Leadership development calls for innovative methods for skill and behavior promotion needed to enact change within healthcare and society. Leadership development is also an important topic within the education and practice of healthcare practitioners. Most healthcare programs in the United States have some requirements for leadership development within their educational accreditation standards. Dugan (2011) emphasized that leadership development is a complex process and requires intentional inclusive capacity building. Leadership development is not a passive process and attention must be given to the theoretical lens used to foster such skills.

Historically, leadership theory types such as trait theory, transactional leadership theory, and more recently transformational leadership theory have been used to describe and foster leadership skill development in all facets of persons and organizations (Schyns et al., 2012). A more contemporary leadership theory, servant-leadership, is an approach healthcare educators can use to build leadership capacity in developing students. This theory fits well with the core philosophy of many healthcare professions through its emphasis on service to others and the betterment of society (Greenleaf, 1977). Servant-leadership theory offers a holistic perspective on the attributes and characteristics of
a leader. This leadership approach emphasizes the importance of empowering the follower and developing a sense of community, with a focus on well-being and ethics (Eva et al., 2019). Used as a guiding model, servant-leadership theory emphasizes social justice principles and collaborative environments within healthcare and human service fields (Eva et al., 2019; Fields et al., 2015; Garber et al., 2009).

To provide a holistic structure to leadership development through leadership learning experiences, educators in the health professions should consider incorporating a servant-leadership framework into educational curricula, as this fits well with the multidimensional personal and environmental factors within the contexts of healthcare delivery. Applying these factors in authentic settings allows students to integrate these concepts in meaningful ways. Participation in service-learning experiences in college curricula can provide an opportunity for altruistic actions and building leadership behaviors innovatively (Komives & Wagner, 2017).

Servant-leadership and service-learning match well together. Stoffel (2013) asserted that “servant-leadership has at its core teamwork and community, involves others in decision making, is strongly grounded in ethical and caring behavior, and works to enhance the personal growth of people while improving the caring and quality of institutions” (p. 638). Service-learning moves theory into practice through immersive community experiences that go beyond volunteerism to support social justice and elevate student leadership growth (Cipriani, 2017; Foli et al., 2014; Higbea et al., 2020; Johnson, 2021). These contexts can be interprofessional, allowing students to work with other team members to address the needs of others.

Interprofessional service-learning is defined as,

a form of experiential education in which two or more professions engage in activities that address human and community needs
together, with structured opportunities intentionally designed to promote active and reflective learning about, from, and with one another to enable collaboration and improve health outcomes. (Higbea et al., 2020, p. 284)

Evidence suggests that student participation in experiences within community settings can enhance the perceptions of servant-leadership principles when this theory is used as a framework (Fields et al., 2015). Community settings may include pro bono clinics, shelters for unhoused persons, and after-school programs and may be further deepened through interprofessional collaboration. Service-learning experiences may also occur in international contexts.

Servant-leadership theory is a good fit for international service-learning experiences because of its emphasis on service to others and the amelioration of society (Eva et al., 2019; Fields et al., 2015; Garber et al., 2009, Johnson, 2021). International service-learning usually involves travel to another region or country to deliver healthcare services to underserved communities. Exposure to other cultures and ways of living can help students increase self-awareness by understanding their belief system lens. Short and St. Peters (2017) ascertained that international service-learning experiences have a positive impact on the cultural competence of the learner. It may also help students build cultural competemility, a newer term defined as “the synergistic process between cultural humility and cultural competence in which cultural humility permeates each of the five components of cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural desire, and cultural encounters” (Campinha-Bacote, 2019, para. 12). Developing cultural competemility also enables students to develop the skills needed to be reflective practitioners and also can uphold professional core values and standards of conduct. Fostering strong foundations in servant-leadership and ethical behaviors is beneficial to both the student and the
students and faculty may reflect on potential ethical concerns that exist when engaging in international service-learning. Providing therapy without consideration for the burden placed on the host community and the quality and minimal duration of services provided can have a damaging effect (Dholakia et al., 2021). Careful consideration for reciprocity through community-driven experiences focuses on the true needs of the individuals and not solely the learning opportunity for students. As such, using a servant-leadership lens can help foster critical reflection to mitigate the potential for unintentional harm toward the host country.

