



Introduction to Reflection in Public Health Practice



Welcome to this short, case-based course to help you build a regular reflective habit that strengthens both your learning and day-to-day practice.

What you'll learn

- **Why reflection matters for safe, effective public health practice.**
- **Key ideas (reflection *on* action vs *in* action; moving toward deeper, critical reflection).**
- **Practical ways to start: simple prompts and habit-forming tips.**
- **How to write concise reflective notes you can use for appraisal/CPD.**

About this Booklet (which is derived from the Peoples-Praxis course of the same name)

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Media disclosure: This course includes AI-generated images created with ChatGPT (Sept 2025). Used for illustration; no real persons shown.



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Learning Outcomes

By the end of this course, you will be able to:

-
1. Understand the power of reflection

🌀 2. Use structured reflection tools (like Gibbs, Rolfe, or Schön) to guide your thinking

📖 3. Learn from your real experiences using reflection

📅 4. Build a sustainable reflection habit

🚀 5. Turn reflection into action using a personal development plan

Why reflection matters in public health

Reflection is a process we go through when we step back and critically think about experiences, decisions and actions and the wider system we work in.

As healthcare workers, we are increasingly being encouraged to reflect on our practice more to learn from it and improve our future practice.



In public health we need to do more than just remember what happened with individual patient care, public health reflections often deal with complex systems, communities and policies as well.

Reflection helps us turn our experience into learning: spotting patterns, testing assumptions, and improving judgement under uncertainty.

In public health reflection supports *safer decisions, better teamwork, and evidence-informed action.*

Benefits you will notice

- **Clarity:** It helps us make sense of complex or ambiguous situations.
- **Quality & safety:** It helps us surface blind spots before they scale.
- **Growth:** Track our development against recognised competencies and values.
- **Communication:** Helps us write concise notes we can share for CPD/appraisal.

Public health lens: Reflection isn't indulgent, it is a systems skill. It makes learning visible and actionable across teams and programmes.



Reflection in Action- a worked example: Teaching Basic Life Support in Northern Nigeria

During a short visit to a Primary Healthcare Centre in Borno State in Northern Nigeria, I was unexpectedly asked to deliver a teaching session on Basic Life Support (BLS) for a group of hospital attendants.

These attendants were often the first point of contact for sick patients, yet most had no prior medical training or exposure to formal teaching. Despite this, they were eager and motivated to learn. Though I felt unprepared, I didn't feel I could say no.

I began the session with about 15 women gathered around me, using an interpreter to explain the key stages of BLS. As I spoke, I noticed blank faces and silence – no questions, no engagement.

It became clear to me that I hadn't presented the information in a way that was understandable, accessible, memorable, or practical for them.

With the support of a senior colleague and mentor, I quickly adapted. We transformed the session into an interactive learning experience – using demonstrations, simple language, and even creating a local song to help everyone remember the key steps.

🎵 By the end, the group was laughing, moving, and confidently recalling the sequence — turning what began as a didactic static session into one of shared learning and empowerment.

One-way teaching versus interactive

One-way (initial approach)

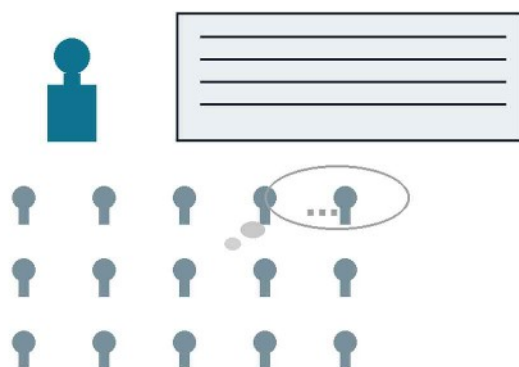
Long verbal explanations via interpreter
Minimal checks for understanding
Little movement or demonstration
Low engagement and confidence
No memory aids

Interactive (after reflection)

