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Assessing the Political Impact of Women's Political Representation on Women's Health in Indonesia, 2009-2023

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Abstract
This study explores the influence of women's representation in the Indonesian Parliament (DPR RI) on women's health outcomes, specifically through the mediation of health policies. The primary objective is to assess whether increased political representation of women leads to improved health conditions for women by influencing policy decisions. The research adopts a quantitative approach, utilizing path analysis using Stata over 15 years. The model examines the relationship between women's representation as the exogenous variable, women's health policies as the intervening variable, and various indicators of women's health as the endogenous variable. Of the 14 health equations analyzed, only two yielded significant results: (1) a direct effect of women's political representation on women's health and (2) a direct effect of women's representation on the coverage of health insurance in Indonesia. The limited significance of these results is attributed to the fact that the 30% gender quota in Parliament has not been fully achieved, and the indicators used to measure women's health may not be fully representative. The study underscores the need for a more balanced representation of women in legislative bodies and the development of more comprehensive health indicators to capture the state of women's health in Indonesia.

Keywords: *Women Health; Representation; Policy; Politics*

INTRODUCTION

The existence of women in the political sphere has increased over the past few decades. Gender quotas in parliamentary seats have been implemented in developing countries. Women's representation is considered to encourage policies that are more friendly to women (Lena & Netina, 2010). This is because the needs related to women will only be understood by women themselves. Issues such as reproductive health, health information, health services, and so on are considered key priorities for women who act as policymakers (Norberg & Johansson, 2021)

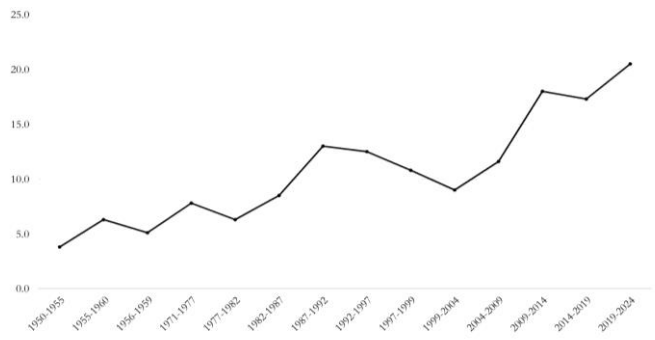

Figure 1. Graphic of Women Representation in National Legislative (1950-2024)
(Source: Processed by Author from Central Bureau of Statistic)

Indonesia has implemented a 30% gender quota since issuing the Law on Women's Representation in the People's Representative Council Number 22-24/PUU-IV./2008 (Constitutional Court, 2008). This regulation spearheads the benchmark for increasing women's representation in the DPR-RI through affirmative policies. Judging from the journey from 1950 to 2019, the percentage fig(1) has never reached 30**%.** Saputra et al., (2020) and Abbas et al., (2023) explained factors that affect the women's political underrepresentation in Indonesia is the thick patriarchal culture in society. The common perception often held by the society due to the belief that women doesn't capable in carrying out roles and functions in politics. This old paradigm inflicts the lack of support which leads to insufficient women's representation in political party whereas none has reached gender quote (Ruriana & Fahadayna, 2023)**.** However, the increase in women's representation in parliament has continued to increase and first touched 20% in 2019-2024. This raises questions about the significance of women's representation in the DPR-RI in influencing policy, especially in the health sector.

A clear positive association exists between women's representation in the legislature and the prioritization of health, social-budget spending, and poverty reduction (Halimatusa'diyah & Arif, 2021;Swiss et al., 2012; Cowell-Meyers & Langbein, 2009). The parliaments of Uganda (Clayton et al., 2017) and Rwanda (Uvuza, 204 C.E.) found that female legislative representation. In the case of Rwanda, despite being one of the poorest countries in the world, Rwanda is known as one of the countries that has succeeded in reducing the Maternal Mortality Rate significantly since the implementation of the Gender

Quota (Abbott et al., 2017). The findings above are empirical evidence of the contribution of gender-based policy preferences by female legislative representatives as policymakers, especially in the health sector.

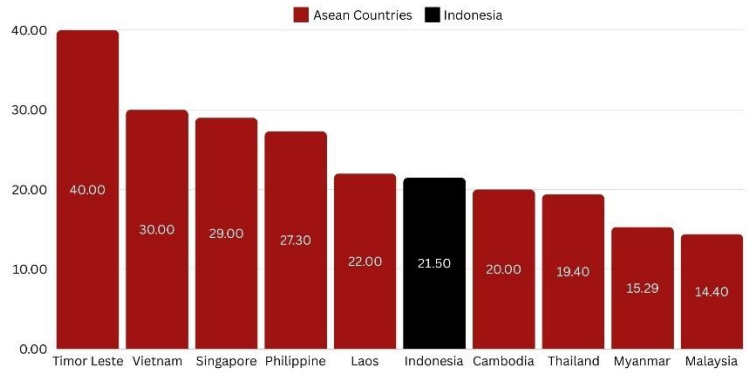

Figure 2. Graphic of Woman Representation in ASEAN Countries in 2024
(Source: Processed by Author from Inter-parliamentary Union)

Data above revealed the percentage of women's representation, with Indonesia highlighted separately in black (IPU Parline, 2024). Countries like Vietnam and the Philippines, which share some similar cultural, societal, and political dynamics with Indonesia, have managed to achieve 30% of women's representation. Indonesia may still face challenges, including potential cultural, institutional, or political barriers that limit higher female representation.

