The Harvard Analytical Framework also called Gender Roles Framework or Gender Analysis Framework and the Levesque's Conceptual Framework of Access to Healthcare both informed this paper. The Harvard Framework recognizes that development policies, programs and projects affect men and women differently. It is built on the awareness of not only the gender differences between women and men, but also of the inequalities that emanate from these differences. This framework has four interrelated components; the activity profile which focuses on gender division of labour bringing out the activities of men, women girls and boys, the access and control profile which determines who has access to and control over the resources of the community. By distinguishing between who has access to, who has control over and who benefits from resources, the Harvard framework brings out the relative power of members of the community. The third component is the influencing factor. This tool analyses which factors (culture and religious beliefs, norms) shape or influence the activities of individuals, and their access to control over resources. The fourth component is the project cycle analysis which consists of examining a project or intervention in the light of gender-disaggregated information to determine whether any gender is disadvantaged by it (Oxfam, 1994). This paper made use of three tools of the Harvard Analytical Framework. These are the activity profile, the access and control profile and the influencing factor profile. These three tools helped identify the stereotypical activities that women do, the resources that women have access to and control over as a result of stereotyping and the traditional, cultural, religious and other factors that influence stereotyping and how all these go to affect women's access to healthcare.

The Conceptual Framework of Access to healthcare explains the different ways in which healthcare can be accessed which includes: approachability (that is when people in need of healthcare services can actually identify that these services exist, can be reached, and do have an impact on the health of the individual); acceptability (understanding that there are cultural and social factors that determine the possibility for people to accept aspects of the service and the judged appropriateness for the persons to seek care); availability/accommodation (ensuring that health units and healthcare workers are available to intervene when needed in a timely manner); affordability (takes into account the economic capacity of people to use appropriate healthcare services); and appropriateness (interrogates whether the available services and treatment appropriate to the health problems people face) (Levesque et al., 2013).

METHODOLOGY

This is descriptive and analytical study that seeks to determine the effects of gender stereotype on women's healthcare accessibility in the Buea municipality with target population being married women in the Buea municipality. This group of women are targeted because gender stereotype and gender roles are very distinct and evident among married couples. A sample size of 108 married women were selected from the various neighborhoods in the Buea Municipality following a stratified convenient sampling technique. The population was stratified according to the different neighbourhoods (Molyko, Bonduma, Great soppo, Bokwoango, Buea Town, Bova, Mile 16 (Bolifamba), Muea, Bomaka, Bwitingi, Bokwai and Bonakanda) of the Buea municipality and nine (9) respondents were conveniently selected from each stratum. These women were selected upon availability. The questionnaire was the main instrument for data collection and was administered to all 180 respondents. A

research assistant was trained and used for data collection and data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 27, and presented using tables, chats and percentages. The instruments for the study went through a Departmental and Faculty scientific and ethical committee that ensured that the participants in the research are protected. Respondents were informed of their right not to participate in the study and to discontinue whenever they felt like. They were assured confidentiality, their identities were well protected all through the study and their dignity preserved.

FINDINGS AND DISCUSSION

Profile of respondents

Table 1: Some demographic characteristics of respondents

Variables	Age range	n	(%)
Age Range	15- 25 years	7	6.5
	26-35 years	41	38.0
	36-45 years	33	30.6
	46-55 years	21	19.4
	Above 55 years	6	5.6
	Total	**108**	**100.0**
Educational Level	No formal education	14	13.0
	Primary education	25	23.1
	Ordinary level	24	22.2
	Advance level	14	13.0
	Degree	19	17.6
	Postgraduate	12	11.1
	Total	**108**	**100.0**
Religion	Christianity	86	75.4
	Islam	5	3.5
	None	17	14.9
	Total	**108**	**100.0**
Number of children	1-3 children	10	9.3
	4-6 children	58	53.7
	7-10 children	39	36.1
	Above 10 children	1	.9
	Total	**108**	**100.0**
Educational level of spouse	No formal education	10	9.3
	Primary education	26	24.1
	Ordinary level certificate	18	16.7
	Advance level certificate	19	17.6
	University education	35	32.4
	Total	**108**	**100**
Age range for children	0-5 years	27	25.0
	6-10 years	35	32.4
	11-15 years	18	16.7
	Above 15 years	28	25.9
	Total	**108**	**100**

