International Journal of Community Medicine and Public Health
Sharma S et al. Int J Community Med Public Health. 2026 Jan;13(1):143-149
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20254249

Original Research Article

Intrinsic capacity declines and fall risk among older adults: an integrated care for older people-based assessment at an urban health training centre in Western Maharashtra

Sakshi Sharma[1]*, Indranil Samanta[2], Kunal Chatterjee[1], Akshay Misra[3], Saurabh Mahajan[4]

[1]Department of Community Medicine, AFMC, Pune, Maharashtra, India
[2]Station Health Organisation, Delhi Cantt, Delhi, India
[3]Department of Hospital Administration, AFMC Pune, Maharashtra, India
[4]Station Health Organisation, Shakurbasti, SHO, Delhi, India

Received: 28 November 2025
Revised: 12 December 2025
Accepted: 13 December 2025

***Correspondence:**
Dr. Sakshi Sharma,
E-mail: sakshi99100@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Intrinsic capacity (IC), defined by the world health organization (WHO) as a composite of all physical and mental capacities of an individual, is central to healthy ageing. The WHO integrated care for older people (ICOPE) step 1 screening tool is a rapid, feasible approach to detect early declines in locomotion, cognition, vitality, sensory function and psychological well-being. Indian evidence from primary care settings, especially urban health training centres (UHTCs), remains limited. To assess the prevalence of IC declines using the WHO ICOPE Step 1 tool among older adults attending an UHTC in Pune, and to determine associated factors.
Methods: A cross-sectional study was conducted among 120 older adults (≥60 years) attending the UHTC in Pune. Consecutive sampling was used. Data were collected using a structured questionnaire including socio-demographic factors, chronic diseases, falls, functional ability and the WHO ICOPE Step 1 screening tool.
Results: The mean age of participants was 68.9±6.4 years; 54.2% were female. IC decline was present in 72.5% of older adults. Domain-wise declines were: sensory (52.5%), locomotion (48.3%), psychological (35%), cognition (31.7%) and vitality (28.3%). Age ≥70 years (OR 2.1; p=0.04), multimorbidity (OR 2.3; p=0.03) and ≥1 fall in past year (OR 3.0; p=0.01) were significantly associated with IC decline. ADL/IADL dependence was reported in 41.6% of those with declines.
Conclusions: IC decline is highly prevalent among older adults attending the UHTC in Pune. The ICOPE step 1 tool is practical and effective for community and primary care screening.

Keywords: Intrinsic capacity, ICOPE, Elderly, UHTC, Healthy ageing, Screening, Functional decline, Maharashtra

INTRODUCTION

India is undergoing rapid demographic ageing, with the proportion of older adults projected to rise sharply over the next two decades. As longevity improves, attention has shifted from merely extending life to enhancing functional ability and maintaining independence in older age.[1] Older people make up a larger part of the world's population than ever before. In 2024, there were an estimated 1.18 billion people aged 60 years or over in the world (14.5% of the global population). This percentage will rise rapidly in the coming decades, particularly in low- and middle-income countries. Maintaining the health of older people is an investment in human and social capital and supports the United Nations (UN) sustainable development goals (SDGs) and the right of all people everywhere to the highest attainable standard of physical and mental health.[2,3]

The WHO introduced the concept of IC-the composite of all mental and physical capacities. IC consists of five domains: locomotion, cognition, vitality, sensory (vision/hearing), and psychological well-being.[4] The ICOPE approach, referred to as ICOPE, aims to facilitate the reorientation of health and social services towards more person-centred and coordinated care that supports the optimisation of IC and functional ability for older people.[5] ICOPE is WHO's approach to support the delivery of ICOPE within the context of a primary health care-oriented health system.[6]

To operationalise healthy ageing, WHO introduced the ICOPE approach.[3,7] The ICOPE step 1 screening tool is a brief, easy-to-administer instrument designed for use in community and primary care settings to identify early declines before disability occurs.[8]

Locomotion impairment is an early marker of frailty and fall risk. Hence, WHO recommends supplementing self-report locomotion questions with a chair rise test, a simple performance-based marker that predicts sarcopenia, disability, institutionalisation and mortality.[9]

In India, most research on ageing focuses on chronic diseases, frailty or disability. IC as a measurable construct is still new, and very few studies have assessed IC in primary care settings like UHTCs, which serve as key contact points for older adults in public health and medical education systems. UHTCs provide an ideal environment to implement ICOPE screening and link older adults to appropriate care pathways.