While the reciprocal relationship between the community and the student is an important factor in a service-learning experience, personal reflection is another key component required to synthesize and understand the experience at a deeper level (Buff et al., 2015; Cipriani, 2017). As Fink (2013) noted, “without this reflection, [students] have learned something but they have not made that learning fully meaningful to themselves” (p. 122). Within their professional education, students need opportunities to reflect on leadership and their attributes to support the development of leadership skills (Dugan, 2011). There are different methods to support reflective practice and leadership development, and educators must be thoughtful in their approach. Critical reflection is a core component of leadership development and enables students to recognize previous behaviors or assumptions and identify skills needed for growth (Dugan, 2018; Torrez & Rocco, 2015). Opportunities for self-reflection in a leadership context can build student capacity prompting educators to use multimodal strategies such as journaling, debriefing sessions, discussion boards, and audiovisual modalities.

Thought for how to assess leadership development is pivotal for healthcare educators as they examine outcomes of pedagogy, curricular
design, and experiential learning opportunities. The first step in leadership development and building leadership capacity is for the individual to recognize associated behaviors. Understanding student perceptions within the context of building leadership capacity provides valuable insight into whether the educational design meets the intended outcome. Additionally, Garber et al. (2009) identified a gap in the literature regarding healthcare providers’ perceptions of servant-leadership in the healthcare environment. Assessment of servant-leadership interactions is often difficult to analyze as these encounters are subjective and rely on both internal and external factors of the experience that contribute to the growth of the practitioner. Novel strategies are needed to capture the lived experiences of persons and assess how perceptions of an experience reflect servant-leadership capacity building.

This study seeks to address the dearth of literature and contribute to this area of knowledge, deepening the understanding of how future healthcare practitioners perceive the connection of servant-leadership concepts of professional practice within the context of international service learning. This led to the following research question: What are student perceptions, beliefs, and meanings of servant-leadership through an international service-learning experience?

METHOD

Research Design

The authors of this manuscript designed an exploratory, qualitative, phenomenological research project to investigate student perceptions, beliefs, and meanings of servant-leadership following an international service-learning experience. This study used qualitative inquiry to generate and interpret narratives and personal reflection which are often difficult to assess systematically. Qualitative inquiry is a useful tool to explore phenomena through the lens of a person’s lived experience. For
this project, thematic data exploration hopes to establish consistency in
the lived experiences of health professions students and the emergence of
servant-leadership attributes as identified in current literature as
*stewardship, obligation, partnership, emotional healing, and elevating
purpose* (Johnson, 2021, p. 250). Additionally, anticipated results hope to
emphasize the importance of service-learning leadership experiences in
current and future health profession curricula.

After an extensive literature search, the researchers selected
Photovoice as the qualitative methodology to investigate servant-
leadership theory in a healthcare education program. Photovoice is a
methodology that helps people tell a story through visual photographic
representation. Predominantly used in participatory action research,
Photovoice elicits the lived experience of individuals (Lal et al., 2012).
Related to this study, participatory action research methods include study
participants sharing and collaboratively dialoguing to inform outcomes
“rather than experts inserting or extracting meanings” on behalf of a group
(Green & Thorogood, 2009, p. 21). When using the Photovoice
methodology, participants photographically capture images that represent
their perceived experiences of a particular phenomenon (Wang & Burris,
1997; Wang et al., 1998). Subsequently, participants engage in a structured
critical reflection and discussion to explore the collective experiences and
emergent themes. Narrative data elicited from the Photovoice methods are
collected and codified. Shaffer (1983) established, with Wang and Burris
(1997) later supporting, that codified themes from this type of qualitative
inquiry are meaningful data. Discussion of these images often reflects
areas where participants would like to see change or where they feel
greater attention or awareness is needed. Therefore, intentional discussion
points are needed to elicit a common understanding.

Originally developed by Shaffer (1983), the acronym SHOWED
helped guide discussions by asking five specific questions to
contextualize a concept through pictorial representation. The questions ask:

- What do you see here?
- What is really happening here?
- How does this relate to our lives?
- Why does this concern, situation, or strength exist?
- How can we become empowered through our new understanding?
- And, what can we do?

