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Role and experiences of youth community health volunteers in a community health coaching programme for older adults in Singapore: a qualitative study

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ABSTRACT

Introduction Older adults are often faced with a multitude of physical and social challenges that impede their ability to age healthily. To tackle this issue, the use of trained lay volunteers as health advocates has become increasingly popular; however, their perceptions and experiences remain to be explored. This study aimed to explore the experiences of youth community health volunteers (YCHVs) who participated in HealthStart, a community health coaching programme for older adults in Singapore.

Methods We conducted purposive sampling and carried out semi-structured interviews with 16 YCHVs and eight healthcare volunteers. Data were analysed thematically using deductive and inductive coding.

Results We generated four themes: (1) structured training, resources, and in-person mentorship helped YCHVs effectively support older adults in their health journeys, (2) facilitators and barriers influenced older adults' receptiveness to YCHVs, (3) YCHV motivations to volunteer, and (4) YCHVs becoming trained health advocates and contributing to preventive health strategies. Findings illustrated the facilitators and challenges experienced by YCHVs and the contributions they can make to preventive health strategies.

Conclusion The exploration of YCHVs' motivation and experience can potentially improve the uptake, acceptability, and satisfaction of using trained youth health advocates in community health coaching programmes for older adults.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ We know that many older adults face challenges with healthy ageing and community-based initiatives are becoming increasingly popular to support this population.

WHAT THIS STUDY ADDS

⇒ This study contributes to the literature that youth community health volunteers can become health advocates for community-dwelling older adults with a structured programme and mentorship from healthcare volunteers.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND POLICY

⇒ This study informed future research, practice, and policy on integrating youth community health volunteers as health advocates within the healthcare system and in promoting preventive health strategies in Singapore and potentially elsewhere.

INTRODUCTION

In recent decades, the global population has undergone a significant demographic shift characterised by an increasing proportion of older adults. The number of people aged 60 years and older is projected to double from 2015, reaching 2.1 billion by 2050.[1] As the population ages, the prevalence of chronic conditions will also rise. Individuals with chronic conditions often experience psychological and physical difficulties resulting from chronic symptoms, poorer function, increased risk of mortality, higher personal medical expenses, and poorer health-related quality of life.[2 3] Aside from the burden on the individual, the rising pervasiveness of chronic conditions places a significant strain on the healthcare system as demands for healthcare-related services continue to surge, such as higher rates of bed occupancy and emergency department presentations.[4] Consequently, increasing emphasis has been placed on empowering community-dwelling older adults to manage their conditions.

Community-based interventions have been gradually employed to address the needs of older adults. Notably, the use of community health volunteers (CHVs), individuals from the community who undergo training to disseminate health promotion messages to empower their community, has been in the global spotlight for their ability to be ambassadors for the healthcare system and advocates for their community.[5 6] For instance, the Coaching Ongoing Momentum Building On Stroke Recovery Journey (COMBO-KEY) programme improved stroke survivors' self-efficacy, outcome expectations, and engagement in self-management behaviours using trained volunteers.[7] Similarly, the Health Teams Advancing Patient Experience: Strengthening Quality (Health TAPESTRY) programme used trained community volunteers to be extensions of primary care teams by helping older adults to set lifestyle goals and connect them to community resources,[8] resulting in fewer hospital admissions and increased physical activity.[9]

Despite the growing literature on the efficacy of such community-based interventions on improving health among community-dwelling older adults, the experiences of these trained CHVs are underexplored.[6] There is limited literature on the experiences and impact of CHVs on improving population health indicators as well as facilitators and challenges they face when delivering more complex interventions beyond raising awareness.[6] Finally, the existing literature primarily involved adult CHVs or volunteers across wide age groups, with limited studies on youth volunteers (15–35 years old) who may bring with them a different set of skills and perspectives. While the involvement of youths in ageing and intergenerational programmes has been extensively documented, existing programmes are often broad in scope and do not focus on health promotion. While the World Health Organisation (WHO) defines youths as those aged 15–25 years old, Singapore's Ministry of Culture, Community, and Youth categorises youth more broadly as those 15–35 years old, we thus used the latter definition.[10]

Youth volunteers may bring with them fresh ideas, technological familiarity, and unique communication styles, all of which enhance health promotion efforts.[11] Training youth CHVs (YCHVs) promotes intergenerational transfer of health-promotion knowledge, while also encouraging youths to shape their health behaviours at a critical stage, which would benefit their personal well-being as well as that of the broader community.[12–14] Exploring their experiences would contribute to understanding the potential for youths to become CHVs as a possible health intervention. This study aims to explore the experiences of YCHVs who have participated in a community health coaching programme for older adults in Singapore. While this study focuses on YCHVs' experiences of a specific intervention, findings on their role, challenges, and facilitators can contribute to understanding their potential impact on health promotion interventions.

