Developing a Volunteer Leadership Development Model for Village Health Volunteers: A Case Study of Community-Based Empowerment through Adult Learning

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Abstract

This study proposes a volunteer leadership development model based on ethical leadership, adult learning, and community empowerment theories. Employing a mixed-methods case study in rural Thailand, quantitative surveys (n=218) (assessed current leadership competencies, while qualitative interviews (n=10) provided deeper insights into development needs. Findings revealed strong ethical and empathetic leadership among VHVs, yet highlighted gaps in transformational leadership, and motivation and empowerment of others. Consequently, a volunteer leadership development model was proposed, comprising Inputs (community context, existing competence of VHVs, supportive networks), Processes (training activities, leadership development, competency-based learning), Support Mechanisms (community acceptance, incentives, emotional support, leadership opportunities), Outputs (enhanced confidence, communication, role modeling), and Outcomes (community-level leadership, community engagement, community self-management). The model offers practical guidance for fostering VHV capacities, promoting community empowerment, and strengthening grassroots primary healthcare.

Keywords: Village Health Volunteers; Volunteer Leadership Development Model; Adult Learning; Community-based empowerment

Introduction

Village Health Volunteers (VHVs) are the cornerstone of Thailand's community-based health system, with over one million serving nationwide. They play vital roles in linking formal healthcare services and rural communities, especially during crises like the COVID-19 pandemic, by managing health surveillance, vaccination programs, and public health communication (Borrisut, 2020; Department of Health Service Support, 2021). Despite their significance, VHV training often emphasizes technical skills while overlooking their potential as community leaders. This gap represents a missed opportunity to cultivate grassroots leadership that could foster

innovation and mobilize community resources in the face of shifting health dynamics, demographic transitions, and the digitalization of healthcare (Kok et al., 2015; WHO, 2018).

During prolonged fieldwork in Ban Suan Subdistrict, Sukhothai Province, the researchers engaged closely with VHVs and healthcare staff, gaining a deeper understanding of the practical challenges facing rural public health leadership. Informal conversations and structured interviews with VHVs revealed their strong moral dedication and social capital, yet also pointed to substantial limitations in initiating new health initiatives, facilitating peer learning, or adapting to emerging health trends. Furthermore, local medical personnel repeatedly expressed the need for a structured leadership development model that could serve both as a prototype and a guiding framework for systematically enhancing the leadership competencies of VHVs. Such a model, they emphasized, should be empirically grounded and adaptable to other rural settings with similar socio-cultural characteristics.

Volunteer leadership—defined by the ability to influence, motivate, and coordinate others without formal authority—is essential for VHVs, who function within frameworks of relational trust, moral legitimacy, and intrinsic motivation (Brudney & Meijs, 2009; Macduff, 2005). Such leadership depends on ethical standards, transparency, and a community orientation, which together foster the trust and cohesion crucial to sustainable health volunteerism (Brown et al., 2005; Ciulla, 2014). Adult learning theory reinforces the value of experiential and problem-based learning tailored to VHVs, many of whom possess extensive community knowledge but limited formal education (Knowles et al., 2015; Merriam & Bierema, 2014). Experiential learning, based on Kolb's (1984) model, allows VHVs to integrate new health knowledge with lived experience, thereby enhancing both skills and confidence. Similarly, community empowerment theory highlights the importance of enabling environments where volunteers are supported to take on leadership roles, fostering sustained motivation and self-efficacy (Bandura, 1977; Laverack, 2006; Zimmerman, 2000).

International literature offers valuable insights. In Iran, participatory action research with health volunteers led to enhanced leadership confidence and community engagement (Vizeshfar et al., 2021). In Kenya and Indonesia, structured leadership training programs for community health volunteers—emphasizing communication, advocacy, and ethical decision-making—produced measurable improvements in maternal health, public health awareness, and volunteer retention (Perry et al., 2014; Agarwal et al., 2019). Similar results were found in sub-Saharan Africa, where training in transformational leadership significantly improved team motivation and health outcomes (Valentijn et al., 2016). These cases affirm that well-designed leadership frameworks can be adapted to resource-limited contexts, building resilience into local health systems.

