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Commentary

Social isolation and loneliness in older adults: A growing public health challenge with evidence from Nepal

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Abstract

Social isolation and loneliness are increasingly recognized as major public health concerns in ageing populations, yet they remain under-addressed in low- and middle-income countries. This article examines the definitions, epidemiology, health consequences, and evidence-based responses related to social isolation and loneliness among older adults, with focused attention to Nepal. Nepal faces a dual challenge: a rapidly growing older adult population—exceeding 10% of the national total in 2021 —and large-scale youth labor migration that has eroded the family-based support structures upon which older Nepali adults have traditionally relied. Research consistently demonstrates that social support is the most powerful buffer against loneliness and its downstream health effects in this population. More recently, a study provided direct evidence that perceived social support mediates the relationship between loneliness and depression among community-dwelling older adults in Nepal. Despite this evidence, loneliness screening is largely absent from primary care, and the policy response remains fragmented. This article calls for validated screening, stronger community-based programming through Older People's Associations (OPAs), and targeted national policy reforms.

Keywords: Older adults, Social isolation, Loneliness, Nepal, Ageing, Social support, Migration, Community health

Introduction

Ageing populations are a defining feature of twenty-first century public health. The United Nations [1] projects that the global population of people aged 60 and over will surpass two billion by 2050, with the fastest growth occurring in low- and middle-income countries. Yet extending life expectancy does not automatically improve its quality. Among the most consequential—and most overlooked—threats to well-being in later life are social isolation and loneliness, which the World Health Organization [2] has formally recognized as important determinants of health.

These conditions arise from and are amplified by transitions common in later life: retirement, bereavement, physical decline, and reduced mobility [3]. The COVID-19 pandemic intensified their reach, with lockdowns and visiting restrictions forcing large numbers of older adults into involuntary social withdrawal—a disruption with measurable effects on mental and physical health globally and in Nepal [4].

Nepal presents a context of particular importance. Its traditional joint family model, in which older people were customarily respected and relied upon as central figures in family and community life, has historically protected older adults from social disconnection [5], but rapid urbanization and unprecedented labor out-migration—Nepal's 2021 census recorded over five million citizens living and working abroad [6]—have dismantled this safety net for many families. Chalise [7] notes that older adults now make up more than a tenth of Nepal's national population, making the social welfare

of this group a pressing national concern, a trajectory confirmed by Nepal's most recent national population policy update [8]. This article synthesizes current evidence, highlights Nepal-specific considerations, and proposes practical responses. As a narrative commentary rather than a systematic review, sources were identified through targeted searches of PubMed, Google Scholar, and NepJOL for peer-reviewed literature on social isolation, loneliness, and ageing in Nepal and South Asia, supplemented by national census reports, WHO publications, and Nepal government policy documents; global evidence was included where Nepal-specific data were unavailable. Because the Nepal-specific evidence base remains small and is concentrated in a limited number of research groups, this concentration is itself identified below as a priority for future, more geographically and institutionally diverse research.

Distinguishing Social Isolation from Loneliness

The terms social isolation and loneliness are often used as if they were synonymous, but they refer to meaningfully different phenomena with different causes, different health pathways, and different optimal interventions. Social isolation is an objective condition: it refers to the absence or scarcity of social contacts and engagement with community life [9]. Loneliness, by contrast, is a felt experience—a subjective sense of disconnection that arises when one's relationships fall short of what one desires or needs [3]. A person can be objectively isolated yet feel at peace; another can be socially surrounded yet profoundly lonely.

Researchers identify three overlapping dimensions of loneliness: emotional loneliness (loss of an intimate confidant), social loneliness (an unsatisfying or insufficient social network), and existential loneliness (a broader sense of meaninglessness or separation) [10]. **Table 1** presents a structured comparison of the two constructs, including their relevance to older adults in Nepal.

This distinction has direct clinical implications. In Nepal, an older adult whose children have migrated abroad may experience both conditions simultaneously, but the appropriate response differs: rebuilding social contact through OPA membership addresses isolation, while grief counselling and peer befriending are more suited to emotional loneliness. Treating the two as interchangeable risks applying an ineffective remedy.