These questions were later adapted by Wallerstein and Bernstein (1988) to better suit health promotions perspective questions and used the acronym SHOWeD. These questions were then modified slightly by the researchers to capture perceptions through an occupational therapy-specific lens (Table 1).

<table>
<thead>
<tr>
<th>S</th>
<th>What is this picture of? What do you see here?</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>What is really happening here? What is happening here in terms of servant-leadership?</td>
</tr>
<tr>
<td>O</td>
<td>How does this relate to your (our) life as an occupational therapy student or future healthcare professional?</td>
</tr>
<tr>
<td>W/e</td>
<td>Occupational therapy and servant-leadership - Why do you think this exists?</td>
</tr>
<tr>
<td>D</td>
<td>What can we do about it as an occupational therapy profession?</td>
</tr>
</tbody>
</table>

Photovoice methodology can provide a novel strategy of meaning-
making through the selection and presentation of photographic images and personal reflection to assess the leadership capacity of graduate students as they develop into early healthcare professionals. Additionally, with the popularity of social media and instant image sharing, the researchers felt that photographically capturing a lived experience would resonate well with young, college-aged, media-savvy graduate students in the recruitment population. Using this approach intends to provide an opportunity for reflection and self-awareness of leadership behaviors.

This study received Institutional Review Board approval from Saint Joseph’s University (former University of the Sciences in Philadelphia). The Department of Occupational Therapy of this institution provided a small stipend to research participants in support of research endeavors. Samson College of Health Sciences Dean’s funds and/or Travel Abroad scholarships were distributed to students engaged in the international experience regardless of their participation in the research process. No financial or other conflicts of interest were identified.

Study Context and Procedures
This research was part of an independent study course run by the occupational therapy department of a mid-sized, urban university in the United States. The course occurred during the spring semester of the academic years 2019 and 2020 (Year 1 and Year 2 respectively) and included a 10-day international service-learning experiential component. Didactic coursework centered on investigating types of leadership, servant-leader qualities, reviewing examples of persons exhibiting said qualities, and discussions of bias, ethics, client-centered practice, and interprofessionalism. Also, students reviewed material that provided an overview of the medical system structure, cultural priorities, and religious background of the host country. Early orientation to the unique nature of this international experience
included an emphasis on providing sustainable interventions so that clients and organizations may benefit beyond the student’s brief encounter to maximize long-term benefits.

Additionally, this experience had an interprofessional component with physical therapy students from the same university also participating in a separate, but similar, independent study course which included the service-learning trip. Students traveled for 10 days to a Central American country where they provided supervised therapy services in diverse settings including a community outpatient clinic, residential nursing home, adult senior center, vocational training center for adults with intellectual disabilities, and a special needs school of elementary education. Nightly debriefing meetings were conducted to digest the day’s experiences and to make sense of client interactions within the context of health services in the host country.

**Participants and Recruitment**

All students registered for the occupational therapy independent study courses were invited to participate in this research and made up the population for this study. In Year One (Y1; 2019), five participants were enrolled and five participated \((n = 5)\). In Year 2 (Y2; 2020), six participants enrolled and six were recruited \((n = 6)\). There were eleven total study participants \((n = 11)\) with 100% recruitment. Appropriate consent forms for subject participation were signed and retained. A small stipend was offered to incentivize participants. Participation in this study was not mandatory to complete the independent study course, nor had any effect on student performance evaluations. No formal exclusion criteria were established.

Toward the end of the spring semester and after the international experience, this individual work was put forward to the instructor as a course assignment, but, before students presented their selections, a subject recruitment period began. Students were informed of this
research study, its purpose and procedure, and were provided consent forms. As stated previously, participation in this study was completely voluntary. This assignment served as the first part of this research and, while required for the course, ample time was allowed for students to decline study participation but still complete course requirements. Depending upon recruitment, the presentation of the individual work could have occurred in separate sessions (all enrolled students versus only study participants). Had students declined participation in the study, all course-enrolled students would have still engaged in a broad discussion of images. For the two years this project was run, 100% of students were recruited which allowed for broad and deep contextualization of the work to take place sequentially.