Source: Fieldwork, 2022

The profile of respondents as seen on Table 1 reveals that almost 70% of the respondents were between the ages of 25-45 years, while 25% were above 45 years and 7% were below 25 years. This basically denotes a youthful female population, supposedly active enough to interact on daily basis exposing them to probable gender stereotype cases. With respect to the level of education, almost all (85%) respondents had some formal education. About 23% had primary education, 22.2% of them had secondary education (ordinary level) with the same number having advanced level certificates. Above 28% of them had a university education. 17.6 % had First degree and 11.1 % had postgraduate certificates. In essence, the sample consisted mostly of a literate population who were able to understand the issues raised. Furthermore, more than three quarters 75.4% of respondents were Christians, while only 3.5% were Muslims and the remaining 14.9% were neither Christians nor Muslims. This can be understood

because municipality of Buea is a predominantly Christian. In relation to the number of children, more than half (53.7%) of respondents had between 4 and 6 children, followed by 36.1% with 7-10 children, 9.3% had below 3 children while below 0.9% of respondents had more than 10 children. With respect to the educational level of the spouses, 32.4% of respondents had obtained university education, 24.1% had primary education, 17.6% had advanced level education while 16.7% had obtained secondary education. These indicate that most spouses/partners were more educated than the respondents (women). Finally, concerning the age range of the children of the respondents, 32.4% of them said their children are between 6-10 years, 25.9% of them said over 15 years, 25.0% of them said between 0-5 years, and the least proportion 16.7% said between 11-15 years.

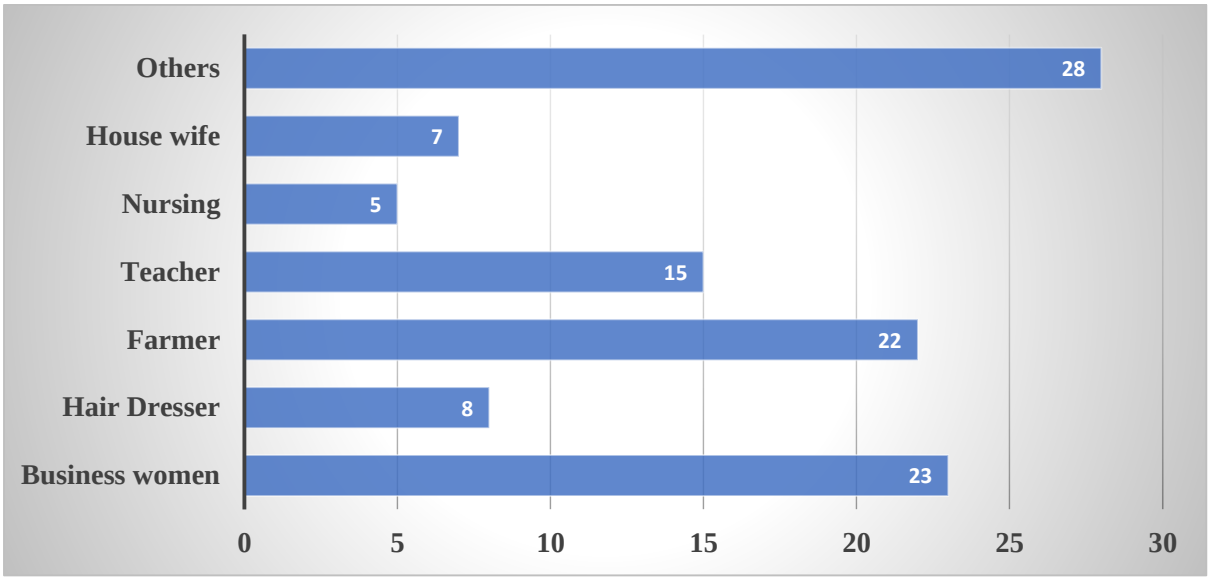

Figure 1: Distribution of Respondents by Occupation

Figure 1 above reveals that 21.3% of the women are involved in business, 7.4% of them are hairdressers, 20.4% are farmers; 13.9% are teachers; the least 4.6% of them are nurses while 6.5% are house wives and 25.9% had other occupations like food vendor, house keeper etc. This shows that very few of them have regular salaries, the rest are struggling with businesses to make ends meet for themselves and their families.

