Jurnal Keperawatan Global
Vol. 10, No. 2, December 2025
https://doi.org/10.37341/jkg.v9i2.1321

Original Research

Health Status and Quality of Life in Depok Slum Communities through Stunting Prevention

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ABSTRACT

Background: *There are 11 slum areas in Depok City. Slums are correlated with populations that are easily exposed to diseases and have limited economic capabilities, resulting in the lack of hygiene and healthy living behaviors (PHBS), including adequate nutritional needs. This living condition poses a risk of reducing the quality of life of the residents. This research aims to determine the correlation between health status and quality of life to prevent stunting among residents in slum areas of Depok City.*

Methods: *This study employed a quantitative cross-sectional research design. A total of 160 respondents were selected using a non-probability quota sampling technique from a population of 400 heads of households across four identified urban slum areas. Data were collected using the World Health Organization Quality of Life–BREF (WHOQOL-BREF) instrument and were analyzed using Chi-Square test.*

Results: *All dimensions of the health status variable namely physical environment, social conditions, economic conditions, mental health, healthcare support, and family support demonstrated a significant relationship with each dimension of quality of life, including physical health, psychological health, social relationships, and environmental well-being (all dimensions $p < 0.05$). All independent variables showed p-values < 0.05 based on Chi-Square analysis.*

Conclusion: *Given the proven significant influence of health status on the quality of life of residents in slum areas, it is hoped that the Depok City government will undertake development efforts to improve these slum areas so that the Human Development Index (HDI) of Depok City can be achieved, thereby fulfilling the Sustainable Development Goals (SDGs).*

ARTICLE HISTORY
Received: October 19th, 2025
Accepted: December 15th, 2025

KEYWORDS
health status, hygiene and healthy living behaviors, slum areas, stunting;

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Cite this as: Siregar, T., Ritanti, R., Permatasari, I., Utari, D. & Ratnawati, D. (2025). Health Status and Quality of Life in Depok Slum Communities through Stunting Prevention. *Jurnal Keperawatan Global*, 10(2), 147-161. https://doi.org/10.37341/jkg.v10i2.1321

INTRODUCTION

Depok City spans an area of approximately 200.9 km² and serves as a buffer zone for the Jakarta-Depok-Bogor-Tangerang-Bekasi transportation corridor (Badan Pusat Statistik Kota Depok, 2019). On one hand, this potential supports its development as a residential area, a business center, and a regional government center. Depok city covers an area of approximately 200.29 km² and is divided into 6 districts and 63 subdistricts/villages (Pemerintah Kota Depok, 2020). As a buffer city for the national capital, ideally there should be no slums as per Law No. 1 of 2011 on Housing and Settlement Areas, which mandates the central and regional governments to be responsible for providing decent settlements for their citizens (Pemerintah Republik Indonesia, 2011; Muhtar, 2020).

The persistence of poverty makes it difficult for people to have decent housing, which in turn affects environmental quality and health, like those living along riverbanks or near garbage dumps. Depok Mayor's Decree No. 591/250/Kpts/Bapp/Huk/2015 determined 132.72 hectares as slums, spread across 11 areas in 7 subdistricts. These 11 slum areas are: Sukmajaya, Pancoran Mas of Depok District, Pancoran Mas of Depok Jaya District, Beji of Kemiri Muka District, Beji of Pondok Cina District, Cinere of Gandul District, Cinere of Cinere District, Cipayung of Bojong Pondok Terang District, Cipayung of Cipayung Jaya District, Cimanggis of Cisalak district, and Tapos of Sukamaju Baru District.

Slum areas are strongly associated with the community's increased vulnerability to diseases (Siregar et al., 2023). This increased vulnerability is due to the lack of proper implementation of clean and healthy living behaviors (PHBS) among the community (Siregar & Febriani, 2020). These slums will impact on the performance of the Depok City Government, as it is related to the success of increasing the Human Development Index (HDI). It has been proven that there are 2.10 diseases per 100 people, and thus improving the quality of settlements can significantly reduce the risk of disease. Slums are at risk of infectious diseases, which also contribute to stunting (Megantari et al., 2020). The National Population and Family Planning Agency (BKKBN) has also released data showing that slums contribute to stunting by 75% (Pratiwi et al., 2024). If the residents' settlements are revitalized, it will significantly improve environmental health (Octalita & Situmorang, 2022).