This study was therefore conducted to estimate the prevalence of IC declines using the WHO ICOPE step 1 screening tool among older adults attending a UHTC in Pune, and to analyse associated factors.

Objectives

Objectives were to assess the prevalence of IC declines using the WHO ICOPE step 1 tool among older adults attending an UHTC in Pune, and to determine associated factors.

Operational definitions for the study

Older adult

An older adult is defined as any person aged sixty years or above attending the UHTC during the study period.

IC

IC is defined as the composite of all physical and mental capacities of an individual, operationalised in this study through five domains assessed using the WHO ICOPE step 1 screening tool-Locomotion, cognition, vitality (nutrition), sensory (vision and hearing) and psychological (mood) and fall.[10]

Fall

A fall is defined as: An event which results in a person coming to rest inadvertently on the ground, floor, or other lower level, not due to a major intrinsic event (such as stroke or syncope) or overwhelming hazard. For this study, fall history refers to any such event occurring in the past twelve months. Any fall: ≥one fall in last twelve months and recurrent falls: ≥two falls in last twelve months.

METHODS

Study design

A community-based cross-sectional study was conducted to assess the IC declines and fall risks among older adults using the WHO ICOPE step 1 screening tool.

Study setting

The study was carried out at the UHTC, department of community medicine, Armed Forces Medical College (AFMC), Pune, Maharashtra, India. The UHTC caters to an urban population of approximately 1500 and provides preventive, promotive, and primary healthcare services including chronic disease care, elderly care, health education and community outreach activities.

Study duration

The study was conducted over six months, from June 2025 to November 2025.

Study participants

Older adults (≥60 years) attending the UHTC for routine care, medicine refills, chronic disease follow-up or other services or general outpatient services during the study period.

Ethics committee approval

The ethical approval was obtained from the institutional ethics committee. Informed consent was obtained from all participants, maintaining data confidentiality and anonymity. The objectives for the study were clearly stated, and confirmed voluntary and confidential participation. Privacy of subjects and confidentiality of information were maintained.

Sample size

Using Cochran's formula for proportions, the prevalence of IC decline was assumed to be 50%, with a confidence level of 95% and margin of error of 5%, the sample size was 120.

Using the Cochran's formula:

$n = Z^2pq/d^2$

Where,

$Z = 1.96, \quad p = 0.5, \quad q = 1 - p = 0.5, d = 0.10: \quad n = 3.84 \times 0.25/0.01 = 96$

Accounting for 20% non-response, the final sample size was 120 older adults.

Sampling technique

A systematic random sampling technique was used. Based on daily outpatient attendance of older adults at the UHTC, the sampling interval (k) was calculated as:

$$k = \frac{\text{average elderly OPD load}}{\text{required daily sample}}$$

With an average of ~30 elderly attendees per day and a target of ~10 participants/day,

$$k = \frac{30}{10} = 3$$

The first eligible participant of the day was selected by simple random method (lottery), and thereafter every *k-th* eligible older adult (every 3rd elderly patient aged ≥60 years) was approached for inclusion until the required sample size of 120 was achieved.

Inclusion criteria

Adults aged more than 18 years up to the age of 59 years stationed in the selected urban community for at least a period of >3 months and willing to provided informed consent will be included in the study.

Exclusion criteria

Individuals with severe cognitive impairment and no reliable informant available and individuals with terminal illness or those unable to participate in the interview/ assessment due to medical or physical limitations were excluded from the study.

Study tools

The following tools were used for data collection: Socio-demographic proforma, which collected information on Age, sex, marital status, education, income, and living arrangement. Health and functional profile, data were collected on the presence of chronic diseases (multimorbidity), history of falls in the past 12 months and Functional status assessed through activities of daily living (ADL) and instrumental activities of daily living (IADL) dependence. WHO ICOPE step 1 screening tool-IC was assessed using the WHO ICOPE step 1 tool, which evaluates declines across five domains defined as:[11]

Locomotion: Difficulty walking 400 metres or climbing one flight of stairs.

Cognition: Self-reported memory decline and delayed recall of 3 words.

Vitality: Unintentional weight loss and/or poor appetite.

Sensory: Difficulty in vision or hearing despite the use of corrective aids.

