International Journal of Advanced Community Medicine

E-ISSN: 2616-3594
P-ISSN: 2616-3586
Impact Factor (RJIF): 5.89
www.comedjournal.com
IJACM 2025; 8(3): 171-176
Received: 06-08-2025
Accepted: 05-09-2025

Subhra Srimani
Ph.D. Scholar, Department of Nursing, Manipur International University, Manipur and Faculty Department of Rehabilitation Nursing, NILD, Kolkata, West Bengal, India

Dr. Irom Shirly
Professor, Department of Nursing Studies, MIU, Manipur, India

Dr. Ameed Equebal
(MD, PMR), Assistant Professor cum Assistant Director (Training), National Institute for Locomotor Disabilities (Divyangjan), Kolkata, West Bengal, India

Dr. Lata Mandal
Guest Faculty, NILD, Kolkata and Research Consultant, Indigen Institute of Neuropsychology council, Kolkata, West Bengal, India

Riyanka Manna
M.Sc (N), Department of Rehabilitation Nursing, NILD, Kolkata, West Bengal, India

Corresponding Author:
Subhra Srimani
Ph.D. Scholar, Department of Nursing, Manipur International University, Manipur and Faculty Department of Rehabilitation Nursing, NILD, Kolkata, West Bengal, India

Disability index and lifestyle practices among persons with locomotor disabilities: An assessment across rural and urban communities

Subhra Srimani, Irom Shirly, Ameed Equebal, Lata Mandal and Riyanka Manna

DOI: https://www.doi.org/10.33545/comed.2025.v8.i3.C.412

Abstract
Health is a resource for daily life rather than the ultimate goal of living. In recent decades, lifestyle has increasingly been recognized as a critical determinant of health. With this perspective, a study was conducted to assess the Disability Index and Lifestyle Practices among persons with locomotor disabilities in selected rural and urban communities. A descriptive survey design was employed, involving 45 participants each from rural and urban units, recruited through non-probability consecutive sampling based on predefined inclusion criteria. Data were collected on a pilot basis and analyzed. The findings revealed that most respondents in both settings had a lower disability index. While the majority demonstrated better control in avoiding substance abuse, unhealthy practices were common in physical activity, sleep quality, and life skill management. These results underscore the need for tailored, holistic interventions in nursing practice, administration, and education to promote healthier lifestyles and reduce disparities among persons with locomotor disabilities.

Keywords: Disability index, lifestyle practices, persons with locomotor disability

Introduction
A person with disability can be both healthy and well. Good health opens the door to employment and education for the disabled people, just as it does for persons who do not have disabilities. Surveys showed that a substantially lower percentage of disabled people than those people without disabilities reported as their health to be excellent or very good (28.4% versus 61.4%), (Rimmer, 1999) [17]. In the first decade of the 21st century, the conceptualization of health as an ability opened the door for self-assessments to become the main indicators to judge the performance of efforts aimed at improving human health (Bassuk & Manson, 2005) [3]. Disability can have negative impacts on the individual as it can stop them from engaging in activities that they otherwise would like to become involved with. This can be demoralizing and have detrimental effects on an individual's mental health, self-esteem and confidence. With good health and lifestyle practices persons with disabilities have the freedom to work, learn and engage actively in their families and their communities (Lee & Wang, 2005) [11]. Unhealthy lifestyle behaviors contribute to a wide range of adverse health outcomes, including metabolic disorders, cardiovascular diseases, hypertension, obesity, and musculoskeletal problems. Some modifiable health risk factors and behaviours are higher in disabled people than people without disability (Zeki *et al*., 2018) [22]. Health promotion strategies, including regular physical activity and adequate sleep (Brunner *et al*., 2007) [5], play a pivotal role in preventing disease and enhancing wellbeing. In recent decades, lifestyle has been increasingly recognized as a critical determinant of health, with WHO estimating that 60% of factors influencing health and quality of life are associated with lifestyle practices (Zeki *et al*., 2018) [22].

Objectives
The objectives of the study were to assess disability status in terms of Disability index, to assess lifestyle practices of persons with locomotor disabilities, to find out correlation between disability index and lifestyle practices and to compare lifestyle practices of persons with disability in rural and urban community.