For the Depok City Government, the condition of slums poses a risk of inadequate nutritional fulfillment and will consequently lower the HDI. According to the Medium-Term Development Plan of Depok City for 2021-2026, Depok is striving to improve the quality of human resources in terms of population control, strengthening population governance, and improving child quality, further providing access to decent housing and settlements as well as better environment. This is due to the high number of health problems in Depok. Many infectious diseases are caused by migrants, with high rates of infectious diseases such as tuberculosis, and even disabilities like leprosy. This is due to the poor implementation of Clean and Healthy Living Behaviors (PHBS) (Medium-Term Development Plan of Depok City for 2021-2026, 2021).

The problem-solving plan outlined in Depok City's Medium-Term Development Plan also supports the government's program in achieving the SDGs 2030, specifically addressing health issues at points 1: No Poverty as well as 3: Good Health and Well-being by 2030. The indicators for No Poverty are 1.3: reduce poverty by 50% and 1.4: equal rights to ownership of technology, basic services, and economic resources. Meanwhile, the indicators for Good Health and Well-being at point 3.2.1 are (a) Under-

five mortality rate (U5MR); (b) Infant mortality rate (IMR) per 1000.0 live births. Additionally, point 3.3.2 is the incidence of tuberculosis (TB) per 100000.0 population; point 3c involves implementing policies to promote physical activity and healthy diets as well as reduce unhealthy behaviors (Ministry of National Development Planning/Bappenas, 2017).

There is a lack of empirical studies that specifically examine quality of life within urban slum environments or implement community-based interventions targeting stunting in these settings. The only relevant work identified is by Megantari et al. (2020), who analyzed factors contributing to stunting in slum areas and reported significant associations with weaning age, infectious diseases, immunization history, emotional bonding, and maternal knowledge.

Existing research on stunting in the slum areas of Depok City largely centers on identifying individual level risk factors, such as low socioeconomic status, inadequate environmental sanitation, and suboptimal parenting practices. However, comprehensive analyses that explore the relationship between health status and quality of life particularly within the framework of sustainable stunting prevention remain limited.

This paucity of research contributes to the absence of robust empirical evidence needed to inform the development of integrated, quality of life-oriented interventions for stunting prevention in Depok's slum communities. Consequently, current interventions tend to be curative and fragmented, without addressing the multidimensional aspects of quality of life that are intrinsically linked to child growth and development in slum environments. Based on the aforementioned background, the researchers are interested in conducting research on the health status of residents in slum areas of Depok City in relation to the quality of life and its impact on preventing stunting, with the aim of achieving an optimal HDI for Depok City.

MATERIALS AND METHOD

Research Design

This research employed a quantitative research method with descriptive-analytic design using a cross-sectional approach. The selection of this research design is grounded in its methodological suitability for examining the association between diverse health status variables and the overall quality of life of residents living in slum communities. Given the complex and multidimensional health challenges faced by populations in informal settlements ranging from limited access to healthcare services, high exposure to environmental hazards, to psychosocial stressors, a cross-sectional design provides an efficient framework to capture variations in health conditions and their direct correlations with quality-of-life outcomes.

Moreover, this design enables researchers to identify key determinants of well-being within a specific timeframe, allowing for the systematic assessment of how physical, psychological, social, and environmental health factors interact to influence perceived quality of life in vulnerable groups. The insights obtained from this approach are critical for generating evidence-based recommendations that can inform targeted and context specific public health interventions.

By elucidating these relationships, the study contributes to a deeper understanding of the structural and individual-level factors that shape quality of life in slum environments. Thereby supporting the development of more holistic, preventive, and sustainable strategies to address stunting and broader health inequities. The primary

objective is to determine the correlation between health status and quality of life among the residents in Depok City's slum areas.