MATERIAL AND METHODS

Study design

We chose a qualitative descriptive design, informed by clinical pragmatism, conducting semi-structured interviews exploring YCHVs' and healthcare volunteers' (HCVs) experiences of participating in HealthStart, a health coaching programme for older adults. This approach, within a pragmatic onto-epistemology, prioritises experiential knowledge, pluralism, fallibilism, and practical recommendations. We used the HealthStart Theory of Change (figure 1), constructed to clarify how its objectives and interventions could achieve intended outcomes to guide data collection and analysis.[15]

Our research question was: 'What are YCHVs' and HCVs' perspectives on their role and experiences as part of a community health coaching programme for older adults?'

Study site

This study was conducted as part of an evaluation of HealthStart, a programme jointly organised by TriGen, a charity organisation, and the Singapore General Hospital (SGH) Division of Population Health and Integrated Care (PHIC), which oversees care integration initiatives in Southeast Singapore. HealthStart is a self-determination theory-based intervention using the Specific, Measurable, Achievable, Realistic, Timely framework (SMART) for goal setting.[15] The longitudinal nature of the programme emphasises establishing connections, promoting health ownership and competence, and fulfilling participants' need for relatedness, as shown in the Theory of Change.[15] The programme aims to increase engagement and follow-up rates of older adults attending a chronic cardiovascular disease community health screening by developing, training, and empowering YCHVs as health advocates that accompany them in their post-screening journey over 3 months, under the mentorship provided by HCVs.

Before embarking on their post-screening journey with older adults, YCHVs undergo training in knowledge of chronic disease management and skills to conduct health coaching with older adults. During the post-screening journey, YCHVs provide knowledge and skills to improve older adults' chronic disease management, e-health literacy, positive lifestyle modifications, follow-up with primary care, and self-efficacy to manage one's health.[15–18] With a high rate of unscreened individuals and poor follow-up adherence, accompanied by an insufficient number of community health workers to effectively address this, YCHVs can help bridge these gaps by augmenting CHVs' work.[19]

Sampling and recruitment

Purposive sampling was used to select two YCHVs (aged 15–35 years with no healthcare background) for every HCV, ensuring a mix of ages and genders. Despite our focus on YCHVs' experiences, we included HCVs' experiences to provide a comprehensive perspective on the