Prevalence and Epidemiology

Globally, between 20% and 40% of adults aged 60 and over report meaningful loneliness [11]. In the United States, approximately one in three adults aged 45 and above reports loneliness, with rates rising in the oldest age groups [12]. Post-pandemic surveillance data from several countries suggest these figures have worsened, particularly among those aged 80 and above [13].

Within Nepal, a body of research built over nearly two decades documents significant loneliness in older adult populations. Chalise, Saito, and Kai [14] identified social network size and family support as the strongest protective correlates among older Newar adults in Kathmandu Valley. A subsequent cross-cultural comparison confirmed that social support consistently predicted loneliness across Nepali sub-populations [15], while Chalise [16] demonstrated the broader consequences for subjective well-being. The most recent Nepali evidence comes from Gautam et al. [17], who showed that perceived social support mediates the loneliness-depression relationship in community-dwelling older adults—findings that directly inform how mental health programming should be designed. Comparable patterns have been documented across South Asia, though prevalence estimates vary with survey methodology and timing: a national analysis of Indian older adults using WHO SAGE data found approximately 18% reporting loneliness, with rates significantly higher among women [18], while a cross-sectional telephone survey conducted during the COVID-19 pandemic found that just over half of older Bangladeshi adults (51.5%) experienced loneliness [19], reflecting the added strain of pandemic-related isolation alongside shared demographic and familial forces operating across the region.

Determinants and Risk Factors

Demographic and health-related factors

The cumulative losses of later life—bereavement, retirement, physical decline—create compounding exposure to isolation and loneliness. Widowhood is among the most consistently identified risk factors across cultures and study designs [13]. Physical health problems, including chronic disease, impaired hearing or vision, and reduced mobility, narrow the range of activities and social contexts available to older adults. Depression and loneliness reinforce one another in a bidirectional cycle, with each condition predicting the worsening of the other over time [3]. Within Nepal, limited geriatric services and high rates of unmanaged non-communicable disease intensify these pathways [20].

Family migration and the left-behind phenomenon

Nepal's labor migration represents perhaps the most significant structural driver of elder isolation in the country. The 2021 national census counted over five million Nepali citizens living abroad [6], the

Table 1. Distinguishing social isolation from loneliness: definitions, assessment, and relevance to Nepal.

Feature	Social Isolation	Loneliness
Nature	Objective — externally measurable	Subjective — internally experienced
Core definition	Insufficient quantity of social contacts and community ties	Perceived mismatch between desired and actual relational closeness
Independent occurrence	Yes — an isolated person may not feel distressed	Yes — a socially active person may still feel lonely
Assessment tools	Lubben Social Network Scale (LSNS-6)	UCLA Loneliness Scale; de Jong Gierveld Scale
Intervention focus	Increase contact frequency and network size	Improve relational quality; cognitive approaches (CBT)
Nepal context	Youth out-migration; remote rural geography	Spousal bereavement; perceived abandonment by migrant children

majority of them working-age men from rural households. Chalise et al. [21] established that support from children, spouses, neighbors, and friends plays distinct and non-substitutable roles in protecting older adults from loneliness. When adult children migrate, this support structure is disrupted in ways that financial remittances cannot compensate; migration-driven spousal separation, in particular, removes one of the most protective relationships in later life [22]. Chalise [7] argues that the combination of accelerated demographic ageing and sustained youth out-migration has created a cohort of 'left-behind' older adults—many caring for grandchildren in remote districts—who face social isolation without accessible community resources. Older adults residing in remote hill and mountain districts may experience compounded risks due to geographic isolation, limited transportation, and reduced access to health and social services. In its most severe form, this erosion of family caregiving capacity leads some older adults to relocate to old age homes: a study of institutionalized older adults in Kathmandu found that children's migration was a common reason for admission, and that residents frequently reported loneliness and a persistent desire to see their children [23]. Institutionalized older adults represent a distinct and under-examined subgroup within Nepal's isolation and loneliness literature, since they may have regular social contact within the facility yet still report elevated loneliness and psychological distress [24,25].

