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Motivations, Relationships, Health and Quality of Life of Older Volunteers in Times of COVID-19 Pandemic

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Abstract: Within the active ageing framework, this study was carried out during the COVID-19 pandemic on older volunteers, in order to explore the possible relation between, on the one hand, changes in their health, social relationships and quality of life due to the pandemic and, on the other hand, volunteers' motivations and (direct or indirect) experience of the COVID-19 contagion. Although various active-ageing-related issues have been studied during the pandemic, the studies did not cover the topic of the present study. Therefore, the results of this study advance the knowledge on the matter. A sample of 240 older volunteers was surveyed in Italy in July–August 2021. Bivariate analyses and multivariable logistic regression models were performed. The results highlighted that during the COVID-19 pandemic, for older people, volunteering in order to avoid thinking about personal problems was related to worsened health, while volunteering for social reasons was inversely related to a worsening quality of life. Having indirectly (by acquaintances) experienced the COVID-19 contagion was protective against the worsening physical health of older volunteers. The discussion includes the policy implications of the results.

Keywords: older volunteers; active ageing; Volunteer Functions Inventory; COVID-19 pandemic; health; quality of life; social relationships; Italy



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1. Introduction

In the global context characterized by an ageing population trend, which poses several societal challenges for current and future times, active ageing could be an important tool, among possible others, to be implemented in order to face some of these challenges. Volunteering is deemed as one of the main activities where active ageing can be realized [1]. The relevance that volunteering has in the active ageing framework—which has been receiving increasing interest for several years at the European policy level—entails that it is an activity that can be performed even in older age [2,3].

There is a large body of literature highlighting that volunteering in older age is conducive to positive outcomes for both older people and society [4–8].

Concentrating on the individual sphere, the literature pointed out that being engaged in volunteering in later life is positively associated with a lot of personal aspects of life, such as health, quality of life and social relationships, as shown, for instance, by an increased self-rated health [9,10] and better physical and mental health (general health) and wellbeing [11–13]. Moreover, older people who volunteer are more likely to have a higher life satisfaction and improved perceived wellbeing than older people not engaged in voluntary work [12,14–16]. Among the various other benefits at the personal level associated with volunteering in later life, there are a higher self-esteem and autonomy [17], positive mood and affect [18], and reduced depression and risk of cognitive impairment [5,19,20], as well as a better quality of life [21].

Research also elucidated that volunteering may be associated with better social outcomes [22], by enabling older adults to remain connected to society [2] and to be committed to social activities, helping them to establish new social bonds, connections and friendships with other people [23].

Thus, the benefits of volunteering for health, quality of life and social relationships are particularly evident and important in older age, when physical health problems are more likely to arise and when opportunities to be socially integrated, e.g., through work and/or marriage/cohabitation with a partner, are drastically reduced [14].

Moreover, volunteering is a productive activity that benefits society as a whole [24–26]. For example, in the OECD area, the monetary value of the time that adults and older people devote to volunteering was estimated to be close to 2% of the GDP per year, on average [14]. According to the above, volunteering triggers a virtuous circle leading to a “win-win” situation for both personal and social wellbeing [2].

Within this context, the COVID-19 pandemic caused massive societal upheavals worldwide, increasing the need for voluntary services and activities. Many people, including older adults, especially in the first phases of its spread, experienced extraordinary critical situations, such as food/drug scarcity and mental and/or physical health issues, leading to the need for volunteers’ recurring help. During the various COVID-19 pandemic “phases”, an additional growth in the need for volunteers was observed, to support people infected with the virus or to help provide essential and/or new services/activities to respond to the health emergency in a context of social and physical isolation—suffered especially by older people—due to a wide range of containment measures (i.e., physical isolation) implemented by governments to mitigate the impact of the epidemic [27,28].

Such containment measures served to protect older people from the COVID-19 contagion. Nevertheless, such measures have also had negative consequences for seniors, such as delayed medical treatments, challenges to get basic needs met, social isolation and loneliness, with a marked negative impact on their wellbeing, physical and mental health (especially among older people facing extended lockdowns), quality of life and life satisfaction [29–34]. This situation also negatively affected the engagement of older people in voluntary activities, since most containment measures were developed with an age-based approach [8,35] (e.g., stay-at-home restrictions and strict physical distancing), which affected older adults earlier, for longer and more intensely than younger age groups [36–39].

On the one hand, such age-related containment measures and restrictions can be related to and understood by the fact that COVID-19 hits older adults especially compared to younger persons and that age is linked to a growing morbidity and mortality from COVID-19, due to its association with the presence of chronic health issues and multimorbidity [8,40]. On the other hand, most social gerontologists and international organizations considered such an approach to be characterized by ageism. It indeed implied a reliance on stereotypes and prejudices, by considering older people as a homogeneous vulnerable group, dependent and therefore a burden for society [8,35]. This stereotyped approach, as noted by Morrow-Howell and Gonzales [8], risks the nullification of long-standing efforts of both the scientific community and policy makers at the international level to combat ageism, with the risk of increasing discrimination towards older adults [41].

In spite of this scenario, even in the first phase of the COVID-19 pandemic, a certain number of older people found opportunities to volunteer. For example, in some countries, retired healthcare workers (e.g., physicians, nurses) were asked to volunteer to help younger colleagues, who were overwhelmed in the effort to face the health crisis [42]. Other older adults (mainly those ones having a high human capital and technological skills) engaged in virtual forms of volunteering (e.g., as tutors to help families with home schooling; by offering psychological help through helplines and/or platforms set up during the crisis) [43–45]. In other cases, as shown by a study carried out in Belgium, even during the first lockdown, many older adults provided a wide range of help activities to family members, friends, neighbors and strangers [45] while also receiving some kind of support.