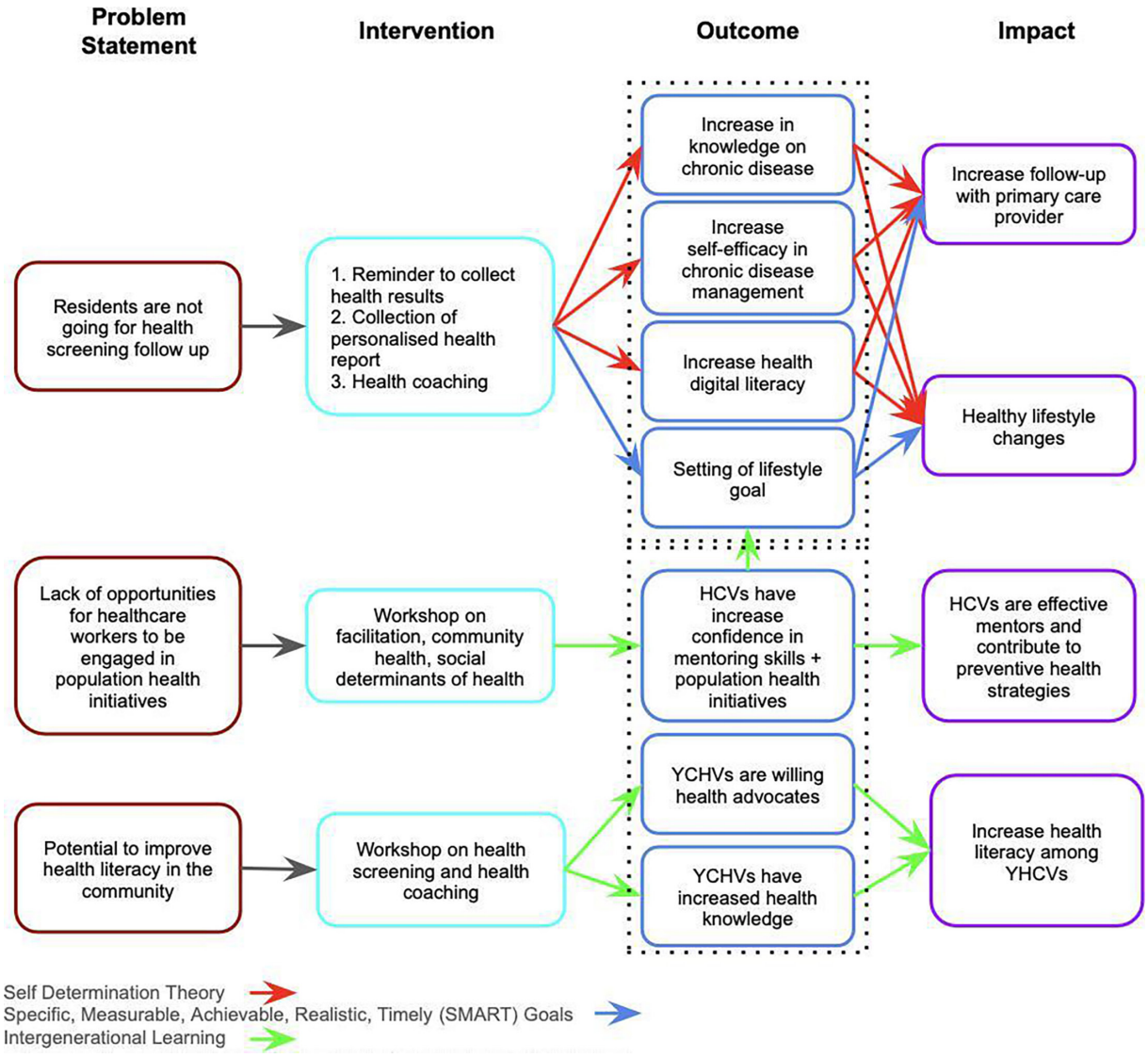

Figure 1 HealthStart Theory of Change. HCV, Healthcare Volunteer; YCHV, Youth Community Health Volunteer.

mentoring relationship, thereby understanding the quality of support needed for volunteers to perform their volunteering role well.

We recruited participants via email or phone invitation in conjunction with an evaluation of the HealthStart programme. Potential participants were asked if they would participate in a follow-up study, and interested participants provided their contact details. We continued recruiting until we considered data saturation had been achieved, when no additional information was arising from interviews.

Data collection

The interview guides (see online supplemental file 1) were formulated based on the Theory of Change (figure 1) to elicit experiences with the volunteer training programme (intervention), the health advocacy process with older adults (intervention to outcome) and perceptions of the programme, the health advocacy process with older adults, and volunteer training. The interview was piloted with the programme team and potential participants to ensure that questions were understandable and relevant to the programme. A summary of the interview guide is presented in box 1.

We obtained written informed consent (and parental consent for participants below the age of 21 years) by sharing the study information sheet, ensuring all questions were addressed, and explaining that participants could skip questions or withdraw at any time.

Four interviewers were trained in qualitative data collection methods. Interviews were conducted face-to-face or via Zoom Web Conferencing.[20] Each interview lasted approximately 60 minutes and was conducted at times and places agreed with participants. All interviews were audio-recorded and transcribed using automated transcription software and verified by an investigator to redact identifiable information and ensure accuracy.

Data analysis

QSR NVivo V.14 software was employed for data management and analysis. Four investigators coded transcripts using primarily deductive thematic analysis, following

Box 1 Summary of interview guide

Health advocacy process

Can you share your experience journeying with your older adult to:

i. Follow-up with a primary care doctor.
ii. Increase their health knowledge of chronic diseases.
iii. Increase their confidence in managing their health.
iv. Learn a digital health skill.
v. Set a healthy lifestyle goal.

Volunteer training

Can you share your thoughts about the training you received?

Can you share how the training impacted your chronic disease and management knowledge?

How did the training impact the way you interacted with your older adult?

Can you share how the training impacted the way you mentored youth community health volunteers?

Perceptions about the programme

To what extent did you feel like you had everything you needed to perform your role well?

What did you like most about the programme?

How do you think the programme can be improved?

What are your thoughts about volunteering for a similar programme?

Table 1 Participant characteristics

YCHVs (n=16)	
Sex	
Male	3 (18.75%)
Female	13 (81.25%)
Age	
15–20 years	12 (75%)
21–35 years	4 (25%)
HCVs (n=8)	
Sex	
Male	3 (37.5%)
Female	5 (62.5%)
Age	
20–29 years	2 (25%)
30–39 years	5 (62.5%)
50–59 years	1 (12.5%)

HCV, healthcare volunteer; YCHV, youth community health volunteers.

Braun and Clarke's approach,[21] focusing on perceptions of the programme, health advocacy process, and volunteer training. Inductive coding was used if new or additional issues were identified.

Transcripts were independently coded by two of the four investigators (ASTK, JYRC, JJ, EWS) and then checked by a third to address any discrepancies. Codes were combined iteratively to form themes through discussion within the research team. Final themes were refined and named to ensure they adequately represented the data findings. To ensure the trustworthiness of our findings, we ensured: (1) credibility by keeping our methods transparent and aligned with our research question, (2) confirmability by double-coding data and including minority voices, and (3) transferability by relating our findings to the literature.

Reflexivity

Data collectors (ASTK, JYRC, JJ, EWS) were affiliated with the research and evaluation arm of the Division of PHIC at SGH but were relatively new to qualitative research. All authors are public health researchers or researchers-in-training with an interest in community health. As public health researchers, we acknowledge that our roles and prior involvement in parts of the programme may have shaped our perspectives. While we had minimal interactions with participants prior to the study, our familiarity with the programme may have influenced how we framed research questions and interpreted data.

To enhance reflexivity during data collection, interviewers engaged in pre-interview and post-interview debriefing to reflect on how our perspectives might influence questioning and interpretation. The semi-structured interview guides increased consistency, and several investigators cross-checked responses to highlight and consider diverse perspectives. Given our institutional position, we were conscious of power dynamics. To encourage candid responses, participants were reassured that their perspectives would be received openly and without judgement, and it would not influence their care or the programme. To mitigate potential biases, we critically examined our positionality and its potential impact on data collection, analysis and write-up.