Population and Sample Research

This research was conducted in four different subdistricts within the slum areas of Depok City. Data collection took place from July 29th to September 30th, 2024. The sampling technique employed in this study was nonprobability sampling, specifically quota sampling, with a total of 160 participants selected according to predetermined quotas.

A random sampling method with a quota was used, and each subdistrict had a predetermined quota. The total sample size is set at 160, with an estimated 40 respondents from each subdistrict. The study employed a nonprobability sampling strategy, specifically quota sampling, to obtain an adequate and contextually representative sample of households residing in slum areas. A total of 160 respondents were selected from a defined population of 400 heads of households distributed across four predetermined slum locations. This approach was chosen to ensure that each site contributed proportionally to the overall sample, thereby capturing the heterogeneity of living conditions, health status, and socio-environmental characteristics within these communities.

The use of quota sampling was deemed appropriate given the dynamic and often unregistered population structures commonly found in informal settlements, where probabilistic sampling frames are difficult to establish. By systematically allocating quotas for each study area, the sampling procedure ensured balanced inclusion across sites and enhanced the study’s capacity to generate reliable empirical insights regarding the relationship between health status and quality of life among slum dwelling populations.

The inclusion criteria for the respondents are as follows: (1) residing in a slum area; (2) being literate; (3) being physically and mentally healthy; (3) having a family; and (4) having at least one child between having at least one child with the age below or equivalent of a first-grade elementary school student. Exclusion criteria include: (1) families with disabled children; (2) families with members suffering from non-communicable diseases or stroke; (3) and families with an income equivalent to the regional minimum wage (UMR) of Depok City.

Data Collection

The research was conducted in four sub-districts, namely Cinere Limo, Gandul, Pondok Cina, and Kemiri Muka. These four sub-districts have slum areas. Previous research conducted a field survey in April 2024 and submitted permit letters to each sub-district. Then, all responses in the period from May 24 came from the four sub-districts for data collection permits during the period of July to September 2024. After that, the research team conducted data collection at each house, conveyed the research objectives to residents, and asked them to sign a letter of consent to be involved in this research. Residents then filled out a questionnaire containing statements from each variable.

Instruments

The instrument used in this research to measure health status is a modified version of the tools developed by Fortunka (2020) dan WHO (2020). This instrument includes

dimensions such as physical environment, social conditions, economic conditions, mental health, healthcare support, and family support. Its validity and reliability have been tested in the slum areas of Tangerang Regency and yielded the following results: physical environment 0,443 – 0,817 (r=0.918); mental health 0.494 – 0.707 (r=0.891); social conditions 0,388 – 0,801 (r=0,888); economic conditions 0,381 -0,863 (r=0,866); family support 0.365 – 0.763 (r=0,807); healthcare support 0.404 – 0.685 (r=0,841).

Meanwhile, for the quality of life variable, the WHOQOL-Bref questionnaire was used (Ruževičius, 2014; Albouy et al., 2008). The validity of the WHOQOL-Bref has been tested for its four dimensions: physical health 0.384 (r=0.83); psychological health 0.464 (r=0.72); social relationships 0.346 (r=0,.7); environment 0.424 (r=0.76). The overall reliability amounted to 0.91 (Almarabheh et al., 2023).

Data Analysis

The researcher assigned codes to the responses of the questionnaire items. The health status questionnaire used a Likert scale with the following codes: 1 = Very rarely; 2 = Never; 3 = Sometimes; 4 = Often; and 5 = Very often. The social status questionnaire was coded as follows: 1 = Very rarely; 2 = Never; 3 = Sometimes; 4 = Often; and 5 = Very often. For the economic condition questionnaire, the Likert scale codes were: 1 = Strongly disagree; 2 = Disagree; 3 = Sometimes; 4 = Agree; and 5 = Strongly agree.