Methodology

- **Research design:** A quantitative research approach and a descriptive survey design were adopted to assess the study variables.
- **Study variables:** i) Disability Index is the rating score of individual's self-reported functional difficulty level which is measured by Health Assessment Questionnaire Disability Index (HAQ-DI) indicating higher the difficulty index, lowers the functional health. **ii)** Lifestyle Practices refer to individual self-reported practices regarding habits of diet, physical activities, sleep, life skill and substance abuse. It would be measured by four-point Likert scale.
- **Study location:** According to the Census of India, 2011 North 24 Paragana is one of the district with higher PWD population among West Bengal. Study was conducted in rural and urban organizations of North 24 Parganas district of West Bengal. Study was conducted from June, 2024 to August, 2024 in OPD of selected institutes.
- **Sample and Sample Size:** Study sample was adult person aged above 18 years, meeting or exceeding the benchmark criteria (40% disability), the same was checked by the investigator through medical record analysis during the period of data collection. Person with locomotor disabilities with other disabilities (intellectual, cognitive, speech and hearing), pregnant women with locomotor disabilities and severely ill (acute condition which needs immediate hospitalization, person with disability having high support needs) were excluded from the study. As study was done on pilot basis, so 30% sample was considered from the calculated sample size of the main study i.e. total sample was 45 from each rural and urban unit.

Sampling technique

The Non-Probability Consecutive Sampling method was applied based on predefined inclusion criteria, as the researcher considered these samples to be representative of the target population. The patient attending OPD was recruited until the desired sample size was achieved. Informed consent from each respondent was obtained after explaining the purpose and method of study. Study tools and technique: Baseline data were obtained by using a translated & predesigned, pretested standardized schedule in the local language. i) Disability Index was measured by Health Assessment Questionnaire (HAQ-DI) consists of eight sub-groups of activities of daily living. For each of these groups, patients inform the depth of difficulty they have in executing two or three particulars' activities. Scoring is done 4-point Likert scale, which ranged from 0 to 3. A global score is calculated for disability index. Lower the disability score indicative of poorer status of ability in daily living activities.

ii) Lifestyle practices were assessed in regards to diet, physical activity, substance abuse, and sleep and life skill. This tool has five domain and each domain has three questions. The questions was evaluated by four-point Likert scale. This tool consists unstructured questionnaire developed with help of various similar tool through literature search. All of this tools is not from India so, for cultural adaptation modification done. The scoring system are done as per Simple Lifestyle Indicator Questionnaire. The developed tool has five categories and each categories has three questions. The categories are Diet, Physical Activity, Substance Abuse, Sleep and Life Skill. The questions are evaluated in four-point Likert scale. Total lifestyle practice questionnaire score=(diet category score + physical activity category score + substance abuse category score + sleep category score + life skill category score). The higher the score means the healthier the lifestyle practices. Validity and reliability was established prior to the data collection of pilot study. Reliability of structured lifestyle practice questionnaire is 0.92.

Ethical aspects

Ethics committee clearance was taken from the ethical committee of NILD, Kolkata and Faculty Research Committee of Manipur International Institute, Manipur before the study. Interview of the study subjects was done after taking informed consent.

Results

After collecting data a master datasheet was prepared with the obtaining data through interview schedule. The data was planned to analyze by using both descriptive and inferential statistics based on objective of the study.

Table 1: Distribution of respondents across socio-demographic characteristics in rural and urban area, N=90, (n_1=45, n_2=45)

Risk Factors		Total		Rural		Urban	
		F	%	F	%	F	%
Age (years)	<30	27	30	11	24	16	36
	30-49	41	45.56	22	49	19	42
	50-60	22	24.44	12	27	10	22
Gender	Male	49	54.44	20	44.4	29	64.4
	Female	41	45.56	25	55.6	16	35.6
Education	Illiterate	26	28.89	17	37.78	9	20
	Up to secondary	53	58.89	26	57.78	27	60
	Up to Graduation	11	12.22	2	4.44	9	20
Occupation	Unemployed	74	82.22	45	100	29	53.3
	Employed	13	14.45	0	0	13	28.9
	Students	3	3.33	0	0	3	6.7
Marital status	Married	58	64.44	31	68.89	27	60
	Unmarried	32	35.56	14	31.11	18	40
Type of family	Joint	27	30	16	35.56	11	24.44
	Nuclear	63	70	29	64.44	34	75.56
Monthly income	BPL	46	51.11	25	55.6	21	46.7
	> BPL	44	48.89	20	44.4	24	53.3