Thai studies also underscore the importance of developing volunteer leadership. Rukongprasert (2021) identified strong correlations between social support, self-confidence, and VHV leadership behavior but pointed to weaknesses in digital literacy and proactive engagement. Borrisut (2020) similarly observed that VHVs possess admirable ethical commitment yet lack

structured leadership tools for community empowerment. These findings support the notion that effective leadership development must go beyond technical training to address relational, ethical, and motivational components as well.

Despite these promising examples, Thailand still lacks a comprehensive model tailored to its rural socio-cultural and healthcare context—one that integrates ethical leadership, adult learning principles, and empowerment frameworks. Given the nation's aging population, increasing health complexity, and the growing emphasis on self-managed community health, there is a pressing need to prepare VHVs not only as assistants to health professionals but as transformative leaders capable of driving community wellness. This study, therefore, responds to that need by developing and validating a context-specific volunteer leadership development model designed for VHVs in rural Thailand.

Research Objectives

1. To assess current volunteer leadership competencies among Village Health Volunteers (VHVs) and to identify their roles, challenges, leadership development, community engagement, motivation, and training approaches.

2. To develop and validate a comprehensive volunteer leadership development model for VHVs, integrating ethical leadership, adult learning, and community empowerment theories tailored for rural community contexts.

Research Methodology

Research Design

This study employed a mixed-methods case study design integrating quantitative and qualitative data to develop and validate a leadership development model tailored for Village Health Volunteers (VHVs). The research process consisted of three sequential phases: (1) a quantitative survey to assess the current state of leadership competencies among VHVs, (2) qualitative interviews with key informants to explore experiential insights and development needs, and (3) validation of the proposed model through stakeholder review.

Participants

Quantitative Phase

The target population comprised all 233 VHVs affiliated with the Ban Suan Subdistrict Health Promotion Hospital, located in Sukhothai Province, Thailand. Since the research aimed to assess the leadership competencies of the entire population of VHVs within this specific rural health unit, no sampling was conducted. A total of 218 VHVs completed the survey, yielding a high response rate of 94%.

Qualitative Phase

The qualitative phase involved purposive selection of 10 key informants representing three distinct stakeholder groups, as shown in Table 1.

Table 1. Key Informants and Selection Criteria

Key Informant Group	N	Selection Criteria
Senior VHVs	5	• Minimum 16 years of experience • Willingness to participate in the interview
Public Health Professionals	3	• Minimum 5 years of professional experience • Willingness to provide insights
Experts in Community Health and VHV Programs	2	• Academic/research roles with 15+ years' experience • Demonstrated experience working with VHVs or subdistrict health promotion hospitals • Willingness to participate in the study

All key informants were either from or had extensive experience working within the Ban Suan Subdistrict context or similar rural Thai settings.

Instruments

1. Quantitative Instrument. A structured questionnaire was developed to assess six core dimensions of volunteer leadership among VHVs, including: (1) ethical and moral leadership, (2) empathy and helping others, (3) communication and relationship-building, (4) transformational leadership, (5) continuous self-improvement, and (6) motivation and empowerment of others.

The instrument utilized a 5-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). The questionnaire was developed based on an extensive review of relevant literature and adapted to the local context. Content validity was verified by five experts in public health and volunteer development using the Index of Item-Objective Congruence (IOC). All items demonstrated acceptable content validity (IOC values ≥ 0.6). The instrument demonstrated strong internal consistency with a Cronbach's alpha coefficient of 0.88.

2. Qualitative Instrument. Semi-structured interview protocols were developed to guide in-depth interviews with key informants. The interview covered six major thematic areas: (1) characteristics and roles of VHVs, (2) challenges and obstacles in the work of VHVs, (3) systems and mechanisms for developing leadership capacity, (4) building community networks and collaboration, (5) motivational factors and strategies to promote the roles of VHVs, and (6) training approaches for the capacity development of VHVs.

The content of the interview protocol was reviewed by the same panel of five experts to ensure alignment with the research objectives and conceptual framework.

Data Collection and Analysis

Data collection was conducted sequentially in three phases. The quantitative data from the 218 VHV respondents were analyzed using descriptive statistics, including means, standard deviations, and rank-ordering of leadership competencies. The qualitative data obtained from 10 key informant interviews were analyzed thematically using an inductive-deductive approach.