The mental health questionnaire used the following response codes: 1 = Strongly disagree; 2 = Disagree; 3 = Sometimes; 4 = Agree; and 5 = Strongly agree. The health service support questionnaire responses were coded as: 1 = Strongly disagree; 2 = Disagree; 3 = Sometimes; 4 = Agree; and 5 = Strongly agree. The family support questionnaire used a Likert scale with the following codes: 1 = Very rarely; 2 = Never; 3 = Sometimes; 4 = Often; and 5 = Very often. During data entry, no missing data was found, and no variables were changed.

For the WHOQOL-Bref quality of life questionnaire, the coding followed the standard procedure as outlined in the existing questionnaire guidelines. Univariate analysis was conducted using mean, median, and frequency. For bivariate analysis, the Chi-Square test was used as the data was categorical.

The independent variables representing health status were categorized into two levels for each construct, including physical environment (good vs. poor), social support (good vs. poor), economic conditions (good vs. poor), mental health (good vs. poor), healthcare service support (good vs. poor), and family support (good vs. poor). The dependent variables, which reflect the dimensions of quality of life, were likewise classified into two categories for each domain, comprising physical health (good vs. fair), psychological health (good vs. fair), social relationships (good vs. fair), and environmental quality (good vs. fair). 4). The data was processed and analyzed using SPSS IBM v22 software.

Ethical Clearance

The researchers applied research ethics towards the respondents by adhering to the principles of health research ethics, namely: respecting dignity and worth; maintaining confidentiality of respondent names; doing good and avoiding harm; and ensuring fairness by explaining the benefits and risks to the respondents (Kemenkes RI, 2021).

Before collecting data, respondents were asked to sign a consent or refusal form to participate in the study. This research has obtained ethical approval from the Health

Research Ethics Committee of Universitas Fort de Kock Bukit Tinggi, with approval number 372/UFDK.KEPK/VII/2024, dated July 25, 2024.

RESULTS

The researchers have collected data from respondents in four slum areas of Depok City, which were randomly selected with a target of 160 respondents. The characteristics of the respondents are presented in Table 1.

Table 1. Characteristics Of Respondents in The Slum Areas of Depok City, 2024 (n =160)

Variable	Frequency (n)	Percentage (%)
Age (years)		
Early Adulthood (18 – 40)	133	83.1
Middle Adulthood (40 – 60)	27	16.9
Total	**160**	**100**
Gender		
Female	152	95.0
Male	8	5.0
Total	**160**	**100**
Religion		
Islam	156	97.5
Christian	1	0.6
Catholic	2	1.2
Buddhist	1	0.6
Total	**160**	**100**
Education		
Elementary School	14	8.8
Middle School	16	10.0
High School or Equivalent	101	63.7
Diploma	21	13.1
Bachelor's Degree	7	4.4
Total	**160**	**100**
Marital Status		
Married	158	98.7
Widowed	2	1.2
Total	**160**	**100**
Family Category		
Nuclear Family (2-6 people)	152	95.0
Extended Family (>6 people)	8	5.0
Total	**160**	**100**
Occupation		
Housewife	132	82.5
Unemployed	2	1.2
Private Sector Employee	13	8.1
Self-employed	8	5.0
Total	**160**	**100**
Household Income		
No Fixed Income	90	56.3

Variable	Frequency (n)	Percentage (%)
< Rp 50.000/day	52	32.5
< Regional Minimum Wage of Depok City	8	5.0
>= Regional Minimum Wage of Depok City	10	6.3
Total	**160**	**100**

Table 1 presents the characteristics of 160 respondents: 88.31% were in the early adulthood age group; 95% were female; 97.5% were Muslim; 63.75% had a high school education or equivalent; 98.75% were married; 82.5% were housewives; 95% lived in nuclear families; and 56.3% had no fixed income. Data on the respondents' children and their anthropometric measurements are presented in Table 2.