Socio-demographic Characteristics of Respondents

The sociodemographic profile of respondents indicated that a slight majority were male (49, 54.44%); however, in rural communities, females (55%) outnumbered males (44.4%). With respect to educational attainment, more than half of the respondents had studied up to the secondary level (53, 58.89%). Employment status showed a high level of unemployment overall (74, 82.22%), encompassing all respondents from rural areas (100%) and more than half of those from urban areas (53.3%). In terms of marital status, the majority were married (58, 64.44%). Family structure analysis revealed that most participants belonged to nuclear families (63, 70%), with comparable proportions in rural (64.44%) and urban (75.56%) settings. Economic status data demonstrated that nearly half of the respondents were living below the poverty line (46, 51.11%); however, a larger share of urban respondents (53.3%) were above the poverty line compared to their rural counterparts.

Table 2: Frequency and percentage distribution of respondents according to Disability Index, N=90(n_1=45,n_2=45)

Disability index	Total		Rural		Urban	
	f	%	f	%	F	%
0-1	60	67	33	73.33	27	60
1-2	23	25	10	22.22	13	28.89
2-3	7	8	2	4.45	5	11.11

Minimum score-0, Maximum score-3

Disability Index of Respondents

As shown in Figure 3, the majority of respondents demonstrated better activity status, with 33 (73.33%) in rural and 27 (60%) in urban areas reporting a lower Disability Index (0-1). Moderate Disability Index scores were observed in 10 (22.22%) rural and 13 (28.89%) urban respondents, while only 2 (4.45%) rural and 5 (11.11%) urban respondents reported a higher Disability Index (2-3), indicating least activity level.

Table 3: Distribution of respondents according to category score in each category of life style practices in rural and urban area, N=90(n_1=45, n_2=4)

Domain	More healthy practice (0)	Moderate healthy practice (1)	Less healthy practice (2)
Control in dietary practice	6(6.6)	**51(56.7)**	33(36.7)
Habits of doing physical activity	0(0)	15(16.7)	75(83.3)
Control in substance abuse	**56(62.2)**	31(34.4)	3(3.4)
Control in sleep quality	4(4.4)	19(21.1)	67(74.5)
Control in life skill practice	0(0)	32(35.6)	58(64.4)

Table 3 depicts that majority of respondents that is 56 (62.2%) having more control in substance abuse whereas 75 (83.3%) respondents having the less healthy practice in habits of doing physical activity followed by 67 (74.5%) having less control in sleep quality and 58(64.4%) having less control in life skill practice. 51(56.7%) respondents having moderate control in dietary practice.

Table 4: Distribution of lifestyle practices among respondents in rural and urban areas, N=90(n_1=45, n_2=45)

Lifestyle Practice	Rural-Majority Practice (n,%)	Urban-Majority Practice (n,%)
Dietary control	Moderate healthy (32, 71.11%)	Less healthy (26, 57.78%)
Physical activity	Less healthy (32, 71.11%)	Less healthy (43, 95.64%)
Substance abuse	More healthy (41, 91.11%)	Moderate healthy (27, 60%)
Sleep quality	Less healthy (26, 57.78%)	Less healthy (41, 91.11%)
Life skill practice	Moderate healthy (32, 71.11%)	Less healthy (45, 100%)

Lifestyle Practices of Respondents

Table 4 illustrates the distribution of lifestyle practices among respondents across rural and urban areas. In dietary control, the majority in rural areas reported moderate healthy practices (32, 71.11%), while in urban areas, most practiced less healthy control (26, 57.78%). With respect to physical activity, the majority in both settings reported less healthy practices, comprising 32 (71.11%) in rural and 43 (95.64%) in urban respondents. Regarding substance abuse, healthier practices were more common in rural areas, where 41 (91.11%) reported more healthy control, compared to urban areas, where the majority (27, 60%) exhibited moderate control. Sleep quality showed a predominance of less healthy practices in both rural (26, 57.78%) and urban (41, 91.11%) groups. Finally, rural respondents reported healthier practices in substance abuse and life skills, while urban respondents demonstrated poorer outcomes across most domains.