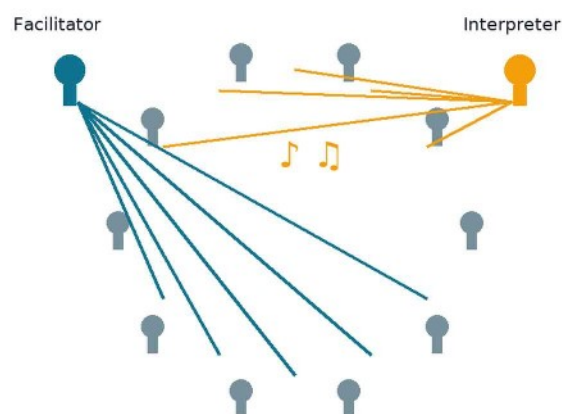
Short, clear steps in plain language
Call-and-response and quick practice checks
Demonstrations, role-play, learners practicing
High energy; learners recalled the sequence
A simple local song as a memory aid

Teaching basic life support at a PHC — adapting delivery after reflection.

Before: one-way teaching



After: interactive practice



Reflect & adapt delivery




Reflection point 1

Spot the reflection moments


Reflect on the questions below

1. **What happened initially?** Briefly note my approach and the outcome.
2. **Trigger for reflection:** What signalled that a change was needed?
3. **Adaptation:** Describe what I changed and why.
4. **Carry-forward learning:** Which one key learning will you take into your next session.

Reflection point 2

 **What is reflection to you?** How do you practice it now?

 **Why learn more?** What's your motivation for doing more now?

 **Barriers & plan:** What might get in the way? Note 2–3 steps you will take to overcome these.

Key takeaways

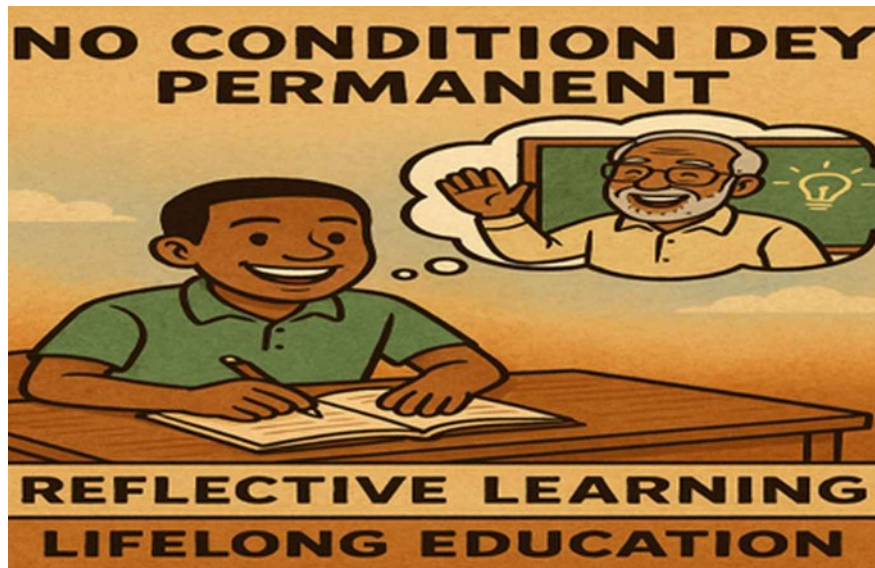
- Reflection helps you adjust *in the moment* to needs and consider what additional needs might be present after the moment.

- Small changes (in this case plain language, demonstration, practice, memory aids) can transform our actions and impact.
- Capture your learning now, so you can apply it in your next session.

A recap of why reflection matters

“The only constant in life is change” — Heraclitus

“No condition dey permanent” — West African Pidgin English proverb



Reflection supports lifelong learning and helps us respond to professional, political, and social change.

Through reflection, we:

- Keep our knowledge up to date
- Learn from success and mistakes
- Strengthen our adaptability and curiosity
- Improve our judgement and teamwork

💡 Tip: Reflection is not about criticism — it’s about curiosity and improvement.