Themes were derived based on both pre-defined codes from the conceptual framework and emerging patterns from participant narratives. Insights from both quantitative and qualitative phases informed the construction of the proposed leadership development model.

Model Validation

The model underwent member checking by ten stakeholders who belonged to the same group as the key informants, as well as by one expert with experience in the development of village health volunteers (VHVs).

Results

Current State of Volunteer Leadership among VHVs

Survey Findings

The quantitative results indicated a high overall self-reported leadership level among Village Health Volunteers (VHVs), with an average mean score of 4.19 (SD ≈ 0.71) on a five-point scale. While cultural tendencies to avoid low ratings should be considered, notably, all leadership dimensions scored positively.

Table 2 - Volunteer Leadership Dimensions among VHVs

Volunteer Leadership Dimension	Mean	SD	Rank
Ethical and Moral Leadership	4.35	0.69	1
Empathy and Helping Others	4.29	0.68	2
Continuous Self-Improvement	4.27	0.68	3
Communication and Relationship-Building	4.15	0.76	4
Motivation and Empowerment of Others	4.10	0.71	5
Transformational Leadership	4.01	0.76	6
Average mean	4.19	0.71	

When analyzed by dimension (see Table 2), clear rankings emerged. The highest-scoring dimension was Ethical and Moral Leadership (mean = 4.35), indicating strong agreement among VHVs regarding their honesty, integrity, and role-modeling behaviors. The next highest dimension, Empathy and Helping Others (mean = 4.29), highlighted volunteers' compassionate attitudes, with many strongly agreeing they consistently support and care for community members. Both dimensions reflect VHVs' altruistic values, reinforcing their image as trustworthy community figures. The third-ranked dimension, Continuous Self-Improvement (mean = 4.27), showed VHVs' strong commitment to personal growth and learning, with volunteers proactively seeking health information and training opportunities. A respondent humorously noted, "Even though I'm older, I still aspire to learn", encapsulating the volunteers' openness to lifelong learning.

However, there were three dimensions that fell into the group with lower average scores compared to the aforementioned areas: Communication and Relationship-Building (M = 4.15),

Motivation and Empowerment of Others (M = 4.10), and Transformational Leadership (M = 4.01), respectively.

In summary, VHVs demonstrated strong ethical, empathetic, and lifelong learning attributes, providing a robust foundation for trust-based community leadership. Nevertheless, their relatively lower confidence in transformational and proactive leadership highlights crucial areas for targeted development.

Interview Findings

VHVs take pride in serving as ethical role models, emphasizing honesty and altruism without expecting rewards. Many cited Buddhist principles and the concept of "bun khun" (reciprocity) as foundations of their volunteer service. Their strong empathy and long-standing community relationships enhance trust and informal leadership. As one volunteer expressed, “We know every household,” highlighting their embeddedness within local social networks. However, some noted difficulties maintaining connections with younger, transient community members, occasionally requiring newer communication tools like Line or Facebook. Regarding learning orientation, VHVs proactively seek health knowledge through training materials or local media. Despite high enthusiasm, volunteers indicated that training opportunities are infrequent and repetitive, limiting continuous skill development. Key challenges identified include:

1. Lack of confidence in initiating change: VHVs often await direction from health authorities due to hierarchical norms. Volunteers who attempted independent initiatives faced bureaucratic barriers, discouraging further proactive attempts.

2. Technological adaptation: Many older VHVs face significant challenges with digital tools, limiting their ability to engage effectively in modern health initiatives. Volunteers expressed the need for accessible digital literacy training to reduce anxiety about technological integration into their roles.

3. Innovation and proactiveness: Volunteers exhibited hesitation and uncertainty about initiating new projects due to structural norms and self-doubt. Examples include reluctance to independently manage social media outreach or community exercise initiatives without explicit authorization.

4. Personal and structural barriers: Age, health limitations, and low educational attainment among older VHVs restrict their leadership activities. Family responsibilities and seasonal workload fluctuations further impact their volunteer commitment. Additionally, VHVs expressed dissatisfaction with top-down policies emphasizing quotas over genuine community engagement, causing demotivation and passivity.

5. Group dynamics and communication: Volunteers noted unequal activity levels within groups, with only a few consistently active individuals. Active volunteers struggled with motivating less involved peers due to the lack of formal authority, highlighting the necessity for targeted leadership training to enhance peer motivation skills.