Table 5: Correlation between Disability Index and life style practices of persons with locomotor disabilities in rural and urban, N=90 (n_1=45, n_2=45)

Variables	Rural					Urban				
	Mean	SD	'r' value	'P' Value	Correlation	Mean	SD	'r' value	'P' Value	Correlation
Disability index	11.89	11.94	-0.46	0.001	Moderate negative	16.38	13.65	-0.17	0.26	Weak negative
Lifestyle practice	9.4	1.09				6.82	0.94			

Table 5 depicted that urban setting having moderate negative correlation yet statistically significant in respect of Disability index and lifestyle practices; whereas in rural area Disability index and lifestyle practices has weak negative correlation also not statistically significant.

Table 6: Comparison of disability index and life style practices of persons with locomotor disabilities between rural and urban, N=90(n_1=45, n_2=45)

Variables	Rural		Urban		'T' Value (DF=88)	'P' Value	Significant
	Mean	SD	Mean	SD			
Disability index	11.89	11.94	16.38	13.65	1.66	0.1004	
Lifestyle practice	9.40	1.09	6.82	0.94	12.02	0.0001	S

Table 6 depicted that comparison of disability index in rural versus urban is not significantly different but lifestyle practice between two settings showing difference which is statistically significant.

Discussion

Rehabilitation-related studies highlight that functional independence post-injury is achievable through structured programs and psychosocial support. Discharge FIM scores were shown to be strong predictors of successful community reintegration (Andrews & Bohannon, 2023) [1]. Additionally, 24% of patients with severe post-stroke hemiplegia achieved independence after rehabilitation (Kurosaki *et al*., 2022) [10]. Other studies also emphasized the role of self-control and emotional regulation in recovery, with significant physical improvements observed over an eight-week rehabilitation program (Choe & Kim, 2021) [6].

In contrast, the present study paints a less optimistic picture. Among individuals with lifelong or permanent disabilities such as SCI and congenital disorders, 67% had the lowest level of disability Index, with substantial percentages unable to perform basic activities such as dressing, eating, and walking independently. Studies that further illustrate the potential for physical function improvement through targeted interventions. They identified muscle strength and Range of Motion (ROM) as key factors in locomotion disability among older adults, suggesting that exercise programs can mitigate mobility issues (Jung *et al*., 2021) [7] and demonstrated how advanced technologies (e.g., myoelectric prostheses) and early, intensive rehabilitation can lead to notable functional gains even in patients with complex amputations (Monné Cuevas *et al*., 2021) [13]. These findings sharply similar with the high levels of dependency found in the present study, Overall, while the stroke and mobility-focused studies suggest a degree of plasticity and improvement with appropriate intervention, the present study highlights the persistent nature of functional impairments in certain populations. This contrast underscores the critical need for long-term disabilities to potentially improve quality of life and independence.

The reviewed literature on lifestyle practices among persons with locomotor disabilities presents a multidimensional perspective on how behaviours such as physical activity, diet, substance use, and stress management influence overall health and wellbeing. These findings align in many ways with the current study's results, which indicate that while there were no significant differences in diet and physical activity levels across disability types, lifestyle practices do have weak but meaningful associations with health and wellbeing outcomes.

Studies like those by Blumenthal *et al*. (2023) [4] and Van Helm *et al*. (2022) [20] affirm the role of exercise and stress management in improving both psychological and physical health (Blumenthal & Rozanski, 2023) [4], (Van Helm *et al*., 2022) [20]. These findings support the current study's correlation between better lifestyle practices and improved wellbeing (r=0.35, p<0.001), suggesting that even within a population facing physical limitations, lifestyle adjustments can have substantial effects. Similarly, Pahor *et al*. (2014) [15] demonstrated that a structured physical activity program reduced mobility-related disabilities among older adults, reinforcing the value of activity-focused interventions even in those at high risk (Pahor *et al*., 2014) [15].