RESULTS

Participant characteristics and themes

Table 1 shows essential characteristics of the 16 YCHVs and eight HCVs included. Most YCHVs (81%) were women and aged 15–20 years (75%). Most HCVs were also women (63%) and aged 30–39 years (63%).

We generated four themes: (1) structured training, resources, and in-person mentorship helped YCHVs effectively support older adults in their health journeys, (2) facilitators and barriers influenced older adults' receptiveness to YCHVs, (3) YCHV motivations to volunteer, and (4) YCHVs becoming trained health advocates and contributing to preventive health strategies.

Structured training, resources, and in-person mentorship helped YCHVs effectively support older adults in their health journeys

This theme described YCHVs' experiences and perceptions of their training, HCVs' experiences mentoring YCHVs, and YCHVs' perceptions of HCVs. Training entailed pre-training quizzes and online reading materials on chronic disease management, and a 1-day

training to practise motivational interviewing (MI) skills and role-playing.

Most YCHVs indicated that resources on chronic disease management were relevant and appropriately written in lay terms. They described these as beneficial in helping them understand the information needed to conduct health coaching with older adults:

> …the brochures were rather simple for me to understand, considering I'm not a healthcare volunteer, and I might not know much about this type of health condition. (YCHV02)

While some YCHVs described the information as sufficient, many mentioned that the volume was overwhelming and thus challenging for YCHVs to discern what was essential to fulfil their role and information that was simply good to know. This was corroborated by HCVs who noted that the information could be further streamlined.

> I mean it's just too many information, but I mean information are useful, but it's a lot…I don't know how else y'all can reduce it… (YCHV14)

Having a structured programme was helpful for YCHVs. Many had minimal or no knowledge of health coaching and described the structured programme, which detailed the information needed to be shared and milestones to achieve, as useful to ensure they were on track. Moreover, the YCHVs learnt how to apply MI skills. Being able to tailor health plans to suit the motivation, needs, and preferences of older adults helped to meaningfully engage them, especially in the first few sessions. Furthermore, the role-playing helped YCHVs know what to expect during actual health coaching sessions, identify gaps in their knowledge, and learn practical skills they would not have otherwise learnt just from reading the materials. The training prepared them and gave them the confidence to carry out their health coaching sessions.

> …I was really scared that I would just be given all this knowledge and then I [would] have to straightaway go and meet my [older adult] and be able to like, know what to do, what to say, and how to interact with them…I feel like the situational role-play helped me to at least give it a try; know[ing] what are the possible things that might happen, and what to expect, and how to adapt and change in situations that I don't really like, know what to do. (YCHV05)

Most YCHVs highlighted the importance of having mentors and the positive impact they had on their volunteering experience. YCHVs with involved and active mentors described feeling comfortable approaching them if they had doubts or questions and felt more confident to do their volunteering work well. Moreover, most YCHVs highlighted that without their mentors, they would have struggled to understand unfamiliar technical knowledge and navigate difficult situations. Many YCHVs expressed appreciation for the guidance provided by their HCVs.

> [HCV] gave—inspired a lot of confidence…I'm quite introverted honestly, so yah, he gave me a lot of confidence and also gave me a lot of tips on how to interact with people. (YCHV10)

In turn, HCVs reported that they helped to develop YCHVs' knowledge of chronic disease management, clarify questions about the healthcare industry, and provide support through regular meetups. HCVs described how they guided, reassured, and facilitated YCHVs' learning:

> So, I think what helped to balance [the complex case] was that we had this group check-in so that they can also learn from the experiences of other volunteers and other things that they went through, and they also brainstorm together… (HCV01)

> …I think one of my volunteers got blocked…these kinds of things are to be expected…I believe they can always try again [contacting other residents]. There are always opportunities everywhere. (HCV08)

This was supported by many YCHVs who were able to describe learning health-related knowledge from their HCVs.

Facilitators and barriers influencing older adults' receptiveness to YCHVs

This theme described the facilitators and barriers that YCHVs experienced during their health coaching sessions with older adults, including how vital rapport building with older adults was, and communication challenges.

YCHVs identified the ability to build rapport with older adults as a key factor in conducting effective health coaching sessions. Many YCHVs reported that building rapport with older adults created feelings of trust and a safe space for them to voice their concerns and questions.

> I think it took us time to gradually like, we kept, you know, reassuring her that we're just here to help her, that we're not really going to judge her…so, I think because of that, then she felt like, um, more comfortable with us as well. (YCHV16)

Older adults' trust in YCHVs encouraged them to share health information which helped YCHVs personalise their health plans. This sense of trust made older adults more inclined to listen to YCHVs and heed their advice; at times, older adults preferred to listen to them, as opposed to healthcare professionals. This was illustrated in one participant's recount of their experience:

> …I guess they value rapport more…like [older adults] just [said], 'I don't even know [the HCV], why do I need to listen to him'… (YCHV16)

To strengthen relationships with older adults, YCHVs also sought creative methods, such as working together with older adults' support systems, to encourage them to follow through with their health plans, such as going on regular walks together to encourage exercising. By leveraging familial relationships, older adults felt more reassured and were more motivated to stick to their health plans.