This highlights an “interdependence” perspective [45,46]. A study carried out in the United Kingdom showed that older adults were more likely to have both volunteered and increased their non-formal volunteering activities (mainly by engaging in neighborhood help) during the first wave of the pandemic [28].

Still, the literature clearly shows that older people faced several difficulties in accessing volunteering and that volunteers, including many older adults, changed volunteering patterns, reduced their voluntary engagement and volunteering time [35] or became unable to perform voluntary work because of the mentioned pandemic-related stay-at-home regulations based on chronological age, as well as changes in the operational practices of social services and voluntary organizations [43,47,48]. All this made it very difficult, less attractive and in some cases not feasible for older adults to continue to provide volunteer services during the pandemic [49].

Cases of unexpected and abrupt interruptions of volunteering during the COVID-19 outbreak had several negative consequences for older volunteers, such as a worsening of their health and wellbeing [50], a decline in both life satisfaction and quality of life [34], higher levels of loneliness and a higher likelihood of having both psychological distress and a probable serious mental illness, compared to those who continued to volunteer [51]. Indeed, volunteering has been a protective factor for seniors’ health and wellbeing even after the COVID-19 outbreak [35].

2. Background and Hypotesis

2.1. The Italian Situaton during the COVID-19 Pandemic

Italy—where the present study was carried out—was the first country in the Western world affected by the COVID-19 pandemic (the first cases of the disease were confirmed in January 2020), with over 25 million documented cases and 190,000 deaths related to the infection as of 30 April 2023 (Source: WHO Coronavirus (COVID-19) Dashboard, <https://covid19.who.int/>; accessed on 5 May 2023). In order to face the incoming pandemic crisis, Italy was the first European country to introduce a comprehensive and stringent lockdown, declaring a state of emergency on 31 January 2020, renewed with various government acts, until 31 March 2022. The Italian government enacted a wide range of containment measures and restrictions (also age-related) throughout the pandemic period, more stringent and comprehensive or less, according to, and in line with, the different intensities of the various pandemic waves (for more details, see [35]).

According to the COVID-19 Containment and Health Index [27], which is aimed at recording and understanding the strictness of policies introduced by governments for facing the health crisis during the pandemic (value from 0 to 100 = strictest response), throughout the period between January 2020 and December 2022 (Figure 1) the Italian government introduced a more stringent range of measures than France, Germany, Spain and the United Kingdom (with a few exceptions, e.g., January–February 2021 and October 2022).

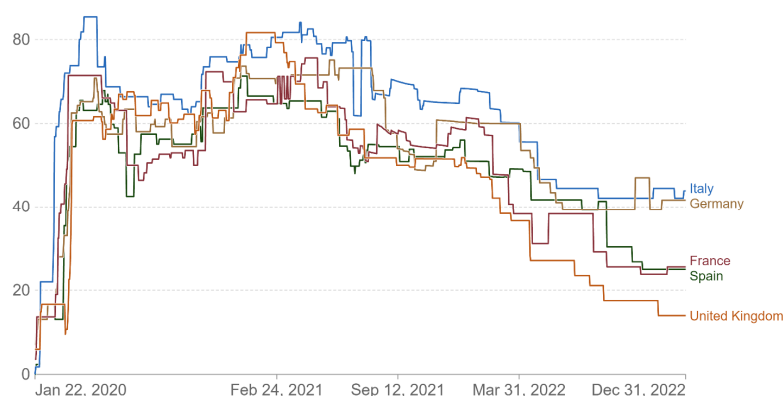


Figure 1. COVID-19 Government Containment and Health Index in some European countries (2020–2022). Source: Oxford COVID-19 Government Response Tracker, Blavatnik School of Government, University of Oxford. Authors’ own elaboration.

Between July and August 2021, when this study was conducted, a loosening of the stringency of government containment measures was observed, which, in part, together with the concomitant diffusion of the delta variant of COVID-19 (characterized by a higher transmissibility than previous variants of the virus), contributed to the growth in cases of COVID-19 contagion in Italy [35].

2.2. The Role of Volunteer Motivations

Research on volunteer motivations in social science dates back to the early 1980s [52] and several studies on motivational factors of seniors linked to voluntary work are available (e.g., [1,53–56]). Such studies highlighted that people engage in volunteering for several and different kinds of motivations and that this involvement can vary according to age groups as well as cultural contexts. For example, motivations related to self-development and protection from negative feelings (i.e., emotional-related volunteer motives or present-oriented motives) were found to be more related to volunteering in older age, while knowledge-related motivations—future oriented ones included—(e.g., a desire to learn new skills or future work-related benefits) were associated with a younger age to a greater extent [45,55,57,58].

Some studies also investigated motivations to volunteer during previous pandemics (e.g., HIV/AIDS, tuberculosis and Ebola) [59–61]. However, few studies focused on the motivations to volunteer of older adults during the COVID-19 pandemic. These few studies concentrated on their connections with possible changes in volunteering activities and habits and, according to their results, it seems that altruistic and social-related motivations are those more relevant, in this respect [45]. However, to our knowledge, no study (both in the presence or not of a pandemic) has dealt with the possible relation between volunteer motivations and changes in health, quality of life and social relationships.

2.3. Aims of the Study and Hypotheses

Taking in consideration the above, in order to fill a gap in knowledge, an aim of the present study is to investigate the possible relationship between volunteer motivations and changes in the health, quality of life and social relationships of older volunteers due to the pandemic.