The observed significant variation in sleep and life skill practices across disability types in the current study (P=0.043 and p<0.001, respectively) aligns with findings by Mathew Barrett *et al*. (2018) [2], who documented high levels of sedentary behaviour and inadequate rest/activity balance during stroke rehabilitation (Barrett *et al*., 2018) [2]. This supports the notion that the type of locomotor disability may influence daily routines, such as sleep and functional independence, requiring tailored lifestyle guidance.

Research Kim *et al*. (2013) [8] identified higher rates of smoking, obesity, and physical inactivity among disabled individuals compared to non-disabled groups (Kim *et al*., 2013) [8]. While our study did not find statistically significant differences in diet (P=0.121) or physical activity (P=0.205) across disability types, there was a near-significant difference in substance abuse practices (P=0.051), echoing Zhou's concerns and hinting at the need for targeted interventions among subgroups (Zhou *et al*., 2019) [23].

Saunders *et al*. (2021) [19] and Lynch *et al*. (2018) [12] called for more rigorous trials focused on reducing sedentary behaviour and enhancing activity levels post-stroke (Saunders *et al*., 2021) [19], (Lynch *et al*., 2018) [12], which supports the present findings that although respondents reported healthier physical activity, the impact on actual health markers such as BMI and NCD risk was weak or statistically non-significant (r=-0.08, P=0.16; r=-0.11, P=0.06). This discrepancy suggests that self-reported lifestyle practices may not always translate into measurable health outcomes, possibly due to limitations in intensity or consistency of the activities.

Furthermore, some studies emphasized the limited effectiveness and high variability of lifestyle interventions among people with intellectual or learning disabilities (Willems *et al*., 2018) [21], (Rana *et al*., 2021) [16], which may be comparable to present study observed variation in life skills across locomotor disability types. This again underscores the importance of customized approaches in lifestyle education and rehabilitation planning.

Notably, O'Donnell *et al*. (2016) [14] underscored the importance of modifiable risk factors such as diet, stress, and substance use in stroke outcomes (O'Donnell *et al*., 2016) [14], which complements the present study's finding that poor health status and higher disability index are weakly correlated with increased NCD risk (r=0.11, P=0.05), even though lifestyle alone does not strongly predict BMI or pain levels.

In conclusion, the body of literature strongly supports the idea that lifestyle practices are important contributors to health and wellbeing, though their effects may vary based on the type and severity of disability. The present study confirms this by showing weak but significant correlations between lifestyle practices, and Disability Index, and calls attention to areas like physical inactivity, dietary habit, sleep and life skills, which differ across disability types and deserve focused intervention. These findings collectively advocate for comprehensive, tailored lifestyle management

programs to enhance the quality of life among individuals with locomotor disabilities.

Conclusion

The study indicates that control over dietary habits, physical activity, sleep, and life skill practices is generally consistent across disability types and disability scores; however, outcomes remain significantly poorer in both rural and urban populations. Lifestyle practices showed a significant negative correlation with disability scores, particularly in rural settings. These findings highlight the need for targeted interventions in diet, physical activity, sleep, and life skills to enhance well-being among individuals with locomotor disabilities. Furthermore, awareness generation and health education for persons with disabilities are crucial for promoting healthier lifestyle practices. Although the correlations between lifestyle and functional health among persons with disabilities were modest, they suggest that improvements in these areas may contribute meaningfully to better health outcomes. Overall, the study underscores the importance of tailored, holistic interventions that integrate lifestyle modifications with disability-specific needs, thereby fostering improved health and reducing disparities among persons with locomotor disabilities.

Implications

Nursing Education

Nursing education should integrate specialized training on managing locomotor disabilities, particularly spinal cord injuries (SCI) and congenital disorders, to address their unique health challenges. It should emphasize a holistic, multidisciplinary approach to care that considers physical, mental, and social health. Furthermore, nursing programs must raise awareness about the challenges faced by individuals with locomotor disabilities, preparing future nurses to deliver inclusive and patient-centred care.