Previous studies in Indonesia, such as research by Saputra (2019) have analyzed the impact of female representation on the DPR, but most are limited to discussing political and regional aspects only. The closest research discussing the relationship between women's representation and women's health is by Halimatusa'diyah & Arif (2021), which results in a positive and significant relationship between women's representation at the regional level and a decrease in maternal mortality rates. Empirical studies related to the influence of women's representation on women's health are still minimal.

The complexity of measuring women's health requires a thorough understanding of biological, social, psychological, and political perspectives, is one such limitation. Due to the broad scope and limited studies in this area, it is challenging to identify comprehensive

measurements of women's health in general. A study by (Garcia et al., 2010) and (Edström, 1992) identified aspects to measure progress in women's health, namely (1) aspects of education/health promotion, (2) aspects of health access, (3) aspects of mortality, (4) aspects of poverty, and (5) aspects of prevention healthcare. The study will use these five aspects to represent women's health.

An intervening variable is needed to link women's representation in the DPR-RI with women's health. Several studies, such as (Swiss et al., 2012) and (Mechkova & Edgell, 2023), use indicators of democracy and state regimes as intervening variables. Referring to the leading theory, namely descriptive and substantive representation by (Pitkin, 1967), the transformation of descriptive to substantive roles is based on women-friendly policies. Similar research has also been conducted by (Cowell-Meyers & Langbein, 2009) in the United States. Therefore, researchers will use policies related to women's health as intervening variables by scoring policies according to the pillars of Universal Health Coverage.

UHC, according to the World Health Organization (WHO), is the goal for all people to obtain the preventive and curative health services they need without experiencing financial difficulties when paying for them (Savedoff et al., 2012). UHC is a powerful driver of women's health in low- and middle-income countries, including Afghanistan, Mexico, Rwanda, and Thailand. Success requires a gender-sensitive approach to designing and implementing (1) essential services packages, (2) access to services, (3) financial barriers, (4) social and other non-financial barriers, and (5) performance monitoring indicators (Quick et al., 2014).

Table 1. Pillars of Women's Health

No.	Pillar	Description
1.	Essential Services Package	Provision of essential services for women, including contraception and reproductive health services, antenatal care, breast and cervical cancer screening and treatment, and abortion services where legal.
2.	Access to service	Promoting convenient and close-to-home services through the integration of one-stop services for women and children, provision of AIDS screening with treatment initiation, assistance with contraceptive costs,

3.	Financial Barriers	Providing access to women's health insurance by minimizing out-of-pocket payments for women's health services
4.	Social and other non-financial barriers	Systematic monitoring of women's access to services.
5.	Performance monitoring indicators	Measurement of targets and achievements of women's health services with gender disaggregation in their outputs.

Processed by Author from (Quick et al., 2014)

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This research investigates the relationship between women's representation in the House of Representatives, the formulation and implementation of women's health policies, and the resulting impact on women's health in Indonesia. The study includes three main variables: women's representation as the independent variable, women's health policy as the intervening variable, and women's health as the dependent variable.

Table 2. Women's Health Policy Scoring

Score	**Scoring description for each policy issued**
0	Does not meet any of the pillars
1	Meet only one pillar
2	Meet two pillars
3	Meet three pillars
4	Meet four pillars
5	Meet five pillars

Processed by Author (2024)

The methodology involves a comprehensive assessment of fourteen health policies issued by the House of Representatives from 2009 to 2023. Each policy is evaluated against specific indicators, with a score of 1 assigned to policies that meet these criteria. This scoring continues for each policy until it is revoked, creating a cumulative measure of the focus on women's health policy over time as following above This approach covers three legislative periods—2009, 2014, and 2019—following the implementation of the gender quota policy aimed at increasing women's representation. Due to the timing of the research, conducted in early 2024, the dataset is limited to policy developments up to 2023.

This quantitative research uses a literature study technique using secondary data. Furthermore, the data will be processed using two analysis techniques, simple linear

regression and non-simultaneous path analysis, to measure the magnitude of the influence of the independent variable on the indicator variable through the intervening variable. Furthermore, this research is essential to fill the gaps about the absence of women's health and women's political representation in the national legislation in Indonesia.

RESULTS & DISCUSSION

The Effect of Women's Political Representation to Health Policy

The relationship between women's political representation and health policies has been explained using the theory of substantive and descriptive representation introduced by Pitkin in 1967. Descriptive representation will transform into substantive representation whether the representative contributes in terms of substance, such as policy. The study of representation was then further studied with the introduction of gender quotas as a minimum quota for a country to increase women's representation, especially in legislative institutions, which is 30%. Gender quotas are used as a tool by the state and parties in the hope of realizing gender equality and more inclusive policy outputs. Pitkin (1967) and research by (Mechkova & Edgell, 2023) also said that women's representation would work more effectively if an open democratic system and a proportional electoral process protected it. Descriptive and substantive representation are often associated with women's representation in political parliaments. Women comprise almost half the world's population, but their representation in parliament is deficient (Lena & Netina, 2019.).

