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Loneliness Among the Elderly: A Public Health Concern - Part II

This is the second article of two in a series on "Loneliness Among the Elderly: A Public Health Concern"

Risk factors for loneliness

A complex interplay of individual, social, and environmental factors drives loneliness. At the individual level, older age, being unmarried or widowed, low education, unemployment, and living alone increase susceptibility. Health challenges, such as chronic diseases, poor self-rated health, cognitive decline, and mobility limitations, exacerbate vulnerability, making social engagement difficult. Mental health issues, like depression and anxiety, have a bidirectional

relationship with loneliness, each worsening the other. Socially, strained family relationships, lack of children, infrequent contact with loved ones, or disruptive life events, such as the loss of a spouse, increase the risk of loneliness.

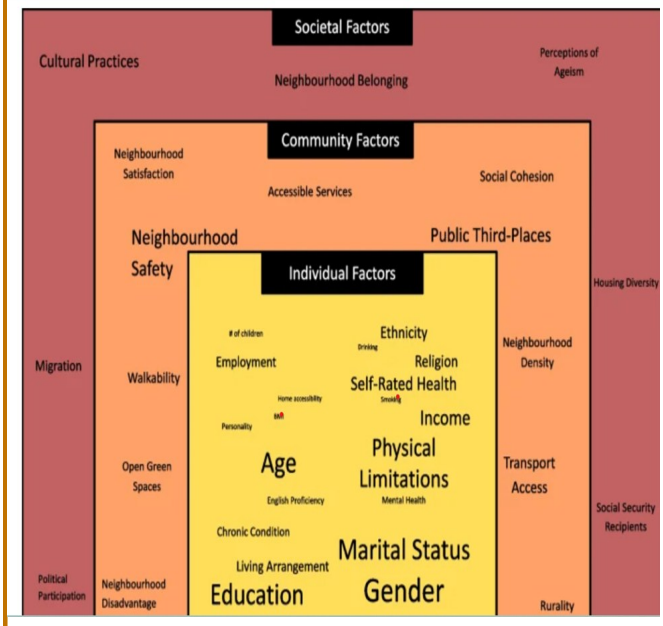

Photo credit - Fierloos, I. N., Tan, S. S., Williams, G., Alhambra-Borrás, T., Koppelaar, E., Bilajac, L., Verma, A., Markaki, A., Mattace-Raso, F., Vasiljev, V., Franse, C. B., & Raat, H. (2021). Socio-demographic characteristics associated with emotional and social loneliness among older adults. BMC Geriatrics, 21(1), 1–10. https://doi.org/10.1186/s12877-021-02058-4

Conversely, strong social networks and active community engagement, such as participation in group activities, act as protective factors for loneliness. Safe neighborhoods, accessible recreation facilities, green spaces, and reliable transportation foster social connections, while societal issues like ageism, migration of younger generations, and cultural shifts increase loneliness.

Measurement of loneliness

Measuring loneliness is challenging due to its subjective nature, which varies across individuals and cultural contexts. Developing valid and reliable surveillance tools is complex, as perceptions of loneliness are shaped by social norms, cultural expectations, and stigma. Globally, tools like the UCLA Loneliness Scale and De Jong Gierveld Loneliness Scale are widely used, but their effectiveness can be limited by differences in urbanization, education, and cultural practices. Underreporting of loneliness is common, particularly where stigma discourages open acknowledgment of the condition, complicating efforts to assess the true extent of the problem. Culturally validated tools are urgently needed to accurately measure loneliness across diverse populations, ensuring a comprehensive understanding of its burden.

The aging global population amplifies the loneliness crisis, with significant implications for health systems and societies. As the elderly population grows, loneliness exacerbates chronic diseases and mental health conditions, increasing healthcare demands and costs.

This burden disproportionately affects vulnerable groups, such as rural elders, ethnic minorities, low-income individuals, and those in institutional settings, increasing health inequities. The shift toward nuclear families and migration of younger generations for work disrupts traditional caregiving systems, leaving elders increasingly isolated. Addressing loneliness is crucial for reducing health disparities, promoting equitable care access, and supporting sustainable aging populations, fostering healthier and more inclusive communities.