Data Collection

Data were collected at two stages: a broad stage and a deep stage which provided investigation into servant-leadership understanding (Figure 1). In the broad stage, participants submitted personal collections of photographs that represented their interpretation of servant-leadership. These were then thematically coded. In the deep stage, together the subjects selected three main photographs from all of their submissions. They were then guided through the SHOWeD method of inquiry as a group. This narrative was then codified as deep contextualization. Having a linear sequence to evaluate selected photographs helped to create a systematic approach to interpreting the meaning of the photographic images for servant-leader themes (Fig. 1). These procedures were replicated for all study years.
DATA ANALYSIS

Data Stage 1: Broad Contextualization

All recruited participants were asked to present their chosen series of five photographs. Participant narratives discussed broad contextualized meanings of the “story” the photographs depicted. Detailed observation notes were taken by a recorder and served as the first data set for this study. Next, as a study group, recruited participants were asked to review and reconsider all of the pictures presented. They were then instructed to come to a consensus and identify three photographs that best represented servant-leadership to their group. The three selected photographs were placed in view to begin the next stage of the study.

Data Stage 2: Deep Contextualization

A deeper contextualization of the three photographs and servant-leader experience was explored using the SHOWeD methodology within the Photovoice methodology, which is the action of meaning-making a lived experience. A draw to the use of the SHOWeD process (within Photovoice) for deep contextualization was its specific focus on critical reflection, an important evidence-based learning process in leadership.
development (Dugan, 2011; Foli et al., 2014). Using the SHOWeD method, students were brought through the five questions of contextualization of their experience (Table 1).

Using the three photographs, the researchers facilitated discussions using the five questions of the SHOWeD method. This was a standardized way to contextualize the meaning-making of the chosen photographs and enabled a closer exploration of perceptions on themes of servant-leadership. Within this stage, group members more clearly articulated the meaning of each picture. They linked to how the experience impacted them as they reflected on the lived experience of the international service-learning trip.

The collection of themes at the group level (Data Stage 1) and using the SHOWeD methodology to examine student viewpoints (Data Stage 2) were member-checked for agreement and triangulated between the groups for accuracy, adding rigor to this qualitative inquiry.

RESULTS

Stage 1: Broad Contextualization

Distinct themes emerged from these first group discussions in both years. Within each, the story of servant-leadership took shape through the participants telling of their perspectives of the cultural and healthcare immersion experience. Similarities and keywords were identified and through a stepwise organization, broader meanings were extracted as a textural description of the [lived] experience (Creswell & Poth, 2018, p. 201).

During this stage, researcher-generated themes of collaboration (teamwork), enabling others/creating opportunity, greater good, and leadership through caring and service were established as prominent from the recorded notes of each year. These were then easily aligned with established themes in current servant-leader literature: partnership,
emotional healing, obligation, stewardship, and elevating purpose (Johnson, 2021). Of note, at the broad contextualization stage, the researcher-derived theme of greater good more closely aligned with the more specific literature-derived themes of both obligation and stewardship; thus, these were combined (Figure 2).

Figure 2 Alignment of Literature Derived Themes with Generated Themes from Data Stage 1: Broad Contextualization and Data Stage 2: Deep Contextualization

<table>
<thead>
<tr>
<th>Stewardship</th>
<th>Broad: Greater Good</th>
<th>Deep: Building Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership</td>
<td>Broad: Collaboration/Teamwork</td>
<td>Deep: Active Collaboration</td>
</tr>
<tr>
<td>Obligation</td>
<td>Broad: Greater Good</td>
<td>Deep: Need for Experiential Learning</td>
</tr>
<tr>
<td>Emotional Healing</td>
<td>Broad: Enabling Others/Creating Opportunity</td>
<td>Deep: Inclusion</td>
</tr>
<tr>
<td>Elevating Purpose</td>
<td>Broad: Leadership through Caring and Service</td>
<td>Deep: Professional Identity and Advocacy</td>
</tr>
</tbody>
</table>