Related to women's representation, the development of studies on women's descriptive and substantive representation were developed by Dahlerup (1988) by introducing a theory called critical mass to examine women's participation in a corporation.According to Dahrelup, when the percentage of women is less than 15% of the organization, they tend to avoid topics about gender. However, if women succeed in reaching 15% or more, they tend to ally to raise gender issues.

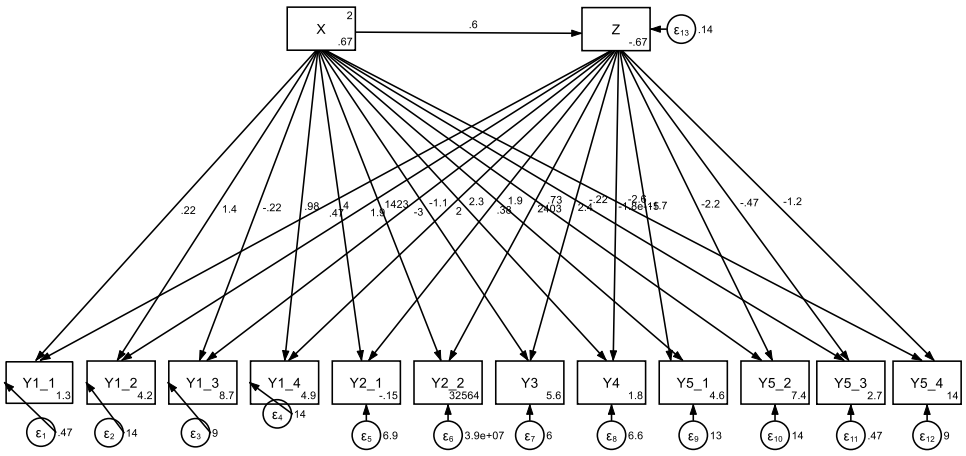

Figure 3. Model Building and Estimation

(Source: Processed by Author using StataMP 17)

*X = Percentage of Women Politicians in the Indonesian House of Representatives
*Z = Health policy scoring based on the pillars of women's UHC
*Y1_1 = Percentage of households practicing PHBS
*Y1_2 = Percentage of households with proper sanitation
*Y1_3 = Percentage of women aged 15-49 years and married who use birth control
*Y1_4 = Female illiteracy rate
*Y2_1 = Coverage of National Health Insurance participants
*Y2_2 = Number of health facilities in Indonesia
*Y3 = Maternal mortality ratio
*Y4 = GNI per capita
*Y5_1 = Coverage of cervical cancer screening
*Y5_2 = Coverage of breast cancer screening
*Y5_3 = Proportion of adolescent girls aged 10-19 years who receive/purchase TT
*Y5_4 = Coverage of basic immunization

The model above is a path analysis model used in the study. One simple linear equation and 12 path equations will be tested partially. The twelve path equations come from measuring each indicator of women's health influenced by women's political representation in the DPR-RI through Indonesian women's health policies, both direct and indirect effects. The direct effect is the influence given directly, while the indirect effect is the influence given through intervening or mediation. In this study, the unstandardized coefficient will show changes in the dependent variable (Y) when the independent variable (X) and intervening (Z) change by one unit.

Table 3. Results of the Direct Influence Test of Women's Political Representation on Health Policy Scoring

		Direct Coef	P>|z|	Indirect coef	P>|z|
Woman Pol. Representation	<-- Women Health Policy	0.6	0.000		

(Source: Processed by Author from StataMP 17)

The test results above show a positive and significant relationship between women's political representation in the DPR-RI and the quality of health policies in Indonesia based on UHC scoring. This means that a 0.6% increase in women's political representation in the DPR-RI can increase the quality of women-friendly health policies by 0.6 points.

When women gain seat in the legislative, they are often more likely to advocate for health policies that address reproductive health, maternal health, family planning, and child care service, given their awareness of issue directly affecting women (Wahyuni et al., 2021). Moreover, women in the legislature can influence budget allocations to ensure that healthcare funding includes programs targeting cervical cancer screenings, breast cancer awareness, and family planning. This focused budget allocation can directly lead to an increase in access to these crucial services, which would improve indicators like maternal health outcomes (W. A. Saputra, 2019).