It has been observed that volunteer motivations are based on an interplay of co-existing altruistic and egoistic elements [62]. Fears and difficulties encountered during the pandemic may have affected the relationship between volunteer motivations and the health, quality of life and social relationships of older volunteers. According to Clary and colleagues [63], there are six kinds of volunteer motivational functions: values (volunteering related to altruistic beliefs); understanding (e.g., to volunteer in order to learn new skills); social (e.g., volunteering as an opportunity to have relationships with others); career (career-related benefits from volunteering); protective (to protect the ego from personal problems through volunteering); and enhancement (e.g., to volunteer due to the desire of personal growth and development). These motivational functions may have in some cases a connection with health outcomes, as well as with social relationships and quality of life. It is interesting to study this connection during the pandemic. Indeed, both health-related fears caused by the pandemic and restriction measures highly jeopardized the volunteering of older people and may have conditioned their attitudes and behaviors, with a connection to health, quality of life and social relationships.

For instance, those older people volunteering in order to protect themselves from personal problems includes the possibility that health-related personal problems may arise during the pandemic for the above-mentioned reasons. Therefore, our first hypothesis is as follows:

H1: *Protective motivations are positively related to worsened health and a worsened quality of life.*

It is known that the volunteering of older people was highly challenged during the particular pandemic situation, due to social restrictions. The older volunteers included in

our study are active volunteers, since they found a way to continue to serve as volunteers, either as before the pandemic or adapting their volunteering schedule. In light of this, we may assume that the social motivational function continued to be served during the pandemic, with related benefits from this. Therefore, our second hypothesis is as follows:

H2: *Social motivations are negatively related to worsened social relationships and quality of life aspects.*

About altruistic motivations, it can be assumed that the decision to keep on serving this motivational need during the pandemic through volunteering could have made volunteers feel better, especially in terms of quality of life. So, our third hypothesis is as follows:

H3: *Altruistic motivations are negatively related to a worsened quality of life.*

As for the role of other motivational functions during the COVID-19 pandemic (understanding, career, enhancement), we do not hypothesize any particular influence on health-related, social relationship and quality of life aspects.

A further aim of this study is to explore whether having experienced (both directly or indirectly, e.g., through friends or other volunteers) a COVID-19 infection may have had a role, too, on the health-related, social relationship and quality of life aspects of older volunteers. It could be assumed that the direct experience of the disease may have influenced the latter and especially health. In addition, the indirect experience may have especially negatively influenced the desire to meet other people, due to a fear of contagion. Following this, additional hypotheses are as follows:

H4: *Direct experience of the COVID-19 contagion is positively related to worsened health.*

and

H5: *Indirect experience of the COVID-19 contagion is positively related to worsened social relationships.*

By investigating the former, this study would add new evidence to the literature, contributing to fill a research gap.

3. Materials and Methods

3.1. Sampling

The present study was carried out in the Marche region (Central Italy) from 1 July to 31 August 2021, on volunteers aged 55 years and older engaged in the local divisions of the three major Italian senior voluntary organizations: AUSER (self-management of solidarity services—association for active ageing); ANTEAS (national association of all ages and solidarity) and ADA (association for the rights of older people). Each volunteer organization was used as a sampling unit, by employing a cluster-sampling methodology. The researchers who carried out the investigation contacted the regional heads of the aforementioned organizations, asking them to invite senior volunteers to complete an online survey prepared via LimeSurvey. In total, 240 older volunteers filled in the questionnaire. This sample cannot be considered as representative of older volunteers involved in such organizations. The questionnaire was broken down into the following sections: socio-demographics; activities of volunteering (including volunteer motivations); the COVID-19 pandemic impact on personal circumstances, activities and various aspects of volunteering in older age.

3.2. Measures

3.2.1. Endpoints

Potential changes in personal aspects experienced by older volunteers during the pandemic were measured by asking older volunteers: “Thinking about your personal situation, compared to before the pandemic started, has the situation worsened with regard to the following aspects?” (answer categories Y/N): (a) Physical health; (b) General health; (c) Quality of life; (d) Family and Friendship relationship.

3.2.2. Explanatory Variables

Motivations for volunteering were measured via the Volunteer Function Inventory (VFI) [63], as it is a widely used and standardized tool for assessing volunteer motivations [64,65], applied in several studies at the international level (e.g., [56,66,67]), as well as in Italy (e.g., [1,35,55,56]).

The VFI is a 30-item questionnaire divided into six motivational functions scales of five items each, which are scored using a 5-point Likert scale, ranging from 1 (not at all important) to 5 (very important). The six functional motivations (i.e., factors) assessed are the following: values (related to altruistic and humanitarian concerns); understanding (gaining and/or improving knowledge, skills, experiences and capacities through volunteering); social (volunteering as a chance to develop and strengthen relationships with others); career (related to professional and academic developments/benefits from volunteering); protective (volunteering as a way to protect the ego from difficulties in life); and enhancement (centered on self-knowledge, self-development and growth, and, overall, feeling better about oneself through volunteering). Each motivational factor was obtained by summing the respective five items and the results were divided by 5: in this way each factor ranged from 1 to 5 with the possibility of assumed intermediate values among each unit. This study, therefore, represents the first attempt to apply this tool in order to understand potential influences of volunteer motivations on changes in personal aspects of older volunteers during the pandemic. Examples of questions measuring the different motivational functions are the following: “I am concerned about those less fortunate than myself” (values); “I can learn how to deal with a variety of people” (understanding); “volunteering makes me feel better about myself” (enhancement); “others with whom I am close place a high value on community service” (social); “no matter how bad I’ve been feeling, volunteering helps me to forget about it” (protective); and “volunteering allows me to explore different career options” (career).