Table 2. Data of the Respondents' Children and Their Anthropometric Measurements in the Slum Areas of Depok City (n=160)

Variable	Frequency (n)	Percentage (%)
Child's Age (months)		
0 – 24	70	43.8
25 - 48	65	40.6
49 – 60	25	15.6
Total	**160**	**100**
Immunization Records		
Complete	115	71.80
Incomplete	42	26.25
Unvaccinated	3	1.87
Total	**160**	**100**
Weight		
Severely Underweight (<-3 SD)	1	0.6
Underweight (- 3 SD – +2 SD)	9	5.6
Normal Weight (- 2 SD – +1 SD)	127	79.4
Overweight (> +1 SD)	23	14.4
Total	**160**	**100**
Height		
Very Short (< -3 SD)	15	9.4
Short (-3 SD - -2 SD)	17	10.6
Normal (-2 SD – +3 SD)	126	78.8
Tall (>+3 SD)	2	1.3
Total	**160**	**100**
Upper Arm Circumference		
Obese (> 120%)	2	1.3
Overweight (110 – 120%)	4	2.5
Well-nourished (85 – 110%)	111	69.4
Malnourished (70,1 – 84,9%)	38	23.8
Severely Malnourished (<70%)	5	3.1
Total	**160**	**100**

Table 2 presents the results of anthropometric measurements of children, including weight, height, and upper arm circumference. The measurement data has been processed to obtain categorical anthropometric data according to the indicators (Al-Rahmad & Fadillah, 2023) (; Ministry of Health Regulation of the Republic of Indonesia Number 2 of 2020 Concerning Child Anthropometric Standards, 2020). 43.8% of the respondent families have children aged 0-24 months, amounting to 70 children (43.8%); 115 children (71.8%) have complete immunizations; 1 child (0.6%) was found to be severely underweight; 15 children (9.4%) were found to be very short in height; based on upper arm circumference, 5 children (3.1%) were categorized as severely malnourished.

Table 3. Frequency Distribution of Health Status and Quality of Life Among Respondents in The Slum Areas of Depok City (n=160)

Variable	Frequency (n)	Percentage (%)
Health Status Variables		
Physical Environment		
Poor Physical Environment < 27.01	149	93.1
Good Physical Environment ≥ 29.39	11	6.9
Total	**160**	**100**
Mental Health		
Poor Mental Health < 27.05	106	66.3
Good Mental Health ≥ 27.05	54	33.7
Total	**160**	**100**
Social Conditions		
Poor Social Condition < 28.72	148	92.5
Good Social Condition ≥ 28.72	12	7.5
Total	**160**	**100**
Economic Conditions		
Poor Economic Condition < 28.61	101	63.1
Good Economic Condition ≥ 28.61	59	36.9
Total	**160**	**100**
Family Support		
Poor Family Support < 23.3	108	67.5
Good Family Support ≥ 23.3	52	32.5
Total	**160**	**100**
Healthcare Support		
Poor Healthcare Support < 24.9	112	70
Good Healthcare Support ≥ 24.9	48	30
Total	**160**	**100**
Quality of Life Variables*		
Physical Health Domain		
Fair Physical Health (26–50)	127	79.4
Good Physical Health (51–75)	33	20.6
Total	**160**	**100**
Psychological Domain		
Fair Psychological Health (26–50)	96	60

Variable	Frequency (n)	Percentage (%)
Good Psychological Health (51–75)	64	40
Total	**160**	**100**
Social Relationship Domain		
Fair Social Relationships (26–50)	83	51.9
Good Social Relationships (51–75)	77	48.1
Total	**160**	**100**
Environmental Domain		
Fair Environment (26 – 50)	97	60.6
Good Environment (51 – 75)	63	39.4
Total	**160**	**100**

Table 3 describes the distribution of respondents' health status, which includes: 93.1% with poor physical environment; 63.1% with poor mental health; 63.1% with poor social condition; 63.1% with poor economic condition; 67.1% with poor family support; and 70% with poor healthcare support. The quality of life (*) data was processed according to the WHOQOL-Bref guidelines, categorized into four domains and transformed into four categories: Very Good, Good, Fair, and Poor. However, the data analysis of the respondents only revealed two categories: Fair and Good.