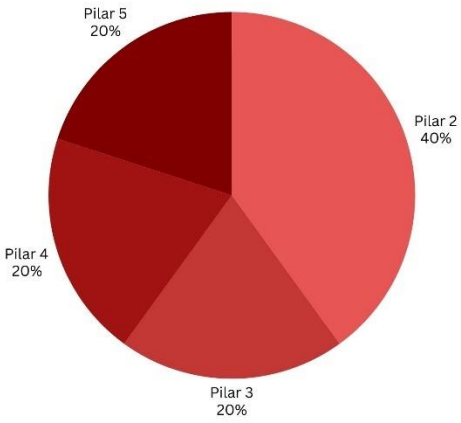

Figure 4. Graphic of Health Policy Scoring by UHC Pillar by Author

Researchers collected 14 health-related laws from 2009-2023 to be assessed based on the five pillars of UHC that focus on women's health. No policies met all pillars. Based on the scoring results, no policies in that span of years met pillar 1, namely the essential services package. The policies produced, on average, talked about health in general, rarely mentioning essential service packages for women, such as antenatal care, contraception, delivery services, and postnatal care. Therefore, none of the policies issued met this pillar.

The second pillar is access to service. The results of the policy scoring saw several health policies starting to pay attention to access to one-stop services for women. In Indonesia, several initiatives specifically provide one-stop health services for women and children, such as the Rumah Sakit Sayang Ibu dan Anak (Oktavia & Prayoga, 2023). This program is a government initiative that operates under the Ministry of Health; the private sector manages some. This hospital usually provides integrated services from antenatal care (ANC) and delivery services to postnatal care.

The third pillar is financial barriers. The scoring results indicate that significant strides have been made in addressing financial barriers, particularly with the implementation of the National Health Insurance (JKN) initiative. This initiative, which aims to provide equal and affordable access to services, is a key component of Indonesia's affirmative policy in implementing Universal Health Coverage (Kosasih et al., 2022). Managed by BPJS, it is responsible for collecting contributions and managing health service financing, especially for women. The services covered include antenatal care, childbirth, postnatal care, contraception, and women's health screening (cervical cancer, breast cancer, and anemia). The fulfillment of this pillar has been steadily improving since 2019, coinciding with the increase of women's political representation in the national legislature.

The fourth pillar is social and other non-financial barriers. Cultural and social norms often limit women's access to health services. In some communities, traditional gender roles limit women's mobility, so they must rely on their husbands or male family members to get care (McCartin et al., 2022). There is also a stigma attached to reproductive or sexual health issues, which makes women hesitate to seek services. Health programs need to include gender education and awareness-raising components to address cultural norms that limit women's access to health services. The fulfillment of this pillar was found and already initiated in 2009 in the Law on Health, a significant institutional support for these initiatives.

The last pillar is performance monitoring output. Performance monitoring indicators are critical to measure targets and achievements in women's health services, especially using gender disaggregation (separation of data by sex). This indicator helps the government and health institutions to evaluate whether health services have achieved their goals fairly and equitably, especially for women. This pillar has also been fulfilled through Law No. 17 of 2023 concerning Health, where there is a monitoring function in the clinical management function of good governance. Based on annual reports from the Ministry of Health, such as the Indonesian Health Profile, the Performance Report of the Directorate General of Disease Prevention and Control, Financial Reports, and other Reports, researchers see that gender disaggregation output has been implemented.

As gender-responsive budgeting gains traction, it indirectly shapes health policy by embedding considerations for women's health in the broader health budget, leading to more consistent funding for women's health services over time. Additionally, increased women's representation can indirectly strengthen health policies by influencing national health indicators related to women's health. For instance, policies promoted by women legislators often emphasize data collection on gender-specific health issues, such as maternal mortality, gender-based violence, and child marriage.

The Effect to Women's Health

Health is a complex issue influenced by many determinants, such as physiological, biochemical, psychological, environmental, and social. Women are one of the groups vulnerable to health problems (Alexander et al., 2020). Generally, women's health includes studying the female body as a whole. Women's health examines the reproductive organs and differences in body structure, childhood development, hormones, genetics, and brain chemistry. Women's health also relates to factors that affect both sexes, including the common cold, heart disease, depression, and the benefits of regular physical exercise. Women's health is a complex and diverse field of study (Savedoff et al., 2012).

A comprehensive understanding of women's sexual and reproductive health requires biological, cultural, historical, psychological, and political perspectives (Maiese, 2002). Not only that, studying reproductive health, for example, requires an examination of the laws, practices, and cultural beliefs that influence when and where women learn about childbirth,

family planning, birth control, and their legal options for terminating a pregnancy. including policies on preventing child marriage which are also a concern in the field of women's sexual and reproductive health (Ihza, I. M., & Fadhilah, N., 2022). Women's position in society influences whether and how often rape, sexual harassment, and other forms of sexual violence occur (Alexander et al., 2020). Women's health also includes women's ability to obtain and benefit from health services. Access to health services includes whether women can physically visit a doctor or health care provider and make decisions about health services for themselves, their relatives, and their families (R. et al., 2011).

Due to its broad scope and limited studies, it is challenging to identify measurements of women's health globally. However, a study by (Garcia et al., 2010) is essential to identify progress in women's health and its indicators to measure progress in women's health. This research used the conventional Delphi method with three rounds of respondents from the Centers for Excellence in Women's Health (CoEs) by the Department of Health and Human Services (DHHS) on Women's Health from 1995-2007. The results showed that in the individual aspect, there were six leading indicators, namely (1) education/health promotion, (2) health access aspect, (3) mortality aspect, (4) poverty aspect, (5) preventive healthcare aspect. These six indicators will later be used to measure women's health in Indonesia every year from 2009-2023.