In order to assess the potential effect of COVID-19 contagion, the following question was asked: “Did the pandemic have an impact on your health or on the health of somebody you know? (answer categories Y/N)”, for the following multiple options: (a) “I have had COVID-19”; (b) “a family member has had COVID-19”; or (c) “an acquaintance (e.g., other volunteers, friends, colleagues) has had COVID-19”.

3.2.3. Confounders

As regards covariates, the following were considered: age, gender, marital status (categorized as married or cohabiting; single, divorced or separated; widowed), educational level based on the International Standard Classification of Education (ISCED 0: less than primary educational attainment; ISCED 1: primary education; ISCED 2: lower secondary education; ISCED 3: upper secondary education; ISCED 4: post-secondary education; ISCED 5: short-cycle tertiary education; ISCED 6: bachelor or equivalent level; ISCED 7: master or equivalent level; ISCED 8: doctoral or equivalent level) (aggregating levels 0–2 as “low education”, 3–4 as “intermediate education” and 5+ as “high education”), working part/full time (Y/N), frequency of voluntary work (categorized as twice a week or more often; once a week; or once every two weeks or less often).

3.3. Sample Description

The sample characteristics are presented in Table 1. Older volunteers who participated in the study have a mean age of about 70 years and men are more represented than women. Seven out of ten respondents are married/cohabiting. As regards education, older volunteers with a high level of education are the least represented in the sample. Only a small group of subjects is still working, while more than half of the respondents are volunteering twice a week or more often.

Table 1. Sample characteristics (N = 240).

Variables	%; Mean \pm SD
Demographics and socio-economic characteristics	
Age	70.26 \pm 6.43
Gender (female)	47.9%
Marital status	
Married/cohabiting	71.6%
Single, separated or divorced	16.3%
Widowed	12.1%
Educational level:	
Low	38.3%
Intermediate	44.2%
High	17.5%
Working part/full-time (yes)	9.3%
Volunteering frequency:	
Twice a week or more often	51.3%
Once a week	29.3%
Once every two weeks or less often	19.4%
Volunteering motivational functions (VFIs)	
Values	3.86 \pm 0.72
Understanding	3.33 \pm 0.89
Enhancement	3.45 \pm 0.91
Social	3.09 \pm 0.93
Protective	2.77 \pm 1.01
Career	1.86 \pm 0.98
COVID-19-related factors	
I have had COVID-19	13.0%
A family member has had COVID-19	28.0%
An acquaintance has had COVID-19	46.5%
Changes in personal aspects in times of COVID-19	
Worsened physical health	28.6%
Worsened general health	21.2%
Worsened quality of life	28.2%
Worsened family and friendship relationship	40.3%

For what concerns the six VFI factors, career-related motivations had the lowest mean value, while the altruistic motivations showed the higher average value. As regards the direct and indirect impact of the pandemic, only 13% of the respondents personally contracted a COVID-19 infection.

In times of COVID-19, 28.6% of the sample reported a worsening in physical health, 21.2% a worsening in general health and 28.2% a worsening in quality of life. A quite large group of subjects (40.3%) reported a deterioration of family and friendship relationships.

3.4. Statistical Analyses

As regards descriptive statistics, categorical variables were reported as the absolute number and relative frequency (i.e., percentage), while mean and standard deviation were calculated for continuous variables. In order to provide comparison between volunteering motivational functions and outcome variables, a bivariate analysis was carried out and evaluations were made by means of a Student's *t*-test. Associations between COVID-19-related factors and personal aspects were evaluated by a Pearson's Chi-square test.

Four models of multivariable logistic regression were estimated for each endpoint, adjusting for all potential confounders, included in the regression by blocks, reporting Odds Ratios (ORs) and *p*-values. Models 1 and 2 reported unadjusted estimations of the association between motivational factors or COVID-19-related factors and outcome variables.

Model 3 represented a combination of Model 1 and Model 2 with the reciprocal adjustment of the two blocks of independent variables. In Model 4, fully adjusted estimations were reported. A 2-tailed p -value < 0.05 was considered significant. Data analysis was performed using STATA 15.1 (StataCorp., College Station, TX, USA).

4. Results

Table 2 reports the relationship between motivational factors (VFIs) and the dependent variables representing changes in older volunteers' personal aspects.

A worsening in physical health shows no statistically significant relationship with the six motivational factors, while a worsening in general health is significantly related to all of them with the exception of values. In each of these five cases, older volunteers who reported a worsening in general health had a lower motivational score in comparison with senior volunteers who did not experience such deterioration.

The same result was obtained with regard to a worsening in quality of life: in this case, older volunteers with a decrease in quality of life reported a lower motivational score in comparison with senior volunteers without a worsening in quality of life.

As regards family and friendship relationships, older volunteers who reported a worsening of such relations had significantly lower motivational scores for values, understanding, social aspects and career in comparison with those who did not report a worsening in family and friendship relationships.

Table 3 shows bivariate analyses about the potential association of possible changes in personal aspects and having had a direct or indirect experience of COVID-19.

This association is not confirmed by results, since no significant result was obtained among the 12 relations tested.

In order to more deeply investigate these aspects, we regressed the four dependent variables, by employing incremental models.

Table 4 reports the results about the relation of the explanatory variables and covariates with worsened physical health.