**Stage 2: Deep Contextualization**

During this stage, participants were guided through a refined discussion of group-selected photographs using the SHOWeD method. This method allows for a focused definition of the elements of the servant-leadership concept through the subject’s eyes. In Y1, the first photo selected was that of a student holding an infant in the clinic so that
the parent could receive services. One participant stated, “this situation wouldn’t exist without servant leadership.” The second photo was of two students assisting an elder resident with mobility (Figure 3). Participants remarked that this photo showed how their actions “enabled an opportunity” and how they were “very concerned “therapists.” The third photo captured a kneeling student offering feeding assistance to an elder resident during a social hour in the recreation room. Participants described the photo as depicting someone taking time to feed a client due to it being difficult for her and [the student] recognized that even though others were engaged in another activity, he took the time to assist her and allow the woman to still be a part of her social circle.

Photographs selected in Y2 offered additional perspectives using the SHOWed method. All three photographs selected in this year were group images. The first was a posed group photo with a special education athletics director. Participants commented that he was “an influential teacher” and they saw the benefits of “having an entire team present” to work with the school’s children. Image two depicted a select group of students completing daily documentation at the end of the day. This elicited conversations from participants around “working together” and “advocating so others know our value” and “pushing through.” Also mentioned was “the privilege to help others.” The third photo was of the students setting up a community pop-up clinic together in a shared workspace (Figure 4). Participants noted the “cultural immersion” occurring within this context and the need for “our skills as a community resource.” They emphasized how this photo showed how they could “come together and find the best way.”

Participant data in Stage 2 were categorized into five themes: active collaboration, inclusion, building capacity, need for experiential learning, and professional identity/advocacy. Though not an exact match to the themes derived from Stage 1, these are also closely aligned with
the established themes in the current servant-leader literature: 
*partnership, emotional healing, obligation, stewardship, and elevating purpose* (Johnson, 2021; Figure 2).

Figure 3 *Data Stage 2 Photo Selection: Two Students Assisting an Elder Resident with Mobility*

Figure 4 *Data Stage 2 Photo Selection: Setting up a Community Pop-up Clinic in a Shared Workspace*
DISCUSSION

Thematic Commonalities

Interestingly, participants in Y1 and Y2 reported similar findings in both broad and deep contextualization of the servant-leader experience. The individual presentations and discussions used more general terms to define servant-leadership. For example, caring and greater good are referenced, connoting a feeling or over-arching sense of stewardship and leadership. These less descriptive terms are then explored further in the second step of deep contextualization; having groups identify three photographs and together arrive at a more focused evaluation of the servant-leadership experience. The five themes derived from the SHOWeD discussion have more specificity about what servant-leadership means to study participants. For example, the literature-identified concept of stewardship, defined by Johnson (2021) as “acting on behalf of others” and “serving the greater good” (p. 250), was first articulated by students as “being there when the client needs” and “small actions have a large impact” which researchers cataloged in the broad contextualization as greater good. Further discussion using the SHOWeD method, refined greater good as the actionable skill of building capacity (as a practitioner).

Stewardship: Emerging Self-Awareness and Building Capacity

Stewards, who act on behalf of others, use acknowledged self-awareness of attributes to build capacity for leadership behaviors. The results of this study reveal a clear emerging sense of self as a leader for student participants. Fostering leadership identity is integral to healthcare professions because individuals who reflect on personal leadership capacity and develop a leadership identity are “more likely to seek out opportunities to practice leadership” (Clapp-Smith et al., 2019, p. 12). Globally, strong leadership is required to propel any profession forward.
The study’s international service experience challenged students to expand their range of leadership behaviors and then asked them to consider the meaning of this perceived growth through their developing healthcare practitioner identity. Outcomes are consistent with Mu et al.’s (2010) findings who described how international learning experiences positively affect leadership development and students’ professional identity development. Additionally, the results show burgeoning self-reflection of one’s role within a non-native culture. This is an important step in traditional constructs of cultural competence and humility. However, the researchers found that the students moved beyond self-awareness to a more action-oriented approach to client engagement. This novel phenomenon required further analysis and distillation by the researchers for clarification of capacity building.