Nursing Research

Future research should examine differences across disability types to inform the development of tailored interventions, conduct longitudinal studies to track lifestyle and health changes over time, and focus on the prevention and management of co-morbidities. In addition, studies should evaluate the effectiveness of health education programs in improving lifestyle practices and overall well-being among individuals with locomotor disabilities.

Nursing Practice

Nurses should develop personalized care plans tailored to individual needs, with a strong focus on functional independence and risk management. Mobility assistance is crucial, requiring nurses to possess the skills necessary for accurate assessment and effective intervention. They also play a key role in promoting healthier lifestyles to improve health and well-being, particularly for those at risk of non-communicable diseases (NCDs). In addition, mental health support including psychosocial counselling and connecting patients to appropriate resources is essential, especially for individuals with locomotor disabilities.

Nursing Administration

Nursing administrators should advocate for comprehensive care services that address the physical, psychological, and social needs of individuals with locomotor disabilities. Continuous training programs are essential to equip nurses with specialized skills that enhance functional independence and overall well-being. Promoting interdisciplinary care teams is vital for ensuring holistic treatment, while the implementation of disability-specific health education programs is particularly important in underserved areas. Furthermore, nursing administrators should support policies that expand access to rehabilitation, vocational training, and employment opportunities for persons with disabilities.

Strength

Positive Correlation between variables emphasises significant predictive value for interventions. Policy maker get a clue to develop and support the project relevant to the field.

Limitations

- There may be limited awareness affecting self-reported lifestyle practices and health literacy.
- Variables were not statistically different across rural and urban, limiting strong comparative conclusions.
- Findings were rely on self-reported functional abilities which are subject to response bias and may not fully capture objective health conditions.

Financial support and sponsorship: Nil.

Conflicts of interest: There is no conflict of interest.

References

1. Andrews AW, Bohannon RW. Functional independence predicts patients with stroke more likely to be discharged to the community after inpatient rehabilitation. Top Stroke Rehabil. 2023;30(4):393-401. https://doi.org/10.1080/10749357.2022.2038834
2. Barrett M, Snow JC, Kirkland MC, Kelly LP, Gehue M, Downer MB, *et al*. Excessive sedentary time during in-patient stroke rehabilitation. Top Stroke Rehabil. 2018;25(5):366-74. https://doi.org/10.1080/10749357.2018.1458461
3. Bassuk SS, Manson JE. Epidemiological evidence for the role of physical activity in reducing risk of type 2 diabetes and cardiovascular disease. J Appl Physiol. 2005;99(3):1193-204. https://doi.org/10.1152/japplphysiol.00160.2005
4. Blumenthal JA, Rozanski A. Exercise as a therapeutic modality for the prevention and treatment of depression. Prog Cardiovasc Dis. 2023;77:50-8. https://doi.org/10.1016/j.pcad.2023.02.008
5. Brunner E, Rees K, Ward K, Burke M, Thorogood M. Dietary advice for reducing cardiovascular risk. In: Brunner E, editor. Cochrane Database Syst Rev. John Wiley & Sons, Ltd; 2007. https://doi.org/10.1002/14651858.CD002128.pub3
6. Choe YW, Kim MK. Could self-control and emotion influence physical ability and functional recovery after stroke? Medicina (Kaunas). 2021;57(10). https://doi.org/10.3390/medicina57101042
7. Jung H, Tanaka S, Iwamoto Y, Kawano T, Yamasaki M, Tanaka R. Reductions in muscle strength and range of motion cause locomotion disability via locomotion-related functional limitation in Japanese older adults: A cross-sectional study. J Aging Res. 2021;2021:1-8. https://doi.org/10.1155/2021/6627767
8. Kim LG, Adamson J, Ebrahim S. Influence of lifestyle choices on locomotor disability, arthritis and cardiovascular disease in older women: prospective cohort study. Age Ageing. 2013;42(6):696-701.