Aspects of Education and Health Promotion

Health promotion and education are crucial in women's health as a bridge to increase awareness, knowledge, and access to health services (Oktavia & Prayoga, 2023). Health education is part of health promotion. It aims to provide information about health rights, available medical services, and how to prevent disease so that women can make better decisions regarding their health.

Researchers evaluated indicators which used to determine the quality aspect of education and health promotion especially for women in Indonesia such as Clean and Healthy Living Behavior (PHBS), sanitation, contraceptive use, and illiteracy rates. The four indicators above are included in the environmental health and health promotion indicators, which are reported annually through the Ministry of Health's report in the Indonesian Health Profile, Performance Report, and PHBS Report every five years.

One of the key indicators, PHBS, is a series of actions aimed at improving individual and community health through healthier changes (Ministry of Health, 2023). The study hypothesizes that women's political representation, through its influence on health policies, has a positive and significant effect on PHBS as an indicator of women's health. This indicator is measured by the percentage of households that practice PHBS. Women politicians often prioritize community education and grassroots health campaign, including access to cleanliness to family planning services.

The second indicator is households that have proper sanitation. Sanitation is directly related to disease prevention and improving the quality of public health (Ministry of Health, 2023). Poor sanitation affects women's health. Therefore, the hypothesis is that women's political representation positively and significantly affects sanitation coverage as an indicator of women's health through women's health policies. The percentage of households with proper sanitation measures this indicator. Align with its focus, women's politicians may focus on ensuring their access and education to increase awareness of hygiene practices.

The third indicator is the use of contraception, a crucial aspect of women's health promotion. Contraception is directly related to reproductive health and empowers women by giving them control over their bodies and reproductive choices (Hidayati et al., 2022). Women in politics tend to support policies that expand access to family planning services and sexual health education, empowering women to make informed reproductive choices. The study hypothesizes that women's political representation has a positive and significant effect on the use of contraception as an indicator of women's health. This indicator is measured by the percentage of women` aged 15-49 years and married who are currently using birth control.

The fourth indicator is the female illiteracy rate. The illiteracy rate is directly related to an individual's ability to understand and access health information. The higher the female illiteracy rate, the more women do not understand and access health information (Ministry of Health, 2023). Therefore, the hypothesis is that women's political representation has a negative and significant effect on women's illiteracy as an indicator of women's health through women's health policies. This indicator is measured through women's illiteracy rates.

Table 4. Direct and indirect influence on aspects of women's health promotion/education

		Direct Coef	P>|z|	Indirect coef	P>|z|
PHBS	<-- Women Health Policy	0.47	0.317		
	<-- Women Pol. Representation	0.22	0.538	0.28	0.32
Sanitation	<-- Women Health Policy	1.9	0.464		
	<-- Women Pol. Representation	1.4	0.478	1.12	0.46
Contraception	<-- Women Health Policy	-3	0.148		
	<-- Women Pol. Representation	-0.22	0.888	-1.78	0.16
Illiteracy	<-- Women Health Policy	2	0.428		
	<-- Women Pol. Representation	0.98	0.613	1.21	0.43

(Source: Processed by Author from StataMP 17)

Political representation of women through women's health policies does not have a significant effect on PHBS, sanitation, and illiteracy. This can be seen from the positive and significant coefficient p-value greater than 0.05, which means there is no significant effect. Furthermore, the contraception indicator is actually negatively affected insignificantly. This means that women's representation through women's health policies reduces the use of contraception among women. The results of the path analysis test above show a striking rejection of the overall assumption, challenging our preconceived notions and sparking further interest in the research findings.

Although there is an affirmative policy on access to Health written in Law No. 17 of 2023 concerning Health (Ministry of Health, 2023), there are obstacles in practice. For example, there is an uneven distribution of medical personnel and socialization in rural areas.

According to Law No. 36 of 2009 concerning Health (Ministry of Health, 2009), Article 99 and the National Health Insurance Program (JKN) states that the government is responsible for providing access to reproductive health information and services, including contraception. Through the JKN program, registered participants are given free access to contraceptives for registered participants.