Overall, these findings align closely with quantitative results, highlighting VHVs' strong ethical, empathetic, and learning-oriented attributes, while simultaneously identifying critical gaps in innovation, proactivity, digital skills, and structural empowerment. These insights provide clear targets for the proposed leadership development model.

Figure 1 - Key Themes from Qualitative Interviews.

As shown in Figure 1, this thematic map illustrates five major themes identified from interviews with Village Health Volunteers. These themes capture the values, challenges, and developmental needs shaping volunteer leadership. Specifically, altruistic identity and ethical values reflect the strong moral foundation guiding VHVs' community engagement; fear of technology and change highlights hesitations in adapting to digital health innovations; interpersonal trust and communication underscore the centrality of relationship-building in volunteer effectiveness; contextual barriers, such as age, education, and family responsibilities, reveal structural constraints on leadership growth; and empowerment and motivation needs emphasize the desire for greater support, recognition, and opportunities to lead.

Table 3 - Barriers and Enablers of VHV Volunteer Leadership

Barrier	**Enabler**
• Age	• Community trust
• Low digital skills	• Intrinsic motivation
• Workload	• Peer support
• Family duties	• Training opportunities

Table 3 summarizes key barriers and enablers influencing the volunteer leadership development of Village Health Volunteers (VHVs) based on qualitative interview findings. Barriers such as age-related limitations, low digital literacy, competing family responsibilities, and workload pressures constrain volunteers' ability to assume leadership roles or adapt to emerging health initiatives. In contrast, enabling factors—including strong community trust, intrinsic motivation

rooted in altruistic values, peer support networks, and opportunities for targeted training—serve to empower VHVs and foster their leadership potential within community health promotion activities.

Developing the Volunteer Leadership Development Model

Based on the integrated findings from quantitative and qualitative data, a revised volunteer leadership development model for Village Health Volunteers (VHVs) was formulated. This model adopts a systemic structure that more explicitly organizes the development pathway into five interconnected components: Inputs, Process, Support Mechanisms, Outputs, and Outcomes (Figure 2). Each component is detailed as follows:

Inputs

The success of Village Health Volunteer (VHV) volunteer leadership development begins with a recognition of foundational conditions, referred to as key inputs. These include the community context, which entails understanding economic, cultural, and demographic characteristics—such as the VHVs' age distribution and educational backgrounds—that significantly influence learning readiness and leadership styles. Another input is the existing competence of VHVs, where assessing current skills, motivation, and attitudes provides a critical baseline for designing tailored development interventions. Finally, supportive networks, including community hospitals and related government organizations, play a vital role by offering institutional backing and ensuring access to technical and logistical resources. Together, these input factors collectively establish the context within which leadership development efforts are initiated and customized.

Process

The development process for VHV volunteer leadership is structured around three main strategies. First, training activities involve community workshops, practical training sessions, on-the-job learning, and simulation-based exercises, all grounded in experiential learning principles to ensure relevance and immediate application. Second, volunteer leadership development emphasizes service-minded activities, communication skill enhancement, technology utilization, and local research practices to cultivate leadership capacities beyond technical competencies. Third, competency-based learning is structured around group-based and mentorship-based models, promoting collaborative skill acquisition and peer-supported leadership growth. Collectively, these strategies operationalize adult learning principles and directly address the leadership gaps identified among VHVs.

Support Mechanisms

Recognizing that individual development alone is insufficient without systemic support, the model incorporates several critical enabling mechanisms. Community acceptance fosters a culture that recognizes and respects VHVs' contributions, thereby enhancing their legitimacy and influence. Incentives, both moral (such as public recognition) and material (such as allowances

and small grants), are included to sustain volunteer motivation. Emotional support structures, including peer networks and mentorship relationships, help mitigate burnout and strengthen resilience. Moreover, providing leadership opportunities enables VHVs to apply the skills acquired through training in meaningful community health initiatives. Collectively, these support mechanisms act as a vital bridge between the development process and the realization of desired volunteer leadership outcomes.