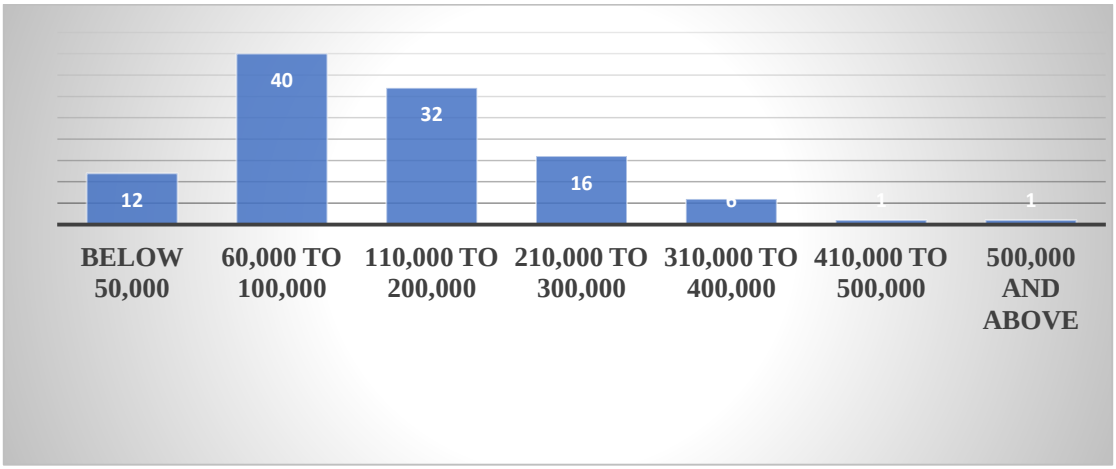

Figure 2: Distribution of Respondents by their Monthly Income

As regards monthly income, Figure 2 above shows that 48.1% of respondents earn between 60,000XAF ($100) to 100.000XAF ($168) while 29.6% of the women earn between 110.000XAF ($184) to 200.000XAF ($336), 14.8% earn between 210.000XAF ($353) to 300.000XAF ($504), 5.6% of them earn between 310.000XAF ($521) to 400.000XAF ($672) while less than 0.9 % of them earn above 400.000XAF ($672). The above finances show that majority of the respondents are struggling financially as almost four-fifth (77.7%) of the respondents make below $400 a month.

4.2 Gender stereotypes experienced by women

Table 2: Gender stereotypes that affect can women's health

Items		Yes	No	Sometime	Total
Good housewives do not go to the hospital without the husband's approval/consent	**n**	33	64	11	**108**
	%	30.6	59.3	10.2	**100**
As a wife I have to allow my husband to control my income	**n**	13	91	4	**108**
	%	12.0	84.3	3.7	**100**
It is shameful for women to have STDs	**n**	22	84	2	**108**
	%	20.4	77.8	1.9	**100**
Ill health can stop a good wife from taking care of their families.	**n**	14	90	4	**108**
	%	13.0	83.3	3.7	**100**
It is the wife's duty to take care of both the immediate and external family at all times	**n**	83	14	11	**108**
	%	76.9	13.0	10.2	**100**
Wives should be submissive to their husbands no matter the circumstances	**n**	32	62	14	**108**
	%	29.6	57.4	13.0	**100**
Women should only take jobs that allow them have enough time to take care of their families, even if less paid	**n**	33	73	2	**108**
	%	30.6	67.6%	1.9%	**100**
The wife is responsible for children's upbringing and how they turn out in life	**n**	24	82	2	**108**
	%	22.2	75.9	1.9	**100**
A good wife must be ready at all times to sacrifice for her family irrespective of her health condition	**n**	73	22	13	**108**
	%	67.6	20.4	12.0	**100**
Women are good in reproductive activities while men are good in productive activities	**n**	84	21	3	**108**
	%	77.8	19.4	2.8	**100**
Wives need to create time for the family regardless of their work schedule	**n**	92	13	3	**108**
	%	85.2	12.0	2.8	**100**
As a wife I can't decide on the number or spacing of our children.	**n**	29	67	12	**108**
	%	26.9	62.0	11.1	**100**

Source: Field work, 2022

Respondents opinions were sampled on the different gender stereotypes in the society and that can affect the health of married women. About two-thirds (59.3%) rejected the statement that they cannot go to the hospital without their husbands' approval, and above 84% revealed that despite societal expectation, their husbands do not control their income. In relation to women and sexually transmitted diseases, 20.4% thought that it was shameful for a woman to have STDs while almost 80% thought it was okay. While 83.3% agreed that good wives do not allow ill health to stop them from taking care of their families and 76.9% confirmed that it is the wife's duty to take care of immediate and external families, 57.4% believe that wives should submit to their husband no matter the circumstance. A further 67.6% women should only take jobs that allow them care for their families even if these jobs are less paid, while 30.6% agreed to that. Furthermore, 22.2% said yes to the assumption that wives are solely responsible for children's upbringing and how children end up in life while almost 80% said no. However, more than 67% agreed that a good wife must be ready at all times to sacrifice for her family irrespective of her health condition, and more than 77% accepted that women are good in reproductive (indoor) activities while men are good in productive (outdoor) activities. This, however, down plays the role of the socialization process in gender identity formation. Another 85.2% agreed that wives need to create time for the family regardless of their work schedule while 62% refused the claim that as a wife they can't decide on the number and spacing of their children although 26.9% agreed. These show the many different forms and types of gender stereotypes that women have internalized and that they practice to get accepted into roles and communities.