As regards VFIs, the protective motivational function kept statistical significance in Models 1, 3 and 4, with ORs ranging from 1.93 to 2.06, meaning that an increase of one point in the protective VFI is associated with a growth of about two points in the probability of a worsening physical health.

As for the experience of COVID-19, in the fully adjusted model (i.e., Model 4), acquaintances that had experienced COVID-19 had a significant role when related to a physical health not worsening. As regards control variables, the only confounders associated with worsening in physical health in a statistically significant way are age (the older the volunteer, the higher the probability of physical health deterioration) and working in the labor market, i.e., individuals still working (part-time or full-time) have 4.9 times the probability of experiencing a worsening in physical health during the pandemic.

In Table 5, the results of the regressions on worsened general health are presented.

Table 2. Potential changes in personal aspects and motivational functions (VFI), bivariate analyses, means \pm sd.

	Values		Understanding		Enhancement		Social		Protective		Career	
	Mean \pm sd	<i>p</i>	Mean \pm sd	<i>p</i>	Mean \pm sd	<i>p</i>	Mean \pm sd	<i>p</i>	Mean \pm sd	<i>p</i>	Mean \pm sd	<i>p</i>
Worsening physical health												
Yes	3.88 \pm 0.69	0.793	3.33 \pm 0.72	0.832	3.37 \pm 0.80	0.263	2.99 \pm 0.92	0.352	2.81 \pm 0.84	0.784	1.79 \pm 0.91	0.597
No	3.91 \pm 0.72		3.36 \pm 0.95		3.52 \pm 0.93		3.13 \pm 0.96		2.76 \pm 1.06		1.87 \pm 1.01	
Worsening general health												
Yes	3.82 \pm 0.75	0.399	3.07 \pm 0.79	0.013 *	3.16 \pm 0.82	0.007 **	2.76 \pm 1.04	0.007 **	2.34 \pm 0.87	0.001 ***	1.56 \pm 0.75	0.028 *
No	3.92 \pm 0.70		3.44 \pm 0.90		3.57 \pm 0.90		3.18 \pm 0.90		2.89 \pm 1.00		1.93 \pm 1.02	
Worsening quality of life												
Yes	3.79 \pm 0.68	0.151	3.10 \pm 0.84	0.009 **	3.22 \pm 0.90	0.011 *	2.69 \pm 1.04	0.001 ***	2.48 \pm 0.97	0.012 *	1.59 \pm 0.90	0.021 *
No	3.94 \pm 0.72		3.45 \pm 0.89		3.57 \pm 0.87		3.25 \pm 0.86		2.87 \pm 0.99		1.94 \pm 0.94	
Worsening family and friendship relationship												
Yes	3.78 \pm 0.67	0.049 *	3.16 \pm 0.82	0.012 *	3.33 \pm 0.85	0.054	2.80 \pm 1.00	0.001 ***	2.60 \pm 1.00	0.051	1.64 \pm 0.83	0.016 *
No	3.98 \pm 0.73		3.47 \pm 0.91		3.57 \pm 0.91		3.27 \pm 0.87		2.88 \pm 0.98		1.97 \pm 1.02	

* $p < 0.05$; ** $p < 0.01$; *** $p \leq 0.001$.**Table 3.** Possible changes in personal aspects and experience of COVID-19 (yes), bivariate analyses, %.

	COVID-19 Myself		COVID-19 Family Member		COVID-19 Acquaintance	
	%	<i>p</i>	%	<i>p</i>	%	<i>p</i>
Worsening physical health						
Yes	16.4	0.355	29.5	0.762	40.0	0.235
No	11.7		27.5		49.0	
Worsening general health						
Yes	15.9	0.524	24.4	0.546	45.5	0.878
No	12.3		29.0		46.8	
Worsening quality of life						
Yes	10.2	0.435	25.0	0.520	44.1	0.695
No	14.2		29.4		47.1	
Worsening family and friendship relationships						
Yes	11.8	0.642	30.2	0.582	44.7	0.716
No	13.9		26.8		47.2	

Table 4. Explanatory variables for possible worsened physical health in times of COVID-19, logistic regression.

	Model 1		Model 2		Model 3		Model 4	
	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>
Motivational functions (VFIs)								
Protective	1.93	0.015 *			2.00	0.015 *	2.06	0.024 *
Values	0.87	0.645			0.87	0.653	0.84	0.622
Career	0.95	0.806			1.02	0.917	1.12	0.652
Social	0.67	0.114			0.61	0.061	0.64	0.135
Understanding	1.27	0.472			1.27	0.503	1.10	0.816
Enhancement	0.58	0.084			0.54	0.057	0.54	0.099
Experience of COVID-19								
I have had COVID-19			1.44	0.414	1.97	0.168	2.09	0.188
A family member has had COVID-19			1.08	0.839	1.01	0.988	1.42	0.469
An acquaintance has had COVID-19			0.69	0.235	0.71	0.334	0.41	0.035 *
Control variables								
Female gender (ref. male)							1.72	0.202
Age							1.08	0.024 *
Marital status (ref. married/cohabiting)								
Single/separated/divorced							2.14	0.144
Widowed							0.81	0.711
Educational level (ref. low)								
Intermediate							0.85	0.715
High							2.06	0.181
Working part/full-time (ref. no)							4.90	0.027 *
Volunteering frequency (ref. twice a week or more often)								
Once a week							0.64	0.321
Once every two weeks or less often							0.33	0.053
Constant	1.19	0.854	0.43	0.000	1.64	0.605	0.01	0.088

* $p < 0.05$.**Table 5.** Explanatory variables for possible worsened general health in times of COVID-19, logistic regression.