Outputs

As a result of the development process, VHVs are expected to demonstrate several immediate observable changes that collectively strengthen their leadership impact. First, increased confidence and a comprehensive understanding of community health leadership roles enable VHVs to engage more proactively in decision-making and health advocacy activities. Second, enhanced communication skills facilitate more effective dissemination of health information and foster deeper community mobilization around health initiatives. Third, the capacity for role modeling promotes healthy behaviors by providing tangible, relatable examples for community members to emulate. These outputs not only signify short-term developmental achievements but also serve as critical levers for initiating sustainable community transformation through strengthened volunteer-driven health leadership.

Outcomes

The volunteer leadership development model aims to generate sustained community impacts by strengthening grassroots health leadership. It positions Village Health Volunteers (VHVs) as influential change agents rather than mere assistants, enabling them to mobilize local resources and inspire community-driven health initiatives. In the long term, the model supports a transition from externally managed interventions to community self-management of health, empowering residents to actively engage in health promotion.

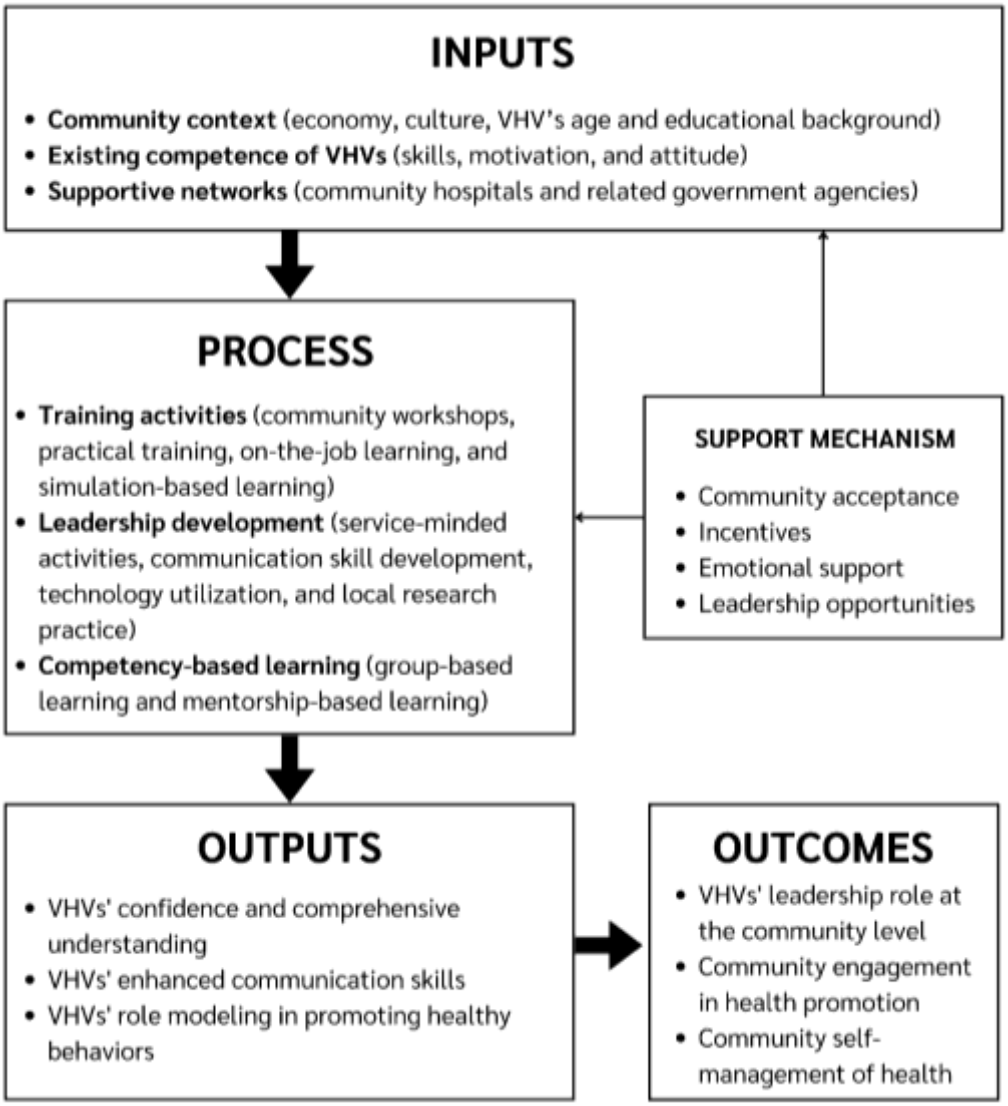

Figure 2 - A Proposed Volunteer Leadership Development Model

As illustrated in Figure 2, the systemic model comprises five interconnected components: Inputs (community context, existing competence of VHVs, supportive networks), Processes (training activities, leadership development, competency-based learning), Support Mechanisms (community acceptance, incentives, emotional support, leadership opportunities), Outputs (VHVs' confidence and comprehensive understanding, communication skills, role modeling), and Outcomes (VHVs' leadership role at the community-level, community engagement, community self-management of health).