Psychological: Low mood or anhedonia in the past two weeks. A domain was coded as "declined" if the screening criteria were positive. Any IC decline was defined as impairment in ≥1 domain.

Performance-based locomotion assessment

In addition to the self-reported locomotion difficulty (walking 400 m or climbing stairs), a chair rise test was performed as recommended in WHO ICOPE step-1 and CARE pathways.

Chair rise test protocol

The participant was asked to sit on a standard chair (height: ~43-45 cm), arms crossed over the chest. They were instructed to stand up and sit down five times as quickly as possible without using their hands. The test was timed with a stopwatch.

Interpretation

Normal locomotion was defined as the ability to complete five chair rises within ≤14 seconds without using hand support. Abnormal performance, indicating locomotion decline, was recorded when a participant was unable to complete five rises, required hand support, or took more than 14 seconds to finish the task, as recommended in the WHO ICOPE 2024 handbook and supported by geriatric mobility performance norms. In a study by Guralnik et al., similar sit-to-stand performance thresholds were shown to reliably predict mobility limitation and future disability. This performance-based assessment was combined with self-reported difficulty in walking 400 meters or climbing stairs to categorise the locomotion domain as "normal" or "declined."

Data collection

Face-to-face interviews were conducted in a designated private area within the UHTC by trained investigators. Each assessment took approximately 10-15 minutes per participant. The questionnaire, originally prepared in English, was translated into Hindi, the commonly spoken regional language, and subsequently validated by

language experts for linguistic accuracy, clarity, and cultural relevance. Data collection included socio-demographic details, health profile, WHO ICOPE step 1 screening, and the performance-based chair rise test. Participants identified with concerns related to vision, hearing, nutrition, mobility, mood, or other health needs were provided with appropriate referrals to UHTC services as part of ethical responsibility.

Statistical analysis

Data were entered in Microsoft excel and analysed using IBM SPSS statistics version 25.0 (IBM Corp., Armonk, NY, USA). Continuous variables were summarised as mean±standard deviation (SD), while categorical variables were expressed as frequencies and percentages.

The prevalence of IC declines and domain-specific impairments was calculated as proportions. The association between IC decline and independent variables such as age group, sex, multimorbidity, fall history and locomotion performance (Chair rise test) was assessed using the Chi-square test or Fisher's exact test, as appropriate. Crude odds ratios (ORs) with 95% confidence intervals (95% CI) were computed to quantify the strength of associations between predictors and IC decline/fall risk. A $p<0.05$ was considered statistically significant. All statistical tests were two-tailed.

RESULTS

A total of 120 older adults were included in the study. The mean age of participants was 68.9±6.4 years, and 54.2% were females. Nearly two-thirds (62.5%) were in the 60-69 years age group, while 37.5% were aged ≥70 years. A majority (88.4%) lived with family, while 11.6% were living alone. About 40% had no education beyond the primary level or were illiterate. Multimorbidity (≥2 chronic illnesses) was present in 43.3% of participants. A history of at least one fall in the last 12 months was reported by 23.3%, and 24.2% had some degree of ADL/IADL dependence (Table 1).

Overall, an IC decline (in at least one domain) was observed in 72.5% (87/120) of participants. Thus, more than two-thirds of the older adults demonstrated impairment in at least one IC domain. Sensory decline was the most common domain affected (Table 2), followed by locomotion and psychological decline. Vitality and cognition domains were also frequently affected.

The chair rise test revealed substantial locomotor impairment beyond self-report. Normal performance (5 rises within ≤14 seconds, no hand support): 70 participants (58.4%). Abnormal performance (unable, used hands, or >14 seconds): 50 participants (41.6%). Among those with abnormal performance (n=50): 23% took >14 seconds, 14% required hand support, 4.6% were unable to complete the test. Chair-rise abnormality showed a strong correlation with fall history.

Distribution number of domains declined per participant was: 0 domains: 27.5%, 1 domain: 24.2%, 2 domains: 21.7%, 3 domains: 15.0% and ≥4 domains: 11.6%. Thus, nearly half (48.3%) of participants had 2/ more IC domain declines, indicating multi-system IC loss.

IC decline was significantly associated with older age (≥70 years), multimorbidity, and fall history in the past year. Age ≥70 years, multimorbidity, and fall history were statistically significant predictors of IC decline.

Table 1: Socio-demographic characteristics of the participants.