	Model 1		Model 2		Model 3		Model 4	
	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>
Motivational functions (VFIs)								
Protective	0.80	0.476			0.85	0.624	0.61	0.217
Values	1.44	0.276			1.42	0.318	1.87	0.138
Career	1.06	0.834			1.17	0.612	1.29	0.475
Social	0.67	0.170			0.59	0.078	0.62	0.198
Understanding	0.74	0.429			0.80	0.580	0.79	0.623
Enhancement	0.88	0.738			0.77	0.505	0.90	0.827
Experience of COVID-19								
I have had COVID-19			1.51	0.411	2.21	0.144	1.53	0.521
A family member has had COVID-19			0.74	0.473	0.89	0.814	1.65	0.391
An acquaintance has had COVID-19			0.96	0.911	0.96	0.922	0.68	0.432
Control variables								
Female gender (ref. male)							1.02	0.969
Age							1.19	0.000 **
Marital status (ref. married/cohabiting)								
Single/separated/divorced							1.66	0.463
Widowed							1.24	0.742
Educational level (ref. low)								
Intermediate							0.57	0.273
High							1.56	0.516
Working part/full-time (ref. no)							5.00	0.046 *
Volunteering frequency (ref. twice a week or more often)								
Once a week							1.20	0.716
Once every two weeks or less often							0.10	0.042 *
Constant	1.25	0.831	0.27	0.000	1.54	0.684	0.00	0.001

* $p < 0.05$; ** $p < 0.01$.

In all four models, neither volunteering motivational functions nor a direct or indirect experience of COVID-19 variables were associated with a worsening in general health. In Model 4, among control variables, age played, again, an important role (the older the volunteer, the higher the probability of having experienced a worsening in general health).

In addition to this, work in the labor market is significantly associated with the outcome variable, i.e., subjects still working (part- or full-time) have 5 times the probability of undergoing a worsening in general health in times of COVID-19.

Concerning volunteering frequency, older study participants who volunteered once every two weeks or less often had a lower probability of experiencing a worsening in general health, compared to more committed volunteers.

In Table 6, the four models were estimated considering a worsened quality of life as the outcome variable.

Table 6. Explanatory variables for possible worsened quality of life in times of COVID-19, logistic regression.

	Model 1		Model 2		Model 3		Model 4	
	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>
Motivational functions (VFIs)								
Protective	1.15	0.608			1.26	0.416	1.11	0.746
Values	0.96	0.887			0.96	0.909	0.90	0.764
Career	0.86	0.563			0.92	0.748	0.99	0.985
Social	0.53	0.015 *			0.49	0.008 **	0.52	0.028 *
Understanding	0.86	0.651			0.91	0.784	0.84	0.655
Enhancement	1.18	0.618			1.04	0.899	1.30	0.511
Experience of COVID-19								
I have had COVID-19			0.70	0.488	1.00	0.996	1.12	0.850
A family member has had COVID-19			0.89	0.755	0.83	0.667	1.15	0.776
An acquaintance has had COVID-19			0.88	0.696	0.79	0.514	0.59	0.214
Control variables								
Female gender (ref. male)							0.96	0.920
Age							1.08	0.029 *
Marital status (ref. married/cohabiting)								
Single/separated/divorced							2.79	0.052
Widowed							1.04	0.949
Educational level (ref. low)								
Intermediate							1.98	0.133
High							5.04	0.005 **
Working part/full-time							0.51	0.432
Volunteering frequency (ref. twice a week or more often)								
Once a week							0.75	0.531
Once every two weeks or less often							0.50	0.225
Constant	2.47	0.336	0.44	0.000	2.98	0.256	0.01	0.085

* $p < 0.05$; ** $p < 0.01$.

As regards motivational functions, the social one has kept the significant level across all models, in which the more there is of this kind of motivation, the lower the probability of experiencing a worsening in quality of life in comparison with before the pandemic era. In Model 4, age and educational level are the confounders with a statistically significant relationship with the outcome. More specifically, the older the volunteer, the higher the probability of experiencing a decrease in quality of life, and, subjects with a high educational level have a 5 times greater probability of a decreased quality of life.

Table 7 reports the results concerning explanatory variables for worsened family and friendship relationships due to the COVID-19 pandemic.

Table 7. Explanatory variables for possible worsened family and friendship relationships in times of COVID-19, logistic regression.

	Model 1		Model 2		Model 3		Model 4	
	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>	OR	<i>p</i>
Motivational functions (VFI)								
Protective	1.08	0.751			1.05	0.849	0.89	0.684
Values	0.94	0.827			0.91	0.748	0.89	0.707
Career	0.81	0.340			0.92	0.700	1.05	0.855
Social	0.63	0.045 *			0.59	0.028 *	0.61	0.059
Understanding	0.90	0.720			0.95	0.858	1.04	0.906
Enhancement	1.16	0.625			1.04	0.885	1.09	0.802
Experience of COVID-19								
I have had COVID-19			0.72	0.458	0.75	0.546	0.70	0.496
A family member has had COVID-19			1.32	0.398	1.78	0.125	2.08	0.077
An acquaintance has had COVID-19			0.88	0.643	0.73	0.328	0.76	0.442
Control variables								
Female gender (ref. male)							0.98	0.950
Age							1.06	0.051
Marital status (ref. married/cohabiting)								
Single/separated/divorced							2.34	0.083
Widowed							1.48	0.464
Educational level (ref. low)								
Intermediate							1.34	0.442
High							1.80	0.256
Working part/full-time							0.83	0.771
Volunteering frequency (ref. twice a week or more often)								
Once a week							2.30	0.040 *
Once every two weeks or less often							1.25	0.640
Constant	3.60	0.145	0.69	0.072	4.92	0.080	0.02	0.165

* *p* < 0.05.