*Emotional Healing: Enabling, Inclusion, and Defining “Cultural Humilitence”*

Analysis of narrative feedback suggests a strong alignment with the second literature theme of emotional healing. Participants used terms like “enablement” and “inclusion” which are often consistent with practitioners traditionally identified as culturally competent. Cultural competency, cultural humility, and cultural sensitivity all touch on a healthcare provider’s sense of self, self as a servant (professional), and self as a leader (engagement of clinical skill competence, health educator, and clinician). A more recent term, cultural competemility, acknowledges the interweaving of cultural humility and cultural competency of the individual practitioner (Campinha-Bacote, 2019). What appears to be missing is the action-oriented use of the practitioner’s cultural competemility within client interactions and its application to therapeutic interventions; a facet yet to be defined. To truly foster emotional healing, the researchers suggest that purposeful and active incorporation of these self-aspects into healthcare practice is
cultural humilitence—the action of intentionally incorporating awareness of culture and context, both through the lens of one’s self (intrinsic) and one’s therapeutic practice (extrinsic) within culturally relevant healthcare delivery. As evidenced in the Y1 student discussion, students identified their culturally inclusive action (holding the baby) as the creation of an opportunity for a community member to engage in the therapy process. Pizzi and Richards (2017) stated the critical importance of the therapeutic relationship created between practitioner and client and how it can affect the overall health outcomes of the clients served. It also substantiates a need for active awareness, now defined as humilitence, as a fundamental practitioner skill.

Elevating Purpose: Leadership, Occupational Justice, and Advocacy

As a study completed with occupational therapy students, data suggest that occupational justice is a prominent construct within the service-learning experience. Wilcock (1998) defined occupational justice as “the promotion of social and economic change to increase individual, community, and political awareness; resources and equitable opportunities for diverse occupational opportunities that enable people to meet their potential and experience well-being” (p. 257). While the term occupational justice is specific to the occupational therapy profession, this concept embodies an understanding of social justice that applies to all healthcare professions (Wilcock & Townsend, 2019). There is a natural alignment of occupational/social justice and the third theme of elevating purpose.

Occupational therapy is a profession that strives to promote inclusive participation of those served by reducing barriers and capitalizing on facilitators that empower clients to more fully participate in activities that they need and want to do. Both servant-leadership and cultural humilitence aim to elevate this purpose of occupational therapy. The development of cultural humilitence by an intentional practitioner
connects theory to practice by operationalizing occupational justice concepts. Nilsson and Townsend (2010) suggested global thinking when considering populations and health by implementing an occupational justice lens; meeting the occupational rights of clients, reducing disparities, and emphasizing the inclusivity of all persons in occupational therapy treatment. These not only align with the now-defined action of cultural humilitence, but bring clarity to the servant-leader concept of elevating purpose.

Additionally, Cipriani (2017) identified international service-learning as a prime opportunity to explore occupational justice behaviors. Thus, students who experience the link between social, psychological, spiritual, and other social and culturally relevant aspects of life, build the capacity to more fully address occupational justice issues and the cultural contexts affecting client engagement. The Y2 selected photograph of the inspirational teacher speaks to the concept of leadership by example and occupational justice. Through interprofessionalism and teamwork, this individual promoted inclusivity of the special needs students within the school environment, which was recognized by the study participants who used words like “inspirational,” “advocate,” and “mentor” when describing this teacher. These researchers propose that when healthcare practitioners understand that therapeutic relationships are a context unto themselves and incorporate occupational justice and cultural humilitence within their practice, they promote social inclusivity and can further elevate the client’s meaningful participation.

Partnership: Collaboration and Servant-leadership within Professional Teams

Students can bring their servant-leader identity and cultural humilitence behaviors to their role in the interprofessional team. The interprofessional experience ideas of Higbea et al. (2020) described the importance of reflection and collaboration within teams of healthcare
workers to better support health outcomes for clients. From the guided discussions, the students’ emerging professional identity included the recognition of their role within an interprofessional team. Students noted, “the power of learning from each other” and “a recognition of the value we bring to the team.” Buff et al. (2015) articulated similar concepts stating “students found the most value in learning with students from other professions as part of the activity with lesser value placed on students increasing their knowledge about their profession’s role in interprofessional work” (p. 161) and substantiates the student narratives and visual representations found within this study (Figures 3 & 4).