Variables	Category	N (%)
Age (in years)	60-69	75 (62.5)
	≥70	45 (37.5)
Sex	Male	55 (45.8)
	Female	65 (54.2)
Living arrangement	With family	106 (88.4)
	Living alone	14 (11.6)
Education	Illiterate	12 (10.0)
	Primary school	36 (30.0)
	Middle school	18 (15.0)
	High school	20 (16.7)
	Intermediate/ diploma	14 (11.7)
	Graduate	14 (11.7)
	Professional degree	6 (5.0)
Multimorbidity	Present	52 (43.3)
Falls in last 12 months	≥1 fall	28 (23.3)
ADL/IADL dependence	Present	29 (24.2)
Entitlement status	Insured	89 (74.2)
	Not insured	31 (25.8)
History of prev hospitalisation	Yes	13 (10.8)
	No	107 (89.2)

Table 2: Prevalence of IC domain declines (n=120).

IC domain	N (%) with decline
Sensory (vision/hearing)	63 (52.5)
Locomotion (self-report + chair rise)	66 (55.0)
Psychological	42 (35.0)
Cognition	38 (31.7)
Vitality (nutrition)	34 (28.3)

Among participants with abnormal chair-rise performance, 47% reported at least one fall in the past year, compared with only 8% among those with normal performance. The odds of experiencing a fall were significantly higher in the abnormal chair-rise group (OR=3.8; 95% CI: 1.6-8.9; p=0.003) (Table 3), indicating that the chair rise test was the strongest predictor of fall

risk among all locomotion-related indicators assessed in this study. Functional dependence was also common among participants with IC decline, with 41.6% demonstrating ADL/IADL limitations. Specific functional challenges included difficulty going outdoors alone (33%) and difficulty managing medications (21%). These findings underscore that functional impairment frequently overlaps with multi-domain IC declines, highlighting the compounded vulnerability faced by older adults experiencing concurrent deficits.

Table 3: Factors associated with IC decline (n=120).

Variables	IC decline (%)	OR (95% CI)	P value
Age ≥70 years	82	2.1 (1.1-4.3)	0.04
Multimorbidity	85	2.3 (1.1-5.0)	0.03
Fall history (past year)	89	3.0 (1.3-6.8)	0.01
Living alone	86	1.48 (0.72-3.04)	0.08

DISCUSSION

This study assessed IC declines and fall risk among older adults attending an UHTC in Pune using the WHO ICOPE step 1 screening tool supplemented with a performance-based chair rise test. The findings demonstrate a high prevalence of IC decline (72.5%), indicating a substantial burden of early functional deterioration in community-dwelling older adults. The prevalence of any IC decline (72.5%) in this study is comparable to international ICOPE implementation research, where multi-domain declines are commonly reported. The high burden underscores the potential of IC screening to detect early functional impairment in older adults who may otherwise appear clinically stable. The IC framework proposed by WHO emphasises early detection of domain-specific declines to maintain functional ability in older populations.[12]

In India, where geriatric screening practices vary across primary care platforms, these findings highlight the feasibility and value of integrating IC-based assessments into UHTCs and similar primary care settings.

Among the IC domains, sensory decline (52.5%) and locomotion decline (55%) were the most prevalent. Sensory impairment-particularly vision and hearing loss-is known to adversely impact mobility, independence, and social participation. Yet, these issues often remain underreported and untreated due to lack of routine screening. Locomotion impairment emerged as a major concern in this study. The integration of the chair rise test provided an objective assessment of lower-limb strength and functional mobility, revealing that 41.6% of participants had abnormal performance, which would not have been captured through self-report alone. Studies show that chair rise performance is strongly related to muscle strength, sarcopenia, frailty, and disability, validating its inclusion in IC assessment.

Cognitive decline (31.7%) and psychological decline (35%) were moderately prevalent. These findings reflect the rising burden of cognitive and mental health challenges in older adults, often under-recognised in primary-care settings. The lancet commission on dementia prevention notes that even mild cognitive impairment significantly increases vulnerability to adverse health outcomes.[13] Vitality (nutrition) decline was observed in 28.3% of participants, indicating possible risks of undernutrition and sarcopenia. These declines may contribute synergistically to frailty progression. Psychological decline (35%) also emerged prominently. Depression and psychological distress are known contributors to frailty, functional decline, and mortality in older adults.[14] Meta-analyses confirm strong associations between depression and physical vulnerability, especially in low-resource community settings.[15]

Falls were reported by 23.3% of participants, consistent with global estimates. Importantly, IC decline was significantly associated with fall history, with an odds ratio of 3.0. This supports existing evidence that IC is a strong predictor of adverse functional outcomes, including falls. In a study by Ambrose et al reduced muscle strength, balance impairment, and sensory deficits were identified as major fall risk factors.[16]

Notably, the chair rise test was the single strongest predictor of falls, with nearly half of those with abnormal performance reporting a fall. Reduced lower-limb strength and difficulty rising from a chair reflect impaired neuromuscular function, balance, and postural control-all critical determinants of fall risk.