🧠 How we learn from experiences

We learn best when we:

- Take an **active role** in learning
- Connect new ideas to **real situations**

- Ask what worked, what didn't, and **why**
- Apply our insights in the **next action**

What do we know

Reflection = thinking about our experiences to gain new understanding and improve practice.

Critical reflection = going deeper - questioning our assumptions, values, policies, and systems to learn and improve.

Ineffective vs effective reflection (a quick view)

Ineffective reflection is vague and backward-looking e.g. “that went badly” with no clear reasons, ownership, or next steps. Effective reflection is specific and forward-looking: it states what happened, why it mattered, your role, what you learned, and the concrete actions you'll take next time, including how you'll check if they worked.

Effective reflection is important because it turns experience into learning: you see what worked, what didn't, and what to do next, so you improve faster and avoid repeating mistakes.

Ineffective	Effective
Just describes what happened.	Describes and explains decisions.
Blames time/others; no ownership.	Surfaces assumptions, values, policy and context.
No lessons learned or planned.	Includes other perspectives/evidence; states lessons learned and a specific action plan.

3 simple steps to practice reflection

1. **Description** — What happened?
2. **Analysis** — Why? Feelings, decisions, other perspectives, context.
3. **Action** — What did you learn? What will you do differently?

Frameworks for reflection

Frameworks as a foundation for reflection in a world that is constantly changing.

A reflection framework is a simple, repeatable set of steps that helps you look back on an experience, make sense of it, and turn the insights into actions for next time.

Here we explore several different frameworks, as well as how we utilise these to learn through experience, adapt to change, and connect our insights to our public health practice.

Meet four reflection frameworks — *Gibbs, Schön, Rolfe, and Triple-Loop Learning*.

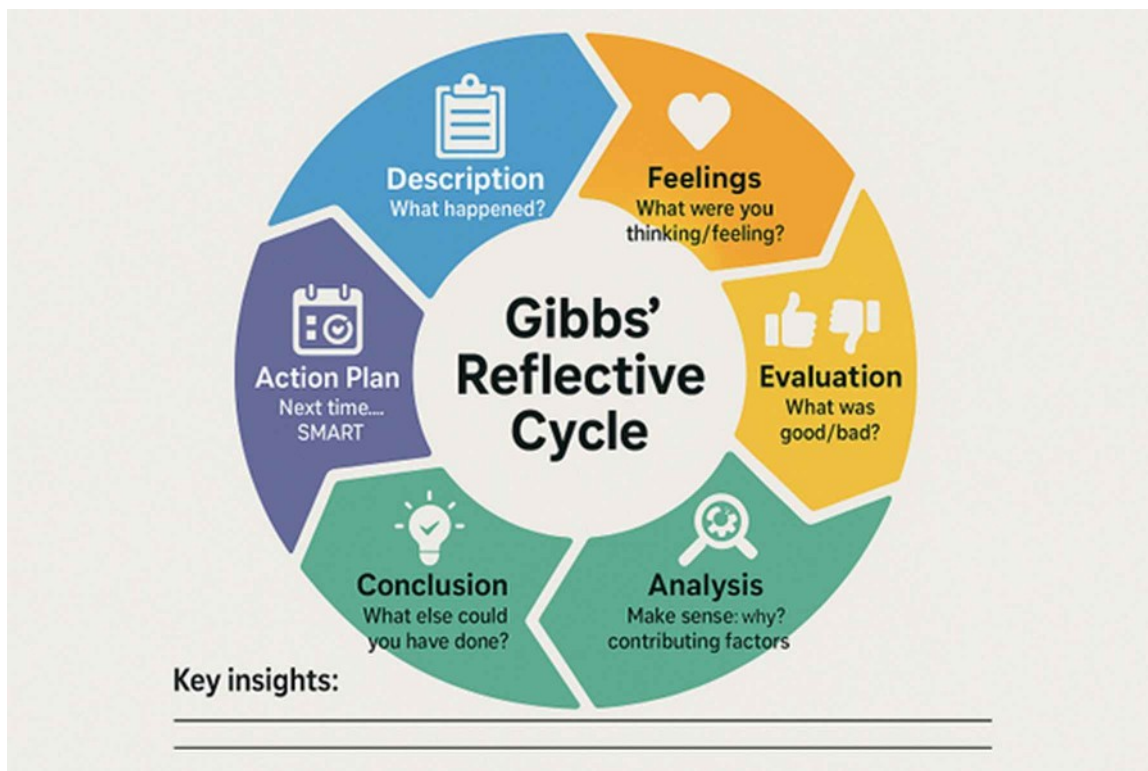
- Learn how to apply them to public-health scenarios.
- Decide how to choose the right one for your context.