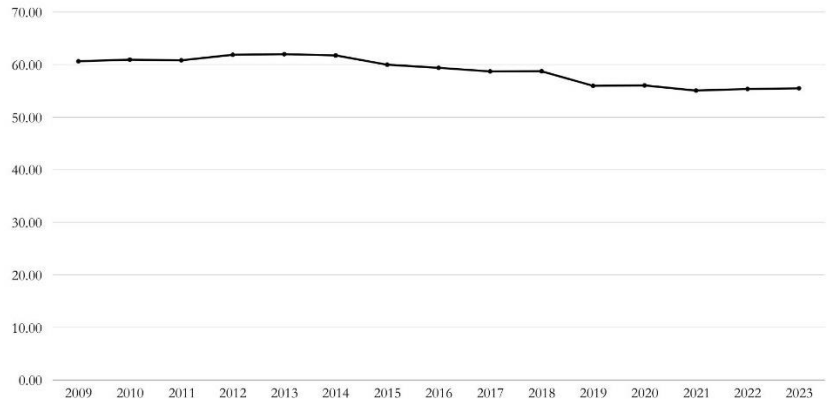

Figure 5. Graphic of Percentage of women aged 15-49 years and married who are currently using contraceptives 2009-2023

(Source: Processed by Author from Central Bureau of Statistics)

Despite the affirmation policy, the recorded rate of contraceptive use among married women was around 60.63% in the 2009 SDKI, which showed a decrease compared to the figure of 55.49% in the 2023 SDI. Kiswanto (2018) explained the discontinuation of contraceptives, where the most common reason was the desire to have many children. In addition, in many communities, the use of contraceptives is still considered taboo and contrary to religious and cultural norms. Another dominant reason is the limited stock and accessibility of services, so many women lack information, education, and willingness to use contraceptives (Hidayati et al., 2022; Fadhilah, N., 2022).

It can be concluded that factors such as social stigma, accessibility of health services, and reproductive health education have a more substantial influence on the use of contraceptives, sanitation, PHBS, and illiteracy. Although women's politicians may push for a more women-friendly health agenda, the reality is often more complex and involves various elements.

Health Access Aspect

The availability of health facilities is essential to ensure that women can access the health services they need. In many cases, access to health facilities is a problem, especially in rural or remote areas, where health facilities may not be available within a reasonable distance (Quick et al., 2014; Haryono et al., 2013). Women in these areas often face additional barriers, such as lack of transportation, which can hinder their ability to obtain medical care. The aspect of health access also includes financial factors. The cost of health care, including consultation fees, medicines, and medical procedures, can be a barrier for women to get the services they need (Haryono et al., 2013). Women politicians often champion universal health coverage, ensuring marginalized groups, including women and children, have access to affordable care. They may advocate for specific subsidies or plans catering to maternal and reproductive health.

To measure health access, researchers used two indicators: health insurance coverage and Indonesian health facilities. Health insurance coverage is the leading indicator of women's health because access to affordable and quality health services greatly determines their welfare (Ministry of Health, 2023). Indonesia itself has a public legal entity formed to organize a health insurance program as referred to in Law of Repubrlic of Indonesia No 24 2011 Concerning Social Insurance Administrator, 2011. BPJS officially started operating on January 1, 2014, as a transformation of PT Askes (Persero). The hypothesis formed in the form of women's political representation has a positive and significant effect on the number of health facilities as an indicator of women's health. Therefore, the indicator used to measure women's health insurance is the national health insurance coverage provided by the government since ASKES to BPJS.

The second indicator is Indonesian health facilities. Health facilities ensure access to various types of care, from reproductive health services to chronic disease management. The indicator used to measure women's health facilities is the number of women's health facilities in Indonesia, with the assumption that the more women's health facilities in Indonesia, the more women's access to health will be guaranteed.

Table 5. Direct and indirect influences on aspects of health access

		Direct Coef	P>|z|	Indirect coef	P>|z|
Health Insurance	<-- Women Health Policy	0.38	0.835		
	<-- Women Pol. Representation	4	0.003	0.22	0.835
Health Facility	<-- Women Health Policy	2403	0.572		
	<-- Women Pol. Representation	1423	0.44	144.519	0.575

(Source: Processed by Author from StataMP 17)

Based on the results of the path analysis test above, women's political representation does not have a significant effect on health facilities either through women's health policies or directly. On the contrary, a positive and significant effect has an impact on health insurance directly. This can be seen from the positive coefficient value of 4 and a significance value of 0.003 <0.005. Every 4% increase in women's political representation in the DPR-RI can increase the health coverage of the Indonesian people, including women, by 4%. Research by Yusiana et al. (2022) shows that the largest number of JKN users are women (65%) and are aged 41-20 years (47%), have graduated from college (30%), and work as farmers and students (25%).). Thus, the coverage of data from the Central Statistics Agency in Indonesia where JKN coverage is currently at 95.92% in 2023. This means that the majority of users are female participants.

A comparative study Maternal healthcare Service utilization using 2012 and 2017 data, before and after the implementation of JKN, was found in Rahmawati & Hsieh (2024) research. The result shows a significant increase in Indonesian women's likelihood to access all four MHS components: four visits of antenatal care, receive care from professional antenatal providers, gain skilled birth assistance, and accesses to facility-based delivery. This significant policy improving lead to increasing number of coverage portion of women in health insurance.

Despite of its wide coverage, the implementation of JKN still faces some challenges such as inadequate healthcare equipment and lack of control mechanism from BPJS towards few hospitals that still charges the maternal healthcare service (Noerdin et al., 2015). The absence of a control mechanism is a result of the unavailability of information regarding the specific fees not included in the healthcare services offered by BPJS Health. However, emergency care received outside of BPJS Health's network of partners would still be reimbursed by BPJS. As a result, numerous patients inadvertently burden the less fortunate with avoidable costs (Noerdin et al., 2015).