Social-related motivations were the only factor playing a role across models (i.e., the higher this motivation, the less likely the worsening of family and friendship relationships), even if in the fully adjusted Model 4 it was only nearly statistically significant. As regards frequency, volunteering once a week rather than more often increased the possibility of worsening family and friendship relationships.

5. Discussion

The well-documented and wide benefits associated with the volunteering of older people for both older adults themselves and society as a whole lead to the consideration of volunteering as a public health strategy contributing to tackling social isolation and health inequalities in older age [68], according to the active ageing approach to be adopted by contemporary ageing societies.

However, the outburst of the COVID-19 pandemic and the subsequent emergency containment measures put in place by governments based on chronological age had serious implications for older people. Ideally and genuinely inspired by the assumption that older individuals were those most at risk of being infected by the virus, which was related to the risk of mortality, such measures forced mainly older individuals—and for longer periods than younger age groups—to stay at home, reducing their physical and social contacts, for the sake of their protection from the COVID-19 contagion. This also, for older people, resulted in reduced opportunities for social participation, including volunteering, with implicit reduced opportunities to enjoy the benefits of this activity in terms of health and wellbeing.

The pandemic also posed several challenges for those older volunteers who managed to continue to perform volunteer work during the health crisis, with possible consequences on health, quality of life and social relationships. By exploring such issues, this paper has been conceived as a study complementary to that of Principi et al., 2022 [35] (who analyzed the same sample), and it is aimed at providing insights and integrating the already published results, which mostly concerned changes in volunteering [35].

The results of this study concerned possible changes in the health, quality of life and social relationships of older volunteers, in relation to volunteer motivations. We hypothesized that volunteer motivations could have a role, in this respect. Older volunteers' motivations have been studied in connection with several aspects [45,55,57,58] but have hardly ever been studied with health, quality of life and social relationships. This is even more true in the specific situation of an ongoing pandemic.

Our first hypothesis concerned the motivational function of volunteering of protecting the ego from personal problems. We hypothesized the latter as being positively related to worsened health and a worsened quality of life (H1). This hypothesis was partially supported, in which a statistically significant connection resulted in this direction, with physical health. This could have been due to the fact that the pandemic and the related implemented containment measures resulted in the prolonged interruption, postponement and cancellation of health, social and community care services for older people. This situation could have caused problems and challenges especially to older volunteers with this kind of motivation, who, according to the motivational factor driving them, could be those ones with more personal problems in terms of health. This would have meant, for them, increased difficulties in accessing medical visits and examinations and in receiving appropriate treatments, and this may have worsened their health conditions even more. This is somewhat in line with the findings obtained by other research [69], which, although it did not focus on volunteer motivations, highlighted a deterioration in the perceived health of older individuals during the pandemic and its association with the postponement or denial of medical treatment. Other research [70,71] still showed a negative impact of the challenges to access to health and care services during the pandemic on the overall mental and physical health of older people with caring responsibilities.

A second hypothesis (H2) was about the social type of motivations being negatively related to worsened social relationships and a worsened quality of life. This hypothesis has been mostly supported. Older people who continued to volunteer during the pandemic could have not experienced a worsening in quality of life, possibly since they enjoyed the privilege of avoiding—at least in large part—the social restrictions (through continuing volunteering), while most of older people did not. Indeed, volunteering can be considered a very useful and meaningful tool to continue to experience feelings related to quality of life, such as life satisfaction, self-fulfillment, self-realization and self-esteem [21]. Volunteering is an important tool for maintaining habits during the COVID-19 outburst, by allowing volunteers to preserve and continue to cultivate social relationships, thus “mitigating” the consequences of the containment measures enacted by the government, which have also led to a disruption of social life and to social isolation being experienced by many older citizens. It makes sense that, especially when older volunteers are driven by social motivations, the fulfillment of this motivational need positively affects quality of life. This is quite in line with findings of other research, pointing out that older people providing informal volunteer help (i.e., outside formal volunteering organizations) to friends, neighbors and local communities driven mainly by social—and other kinds of—motivations during the first phases of the pandemic reported a higher quality of life compared to other groups of seniors (e.g., those who received but did not offer help and those who did not provide and did not receive any kind of help) [72]. To some extent, the results concerning social relationships were also in this direction; however, in the latter case this was not relevant in the final fully adjusted statistical model.

We also hypothesized that altruistic motivations could have been negatively related to a worsened quality of life (H3). This was not supported by the results. Actually, this

kind of motivation was not related to any outcome variable, and this implied that altruistic attitudes during the pandemic were probably considered by older volunteers as normal behavior without any particular personal benefits due (or perceived to be expected) in terms of an (improved) quality of life. This aspect also emerged in other studies, highlighting that volunteers driven by altruistic motivations during the pandemic provide support, e.g., for sharing a community/humanity identity or to support disadvantaged groups, without expecting specific benefits related to quality of life for themselves [73].

As expected, other motivational types, still important for Italian older volunteers [45,73], did not emerge as significant factors during the COVID-19 outbreak, in relation to the study outcome variables.