Environmental and digital barriers

Poor infrastructure, limited transportation, and inaccessible public spaces restrict mobility and social participation, particularly in rural and hill communities. Financial hardship further limits access to social activities. Digital exclusion is a growing concern: while digital tools offer a channel for maintaining contact with migrant family members, national census data indicate substantially lower household internet access in rural areas than urban ones [6]; disaggregated age-specific figures for adults aged 60 and above are not routinely published, but penetration among rural older adults is likely lower still given the compounding effects of age, rurality, and literacy. Low literacy rates, especially among older women, compound this barrier.

Health Consequences

Physical health and mortality

The physical health toll of chronic social disconnection is well established. A meta-analysis of over 300,000 participants by Holt-Lunstad et al. [26] found that individuals with strong social relationships had a survival advantage equivalent to eliminating smoking as a risk factor—a finding that has reframed how researchers and policymakers think about social connection as a health determinant. Social isolation independently elevates risk for coronary heart disease and stroke [27], with proposed mechanisms including dysregulation of the stress-response axis, elevated inflammatory markers, and disrupted sleep. Given that cardiovascular disease is Nepal's leading cause of mortality among older adults [28], the public health relevance of these associations is direct.

Dementia and cognitive health

Social engagement sustains cognitive function by exercising memory, language, and emotional regulation. Its withdrawal accelerates decline. The 2020 Lancet Commission on Dementia identified social isolation as one of twelve modifiable risk factors for dementia, accounting for an estimated 4% of cases globally [29]. Prospective studies show that lonely individuals face a roughly 26% greater risk of developing dementia [30]. In Nepal, dementia is largely unrecognized within the health system, and research examining its social determinants is almost entirely absent.

Mental health and subjective well-being

Loneliness is among the strongest modifiable risk factors for depression in later life. Older adults who are chronically lonely are approximately twice as likely to develop clinical depression as their well-connected peers [31]. The relationship is bidirectional—depression deepens withdrawal, which worsens loneliness [3]. The Nepali evidence is particularly instructive here: Gautam et al. [17] found that perceived social support significantly mediated the pathway from loneliness to depression in a community sample of older Nepali adults, demonstrating that relational quality—not merely frequency of contact—is the active ingredient in psychological protection. Studies also show that older adults embedded in meaningful social roles and community structures report substantially higher life satisfaction and subjective well-being [16,32].

Screening and Assessment

Systematic screening for social isolation and loneliness in clinical settings is rare in Nepal and across much of South Asia. Three instruments are widely used internationally. The UCLA Loneliness Scale [33] is the most extensively validated self-report measure of loneliness. The six-item Lubben Social Network Scale (LSNS-6) provides a brief, practical measure of network size and contact frequency suited to primary care contexts [34]. The de Jong Gierveld Loneliness Scale [10] distinguishes emotional from social loneliness, enabling more tailored responses. All three require Nepali-language adaptation and local normative data before routine deployment.

The primary barriers to screening in Nepal are practical: short consultation times, limited clinician awareness, cultural reluctance to disclose loneliness, and the near-total absence of post-screening referral pathways. The most achievable near-term opportunity lies in Nepal's Female Community Health Volunteer (FCHV) network. Over 51,000 FCHVs conduct regular household visits across Nepal [20]; equipping them to ask brief validated screening questions and link at-risk older adults to local OPAs or health services is a plausible low-cost extension of their existing role, though this specific application has not yet been piloted or evaluated in Nepal and its feasibility—given FCHVs' already broad workload—would need to be tested before wider rollout.

Interventions and Policy Responses

Individual and community-based approaches

Among evaluated interventions, cognitive behavioral therapy targeting maladaptive loneliness cognitions has shown the most consistent and durable effects across randomized trials [35]. Group-based programs—peer support, lifelong learning, physical activity, and intergenerational activities—also contribute to social engagement and have broader reach in community settings [36]. However, evidence from low-resource and South Asian contexts is limited, and culturally adapted interventions for Nepal are an important research priority.