When older adults were more receptive to YCHVs, many reported that their health coaching sessions were smoother and more productive. Therefore, many YCHVs reported feeling encouraged to help older adults and even go the extra mile.

However, rapport building was challenged by language barriers, which many YCHVs described when conversing with older adults. In Singapore, most YCHVs are accustomed to speaking English, whereas many older adults were more comfortable speaking in their mother tongue (eg, Mandarin, Malay, Tamil). While both groups were able to converse in a mix of English and their mother tongue, it was often limited to simple conversations. Differences in proficiency proved challenging when communicating specific health information.

> …it seems very easy to speak to the [older adults], because most of the time we practise in English, but actually, uh, speaking to the [older adults] in a different language is uh, is difficult, especially for my generation. (YCHV14)

Combined with limited proficiency in medical terminology, language barriers made it increasingly challenging for YCHVs to communicate and build trusting relationships with older adults. Moreover, YCHVs reported facing challenges when confronted with complex or sensitive topics, such as not being able to engage in empathetic conversations that were vital in developing therapeutic relationships.

Furthermore, some YCHVs reported that they were often unsure of what to talk about with older adults beyond simple greetings, making it difficult to build rapport. Due to a lack of common topics, YCHVs sometimes indicated that health coaching conversations did not progress as intended. YCHVs commonly attributed older adults' unwillingness to participate in health coaching to generational preferences in health management. For instance, older adults may prefer traditional Chinese medicine over Western allopathic medicine or may be unwilling to use digital health tools. As a result, some YCHVs suggested that older adults felt distrustful of having YCHVs conduct health coaching, which could have further contributed to their resistance. Some YCHVs also indicated that older adults did not find them trustworthy or credible because of their young age and were worried that they were providing false information.

> …they asked me about my age and I told them I was 17. So, they didn't really trust me initially, and they [felt] that I was too young for this. (YCHV14)

Finally, YCHVs noted that they needed to overcome external barriers before they could engage in health coaching. For instance, having limited financial capacity to seek treatment or low literacy rates to understand health reports decreased older adults' receptiveness to health coaching.

Thus, YCHVs who struggled to build rapport with older adults reported significant challenges with getting them to follow through with health coaching plans and, in turn, felt that they were not able to make meaningful progress together.

YCHVs' motivation to volunteer

This theme described YCHVs' intrinsic motivation to volunteer in a health promotion programme and the satisfaction derived from the work, including the satisfaction derived from giving back to the community, stepping out of their 'comfort zone', and interest in healthcare careers.

Many YCHVs were driven by the desire to give back to the community and said that they were able to do so by helping older adults and making a positive impact on their lives:

> …I only have one grandmother that I really cherish a lot so I want to be able to help other [older adults] with their health and lifestyle so that they can live longer. (YCHV12)

They described feeling able to positively impact older adults' health while also enjoying the 'company and rapport' they had with them. For instance, some YCHVs organised activities for older adults, including going to museums or learning tea-making. Some YCHVs were also motivated by their desire to step out of their comfort zone and try new experiences. Most YCHVs had no prior experience interacting with older adults due to a lack of opportunities or preconceived stereotypes. Conducting health coaching for older adults or even interacting with non-familial older adults was something many YCHVs had not done before. Participating in a health coaching programme allowed them to challenge themselves and work with a different population. This opportunity also helped to bridge the generational gap and dispel the stereotype that older adults were 'intimidating' or 'scary'.

> Honestly, my first impression was that he was a scary person…but, gradually like, I think both of us really opened up to each other, and like, we even joked during the session. (YCHV12)

Many YCHVs were motivated by their interest in the healthcare industry. Throughout the programme, YCHVs learnt and honed many beneficial soft skills (e.g., patience, empathy, creative thinking, etc.) that would be essential to healthcare careers. They were also able to learn about the healthcare industry and speak to healthcare professionals about potential career pathways:

> …I actually get to speak to [a healthcare professional] and hear like, their experiences, and like, connect with like, the community and people from the ground… (YCHV08)

While some YCHVs had limited interactions with older adults who became uncontactable, HCVs were still able to meaningfully engage them by turning sessions into learning opportunities.

YCHVs learned to contribute to preventive health strategies

Having completed the programme, YCHVs reported feeling equipped with the necessary knowledge and skills to be health advocates for older adults. YCHVs'

knowledge of chronic disease management helped older adults to better understand their conditions and ways to manage them:

> … [older adults] wanted to find out more, but they weren't really sure about it…like, I think what I tried to help them with was to help them like, break down, like what does it mean to have this condition? What are some implications? What are some things that they can do…what are some things they can tell their family members so that their family members can also like, support them. (YCHV16)

YCHVs alleviated older adults' concerns about their conditions and provided them with the needed information to manage their health. However, translating information into actionable steps was challenging, especially for older adults who were newly diagnosed with chronic conditions. As such, YCHVs helped them create health plans by setting SMART goals.