Sri Lankan situation

In Sri Lanka, where the elderly population is projected to reach around 24% by 2041, loneliness among those aged 65 and older is a growing public health concern, intensified by societal changes such as the shift to nuclear families and youth migration. Research highlights significant prevalence: a study done in Hikkaduwa municipality found 47.8% of elders experienced social and emotional loneliness, measured with the De Jong Gierveld Loneliness Scale (Subathevan et al., 2022). A study done among Colombo, care home residents recorded a median loneliness score of 45 (out of 20-80) on the Revised UCLA Loneliness Scale (Malinga, H.S; Wijesiri, 2019). Major risk factors include widowhood or divorce, limited family interaction due to distance or busy schedules, poor mental health, and restricted access to communication tools, highlighting the need for culturally tailored interventions. A key challenge in evaluating loneliness is the absence of a validated, Sri Lanka-specific scale, which may limit the accurate capturing of the true extent of this issue in the local context.

Public Health Action for Loneliness

Addressing loneliness requires a coordinated public health approach involving governments, health systems, communities, and researchers. Routine health assessments should include culturally appropriate loneliness screening to identify at -risk elders, with healthcare workers trained to provide counselling and link individuals to support networks. Embedding loneliness interventions within primary care can improve access to mental health services and community resources, particularly for underserved populations.

Community initiatives play a key role in fostering social connections through programs such as elderly clubs, group activities, cultural events, and religious gatherings, which create inclusive environments where elders feel valued.

International efforts, including the WHO's Commission on Social Connection (2024–2026) and the Decade of Healthy Aging, emphasize the importance of social connection for overall health.

Robust national and local surveillance is essential to track trends, assess the effectiveness of interventions, and guide evidence-based strategies to alleviate loneliness. Multi-sector collaboration between health, social services, community organizations, and researchers can strengthen community resilience and provide tailored support to meet elders' specific needs.

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Fig. 2. Interventions and strategies to reduce social isolation and loneliness

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Table 1: Selected notifiable diseases reported by Medical Officers of Health 13th – 19th Sep 2025 (38th Week)