Tabel 4. Correlation Between Health Status and Quality of Life Among Residents in The Slum Areas of Depok City (n = 160)

Health Status Variables	Quality of Life Variables	OR CI 95%	*p*
Physical Environment	Physical Health	54.7 (6.6– 448.7)	0.001
	Psychological Health	4.4 (1.1– 17.3)	0.028
	Social Relationships	5.3 (1.1– 25.6)	0.045
	Environment	4.5 (1.1 – 17.9)	0.026
Mental Health	Physical Health	3.0 (1.3 – 6.6)	0.009
	Psychological Health	2.3 (1.2 – 4.6)	0.019
	Social Relationships	2.8 (1.4 – 5.5)	0.004
	Environment	3.9 (1.9 – 7.9)	0.001
Social Conditions	Physical Health	15.5 (3.9 – 61.4)	0.001
	Psychological Health	5.1 (1.3 – 19.5)	0.014
	Social Relationships	6.0 (1.2 – 28.5)	0.025
	Environment	8.9 (1.8 – 42.4)	0.002
Economic Conditions	Physical Health	2.5 (1.5 – 5.4)	0.031
	Psychological Health	2.0(1.0 – 3.9)	0.048
	Social Relationships	3.2 (1.6 – 6.3)	0.001
	Environment	3.0 (1.5– 5.4)	0.002
Family Support	Physical Health	2.3 (1.0 – 5.2)	0.046
	Psychological Health	2.3 (1.2 – 4.5)	0.012
	Social Relationships	2.5 (1.3 – 5.0)	0.012
	Environment	2.1 (1.1 – 4.2)	0.037
Healthcare Support	Physical Health	2.3 (1.1 – 5.2)	0.050
	Psychological Health	2.956 (1.471 – 5.937)	0.003
	Social Relationships	2.978 (1.465 – 6.065)	0.004

Environment	5.226 (2.521 – 10.833)	0.001

As shown in Table 4, all domains of health status are significantly related to each domain of QoL among slum residents. Of these factors, physical environment emerges as the strongest attributable risk factor such that people living with poor physical health are considerably worse off than their peers, and poor housing and exposure to environmental toxins contribute significantly to overall functioning. Mental well-being also shows relatively strong and consistent relationships with all aspects of QOL, reflecting that poor mental health is associated not only with feelings of psychological distress, but also with the restriction in various activities, social participation, and sense of living environment.

In addition, social factors and income status are highly related to quality of life, thus inadequate support networks and financial difficulty handicap individuals as far as their ability to keep both good physical and mental health is concerned. Family support and healthcare access are also important, given that inadequate family support and unavailability of health care resources were associated with lowered quality of life. The results in Table 4 suggest that environmental, psychosocial, economic and service elements interact to influence quality of life in slum neighborhoods. The direction and significance of the relationships were consistently in the same direction, which points to a need for integrated, community-based approaches that concurrently tackle multiple determinants rather than exclusively dealing with clinical or behavioral aspects of well-being better to improve well-being among socially marginalized urban population.

DISCUSSION

The development of slum areas in a region is influenced by various factors, including economic factors, socio-cultural factors, population density, building quality, population factors, land availability, infrastructure, accessibility, and government policies (Sari & Ridlo, 2022). The Depok City slums are located between Depok City and the capital. It has become an attractive destination for urban migration, but limited access to basic services such as housing, clean water, and waste disposal systems has led to various problems for residents in slum areas (Sukmaniar et al., 2023; Araujo et al., 2023). As a result, slums are often characterized by overcrowding, inadequate housing, and poor sanitation, significantly impacting the health status and quality of life of residents, as they are unable to fully practice healthy lifestyle behaviors due to limited access to clean water and proper waste disposal, leading to increased risk of disease (Hermawan et al., 2020).