This helped older adults achieve specific goals while being accountable for them. Aside from helping older adults make positive lifestyle modifications, YCHVs addressed possible misinformation. They helped to improve older adults' digital health literacy by teaching them how to navigate local healthcare apps to search for reliable health information, book medical appointments, access telehealth services, and more.

To encourage older adults' compliance with health plans, YCHVs would ensure they followed up with their primary care provider. One group of YCHVs created a routine by scheduling visits with older adults after medical appointments as a form of check-in:

> …every time he comes back from one doctor's visit, we'll ask him whether he's scheduled another one… so, we will keep it in our calendars as well, and then we will try to schedule a visit with him after that, so that we can ask about how the previous visit with the doctor was… (YCHV05)

This routine ensured older adults followed their health plans which helped them to recognise the importance and benefits of doing so. Moreover, the knowledge and skills imparted to older adults appeared to improve their self-efficacy to independently manage their health.

> And then we were just trying to like, encourage him to continue and keep up this good habit…and it's very repetitive…and then I think he also kind of understands that. So, every time we go, he will show it to us, and then it's like, pretty consistent. (YCHV05)

YCHVs were able to apply these skills and knowledge in their personal lives and use them to nudge their loved ones towards better health:

> So using the knowledge that I was taught, I was also able to also advise my own parents…my parents are living slightly healthier lifestyles… [they] don't really want to change, but I'm trying to, like use the motivational—the MI skills that I learned…yah, so I think [inaudible] sessions like not only really helped me during the whole HealthStart programme, but it also helped me in my like, personal life as well. (YCHV12)

As trained health advocates, YCHVs were able to help older adults during the programme and transfer knowledge and skills to their daily lives to help those around them. This encouraged many YCHVs to look after their health and adopt healthier lifestyles. Their role in ensuring others and they themselves could manage their health contributed to preventive health strategies.

DISCUSSION

This qualitative study explored the experiences of YCHVs who participated in a health coaching programme for older adults. The findings revealed that having relevant training, resources, and guidance for YCHVs was vital in equipping them with the necessary knowledge and skills to conduct health coaching. Moreover, the intergenerational transfer of knowledge helped YCHVs to value add to health coaching sessions, creating a more comprehensive session for older adults. In such skill-based lay-volunteering programmes, volunteers cannot be expected to know how to perform their volunteering roles without the necessary training and guidance. A realist review by Vareilles *et al.* found that skill-based training and formal supervision improved lay community health workers' confidence and self-efficacy in delivering health services.[22] In addition, knowledge application and supervised practice were important aspects of improving health service delivery, as reflected by YCHVs.[23] For instance, having the skills to develop trusting and collaborative relationships with older adults, accompanied by mentors' guidance, encouraged them to make lifestyle modifications and adhere to their health plans.[24] This was evident in YCHVs' ability to build rapport with older adults, facilitating their receptiveness to health coaching. Thus, highlighting the importance of the quality of training needed for volunteers.

YCHVs also faced challenges that hindered older adults' receptiveness to health coaching. For instance, in multilanguage healthcare environments, poor proficiency in other languages and medical terminology, particularly if combined with non-empathetic communication, could result in communication breakdown and disengagement from care.[25 26] A systematic review of 33 studies examining language-concordant care of US patients with limited English proficiency found that 67% of studies demonstrated an improvement in patient outcomes when they received language-concordant care.[27] Moreover, there are generational divides in how one approaches health management. Namely, older adults' preference for the use of Complementary and Alternative Medicine (CAM) and services may result in a reluctance to adopt advocacy for Western allopathic health practices. Teo *et al.* examined the use of CAM among 768 patients in Singapore diagnosed with cardiovascular conditions and reported that CAM use was observed in 43.4% of patients and that

non-compliance with medications and consultations was significantly higher among CAM users compared with non-CAM users.[28] This generational difference in health management may explain older adults' reluctance to adopt Western health coaching practices and distrust towards the young volunteers. Lastly, barriers such as poor literacy rates and limited financial capacity may result in poor uptake of health services. Lee *et al* identified lack of awareness of the accessibility of healthcare services and financial assistance schemes as barriers to older adults' health-seeking behaviours.[29] The inability to communicate, differences in health management practices, and lack of access to healthcare services may have decreased older adults' trust in YCHVs' ability to effectively conduct health coaching.

These challenges contributed to some YCHVs feeling discouraged when they were unable to make progress or perceived older adults to be regressing in their health plans, which is similar to experiences among many healthcare professionals in their practices. This allowed HCVs to impart their experiences and learnings to guide YCHVs to take charge of creating and modifying health plans for older adults. Scott *et al*. highlighted that mentorship and supervision are vital in maintaining the quality and motivation of lay volunteers, as well as in improving their performance in delivering health-related services.[30] Therefore, having mentors to guide YCHVs through challenges empowered them to be involved in decision-making and contributed to volunteers feeling more satisfied and accomplished in their roles.