At times, students also discussed concepts more closely related to transprofessionalism, where the individual characteristics and skills of each profession are undifferentiated to best meet the needs of the patient (Mahler et al., 2014). Students noted “a bending scope of practice” and stated “[it was] the right thing to do at that moment” when talking about their interprofessional engagements. Student perceptions of these transdisciplinary behaviors are inherently linked to the servant-leader principle of partnership, setting aside individualistic perspectives when working towards the greater good. Whether interprofessional (within) or transprofessional (across), servant-leadership development can be seen as a continuum of the collaboration process within professional teams and is a vital workplace culture necessary for the mutual benefit of practitioner relationships. Healthy team behaviors, which should include cultural humilitence, support improved health outcomes of clients served.

Obligation: Facilitators and Barriers to Experiential Learning

One may ask “Do educational programs have the responsibility to develop servant-leaders?” Many experts on servant-leadership acknowledge that opportunities to develop these skills and abilities come from two sources: typically part of an institutional mission, or internally driven by an individual’s motivations (Eva et al., 2019). Additionally,
Johnson (2021) stated that servant-leadership is a bi-directional effort between agencies and individuals. It should be noted that often mission work or international health services experiences have embedded social perceptions of paternalism or colonialism—the affluent using their resources to do good in faraway places, usually with lower socio-economic structure. The purpose of servant-leadership lays bares these concepts and in this context, capitalizes on the nurturing and collaborative nature of graduate healthcare professions for intentional altruistic obligation versus self-serving initiatives. Study participants verbalized “it is a privilege to help others” and “our skills as a community resource” when discussing Y2 photograph selections, which recognizes positionality when meeting the opportunity to improve the client experience (Figure 4).

Individual and/or institutional investment in (international) servant-leadership opportunities has the potential for substantial dividends. Healthcare students often articulate the need to be exposed to diverse contexts and express a desire for such experiences. However, in 2011, Humbert et al. reported that when engaged in an international experience, students struggled with cultural dissonance; this was not a new finding from their research. Facilitating exposure to cultural differences moves individuals through cultural dissonance and is elementally the early development of cultural humilitence. As established earlier, having these experiences ultimately yields early practitioners who can more easily develop ethical, client-centered practice using a culturally sensitive lens.

There are, however, some very practical considerations when evaluating barriers and facilitators and the dual efforts needed to address the obligations of servant-leadership development. One significant consideration is cost and cost-related factors. For both students and educational institutions, offering an international service-learning experience within healthcare programs cost can be a prohibitive factor.
An average student-borne cost can average $1500-$2500 per experience. Many students are already financially overburdened with standard educational expenditures, making costly elective opportunities unattainable. At the college or university level, mission-driven interprofessional education priorities sometimes allow the release of institutional funds to offer financial support or stipends for student opportunities. However, even with stipends, a limitation on available seats for the immersive trip is also a reality. Faculty/student ratios are necessary for proper guidance, safety, and sound practices. The experience abroad may be limited, with different contexts and environments of the host locations. Additionally, large class sizes do not afford a niche experience for all students. To this end, some external partner agencies do offer incentives for schools to maximize student exposure, but this is generally limited to travel groups of less than 25 persons.

Mitigating costs, servant-leadership experiences do not necessarily have to be international. Pro bono clinics, which serve targeted populations or specific health needs, may be found within local community settings and can offer students similar skill-building (Rogers et al., 2017). Other non-institutional settings such as transitional housing programs, local service-learning experiences, and after-school programs are all viable alternatives offering cultural immersion. The use of these non-traditional settings can broaden students’ perspectives and foster leadership skills similar to an international experience (Fleming et al., 1996; Gat & Ratzon, 2014). There are also altruistic benefits for institutions that offer these diverse types of opportunities by creating strong community relationships. Best articulated by Stoffel (2013), “servant-leadership has at its core teamwork and community, involves others in decision making, is strongly grounded in ethical and caring behavior, and works to enhance the personal growth of people while
improving the caring and quality of institutions” (p. 638). The development of servant-leadership behaviors has mutual benefits for all involved.