Gibbs' Reflective Cycle (6 stages)

This is a step-by-step way to think about an experience.

You first describe what happened, note your feelings, judge what went well or not, analyse why, draw a conclusion about what you learned, and finish with a clear action plan for next time.

6 Stages: *Description • Feelings • Evaluation • Analysis • Conclusion • Action plan.*



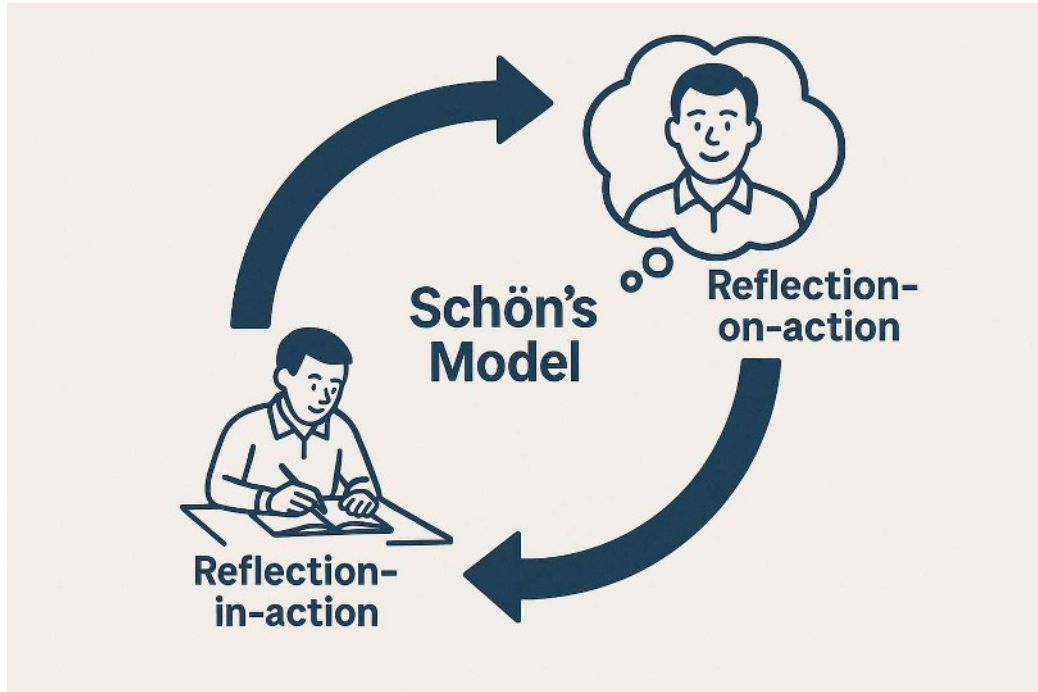
Use Gibbs when: you need a structured, step-by-step review and a clear plan.

Source: Gibbs, G. (1988). *Learning by Doing*. Oxford: Further Education Unit, Oxford Polytechnic.

⚡ Schön's Model — Reflection-in-action & Reflection-on-action

Reflection happens both during and after action.

Reflection-in-action means noticing what is happening and making small adjustments in the moment; *reflection-on-action* means looking back afterwards to understand why things went that way and how to improve.