The model explicitly integrates ethical leadership through role modeling, adult learning principles via experiential training, and community empowerment through structured support mechanisms. Stakeholders positively received the model; one senior volunteer noted, "This is exactly what we have needed for a long time", while local health officials emphasized interest in formal mentorship programs and tailored training based on volunteer experience.

Ultimately, the model promotes a progressive pathway from individual capacity building to community-wide sustainability. By enhancing volunteer confidence and leadership competencies, VHVs can drive greater community engagement in health promotion, fostering collective ownership and resilience, and ensuring sustainable improvements in public health.

Figure 3 - Pathway from Individual Development to Community Health Sustainability

Figure 3 illustrates the progressive pathway from individual development to community health sustainability envisioned by the proposed volunteer leadership development model. Initially, individual-level changes—such as enhanced confidence, communication competencies, and leadership behaviors—are achieved through structured training and support mechanisms. These individual gains catalyze greater volunteer engagement in community-level health initiatives, fostering a culture of shared responsibility and participatory action. Over time, as more community members are mobilized and empowered, the model anticipates a transition toward collective self-management of community health. This cascading process not only strengthens the local health system but also embeds resilience, autonomy, and sustainability into the community's health governance structures. Thus, Figure 3 encapsulates the systemic logic linking micro-level volunteer development to macro-level community transformation.

Discussion

The revised volunteer leadership development model for Village Health Volunteers (VHVs) developed in this study offers a more comprehensive and systematized framework for enhancing leadership capacity in community health settings. By organizing the model into five interrelated components—Inputs, Process, Support Mechanisms, Outputs, and Outcomes—the study provides a clear, causally linked pathway from contextual understanding to sustained community empowerment.

First, the emphasis on Inputs highlights the necessity of aligning volunteer leadership development with the lived realities of community context, existing competencies, and the availability of support systems. Prior studies have demonstrated that contextual fit significantly affects the performance and retention of community-based health volunteers (Kok et al., 2015; Zimmerman, 2000). This approach also draws from adult learning theory (Knowles et al., 2015), which underscores the value of tailoring learning to participants' experiences, motivations, and social roles—particularly relevant for VHVs, many of whom are older adults with deep community ties but limited formal education.

Second, the Process component operationalizes adult learning principles through experiential learning, competency-based progression, and service-minded leadership activities. Kolb's (1984) experiential learning cycle supports such a hands-on approach, allowing VHVs to acquire skills through active engagement and reflection. The model responds to the needs observed in practice—where "learning by doing," peer mentorship, and scenario-based simulations have proven more impactful than conventional classroom training. As Lough (2010) has noted, such forms of experiential development are essential in cultivating leadership confidence and initiative among grassroots volunteers.

Third, the integration of Support Mechanisms represents a notable advancement over earlier leadership frameworks. Volunteers frequently operate without formal authority or material incentives, relying instead on relational influence, intrinsic motivation, and community trust (Macduff, 2005; Wilson, 2012). Without systemic support—such as community recognition, peer networks, emotional encouragement, and meaningful leadership opportunities—volunteers are at risk of fatigue and disengagement (Brudney & Meijs, 2009; Laverack, 2006). This model explicitly embeds these enablers into its structure, ensuring not only the development of skills but also the sustainability of volunteer engagement.

Fourth, the separation between Outputs and Outcomes offers a more nuanced understanding of volunteer leadership development as both an individual and a collective process. Short-term outputs such as increased confidence, communication, and leadership presence are positioned as prerequisites for longer-term outcomes, including stronger community participation in health initiatives and greater capacity for local health governance. This trajectory reflects the layered nature of empowerment as emphasized in frameworks by Wallerstein (2006)

and empirically supported by Benevene et al. (2020), who found strong links between ethical leadership behaviors and volunteer commitment in public health settings.