Nearly 48.3% of participants had two or more IC declines, suggesting clustering of impairments with age. Multi-domain decline was closely associated with ADL/IADL dependence, reinforcing IC as a reliable construct for identifying early functional vulnerability.

This study demonstrates the feasibility and utility of ICOPE step 1 screening-including performance testing-within a UHTC setting. The rapid 10-15-minute assessment can easily be integrated into routine geriatric care. Early detection of IC decline allows timely intervention through: Vision and hearing correction, physiotherapy and fall-prevention exercises, nutrition supplementation, mood screening and counselling, cognitive stimulation programs, assistive technology provision.

Given the high burden of multi-domain decline, UHTCs are ideal settings for implementing the ICOPE care pathways (Step 2 onward) for personalised intervention planning.

Strengths

This study offers several important strengths. It is among the first Indian studies to implement the WHO ICOPE step 1 screening tool in combination with an objective locomotion assessment-the chair rise test-within a UHTC setting, thereby enhancing the comprehensiveness of IC evaluation. The use of systematic random sampling strengthens internal validity and minimizes the potential for selection bias. By incorporating both self-reported measures and performance-based assessments, the study improves the accuracy and reliability of detecting early functional decline. Additionally, the demonstrated association between IC decline and fall risk adds significant clinical relevance, underscoring the utility of ICOPE-based screening for early identification of vulnerable older adults within primary care services.

Limitations

This study also has certain limitations. The cross-sectional design precludes establishing causal relationships between IC declines, multimorbidity, and fall outcomes. Information on fall history, chronic diseases, and cognitive complaints relied on self-report, making the data susceptible to recall bias and underreporting. Conducting the study in a single UHTC may limit the generalizability of findings to other geographic or clinical settings. Performance in the chair rise test may have been influenced by factors such as arthritis, pain, obesity, recent injuries, or hesitation, potentially affecting accuracy. Additionally, the exclusion of individuals with severe cognitive impairment or terminal illness might have led to an underestimation of the true prevalence of IC decline within the community. Finally, the absence of longitudinal follow-up restricted the ability to track progression of IC decline or the incidence of future falls over time.

CONCLUSION

IC decline is highly prevalent in the UHTC population, with sensory and locomotion (chair-rise-based) impairments most common. The significant association between IC decline, chair-rise dysfunction, and fall history highlights the importance of integrating routine ICOPE screening-including simple performance tests-into primary healthcare.