Aside from the sense of achievement obtained from being able to perform their volunteering role well, YCHVs reported satisfaction from fulfilling their motivation for volunteering. The motivation to volunteer in a health promotion programme for all YCHVs was intrinsic and tapped into one's need to fulfil psychological and social functions. This aligned with Clary and Snyder's volunteer function of 'value' (i.e., desire to give back to the community by becoming health advocates for older adults' health), 'enhancement' (i.e., step out of their comfort zone to dispel any misconceptions of older adults and bridge the generational gap), and 'career' (i.e., learn about the healthcare landscape through training, challenges faced during health coaching sessions, and guidance and interactions with their mentors).[31] A qualitative study examining the motivations for volunteering with older adults similarly identified these motivations among lay volunteers in programmes for older adults.[32] Satisfying these motivations contributed to a satisfactory experience for YCHVs.

Importantly, YCHVs were able to contribute to preventive health strategies. Through intergenerational transfer of knowledge and skills, YCHVs played a vital role in boosting older adults' self-efficacy to independently manage their health. Woldie *et al*.'s systematic review on the use of CHVs to improve access and use of essential services supported the notion that training lay volunteers can support formal health systems in delivering health services to their communities.[6] Training and mentorship were key to helping volunteers achieve their volunteer goals, including becoming health advocates for the community. Gaber *et al*.'s qualitative study on Health TAPESTRY similarly found that volunteers identified the importance of having relevant training materials, applying their knowledge to become health advocates in their communities, and being able to gain valuable experiences through their work.[33] This highlighted YCHVs' ability to deliver health services to improve the health of older adults and contribute to preventive health strategies.

By exploring YCHVs' perspectives and experiences, this study illustrated the potential benefits of YCHVs in preventive health strategies and understanding of their experiences may also inform similar and future health coaching interventions. Future community health programmes can leverage YCHV-specific motivations for recruitment and empower them to manage generational gaps and language barriers. Further research is required to assess the effectiveness of YCHVs' ability to deliver health services and improve health outcomes. Such resources can provide insight into the possibility of YCHVs as extensions to primary care.

Strengths and limitations

There are several strengths to this study. The use of qualitative methodology allowed the exploration of the YCHVs' perspectives and experiences, encompassing aspects such as training, volunteering, and interactions with different stakeholders. Furthermore, including the experiences of HCVs, many of whom played a vital role in YCHVs' volunteering experience, contributed to a more comprehensive understanding of YCHVs' experiences. Nevertheless, there are limitations to this study. First, the study focused on one programme and most participants were women; thus, findings may not be fully transferable to male volunteers or other settings. Second, while valuable in surfacing the volunteers' experiences, semi-structured interviews by relatively inexperienced qualitative investigators had inherent limitations in their depth of analysis. For instance, while YCHVs highlighted that it was difficult to discern between information that was essential and supplementary, the precise nature of these challenges, such as complex concepts, gaps in prerequisite knowledge or information processing difficulties, was not explored.

CONCLUSION

Our findings highlight the perspectives and experiences of YCHVs as health advocates in a health coaching programme to empower older adults to improve and manage their health independently. Four key themes of structured training, resources and in-person mentorship helping YCHVs effectively support older adults in their health journeys; facilitators and barriers influencing older adults' receptiveness to YCHVs; YCHV

motivations to volunteer; and YCHVs becoming trained health advocates and contributing to preventive health strategies, aided understanding. Exploring different aspects of YCHVs' experiences contributes to further understanding the motivations behind community volunteerism and how youth volunteers can potentially contribute to larger-scale preventive health strategies.