Based on Table 3, it is evident that the residents' health status falls into the poor category across all dimensions. For instance, 93.1% of residents experience a poor physical environment, 63.1% face poor economic conditions, and 70% have inadequate healthcare support. This situation is alarming. Poor physical environments contribute to various health and well-being problems (Leuwol et al., 2023). Poor physical environments create breeding grounds for mosquitoes, increasing the risk of diseases like dengue fever. This is due to inadequate lighting and high humidity that increases the risk of mosquito larva accumulation (Setyaningsih et al., 2021). Limited access to clean water due to poor physical environments can also lead to skin diseases and diarrhea (Sugiester et al., 2021; Santika et al., 2022).

The poor economic conditions of the respondents limit their access to resources needed for formal employment, leading to a higher prevalence of informal work

(Sibagariang et al., 2023). Moreover, poor economic conditions restrict access to healthcare services (Putri et al., 2023), and poverty hinders individuals from accessing healthcare services (Haemmerli et al., 2021). Consequently, inadequate healthcare support results in a poor quality of life, as adequate healthcare contributes to better health and well-being (Weraman, 2024). Poverty also affects the Human Development Index (HDI) of a region (Novitasari et al., 2021).

Table 2 reveals that children in slum areas still exhibit poor nutritional status, as evidenced by low weight, height, and upper arm circumference. This condition is attributed to weak economic conditions, which significantly impact children's nutritional status (Annisa Nuradhiani, 2023). Another research has also found a correlation between socioeconomic status and stunting in children (p=0.008), and parental education has been identified as another influencing factor (Mustajab & Aristiyani, 2023). Poor nutritional status contributes to a lower HDI (Erdi Fadhilah et al., 2022). Overall, research indicates that poor economic conditions are a significant factor contributing to stunting in Indonesia (Ramdhah et al., 2023).

Slums can contribute to a low HDI. As explained by Dewi (2022) the level of slum conditions in a settlement can reduce the quality of life of its residents, particularly in terms of health. Residents perceive that life can continue as long as basic needs are met, even with minimal infrastructure. HDI measures health, education, and living standard, and slum areas often fall below the average. This becomes an indicator of the success of local government development and the achievement of the Sustainable Development Goals (SDGs) (Sasmita et al., 2021).

The findings of this study carry important implications for community nursing practice, particularly in strengthening the role of nurses as health promoters and preventive practitioners in slum settings. The demonstrated relationship between health status and quality of life provides a critical foundation for nurses to develop more holistic family and community centered nursing care plans that extend beyond clinical concerns to include environmental, psychosocial, and health behavior dimensions. These results also reinforce the need for nurses to advance health education initiatives, enhance family empowerment, and advocate for environmental improvements as integral components of stunting prevention efforts and quality-of-life enhancement among populations living in slum areas.

This study has several methodological limitations, particularly the relatively small sample size, which restricts the ability to conduct subgroup analyses across the four distinct urban subdistricts. The limited sample also reduces the sensitivity to detect small inter-area differences, introduces potential selection bias in sample determination, and prevents calculation of the margin of error or the probability of obtaining a representative sample. Future research is therefore recommended to adopt a case control design which is more efficient for studying rare or moderately common outcomes, such as stunting while also accommodating constraints related to researcher capacity and financial resources. Such a design would allow for more rapid identification of risk factors associated with stunting, and subsequent data analysis could employ multivariable logistic regression to adjust for potential confounders and better elucidate the independent predictors of stunting.

CONCLUSION

Findings indicate a significant correlation between the health status of residents in slum areas and their quality of life. All dimensions of health status, including

physical environment, mental health, family support, and healthcare support, are significantly correlated with all dimensions of quality of life: physical health, psychological health, social relationships, and environment. The significance of slum mitigation initiatives undertaken by the Depok City government in improving residents' health status is crucial. This will enhance the quality of life and well-being of the residents, thereby contributing to a higher HDI and the achievement of SDGs.

ACKNOWLEDGEMENT

This research is funded by the Research and Community Service Institute of Universitas Pembangunan Nasional Veteran Jakarta.

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