Recommendations

Based on the findings of our study, several measures are recommended to strengthen geriatric care and promote healthy ageing in primary care settings. Routine WHO ICOPE step 1 screening should be integrated into UHTC outpatient services for all adults aged ≥60 years, using both self-reported and performance-based assessments such as the chair rise test to enhance early detection of IC declines. ICOPE care pathways (Step 2-3) should be established through structured referral mechanisms connecting older adults with physiotherapy and mobility-strengthening sessions, vision and hearing evaluations, nutrition counselling, mental health support, and cognitive assessment services. Fall-prevention interventions that include balance training, lower-limb strengthening exercises, and home hazard modifications should be prioritised, along with caregiver education on safe mobility. IC screening results should be incorporated into multimorbidity and chronic disease management visits to reinforce medication adherence and lifestyle counselling. Community-based healthy ageing activities such as group exercise sessions, yoga, walking clubs, and health education programs should be introduced. Primary healthcare staff require training in the use of ICOPE tools, mobility assessments, and identification of high-risk older adults. An elderly follow-up register or digital tracking system should be developed for periodic reassessment every 6-12 months. Sensory health must be promoted through regular vision and hearing screening camps and provision of affordable assistive devices. Strengthening family and caregiver engagement is essential to support daily functioning and early recognition of decline. Finally, larger multi-centre and longitudinal studies are recommended to better understand the progression of IC decline over time.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Luque XR, Blancafort-Alias S, Prat Casanovas S, Forné S, Martín Vergara N, Fabregat Povill P, et al. Identification of decreased intrinsic capacity: Performance of diagnostic measures of the ICOPE Screening tool in community dwelling older people in the VIMCI study. BMC Geriatr. 2023;23(1):106.
2. 9789240103726-eng. Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, second edition. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO. Available at: https://www.esceo.org/sites/esceo/files/pdf/ICOPE_handbook_2nd_final.pdf. Accessed on 3 August 2025.
3. Tavassoli N, de Souto Barreto P, Berbon C, Mathieu C, de Kerimel J, Lafont C, et al. Implementation of the WHO integrated care for older people (ICOPE) programme in clinical practice: a prospective study. Lancet Healthy Longev. 2022;3(6):e394-404.
4. Muneera K, Muhammad T, Pai M, Ahmed W, Althaf S. Associations between intrinsic capacity, functional difficulty, and fall outcomes among older adults in India. Sci Rep. 2023;13(1):9829.
5. Gonzalez-Bautista E, de Souto Barreto P, Tavassoli N, Ranarijhon C, Pons JS, Rolland Y, et al. Reliability of Self-Screening for Intrinsic Capacity Impairments Using the ICOPE Monitor App. J Frail Aging. 2023;12(4):291-7.

6. Ma L, Chhetri JK, Zhang Y, Liu P, Chen Y, Li Y, et al. Integrated Care for Older People Screening Tool for Measuring Intrinsic Capacity: Preliminary Findings From ICOPE Pilot in China. Front Med (Lausanne). 2020;7:576079.
7. Leung AYM, Su JJ, Lee ESH, Fung JTS, Molassiotis A. Intrinsic capacity of older people in the community using WHO Integrated Care for Older People (ICOPE) framework: a cross-sectional study. BMC Geriatr. 2022;22(1):304.
8. Mathur A, Bhardwaj P, Joshi NK, Jain YK, Singh K. Intrinsic Capacity of Rural Elderly in Thar Desert using WHO ICOPE (Integrated Care for Older Persons) Screening Tool: A Pilot Study. Medrxiv. 2022.
9. Lu F, Li J, Liu X, Liu S, Sun X, Wang X. Diagnostic performance analysis of the Integrated Care for Older People (ICOPE) screening tool for identifying decline in intrinsic capacity. BMC Geriatr. 2023;23(1):509.
10. Sanchez-Rodriguez D, Piccard S, Dardenne N, Giet D, Annweiler C, Gillain S. Implementation of the Integrated Care of Older People (ICOPE) App and ICOPE Monitor in Primary Care: A Study Protocol. J Frail Aging. 2021;10(3):290-6.
11. de Oliveira VP, Ferriolli E, Lourenço RA, González-Bautista E, de Souto Barreto P, de Mello RGB. The sensitivity and specificity of the WHO's ICOPE screening tool, and the prevalence of loss of intrinsic capacity in older adults: A scoping review. Vol. 177, Maturitas: Elsevier Ireland Ltd; 2023.
12. Cesari M, Araujo de Carvalho I, Amuthavalli Thiyagarajan J, Cooper C, Martin FC, Reginster JY, et al. Evidence for the Domains Supporting the Construct of Intrinsic Capacity. J Gerontol. 2018;73(12):1653-60.
13. Livingston G, Huntley J, Sommerlad A, Ames D, Ballard C, Banerjee S, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. The Lancet. 2020;396(10248):413-46.
14. Schulz R, Beach SR, Ives DG, Martire LM, Ariyo AA, Kop WJ. Association Between Depression and Mortality in Older Adults. Arch Intern Med. 2000;160(12):1761.
15. Mezuk B, Edwards L, Lohman M, Choi M, Lapane K. Depression and frailty in later life: a synthetic review. Int J Geriatr Psychiatry. 2012;27(9):879-92.
16. Ambrose AF, Paul G, Hausdorff JM. Risk factors for falls among older adults: A review of the literature. Maturitas. 2013;75(1):51-61.

Cite this article as: Sharma S, Samanta I, Chatterjee K, Misra A, Mahajan S. Intrinsic capacity declines and fall risk among older adults: an integrated care for older people-based assessment at an urban health training centre in Western Maharashtra. Int J Community Med Public Health 2026;13:143-9.