RDHS	Dengue Fever		Dysentery		Encephalitis		En. Fever		F. Poisoning		Leptospirosis		Typhus F.		Viral Hep.		H. Rabiies		Chickenpox		Meningitis		Leishmania-		Tuberculosis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	120	8844	0	24	0	11	1	13	0	34	5	345	0	5	1	20	0	0	11	443	1	56	1	4	47	1516	100	100
Gampaha	93	5816	1	42	1	26	0	3	0	140	22	615	0	10	1	16	0	0	18	668	1	135	1	38	21	879	100	100
Kalutara	27	1927	0	32	0	6	1	19	8	82	12	508	0	3	0	5	0	0	12	679	0	40	0	2	9	443	100	194
Kandy	79	3546	0	43	0	3	0	7	9	46	4	239	2	46	0	7	0	0	23	455	0	20	0	59	9	487	91	100
Matale	34	1011	1	24	0	2	0	1	0	67	6	200	0	5	0	9	0	0	5	113	0	8	13	235	3	114	92	100
Nuwara Eliya	6	271	1	70	0	6	0	6	1	63	7	143	0	48	2	7	0	0	9	236	0	31	0	0	1	207	100	100
Galle	29	1662	3	45	0	5	0	7	4	85	31	650	3	73	2	10	0	1	15	620	3	130	0	3	19	398	100	100
Hambantota	7	726	0	36	0	5	1	2	0	6	2	308	0	28	0	11	0	0	4	257	1	21	26	260	4	112	100	100
Matara	12	1282	0	14	0	2	0	1	6	18	6	378	0	14	0	16	0	0	13	334	2	37	3	85	3	130	100	100
Jaffna	5	957	1	76	0	2	0	16	1	44	1	131	2	412	0	3	0	2	5	270	1	23	0	0	5	162	100	93
Kilinochchi	1	76	0	14	0	1	0	4	0	7	0	64	0	11	0	1	0	0	0	5	0	0	0	2	0	38	75	100
Mannar	3	137	0	6	0	0	1	1	0	3	1	27	0	16	0	1	0	0	0	18	0	14	0	6	0	41	100	100
Vavuniya	1	73	0	9	0	0	0	1	0	38	0	76	0	10	0	0	0	0	1	45	0	18	0	16	2	47	100	100
Mullaitivu	2	53	0	5	0	0	0	1	0	23	0	53	0	10	1	1	0	0	0	31	0	5	1	4	0	25	100	100
Batticaloa	9	1565	3	119	1	15	0	2	4	198	1	104	0	2	2	24	0	0	1	159	1	29	0	1	7	111	100	100
Ampara	6	210	3	45	0	11	0	0	2	20	2	193	0	3	1	10	0	1	3	179	0	43	0	22	1	45	100	100
Trincomalee	2	909	0	39	0	4	0	2	0	77	2	121	0	9	0	5	0	1	3	108	0	12	0	8	1	86	92	100
Kurunegala	15	1334	1	42	0	16	0	2	1	52	3	573	0	24	0	7	0	1	29	704	1	131	11	474	10	275	100	100
Puttalam	6	526	2	27	0	3	0	0	3	14	6	220	0	33	1	3	0	1	1	124	3	78	0	28	0	136	92	100
Anuradhapura	3	461	1	30	0	6	0	3	1	37	2	315	0	24	0	12	0	2	8	278	0	52	12	575	6	245	87	100
Polonnaruwa	2	290	0	16	0	6	0	1	0	73	1	238	0	1	1	22	0	0	5	162	0	22	6	367	2	69	100	90
Badulla	19	666	0	30	0	10	0	3	1	9	4	238	1	26	4	61	0	0	6	326	1	67	3	53	1	229	100	100
Monaragala	10	695	1	25	0	3	1	1	0	17	4	455	0	36	1	49	0	0	3	163	2	43	11	183	4	118	82	100
Ratnapura	65	3995	1	92	1	9	0	4	0	55	36	1223	0	29	1	15	0	1	11	368	0	93	24	190	9	309	100	100
Kegalle	20	1207	0	50	0	13	0	9	0	34	9	614	0	14	1	19	0	0	19	701	4	105	1	25	1	224	91	100
Kalmunai	9	331	0	33	0	6	0	0	0	21	6	93	0	1	0	5	0	1	15	185	3	49	0	0	6	106	92	100
SRILANKA	**585**	**38570**	**19**	**988**	**3**	**171**	**5**	**109**	**41**	**1263**	**173**	**8124**	**8**	**893**	**19**	**339**	**0**	**11**	**220**	**7631**	**24**	**1262**	**113**	**2640**	**171**	**6552**	**96**	**99**

Source: Weekly Returns of Communicable Diseases (esurvillance.epid.gov.lk). T=Timeliness refers to returns received on or before 25th Sep, 2025 Total number of reporting units 360 Number of reporting units data provided for the current week: 359. **C****-Completeness

A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP 13th – 19th Sep 2025 (38th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2025	Number of cases during same week in 2024	Total number of cases to date in 2025	Total number of cases to date in 2024	Difference between the number of cases to date in 2025 & 2024
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	02	00	00	00	02	02	47	56	-16%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Mumps	01	01	01	00	00	01	00	00	00	04	08	182	218	-16.5 %
Measles	00	00	00	00	00	00	00	00	00	00	00	01	285	-99.6%
Rubella	00	00	00	00	00	00	00	00	00	00	00	04	02	-100%
CRS**	00	00	00	00	00	00	00	00	00	00	00	01	00	0 %
Tetanus	01	00	00	00	00	00	00	00	00	00	00	08	05	60 %
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0 %
Japanese Enceph-alitis	00	00	00	00	00	00	00	00	00	00	00	04	06	33.3 %
Whooping Cough	00	01	00	00	00	00	00	00	00	00	03	18	47	-61.7 %

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

RDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS =**Congenital Rubella Syndrome

NA = Not Available

Number of Malaria Cases Up to End of August 2025,

03

All are Imported!!!

Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk. Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

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