In Nepal, OPAs stand out as the most promising community-level mechanism. Chalise and Brightman [32] documented that

OPA membership promotes social participation, peer solidarity, civic engagement, and access to social protection information—all of which contribute to reduced loneliness and active ageing. Strengthening and scaling OPAs, particularly in rural hill and mountain districts where isolation is most acute, represents a high-return investment within Nepal's community health infrastructure. Realizing this potential, however, is constrained by concrete implementation barriers: FCHVs and OPA volunteers are already stretched across multiple health and social mandates with limited additional financing; rural accessibility and seasonal road closures restrict the frequency of outreach in hill and mountain districts; cultural stigma and low health literacy discourage disclosure of loneliness, particularly among older women; and pre-existing gender, caste, and ethnic disparities in service access mean that scaled programming without deliberate targeting risks reaching the least isolated older adults first. Monitoring mechanisms to track OPA reach and CBT-based program fidelity are largely absent, and would need to be built alongside any scale-up rather than added afterward.

Policy priorities for Nepal

The evidence base underlying these proposals is uneven, and the recommendations below are labelled accordingly: some rest on direct Nepalese evidence, others are extrapolated from international literature and require local validation, and a third group are proposals that still need formal evaluation before adoption. First, Nepal's National Health Policy should mandate loneliness screening as a component of routine geriatric assessment, with validated Nepali-language tools and clear referral pathways—a recommendation extrapolated from international screening evidence that still requires local validation before mandating. Second, local governments (Palikas), which hold constitutional responsibility for social welfare under Nepal's federal structure, should be resourced to fund and oversee OPAs and age-friendly community programs; this rests on direct Nepalese evidence of OPA benefit [32], and the 2024 National Senior Citizen Policy provides the legislative basis for it [37]. Third, a national digital literacy initiative co-led by the Ministry of Communication and the Ministry of Health could substantially improve older adults' capacity to maintain contact with migrant family members—an intervention priority given the scale of Nepal's diaspora, though its feasibility and impact remain to be formally evaluated. Finally, structured transnational support mechanisms—regular community check-ins for left-behind older adults, coordinated through FCHVs and ward offices—would help address the emotional dimensions of family-driven isolation; this, too, is a proposal requiring pilot testing rather than an established practice. Nepal should also align these efforts with the WHO Decade of Healthy Ageing 2021–2030 framework [2] to leverage international technical and financial support.

Key Research Gaps

Several critical evidence gaps limit Nepal's ability to design and evaluate effective responses, and each has a direct consequence for policy that is worth making explicit. Most Nepali studies are cross-sectional; without longitudinal cohort data to establish causal pathways and track how loneliness evolves across the life course, current claims about which risk factors matter most remain associational rather than causal, weakening the case for prioritizing any single intervention over another. Existing research also draws primarily on urban samples from Kathmandu Valley and, notably, on a relatively small circle of Nepali investigators, so recommendations framed as applicable to remote hill and mountain districts—where isolation is likely most severe—are largely extrapolations rather than direct findings; broadening both the geographic and institutional base of Nepali ageing research is itself a research priority. Rigorous evaluation of OPA effectiveness through quasi-experimental or trial designs is absent, which means the strong policy emphasis placed on OPAs in this article rests more on plausibility and observational association than on demonstrated causal impact, and this limits the case for scaled public investment until such evaluation exists. Research on the feasibility and impact of digital literacy programs for older adults with low literacy in rural Nepal is also needed before such programs can be recommended with confidence. Finally, analyses disaggregated by gender, caste, ethnicity, and geography are required to identify the most marginalized subgroups and ensure that policy responses are equitable.