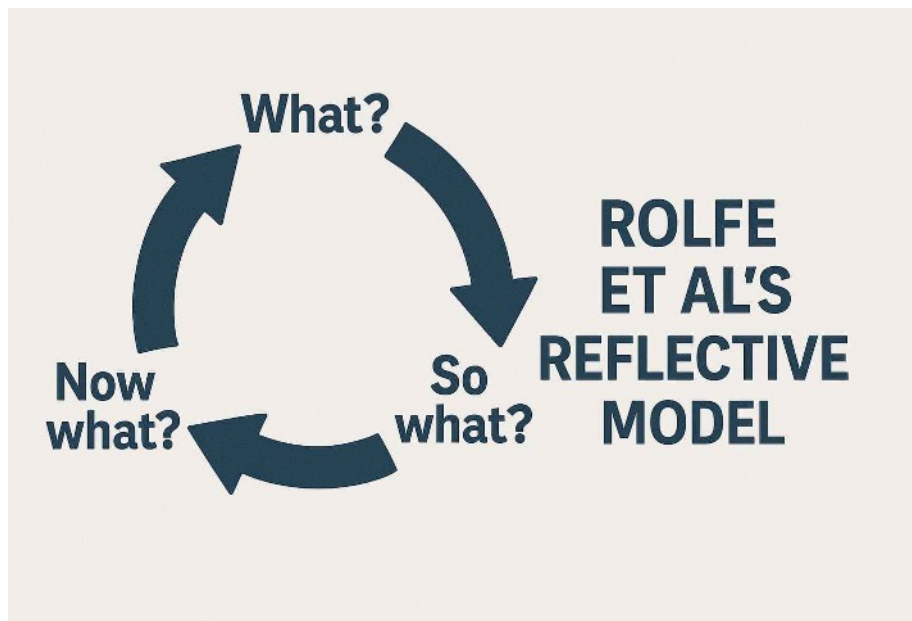
Use when: you must adapt in real time and then debrief.

Source: Schön, D. A. (1983). *The Reflective Practitioner*. New York: Basic Books; and (1987) *Educating the Reflective Practitioner*.

? Rolfe's model — What? • So What? • Now What?

This is a quick, practical framework built on three questions.

1. **What?** describes the event.
2. **So what?** explains why it matters — insights, implications, meaning.
3. **Now what?** turns learning into next steps and changes you will make.



Use when: you need a fast, practical check-in.

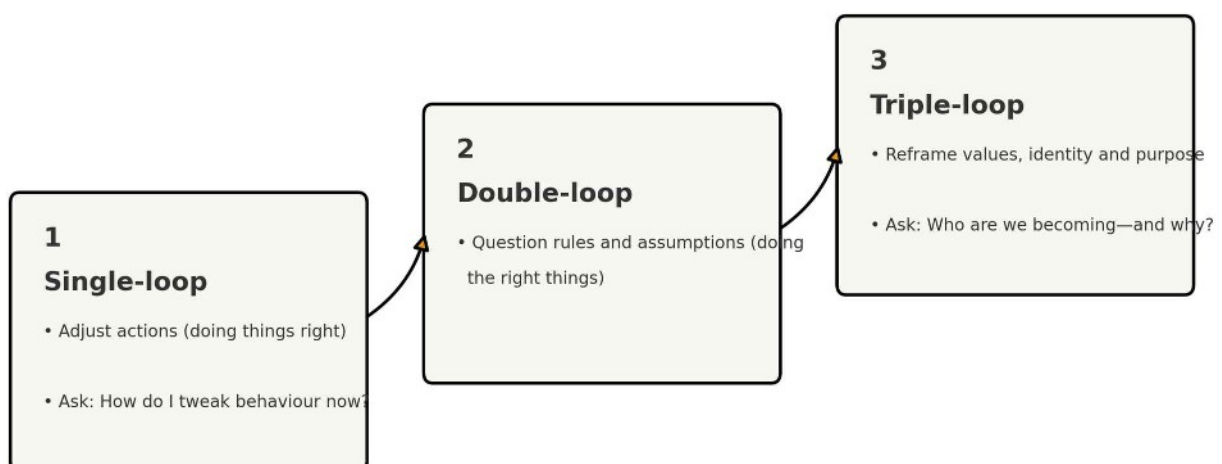
Source: Rolfe, G., Freshwater, D., & Jasper, M. (2001). *Critical Reflection for Nursing and the Helping Professions*. Basingstoke: Palgrave Macmillan. (Earlier roots: Borton, T. (1970). *Reach, Touch, and Teach*; see also Driscoll, J. (1994)).