A further aim of this study was to explore whether having experienced (both directly or indirectly) a COVID-19 infection may have had a role, too, on the health, social relationships and quality of life of older volunteers. We thought that health would have worsened in the case of direct contagion (H4), while the COVID-19-related fear could have been increased in case of an indirect (of a family member or of an acquaintance) experience, inducing older volunteers to reduce social relationships (H5). Neither of these two hypotheses were supported by the results of the study. Trying to give an explanation of this, it could be that respondents who declared that they had contracted the infection (or who reported such a circumstance for a family member or acquaintances) could mainly have experienced a not severe/mild form of the virus or experienced a (direct or closely indirect) contagion quite a long time before the survey, in line with some research on the topic [74].

However, an indirect experience (by acquaintances) of a COVID-19 infection is associated with physical health not worsening. This result is surprising and not easy to explain. Maybe the possible fact of not having contracted the infection (while other familiar people had) made older volunteers feel healthier.

As for the control variables analyzed, it emerged that age, educational level, working in the labor market and volunteering frequency had a role in the personal aspects of older volunteers during the COVID-19 outbreak.

With reference to age, the results showed that the older the volunteers, the higher was the probability of experiencing a worsening in general health, physical health and quality of life. This result is not a surprise in itself, since it is documented that this happens in general and not only in the case of emergency situations [75–77].

As for the educational level, the results of the study put in evidence that older volunteers with a high educational level were those more exposed to the risk of worsening their quality of life due to the COVID-19 outbreak. This is in contrast with findings of other studies [78,79]. This insight might be related to the fact that in Italy social and cultural life is a prerogative for highly educated older people [80–82], and the disruption of all this due to the containment measures may have dramatically hit their quality of life since expectations and aspirations in this respect were highly disregarded.

We also found that older volunteers still working in the labor market had a higher likelihood of experiencing a worsening in both physical health and general health during the pandemic. This may be explained by the potential need to adapt their working conditions/arrangements/routines due to the health crisis and the consequent potential challenges and increasing difficulties in performing their job duties and combining them with volunteering engagement and/or with their caregiving duties, in the case of working carers, which, as shown by some studies (e.g., [83]), experienced a deterioration in their health during the COVID-19 pandemic. Concerning volunteering frequency, findings showed that, compared to older volunteers engaged in volunteering more often, seniors who volunteer less frequently (i.e., once a week or less often), had, on the one hand, a lower likelihood of a worsening in general health, and, on the other hand, a higher possibility of experiencing a deterioration of family and friendship relationships. While the latter aspect could be quite logically related to potentially reduced volunteer activities, the relation between the low frequency of volunteering and a general health that did not decrease should be further investigated. Indeed, it may be expected that the higher the volunteer

frequency, the higher the (health) benefits of volunteering. However, this generally applies to ordinary times, while our study measured worsened health due to the pandemic. It could be that, due to the COVID-19 contagion, i.e., an emergency situation, older people who volunteer more frequently have had to face many additional tasks within volunteer organizations, and this may have resulted in a greater burden and stress, which negatively conditioned the relationship with their health.

The results of this study provide important policy implications. As for the results of older volunteers driven by protective motivations, which are associated with more health problems during the pandemic (assuming as a starting point for them a situation of the presence of such problems), policy implications may concern not only older volunteers but all older people who had to deal with diseases already before the pandemic. Public policies should be able to guarantee regular access to, and the functioning of, health services even in difficult times characterized by a pandemic like the COVID-19 one, in order to allow sick people to deal with their diseases, as these needs are important. Moreover, the result of protection against a worsened quality of life being linked to volunteering for the desire to have relationships with others may indicate to policy makers that they were wrong to set social restrictions based on chronological age, thus treating all older people as a homogeneous group, rather than individuals with different situations, aspirations and attitudes. It was not taken into adequate consideration that older people are different in terms of health, functioning, vocations, life experiences, cultural backgrounds and work status and in terms of the resources available to them [34,41]. As demonstrated by the results of this study, during a pandemic, for certain older volunteers, by continuing to have social relationships through volunteering (thus avoiding or limiting social restrictions), quality of life may still improve. The latter is fully coherent with the result obtained that having hardly experienced a direct or indirect COVID-19 contagion is linked with worsened health, a worsened quality of life and worsened social relationships.

6. Conclusions

The results of this study highlighted that during the COVID-19 pandemic, especially for older volunteers, the motivational drivers of volunteering to avoid thinking about personal problems and of volunteering for social reasons are related to worsened health (the former) and to a quality of life that was not worsened (the latter), while having indirectly (acquaintances) experienced the COVID-19 contagion seems to be protective against the worsening physical health of older volunteers.

This study has some limitations. The explorative design of the study, as well as the convenience (not randomized sampling) strategy used for recruiting the participants, do not allow for the generalization of findings. Another limitation is related to the size of the sample. Due to funding constraints, it was not possible to involve a wider number of older volunteers (e.g., in order to explore potential differences among different areas of the country).

Another point could be about the possible under-representation within the sample of older volunteers who have experienced the virus symptoms, due to health-related difficulties in accessing and completing the questionnaire (in case older volunteers were infected with the COVID-19 virus).

Even considering these limitations, this study adds evidences and insights to the active-ageing-related literature, through findings on changes in the health, quality of life and social relationships of older volunteers due to the COVID-19 pandemic, in relation to volunteer motivations and to the direct or indirect experience of the COVID-19 contagion, thus filling a gap in the literature. These results also call for future research on the same topic in the post-pandemic era, in order to understand possible differences in the relation between motivational drivers of older volunteers and their health, quality of life and social relationships.

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