**Importance of Reflective Practice**

The depth of student reflections and perceptions of servant-leadership behaviors from this study points to the importance of providing structured opportunities for students to engage in reflective practice through methods such as Photovoice. Reflective practice is a critical component of leadership development and helps students and practitioners build self-awareness and foster professional growth (Kinsella, 2001; Wilson et al., 2022). Engaging in reflective practice, especially in times of complex change and diverse challenges supports adaptive capacity (van der Steen et al., 2021). Students’ perceptions and reflections on servant-leadership help to strengthen the connection of their service-learning experience to the development of leadership behaviors.

**FUTURE INQUIRY**

This work highlights a few areas of inquiry where further investigation would contribute to additional advancement of the body of knowledge regarding servant-leadership, reflective practice, and the newly defined concept of cultural humilitence. One obvious limitation of this research was the availability of small cohorts related to institutional and personal costs to participate. Additionally, this study viewed two student cohort perspectives in one moment of time and did not evaluate longitudinal data. Expansion of this study could evaluate whether these behaviors continue to develop and/or are incorporated into an individual’s practice after graduation. Likewise, a comparative group study (between groups design) would be a secondary way to confirm obtained results from this research. Finally, very few studies exist to
measure students’ perceptions of specific servant-leader variables as innate characteristics of students who choose healthcare careers. Another area of inquiry uncovered from this work was the question of cultural humilitence and the influence on the interprofessional or the transprofessional team approach. Further investigation would be beneficial to explore this phenomenon.

CONCLUSION

This research helps to understand healthcare students’ perceptions, beliefs, and meanings on servant-leadership following an international service-learning experience. Scholars reinforce that future healthcare clinicians require servant-leadership and service-learning opportunities to gain the necessary perspectives and skills for inclusive practice (Humbert et al., 2011; Nilsson & Townsend, 2010; Pizzi & Richards, 2017). Understanding student perceptions of these service-learning and servant-leadership development experiences can provide valuable data to support this type of programming. Student perceptions are consistent with the tenets of servant-leadership theory as findings revealed the emergence of students’ professional identity and capacity building of servant-leader qualities while engaging within a culture different from their own. The use of Photovoice methodology is an innovative way to help students process their experiences, foster reflective leadership, and meet the need for rigorous analysis of these more subjective constructs.

Outcomes from this novel qualitative study strongly support incorporating servant-leadership experiences, cultural immersion, and reflective practices to develop leadership identity and cultural humilitence. The extrinsic value of creating opportunities for skill-building, advocacy in action, collaboration, interprofessionalism, and cultural humilitence contributes to the betterment of society as a whole through servant-leadership experiences.
ACKNOWLEDGMENTS

The authors would like to acknowledge the following: International Service Learning (ISL) and its employees Ms. Sonia Hernandez (coordinator) and Mr. Leonardo Rodriguez (team leader) for supporting this multi-year student endeavor in their home country, the Office of the Dean and the institution of University of the Sciences in Philadelphia at large for providing travel stipends for faculty and students engaged in these experiences, and most importantly, the students themselves for both their active participation abroad and for graciously and openly participating in this qualitative research experience.

References


Shaffer, R. (1983). *Beyond the dispensary*. AMREF


Stoffel, V. C. (2013). From heartfelt leadership to compassionate care (Inaugural


Wendy E. Walsh, PhD, OTR/L, FAOTA is an Associate Professor and the Chairwoman at Saint Joseph’s University, Department of Occupational Therapy, in Philadelphia, PA. Her scholarship focuses on policies governing healthcare practice and occupational therapy professional advocacy efforts. She has been a practicing clinician for over two decades with specialty areas in adult and geriatric physical rehabilitation. Dr. Walsh has been grant funded and has authored several articles, chapters, media posts, and has presented at numerous and diverse professional conferences, nationally and internationally.
Tracey E. Recigno, PhD, OTD, OTR/L is the program director and assistant professor for the entry-level doctoral occupational therapy program at Hawaii Pacific University in Honolulu, Hawaii. She has been an occupational therapy practitioner for close to 20 years. Her scholarship focuses on occupational therapy student leadership development, teaching and learning, interprofessional education, and complementary health approaches. Dr. Recigno has presented at numerous national and international professional conferences and has authored several articles in peer-reviewed journals.