Table 3: Effect of Gender Stereotype on Women's Health

Items		Yes	No	Sometime	Total
Total submission to husband in all circumstances is very stressful	**n**	70	28	10	**108**
	%	64.8	25.9	9.3	**100**
Permanently taking care of both immediate and external family members makes me sick	**n**	76	27	5	**108**
	%	70.4	25.0	4.6	**100**
Sacrificing for family at all times even when ill greatly affects my health	**n**	83	24	1	**108**
	%	76.9	22.2	.9	**100**
Reproductive chores keep my busy all day long and this results to ill health	**n**	60	42	6	**108**
	%	55.6	38.9	5.6	**100**

Lack of money makes me resort to self-medication which is dangerous	**n**	31	58	19	**108**
	%	28.7	53.7	17.6	**100**
Waiting for my husband's approval before going to the hospital delays and increases my illness	**n**	60	43	5	**108**
	%	55.6	39.8	4.6	**100**
Having to do all housework alone after productive work in the office is very stressful and mentally challenging	**n**	79	21	8	**108**
	%	73.1	19.4	7.4	**100**
Discomfort in consulting for STDs has devastating health effects on my reproductive health	**n**	19	82	7	**108**
	%	17.6	75.9	6.5	**100**

Source: Field work, 2022

Gender stereotypes do affect women's health as seen in the data on Table 3. More than 64% of respondents say total submission to husband is stressful and for 70.4%, permanently taking care of both immediate and external family members make them sick. Another 76.9% agreed that sacrificing for family at all times even when ill greatly affect their health and 55.6% said reproductive chores keep them busy all day and this results to ill health. Meanwhile 28.7% said the lack of money makes them resort to self-medication without going to the hospital. More than 55% also agreed that waiting for husband's approval or consent before going to the hospital delays and increases their illnesses. Furthermore, 73.1% of respondents acknowledged that having to do all house work alone after productive work in the office is very stressful and mentally challenging meanwhile 17.6% say that the feel uncomfortable consulting for STDs and this has devastating effects on their reproductive health.

COPING STRATEGIES

Faced with the above effects on their health, the study to identify some coping strategies used by women to mitigate the effects of gender stereotypes on the health. Respondents revealed that in relation to inability to access quality health, some resort to traditional medicines while others go to social media to look for home remedies for their illnesses. In relation to house chores, some respondents try to get house helps while many others benefit from the presence of extended family members at home to help. Some women, especially those with outdoor productive work said that they rearrange their time and programme cooking over the weekend. All food for the week is prepared over the weekend and stored in the freezer to reduce her house hold work during the week. In relation to stress and mental health, most women said they social groups where they go and socialize and relax with friends in order to take care of their mental health.

CONCLUSION

Using a sample size of 108 married women, this paper has tried to identify some gender stereotypes and how they affect the health of women in the Buea municipality. It was out to investigate the profile of respondents, the different types of gender stereotypes experienced by women, how these gender stereotypes affect women's healthcare accessibility and how women cope with the challenges of the effects of gender stereotype on their health. Based on the results from the analysis and following the research objectives it can be concluded that the profile of respondents in the Buea Municipality varied and respondents are dominated by 26-35 years, most with less than first degree qualification and mostly Christians with majority having 4-6 children. With most of the women married, the dominant highest educational qualification for the women was first degree and the children average ages were between 6-10 years. Among the different socio-demographic features, the study concluded that educational profile, occupation, monthly income, number of children and religious affiliation are significant predictors of access to healthcare by respondents in Buea. That is, it gives women the autonomy needed to solely decide to access healthcare compared to other respondents.

While most respondents have internalized the fact that ill health should not stop a mother from taking care of her family, only two-thirds of them bought the idea that they need to seek their husband's approval before going to the hospital when ill. However most accept that it is the wife's duty to take care of the immediate and external families and that a good wife should be ready to sacrifice for her family at all times. Many women also buy the idea that women are good in reproductive chores while men are good in productive work and that women need to create time for the family regardless of their work schedule. These imbedded gender stereotypes do affect the health of women as it was seen that total submission to husband in all circumstances is very stressful, while permanently taking care of immediate and external family members make them sick. Sacrificing for family at all times even when ill was also seen to greatly affect their health reproductive chores keep women busy all day long and result to ill health. Lack of money also leads to self-medication which is dangerous and waiting for husband's approval before going to the hospital prolongs and increases illness. The study also found out that having to do all housework alone after doing outdoor productive work is very stressful and mentally challenging.

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