🎯 Triple-Loop Learning — Single • Double • Triple

Moves from improving tasks to reshaping thinking and decision-making.

- **Single-loop:** “Are we doing things right?” — tweak actions.
- **Double-loop:** “Are we doing the right things?” — challenge assumptions.
- **Triple-loop:** “How do we decide what’s right?” — examine values, power, and how ‘success’ is defined; sometimes implies changing the rules.

Triple-Loop Learning — Doing → Thinking → Being



Use when: work involves policy, systems, and values (e.g., service design, governance, equity).

Source: For single/double-loop see Argyris & Schön’s organisational learning tradition; for triple-loop, see Tosey, Visser & Saunders (2012) review.

Pause & Reflect

Consider one situation this week that prompted you to think.

Record your reflections under these headings:

- **Situation:** What happened?
- **Actions:** What did you do?
- **Insights:** What did you learn?
- **Next steps:** What will you do differently next time?

You might also like to look at this short video from the Clinical Excellence Commission (UK):
Reflective Practice https://youtu.be/pdlyKZhJbts?si=v_KLxrpZubB8H60e

Applying the Reflection Frameworks to a Mobile Measles Outreach Clinic Example



Mobile measles clinic at a school yard — logistics strong, turnout low.

Mobile measles clinic: what really happened on the day

We set up a measles clinic in the school yard. The vaccines were cold. The staff were ready. The forms were on the table.

But very few mothers came in. Many stood at the gate. Some turned away.

We asked why.

They feared side effects. They did not know our team. Our posters were in English.

No leader had told them we were coming. It was market day. Childcare was hard. The sun was hot. Waiting felt risky.

People asked for simple things:

“Let the local nurse speak.”

“Let the imam or pastor introduce you.”

“Please talk in our language, we don't understand.”

By late afternoon, numbers were low.

The vaccination kit was fine. The plan was not.

We learned that trust, language, and timing matter most.

Next time, we will come with their voices, and tell them early, in their language and words.

How can each reflective model be applied to this example?

Using the story above and framework descriptions on the previous pages, reflect on what each framework might say for this example before you see the worked examples.

Choosing a framework (quick guide)

- **Need structure** → Gibbs.
- **Need to adapt live** → Schön.
- **Need something fast** → Rolfe (What/So What/Now What).
- **Working on policy/systems/values** → Triple-loop.

See our worked examples below:

Worked Example: Gibbs' Reflective Framework - 6 Stages

1) Description

A one-day mobile clinic was well resourced (cold chain, staff, supplies). Many mothers stayed back, concerned about side effects and an “outsider” team. There was no prior briefing with leaders, and materials were not in the local language.

2) Feelings

We began confident, then felt frustrated and worried. It was surprising to see a gap between strong logistics and low turnout. We were concerned about missing chances to protect children.

3) Evaluation

What went well (+): Smooth logistics; safe clinical flow; some families liked the convenience.

What didn't (-): Low trust; language/cultural mismatch; little pre-engagement; no visible community champions on site.

4) Analysis

Uptake depended more on **trust and relevance** than on access. No co-designed messages; no leaders present; unfamiliar staff → **low social proof**. Local beliefs/rumours were likely **unaddressed**.

5) Conclusion

For outreach to work, **relationship-building and cultural alignment** must sit alongside technical delivery — not after it.

6) Action plan (SMART)

- **T+14 days:** Hold a joint briefing with religious, women's, and youth leaders to **co-design** clinic flow and FAQs.
- **Before clinic:** Produce **local-language** audio/posters with trusted figures; send **radio/WhatsApp** reminders.