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REFERENCES

1 Ageing and health. Geneva World Health Organization; 2022. Available: https://www.who.int/news-room/fact-sheets/detail/ageing-and-health [accessed 01 Oct 2024]
2 Yu S, Wan R, Bai L, *et al*. Transformation of chronic disease management: Before and after the COVID-19 outbreak. *Front Public Health* 2023;11:1074364.
3 Bahall M, Bailey H. The impact of chronic disease and accompanying bio-psycho-social factors on health-related quality of life. *J Family Med Prim Care* 2022;11:4694–704.
4 Foo CD, Surendran S, Tam CH, *et al*. Perceived facilitators and barriers to chronic disease management in primary care networks of Singapore: a qualitative study. *BMJ Open* 2021;11:e046010.
5 Cherrington A, Ayala GX, Elder JP, *et al*. Recognizing the diverse roles of community health workers in the elimination of health disparities: from paid staff to volunteers. *Ethn Dis* 2010;20:189–94.
6 Woldie M, Feyissa GT, Admasu B, *et al*. Community health volunteers could help improve access to and use of essential health services by communities in LMICs: an umbrella review. *Health Policy Plan* 2018;33:1128–43.
7 Lo SHS, Chau JPC, Saran R. Volunteer Engagement in a Stroke Self-Management Program: Qualitative Analysis of a Hybrid Team of Healthcare Providers and Trained Volunteers. *Int J Environ Res Public Health* 2022;19:9341.
8 Dolovich L, Oliver D, Lamarche L, *et al*. A protocol for a pragmatic randomized controlled trial using the Health Teams Advancing Patient Experience: Strengthening Quality (Health TAPESTRY) platform approach to promote person-focused primary healthcare for older adults. *Implement Sci* 2016;11:49.
9 Dolovich L, Oliver D, Lamarche L, *et al*. Combining volunteers and primary care teamwork to support health goals and needs of older adults: A pragmatic randomized controlled trial. *CMAJ* 2019;191:491–500.
10 Here for youth. Singapore Ministry of Culture, Community, and Youth; 2012. Available: https://www.mccy.gov.sg/sector/youth [accessed 10 Mar 2025]
11 Ballard PJ, Ozer EJ. Implications for youth activism for health and well-being. Contemporary youth activism: Advancing social justice in the United States. *Youth* 2006;223–44.
12 Peters R, Ee N, Ward SA, *et al*. Intergenerational Programmes bringing together community dwelling non-familial older adults and children: A Systematic Review. *Arch Gerontol Geriatr* 2021;94:104356.
13 Moore A, Motagh S, Sadeghirad B, *et al*. Volunteer Impact on Health-Related Outcomes for Seniors: a Systematic Review And Meta-Analysis. *Can Geriatr J* 2021;24:44–72.
14 Ballard PJ, Syme SL. Engaging youth in communities: a framework for promoting adolescent and community health. *J Epidemiol Community Health* 2016;70:202–6.
15 Huang X, Yow KS, Kwan AST, *et al*. Healthstart: a layperson-led community health coaching programme. *SSRN* [Preprint].
16 Ngiam NHW, Yee WQ, Teo N, *et al*. Building digital literacy in older adults of low socioeconomic status in Singapore (Project Wire Up): Nonrandomized controlled trial. *J Med Internet Res* 2022;24:e40341.
17 Lim HA, Lee JSW, Lim MH, *et al*. Bridging Connectivity Issues in Digital Access and Literacy: Reflections on Empowering Vulnerable Older Adults in Singapore. *JMIR Aging* 2022;5:e34764.
18 Lu SY, Yoon S, Yee WQ, *et al*. Experiences of a Community-Based Digital Intervention Among Older People Living in a Low-Income Neighborhood: Qualitative Study. *JMIR Aging* 2024;7:e52292.
19 Singapore General Hospital. Many not following up after health screening - healthxchange. Singapore Singapore General Hospital. Available: https://www.sgh.com.sg/news/others/many-not-following-up-after-health-screening [accessed 17 Mar 2025]

20 Zoom Video Communications Inc. Zoom [computer software]. San Jose, CA, 2024. Available: https://zoom.us
21 Clarke V, Braun V. Thematic analysis. *J Posit Psychol* 2017;12:297–8.
22 Vareilles G, Pommier J, Marchal B, *et al*. Understanding the performance of community health volunteers involved in the delivery of health programmes in underserved areas: a realist synthesis. *Implement Sci* 2017;12:22.
23 Schleiff MJ, Aitken I, Alam MA, *et al*. Community health workers at the dawn of a new era: 6. Recruitment, training, and continuing education. *Health Res Policy Sys* 2021;19:1–28.
24 Tahan HA, Sminkey PV. Motivational interviewing: building rapport with clients to encourage desirable behavioral and lifestyle changes. *Prof Case Manag* 2012;17:164–72; .
25 Hull M. Medical language proficiency: A discussion of interprofessional language competencies and potential for patient risk. *Int J Nurs Stud* 2016;54:158–72.
26 Haribhai-Thompson J, McBride-Henry K, Hales C, *et al*. Understanding of empathetic communication in acute hospital settings: a scoping review. *BMJ Open* 2022;12:e063375.
27 Diamond L, Izquierdo K, Canfield D, *et al*. A Systematic Review of the Impact of Patient-Physician Non-English Language Concordance on Quality of Care and Outcomes. *J Gen Intern Med* 2019;34:1591–606.
28 Teo TY, Yap J, Shen T, *et al*. Complementary and alternative medicine use amongst patients with cardiovascular disease in Singapore. *BMC Complement Altern Med* 2016;16:446:446:.
29 Lee JMG, Chan CQH, Low WC, *et al*. Health-seeking behaviour of the elderly living alone in an urbanised low-income community in Singapore. *Singapore Med J* 2020;61:260–5.
30 Scott K, Beckham SW, Gross M, *et al*. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Hum Resour Health* 2018;16:39:39:.
31 Clary EG, Snyder M, Ridge RD, *et al*. Understanding and assessing the motivations of volunteers: a functional approach. *J Pers Soc Psychol* 1998;74:1516–30.
32 Same A, McBride H, Liddelow C, *et al*. Motivations for volunteering time with older adults: A qualitative study. *PLoS One* 2020;15:e0232718.
33 Gaber J, Oliver D, Valaitis R, *et al*. Experiences of integrating community volunteers as extensions of the primary care team to help support older adults at home: a qualitative study. *BMC Fam Pract* 2020;21:1–13.