Conclusion

Social isolation and loneliness are not inevitable features of growing old—they are modifiable conditions with well-documented and serious consequences for health and survival. In Nepal, the convergence of rapid population ageing, large-scale youth migration, and the erosion of traditional family support have created an urgent need for coherent, evidence-based action. Research has established that social support is the cornerstone of older adults' well-being in Nepal and that community-based structures such as OPAs offer a feasible platform for intervention. What is needed now is the institutional commitment to translate this evidence into practice—through validated screening in primary care, empowered FCHVs and local governments, digital inclusion, and migration-sensitive welfare policies. Older adults who have given their productive years to Nepal's development deserve the social infrastructure to age with dignity and connection. Framing this work within the broader concept of healthy ageing—which emphasizes sustained functional ability and well-being rather than the mere absence of disease—reinforces why addressing isolation and loneliness cannot be treated as separate from mainstream ageing policy. Recognizing social isolation and loneliness as public health priorities is essential for achieving healthy and dignified ageing in Nepal.

References

1. United Nations. World Social Report 2023: Leaving No One Behind in an Ageing World. New York: United Nations; 2023. Available from: https://desapublications.un.org/publications/world-social-report-2023-leaving-no-one-behind-ageing-world
2. World Health Organization. Decade of Healthy Ageing 2021–2030. Geneva: World Health Organization; 2021. Available from: https://www.who.int/initiatives/decade-of-healthy-ageing
3. Cacioppo JT, Cacioppo S. Social Relationships and Health: The Toxic Effects of Perceived Social Isolation. Soc Personal Psychol Compass. 2014 Feb 1;8(2):58–72.
4. Armitage R, Nellums LB. COVID-19 and the consequences of isolating the elderly. Lancet Public Health. 2020 May;5(5):e256.
5. Chalise HN. Being Old in Nepali Culture. In: Population Aging in Societal Context. Routledge; 2025. pp. 103–15.
6. National Statistics Office. National Population and Housing Census 2021: Summary of Preliminary Results. Kathmandu: Government of Nepal; 2022. Available from: https://microdata.nsonepal.gov.np/index.php/catalog/124

7. Chalise HN. Aging trend and situation in Nepal. Adv Aging Res. 2023 May 31;12(3):39–48.

8. Chalise HN. Aging in Nepal's 2025 Population Policy. Europasian J Med Sci. 2025 Dec 20;7:1–4.

9. National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Health and Medicine Division; Board on Behavioral, Cognitive, and Sensory Sciences; Board on Health Sciences Policy; Committee on the Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. Washington (DC): National Academies Press (US); 2020 Feb 27.

10. De Jong-Gierveld J, van Tilburg TG. A 6-item scale for overall, emotional, and social loneliness: Confirmatory tests on survey data. Res Aging. 2006 Sep 1;28(5):582–98.

11. Courtin E, Knapp M. Social isolation, loneliness and health in old age: a scoping review. Health Soc Care Community. 2017 May;25(3):799–812.

12. Anderson GO, Thayer CE. Loneliness and Social Connections: A National Survey of Adults 45 and Older. Washington (DC): AARP Research; 2018. Available from: https://www.aarp.org/pri/topics/social-leisure/relationships/loneliness-social-connections/

13. Victor CR, Yang K. The prevalence of loneliness among adults: a case study of the United Kingdom. J Psychol. 2012 Jan-Apr;146(1-2):85–104.

14. Chalise HN, Saito T, Kai I. Correlates of loneliness among older Newar adults in Nepal. Jpn J Public Health. 2007;54(7):427–33.

15. Chalise HN, Kai I, Saito T. Social support and its correlation with loneliness: a cross-cultural study of Nepalese older adults. Int J Aging Hum Dev. 2010;71(2):115–38.

16. Chalise HN. Social support and its correlation with loneliness and subjective well-being: a cross-cultural study of older Nepalese adults. Asian Social Work and Policy Review. 2010 Feb;4(1):1–25.

17. Gautam S, Poudel A, Khatry RA, Mishra R. The mediating role of perceived social support on loneliness and depression in community-dwelling Nepalese older adults. BMC Geriatr. 2024 Oct 21;24(1):854.