- **On the day:** Recruit **two local volunteers** for translation and introductions; run a **3-minute group Q&A** on arrival.
- **Monitoring:** Track **uptake, questions asked, and satisfaction; debrief within 48 hours** to adjust quickly.

✿ Worked Example: Schön’s Reflective Framework

1) Knowing-in-action (our default approach)

We planned a one-day clinic with strong logistics: cold chain, staff, supplies, clear flow.

Assumption was: “If access is easy, families will attend.”

2) Surprise (the situation “talks back”)

Mothers hung back. Concerns about side effects and “outsiders.” Posters in English weren’t landing. No prior word from leaders. Turnout stayed low.

3) Reflection-in-action (thinking on our feet) — during

On the day, we paused and asked: *What’s going on right now and what can we try immediately?*

- Switched to **simple language** and short **verbal FAQs**.
- Pulled a **known CHW** into the welcome area to greet families.
- Offered **brief private chats** for worried caregivers.
- Moved shade and seating closer to the gate to feel more inviting.

4) On-the-spot experimentation (small tests)

- 3-minute **talks** every 30 minutes addressing the top two fears.
- A CHW translated key points for small groups.
- Invited one mother who’d just vaccinated to share her experience (peer signal).

Result during clinic

Conversations improved; a few fence-sitters converted. Coverage rose slightly, but overall remained below target.

5) Reflection-on-action (afterwards)

The core issue wasn’t access; it was **trust and recognition**. Without prior leader endorsement or local-language messaging, the clinic felt like a stranger’s tent.

6) Reframing the problem

From “bring vaccines closer” → to “**earn permission to deliver**” (build social licence through trusted voices, language, timing).

7) Next time (design for learning, not just delivery)

- **Before (T–2 weeks):** Sit with village head, women’s leader, youth rep, and faith leaders. Co-design date, flow, FAQs. Record a **90-second voice note** by the local nurse/leader in the local language (radio/WhatsApp).
- **Materials:** Picture poster + audio FAQ in local language; test with two mothers for clarity.
- **On the day:** **Local nurse** at the welcome table; scheduled short talks and a private consult corner.
- **Timing & access:** Avoid market hours; shade, water, queue tickets.

8) Evidence to collect (so the situation can “talk back” again)

- **Coverage** (overall and by household/compound).
- **Conversion** (number hesitant on arrival → vaccinated after dialogue).
- **Language reach** (materials distributed/played; radio/WhatsApp plays).
- **Experience** (1-question exit poll: “Was the information clear and respectful?” Yes/No).
- **Safety** (follow-up within 48 hours).

Prompt: “What am I noticing right now, and what small change can I test in the next 10 minutes?”

Worked Example: Rolfe’s Reflective Framework

What?

- One-day mobile clinic set up at the school courtyard.
- Logistics strong: vaccines, cold-chain, staff, clear flow.
- Many mothers hesitated: fears about side effects; team seen as “outsiders”.
- No prior briefing with leaders; posters and explanations mostly in English.
- Uptake below target.

So what?

- The main barrier wasn’t access — it was **trust, language, and recognition**.
- Without **leader endorsement** and **local-language** messaging, the clinic felt unfamiliar.
- Health beliefs/rumours were **unaddressed**; families wanted a **trusted local voice** (e.g., nurse, imam/pastor).
- Technical readiness alone does **not** drive demand; **social licence** matters.

Now what?

- **Before clinic (within 2 weeks):**
 - Convene village head, women’s leader, youth rep, and faith leaders. **Co-design** the date, venue, flow, and FAQs.
 - Produce **local-language** audio and pictogram posters; test with two mothers.
 - Share **90-second voice notes** from a local nurse/leader via radio/WhatsApp.
- **On the day:**
 - Welcome desk staffed by a **known local**; name badges with language.
 - **3-minute micro-huddles** every 30 minutes to address top concerns.
 - **Private consult corner** for worried caregivers; translator on hand.
 - Avoid market hours; provide shade, water, and simple queue tickets.
- **After:**
 - Track coverage, hesitant → vaccinated conversions, language reach (poster/audio), 1-question exit poll (“Was the information clear and respectful?”).
 - **Debrief within 48 hours**; adjust for the mop-up day.