On the other hand, increasing the coverage of provision with increasing women's representation in national legislative seats. Sali Susiana, one of the researchers at the Research Center of the DPR RI Expertise Agency in her report stated that since 2021, the DPR through Commission IX has been trying to reduce MMR by approving the revision of the Health Law which was then successfully stated in Law Number 17 of 2023 concerning Health. However, from the data results, it can be seen that women's health policies do not have a significant effect on women's health. There are many other indicator variants that may be able to explain the relationship between women's representation and women's health.

Mortality Aspect

Maternal mortality rate is one of the leading indicators of women's health used globally. MMR measures the number of women who die due to complications of pregnancy, childbirth, or in the postpartum period per 100,000 live births (Ministry of Health, 2023). In developed countries, maternal mortality rates are relatively low because the majority of women have access to quality medical care during pregnancy and childbirth (Halimatusa'diyah & Arif, 2021). The mortality aspect is important to measure as an indicator of women's health because it describes the health system's quality, especially women's access to health services in the country. Therefore, the hypothesis that is built is that women's political representation has a negative and significant effect on the maternal mortality ratio as an indicator of women's health.

Table 6. Direct and indirect effects on mortality aspects

		Direct Coef	P>|z|	Indirect coef	P>|z|
Maternal Mortality Ratio	<-- Women Health Policy	2.4	0.146		
	<-- Women Pol. Representation	-1.1	0.403	1.46	0.163

(Source: Processed by Author from StataMP 17)

The path analysis test results show a direct negative influence between women's political representation and maternal mortality ratio, marked by a negative coefficient and significance of 0.403>0.005. This means that every 1.1 unit increase in women's political representation will reduce the female mortality ratio by 1.1 units. Although the hypothesis is accepted, it is not significant. This also applies to the relationship between women's health policies and MMR.

Poverty Aspects

According to Edström (1992), poverty has a subsequent impact on maternal health in several ways. Some of these include reducing access to obstetric maternal health services, education, and family health, plus the fact that most poor people tend to live in rural areas and have larger families. Women leaders often advocate for poverty reduction programs that include health as a central focus. Policies could address gender wage gaps, provide microloans to women, or prioritize income-generating activities that improve overall family income, indirectly improving health outcomes (Fadhilah, N., & Rohmaniyah, A., 2023). The level of poverty is also often associated with the level of welfare. To measure a country's economic welfare level, researchers use Gross National Income (GNI) per Capita to provide a picture of the average income per person as a direct representation of poverty (Edström, 1992). Therefore, the hypothesis is that women's political representation in the DPR-RI positively and significantly affects GNI per Capita through women's health policies.

Table 7. Direct and indirect effects on social aspects of women's health.

		Direct Coef	P>|z|	Indirect coef	P>|z|
GNI per Kapita	<-- Women Health Policy	-1.8	1		
	<-- Women Pol. Representation	2.3	0.084	-4.97	1

(Source: Processed by Author from StataMP 17)

The test results above show that women's political influence in the Indonesian House of Representatives does not significantly affect GNI per capita directly or through women's health policies. On the contrary, the indirect effect coefficient shows a value of -4.97, meaning that every 4.97 unit increase in women's political representation reduces GNI per capita insignificantly. Therefore, the test results refute the hypothesis.

Aspects of Prevention Healthcare

Preventive health services focus on disease prevention and health promotion rather than treating existing conditions. These services include various interventions to reduce disease risk, extend life expectancy, and improve women's quality of life. In the context of women's health, these services are crucial because women often face specific health risks related to reproduction, such as pregnancy and diseases related to reproductive health (Garcia et al., 2010; Maiese, 2002). Screening for women's health diseases and basic vaccination coverage are the primary forms to ensure every woman has access to health services. According to BPJS Kesehatan Regulation No. 2 of 2019 (BPJS, 2018), health insurance covers three primary screenings: cervical cancer screening, breast cancer, and anemia in adolescent girls. These three diseases have shown an increase in recent years.

To measure the coverage of cervical cancer and breast cancer screening, researcher used the Indonesian health profile report from the Ministry of Health regarding annual screening coverage. Meanwhile, to measure the coverage of anemia screening in adolescent girls, researchers used the proportion of adolescent girls aged 10-19 years who received/purchased iron tablets provided by the government. This proportion is a reliable indicator of the extent to which anemia screening is reaching the target population.