18. Srivastava S, Ramanathan M, Dhillon P, Maurya C, Singh SK. Gender differentials in prevalence of loneliness among older adults in India: An analysis from WHO study on global AGEing and adult health. Ageing international. 2021 Dec;46(4):395–421.

19. Mistry SK, Ali ARMM, Yadav UN, Huda MN, Ghimire S, Saha M, Sarwar S, Harris MF. Loneliness and its correlates among Bangladeshi older adults during the COVID-19 pandemic. Sci Rep. 2022 Sep 2;12(1):15020.

20. Government of Nepal. Ministry of Health and Population Nepal. Annual Report 2022/23. Kathmandu: Government of Nepal; 2024. Available from: https://elibrary.nhrc.gov.np/handle/20.500.14356/2682

21. Chalise HN, Saito T, Takahashi M, Kai I. Relationship specialization amongst sources and receivers of social support and its correlations with loneliness and subjective well-being: a cross-sectional study of Nepalese older adults. Arch Gerontol Geriatr. 2007 May-Jun;44(3):299–314.

22. Dhital S, Chalise HN, Rupakheti D. Migration, ageing and spousal separation: A review of current population trend in Nepal. Jacobs Journal of Gerontology. 2015;1(1):1–7.

23. Khanal P, Rai S, Chalise H. Children's migration and its effect on elderly people: A study at old age homes in Kathmandu. American journal of Gerontology and Geriatrics. 2018;1(1):1001.

24. Khatiwada K, Chalise HN. Successful aging among institutionalized older people: a study from Nepal. Am J Biomed Sci & Res. 2025 29(3).390–8.

25. Suwal RP, Upadhyay B, Chalise HN. Factors associated with anxiety and depression among elderly living in old age homes. KMC Journal. 2024 Jan 31;6(1):280–99.

26. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspectives on psychological science. 2015 Mar;10(2):227-37.

27. Valtorta NK, Kanaan M, Gilbody S, Ronzi S, Hanratty B. Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. Heart. 2016 Jul 1;102(13):1009–16.

28. World Health Organization Nepal. Nepal: Non-Communicable Diseases Country Profile. New Delhi: WHO Regional Office for South-East Asia; 2023. Available from: https://www.who.int/southeastasia/health-topics/noncommunicable-diseases

29. 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 Aug 8;396(10248):413–46.

30. Holwerda TJ, Deeg DJ, Beekman AT, van Tilburg TG, Stek ML, Jonker C, et al. Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL). J Neurol Neurosurg Psychiatry. 2014 Feb;85(2):135–42.

31. Luanaigh CO, Lawlor BA. Loneliness and the health of older people. Int J Geriatr Psychiatry. 2008 Dec;23(12):1213–21.

32. Chalise HN, Brightman J. Strengthening active aging through older people's association and economic activity of the older people in Nepal. Advances in Aging Research. 2024 Mar 28;13(2):15–24.

33. Russell DW. UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. Journal of personality assessment. 1996 Feb 1;66(1):20–40.

34. Lubben J, Blozik E, Gillmann G, Iliffe S, von Renteln Kruse W, Beck JC, Stuck AE. Performance of an abbreviated version of the Lubben Social Network Scale among three European community-dwelling older adult populations. Gerontologist. 2006 Aug;46(4):503–13.

35. Masi CM, Chen HY, Hawkley LC, Cacioppo JT. A meta-analysis of interventions to reduce loneliness. Pers Soc Psychol Rev. 2011 Aug;15(3):219–66.

36. Gardiner C, Geldenhuys G, Gott M. Interventions to reduce social isolation and loneliness among older people: an integrative review. Health Soc Care Community. 2018 Mar;26(2):147–57.

37. Ministry of Women, Children and Senior Citizens Nepal. National Senior Citizen Policy 2024. Kathmandu: Government of Nepal; 2024.

38. Chalise HN. Basic concept of healthy aging. J Patan Acad Health Sci. 2022 Dec 30;9(3):85–8.