Crucially, the model responds to long-standing critiques in the literature that volunteer leadership development—especially in the context of community health—tends to be fragmented, overly technical, and insufficiently grounded in systemic and relational dynamics (Taylor et al., 2020). By explicitly integrating principles from ethical leadership, adult learning, and empowerment theory, the model offers a more realistic, adaptable, and sustainable framework for developing VHVs as transformative community leaders, rather than merely as auxiliary workers.

Finally, the model's adaptability is worth underscoring. While it was designed in response to a specific rural Thai context, the structural logic of the model—rooted in foundational theories and informed by empirical evidence—makes it applicable across diverse settings, including urban environments and international contexts. It provides a replicable framework for volunteer-based leadership development that accommodates variation in governance, culture, and infrastructure. As such, the model contributes not only to localized health system strengthening but also to broader conversations on scalable, community-rooted leadership development in the global South.

Another key contribution of the proposed model lies in its departure from conventional VHV training frameworks, which have traditionally emphasized technical and operational tasks rather than systemic leadership development. For instance, prior models implemented by the Ministry of Public Health in Thailand have largely focused on delivering health information, monitoring disease outbreaks, and providing basic care—activities that position VHVs as intermediaries rather than leaders (Department of Health Service Support, 2021). In contrast, the present model redefines VHVs as transformative agents who mobilize communities, initiate innovations, and build local resilience through ethical leadership and participatory engagement. This conceptual shift echoes the success of leadership models used in countries such as Uganda and India, where structured peer-led training and community-centered empowerment programs have demonstrated improvements in volunteer motivation, retention, and health outcomes (Kok et al., 2015; Singh et al., 2016). For example, Singh et al. (2016) reported that community health workers in India who received empowerment-based leadership training were more likely to initiate local health campaigns and mentor newer volunteers. These findings support the notion that when volunteers are given both the capacity and legitimacy to lead, community health programs evolve from top-down service delivery to grassroots-driven transformation—an orientation that the proposed model embraces and contextualizes for rural Thailand.

Conclusions

This study has systematically developed and validated a comprehensive volunteer leadership development model tailored specifically for Village Health Volunteers (VHVs). The research findings underscore VHVs' inherent strengths in ethical leadership, empathy, and

commitment to continuous learning. However, challenges remain evident in transformational leadership, digital literacy, and proactive community engagement. The proposed model integrates ethical leadership, adult learning, and community empowerment theories, structured into clearly defined interconnected components: Inputs, Process, Support Mechanisms, Outputs, and Outcomes. Implementation of this model offers significant potential for enhancing VHVs' competencies, ultimately strengthening community-level health promotion, empowering local communities, and fostering sustainable health system resilience at the grassroots level.

Recommendations

Based on the conclusions drawn from this study, several recommendations are proposed:

1. *Implementation of the Proposed Volunteer Leadership Development Model*: Health authorities and local governments should systematically integrate the proposed *Volunteer Leadership Development Model for Village Health Volunteers (VHVs)* into the existing capacity-building framework. This model provides a structured approach that emphasizes not only transformational leadership competencies and digital literacy but also ethical leadership, community empowerment, and adult learning principles. Its implementation would promote more sustainable and community-driven public health initiatives at the grassroots level.

2. *Strengthening Institutional and Community Support Mechanisms*: It is recommended that health promotion hospitals and community stakeholders actively establish supportive mechanisms, including continuous mentorship, emotional support networks, and meaningful recognition or incentives, to sustain VHVs' motivation and long-term engagement.

3. *Tailored Digital Literacy Programs*: Local healthcare providers and policymakers should prioritize accessible and practical digital literacy training specifically designed for older volunteers, enabling them to effectively participate in emerging digital health initiatives.

4. *Facilitating Proactive Community Engagement*: Encourage and formally authorize VHVs to initiate local health projects independently, creating an enabling environment where volunteers feel confident and empowered to lead innovative community-based activities.

5. *Further Research*: Future research should explore longitudinal impacts of the *Proposed Volunteer Leadership Development Model*, assessing long-term sustainability, community acceptance, and measurable outcomes in health improvement at the community level.

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