One-liner: “If the community didn’t help shape it, they may not show up for it.”

✿ Worked Example: Triple-Loop Learning Framework

1) Single-loop: Are we *doing things right*?

Adjust actions to fix immediate gaps.

- **Observation:** Low turnout despite strong logistics.
- **Immediate tweaks (on the day):**
 - Move **shade/seating** to the gate; add a **welcome greeter**.
 - Give **simple verbal FAQs** in plain language.
 - Offer **private chats** for worried caregivers; brief **talks** every 30 minutes.
- **Aim:** Improve flow and answer fears quickly.

Quick checks: fence-sitters converted, questions answered, shorter waiting, slight coverage lift.

2) Double-loop: Are we *doing the right things*?

Re-examine assumptions, redesign the approach.

- **Challenged assumption:** “If access is easy, families will come.”
- **New design:** Trust first, then delivery.
 - **Pre-clinic (T-2 weeks):** Meet village head, women’s leader, youth rep, faith leaders to **co-design** date, venue, flow, FAQs.
 - **Language:** Posters + **audio voice notes** in local language; test with two mothers.
 - **Messengers:** Local nurse/CHW and faith leader **co-host** the clinic.
 - **Timing:** Avoid market hours; provide childcare corner/shade; **queue tickets**.

Success signals: Higher first-dose uptake, more families from distant compounds, fewer walk-aways at the gate.

3) Triple-loop: How do we decide what is “right”?

Examine values, governance, and power; change how we learn and decide.

- **Guiding values:** Respect, co-creation, equity.
- **Governance shift:**
 - Create a **community advisory huddle** (leaders + CHWs + women’s rep) that signs off dates, messages, and messengers.
 - Set a rule: “**No clinic without community briefing.**”
 - Budget time for **listening sessions** and translation as core inputs, not add-ons.
- **Learning culture:**
 - After each clinic, run a **15-minute debrief** with a local representative; share back what changed because of community input.
 - Track **trust metrics** alongside coverage; publish a one-page feedback note to the community.

End-state: Decisions are made *with* the community, not just *for* the community.

Simple measures at each loop

- **Single-loop (process):** wait time, number of questions answered, number of private consults, fence-sitters converted.
- **Double-loop (design fit):** percentage of materials in local language distributed/played; attendance by hamlet; turnout outside market hours.
- **Triple-loop (trust/governance):** leader co-sign-off recorded; number of advisory huddle meetings; exit poll “Information clear & respectful?” (Yes/No); repeat attendance next round.

Governance prompt: “Who helps define success, and who has authority to change the plan?”

Final Reflection

1. Choose a recent situation you have encountered (it can be routine, tricky, or a “near miss”).
2. Write 150–250 words or a 2-minute voice note using either *Rolfe* or *Gibbs framework*.
3. Add one area to **DO** - when/where you’ll reflect weekly.

Make it a habit - How can you make sure this happens?

- **Anchor:** Pair this reflection with an existing routine (e.g. Friday 15:00, debrief with team about learning).
- **Small:** Aim for 5–10 minutes weekly; longer is a bonus.
- **Template:** Re-use the same prompts to help you remember and reduce friction.
- **Track:** Keep a one-line log (date + topic + “one learning is...”).
- **Team:** When you have embedded, try a monthly peer reflection group (15 mins).

Privacy & ethics: De-identify cases, follow confidentiality policies, and focus on learning not blame.

In conclusion

We hope that you have found the information to be of some interest and value. We invite you to post your reflections, either on some or all of the reflection points from the various sections, or in general about your experience or reflections on mentoring as a mentor or mentee.

Please [contact us](#) if you have any comments or questions, or would like to join [Peoples-Praxis](#) in any way as a mentor, mentee or partner.