https://doi.org/10.1093/ageing/aft127
9. Krishnan L, Madankumar P. Oral health status of people with locomotor disability in India: A systematic review. Sci Dent J. 2021;5(1):12. https://doi.org/10.4103/SDJ.SDJ_40_20
10. Kurosaki M, Tosaka M, Ibe Y, Arii H, Tomono J, Tazawa M, *et al*. Functional recovery after rehabilitation in patients with post-stroke severe hemiplegia. Prog Rehabil Med. 2022;7:20220039. https://doi.org/10.2490/prm.20220039
11. Lee FH, Wang HH. A preliminary study of a health-promoting lifestyle among Southeast Asian women in Taiwan. Kaohsiung J Med Sci. 2005;21(3):114-20. https://doi.org/10.1016/s1607-551x(09)70287-6
12. Lynch EA, Jones TM, Simpson DB, Fini NA, Kuys SS, Borschmann K, *et al*. Activity monitors for increasing physical activity in adult stroke survivors. Cochrane Database Syst Rev. 2019;(10). https://doi.org/10.1002/14651858.CD012543.pub2
13. Cuevas MP, Correa BA, Fortuny VE, Vela ADM, Sanz CJ. Traumatic quadruple amputee rehabilitation from amputation to prosthetic functionality: A case report. Disabil Rehabil Assist Technol. 2021;16(1):112-8. https://doi.org/10.1080/17483107.2019.1644675
14. O'Donnell MJ, Chin SL, Rangarajan S, Xavier D, Liu L, Zhang H, *et al*. Global and regional effects of potentially modifiable risk factors associated with acute stroke in 32 countries (INTERSTROKE): a case-control study. Lancet. 2016;388(10046):761-775. https://doi.org/10.1016/S0140-6736(16)30506-2
15. Pahor M, Guralnik JM, Ambrosius WT, Blair S, Bonds DE, Church TS, *et al*. Effect of structured physical activity on prevention of major mobility disability in older adults. JAMA. 2014;311(23):2387. https://doi.org/10.1001/jama.2014.5616
16. Rana D, Westrop S, Germeni E, McGarty A, Ells L, Lally P, *et al*. Understanding the effectiveness and underlying mechanisms of lifestyle modification interventions in adults with learning disabilities: protocol for a mixed-methods systematic review. Syst Rev. 2021;10(1):251. https://doi.org/10.1186/s13643-021-01808-0
17. Rimmer JH. Health promotion for people with disabilities: The emerging paradigm shift from disability prevention to prevention of secondary conditions. Phys Ther. 1999;79(5):495-502. https://doi.org/10.1093/ptj/79.5.495
18. SS, MK. Prevalence and pattern of locomotor disability in rural Puducherry. Int J Curr Res Rev. 2015;7(21):50-3.
19. Saunders DH, Mead GE, Fitzsimons C, Kelly P, Wijck VF, Verschuren O, *et al*. Interventions for reducing sedentary behaviour in people with stroke. Cochrane Database Syst Rev. 2021;6(6):CD012996. https://doi.org/10.1002/14651858.CD012996.pub2
20. Helm VS, Krops LA, Dekker R, Vrieling AH. Effectiveness of (active) lifestyle interventions in people with a lower limb amputation: A systematic review. Arch Rehabil Res Clin Transl. 2022;4(4):100207. https://doi.org/10.1016/j.arrct.2022.100207
21. Willems M, Waninge A, Hilgenkamp TIM, Empelen VP, Krijnen WP, Schans VDCP, *et al*. Effects of lifestyle change interventions for people with intellectual disabilities: systematic review and meta-analysis of randomized controlled trials. J Appl Res Intellect Disabil. 2018;31(6):949-61. https://doi.org/10.1111/jar.12463
22. Zeki AM, Ramadan AM, Zeb FK, Ibrahim M. Impact of lifestyle on health and physical capability: A data mining approach. ACM Int Conf Proc Ser. 2018;2018-Mar(11):119-24. https://doi.org/10.1145/3177148.3180101
23. Zhou Q, Glasgow NJ, Du W. Health-related lifestyles and obesity among adults with and without disability in Australia: implication for mental health care. Disabil Health J. 2019;12(1):106-13. https://doi.org/10.1016/j.dhjo.2018.08.007

How to Cite This Article
Srimani S, Shirly I, Equebal A, Mandal L, Manna R. Disability index and lifestyle practices among persons with locomotor disabilities: An assessment across rural and urban communities. International Journal of Advanced Community Medicine. 2025;8(3):171-176.