Table 8. Direct and indirect influence on prevention healthcare aspects

	Direct Coef		P>|z|	Indirect coef	P>|z|
Cancer Servix Screening	<-- Women Health Policy	-1.7	0.487		
	<-- Women Pol. Representation	1.91	0.302	-1.03	0.491
Cancer Breast Screening	<-- Women Health Policy	-2.2	388		
	<-- Women Pol. Representation	0.73	0.707	-1.33	0.395
Anemia Blood Suppement	<-- Women Health Policy	-0.47	0.317		
	<-- Women Pol. Representation	-0.22	0.538	-0.28	0.327
Basic Immunization	<-- Women Health Policy	-1.2	0.552		
	<-- Women Pol. Representation	-2.6	0.098	-0.73	0.555

(Source: Processed by Author from StataMP 17)

Based on the test results above, the indicators of cervical and breast cancer screening did not show any influence, either from a direct or indirect effect. This can be seen from the positive direct coefficient with P> |z| 0.302> 0.005, while the indirect effect relationship is negative and insignificant. Likewise, the women's health policy has a direct effect on cervical cancer screening. The test results above automatically reject the two researcher hypotheses.

The test results of the influence of women's political representation in the Indonesian House of Representatives on anemia blood supplement and primary immunization show a negative and insignificant relationship. This negative influence means that increasing women's representation units will decrease anemia blood pressure and basic immunization units directly and through women's health policies.

Of the four indicators above, a negative influence was found between women's representation in the Indonesian House of Representatives and prevention healthcare.

Research by Anwar et al. (2018) conducted a Family Life Survey on 5397 women who had had cancer. The results showed that only 5% knew about mammography; most were associated with higher education and household expenditure. In comparison, women who only graduated from high school and below do not know about PAP SMEARS and mammography. The findings can be input for priority targets to promote health education.

The Effect of Women's Representation, Women's Health Policy, and Women's Health

In this section, the researcher will use the mean of 13 women's health indicators to represent them. The purpose of this test is to see whether there is a significant influence of the mean of women's health on women's representation either through women's health policies or directly.

Table 9. Direct and indirect influences on prevention healthcare aspects of women's health

		Direct Coef	P>|z|	Indirect coef	P>|z|
Women's Health	<-- Women Health Policy	195.92	0.611		
	<-- Women Pol. Representation	152.19	0.602	117.22	0.613

Source: Processed by Author from StataMP 17

The test results above show no significant positive relationship between women's political representation and health, either through women's health policies or directly. Although both coefficients are positive, both P>|z|> 0.005 indicate an insignificant effect. This could be because the indicator does not represent women's health variables. A positive coefficient means a positive relationship between variables but is not a significant indicator that can represent each variable.

There are several assumptions to answer the rejection of this hypothesis. First, Indonesia's gender quota has not yet met the 30% gender quota. Dahlerup (1988), through research on the critical mass addressing of 30% as an ideal proportion, that minority groups tend to raise their concerns about their minority groups and are widely heard by other members. In this case, it could be that many insignificant or negative influences are due to

the gender quota not yet being achieved. A case study of women's representation in Rwanda positively influences affirmative action policies and critical action because their representation reached 63.8% (Abbott et al., 2017). They successfully reduced the Maternal Mortality Rate, which is still an obstacle in Indonesia. This assumption shows that to see the influence of women's roles significantly, it should be after the gender quota has been achieved..

The second assumption is based on the emphasis on "critical action" in the "critical mass" itself. Dahlerup (1988), in an article entitled "From a Small to a Large Minority: Women in Scandinavian Politics," shows a typology of group representation in organizational culture. The first is the skewed group, where the minority fills a maximum of 15% of people who act as "tokens." When a group is considered a token, they are less likely to recruit their peers (gender/race/sexuality/marginalized group), let alone raise issues. Simply because their actions are considered minor and unimportant and are seen as representing a minority. The second group, the tilted group, is filled by a minority of 15%-40% of people who are considered strong enough to begin to influence the organization's culture. There is little evidence that 30% is a significant quota to ensure substantive and descriptive representation by women. Kanter suggested that the most important thing related to substantive representation is "critical acts," not a single figure. This assumption tries to highlight that even 15% of seats in a political parliament can change the political agenda if they have high "critical acts," but it also requires 40% to make women-friendly policies (Grey, 2006).

CONCLUSION

The study's conclusion on the influence of women's representation in the Indonesian House of Representatives on women's health through women's health policies shows that of the 14 equations analyzed, only two were proven significant. First, there is a direct influence of women's political representation on women's health, indicating that when more women are in policy-making positions, there is a direct positive impact on improving aspects of women's health. Second, women's representation also significantly affects health insurance coverage in Indonesia, meaning that women in parliament tend to push for policies that expand access to health insurance. However, the low number of significant indicators can be explained by two main factors. The unfulfilled 30% gender quota in parliament hinders

women's maximum potential in influencing policy, including health policies. Many important aspects of women's health need to be adequately covered in the existing indicators, thus limiting the analysis results related to women's health policies. Therefore, increasing women's representation in parliament and using more comprehensive and representative indicators are needed to see a broader and more profound impact on women's health in Indonesia.

Although there is significant impact between women's representation on women's policy health, this research has still not proved how the policy mediate women's representation to women's health both directly and indirectly. Another limitation in this research may be found in the indicators of women's health itself which has multiple aspects. There might be other indicators which are relevant to represent each of the aspects that isn't included in this research. Therefore, recommendation that could be given to similar or relevant article is to find more suitable variable to measure women's health in Indonesia and how it is affected by women's representation descriptively and substantially.

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