Creative Health Communication and Curation:
A Case Study from Ikon Gallery

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HEALTH COMMUNICATION CONTEXT

Health communication describes the use of targeted messaging to inform and influence the decisions of individuals and communities to positively impact their health. A large share of health communication comes from *Public Health* teams. These are leaders within healthcare who are responsible for improving and protecting the health of whole populations (rather than treating individual patients), through approaches such as behaviour change, disease prevention, and mitigation of health inequalities.

In the UK, public health communication has typically relied on top-down, information-led approaches that assume a rational uptake of expert guidance. While these approaches can be effective for standardised messaging, these models have struggled to address persistent health inequalities, low trust in institutions, and uneven levels of *health literacy* across populations – that is, a person's ability to find, understand and use health information to make decisions about their health. Health inequality leaders, such as Marmot[1] demonstrate that strategies that neglect to consider and adapt around social determinants of health risk reinforcing existing *gradients* – that is, 'the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged'[2]. Similarly, Nutbeam[3] highlights the limitations of functional, deficit-based approaches to health literacy.

Against this backdrop, curated creative health interventions offer an alternative, or complementary, mode of health promotion; one that fosters participation, supports *critical* health literacy, and repositions members of the public as active agents in meaning-making, thereby contributing to the democratisation of healthcare.

CASE CONTEXT

The case study presented in this article builds upon research from the *Mobilising Community Assets to Tackle Health Inequalities* programme[4,5], which captures insights about Birmingham's Public Health Research Officers in Residence (PHROiR). Through this model PHROiR were embedded within four creative organisations:

- Birmingham Museums Trust,
- Birmingham Hippodrome,
- Midlands Arts Centre,
- Ikon Gallery.

The PHROiR Program was established to address rising local and regional health inequalities through the exploration of alternative models of service provision and redesign.

Regan was appointed to Ikon Gallery, with a remit focused on the impact of contemporary visual arts on health and wellbeing. His role encompasses research and evaluation, systems and partnership

working, and production. He is fundamentally embedded within Ikon's production-oriented Education team, rather than positioned as an external or retrospective evaluator. This enables public health frameworks to be incorporated upstream into curatorial thinking, programme design, and delivery, as well as strategic planning – particularly within workstreams overseen by Ikon's Artistic Director of Education, Linzi Stauvers.

The research and evaluation component of Regan's role uses a mixture of approaches, combining methods that explore people's experiences in depth (qualitative) with measures that track change using numerical data (quantitative). The latter measures have been formally "validated" and are widely used in health settings. This combination of methods enables Regan's work to capture partnership dynamics, participants' experiences, and learning within the organisation, including insights that are often poorly accounted for in conventional public health metrics or arts and culture sector evaluations. In parallel, Regan's role involves production responsibilities, including commissioning, coordinating, and supporting artist-led projects and cross-sector collaborations. This positioning supports sustained systems working across academic institutions, third-sector organisations, local authority health priorities, and community participants.

Embedded within Ikon's program are projects such as artist Niki Gandy's prison residency[6] – a project that exemplifies how an embedded, co-productive approach can build trust, support critical health literacy, and engage communities typically marginalised by mainstream public health communication, while simultaneously producing data through metrics such as the Warwick-Edinburgh Mental Wellbeing Scale[7].

COMPETENCIES OF A CREATIVE HEALTH COMMUNICATOR

Part of the role of a creative health communicator is in strategising around the placement and curation of communications. To illustrate, we explore the example of an Ikon exhibition entitled *What are the Odds?*[8] *What are the Odds?* brought together seven creative installations relating to health and gathered them into an imagined life course. The life course was explored through architectural installations, film and photography, with public engagement taking place throughout.

The placement of *What are the Odds?* was the Library of Birmingham rather than the Ikon gallery, as libraries are thought to attract broader and more socio-demographically diverse audiences than many cultural institutions, including individuals who may not self-identify as gallery visitors. In the UK in particular, libraries function as trusted, non-stigmatising civic spaces, routinely accessed for education, access to computers, welfare advice, and social support. Increasingly, they also operate as informal health and wellbeing hubs, hosting regular service provision and advice sessions. In Birmingham, a dedicated Health and Wellbeing zone is managed in partnership with Birmingham City Council Public Health to embed preventative health activity within everyday civic infrastructure, positioning health as a shared social concern rather than a specialist domain or contained within (quasi) clinical spaces.

In the curation of *What are the Odds?,* Regan aimed to surface lived experience, ambiguity, and contestation, enabling members of the public to recognise themselves as legitimate contributors to health meaning-making. The library setting enabled a shift from health communication as *transmission* to health communication as *authorship*. By situating *What are the Odds?* within the library, health narratives were encountered

alongside everyday life, supporting a loose and informal, yet well-established, tradition of *civic epistemology*[9] around health – that is, the culturally specific ways in which a society tests, validates, and uses knowledge to make public and collective choices – rather than reinforcing expert-led hierarchies of knowledge.

These dynamics can be understood through *social movement* and *collective behaviour* theory. For example, Granovetter's "threshold models"[10] demonstrate how individual participation depends on perceived levels of existing engagement; once a visible critical mass is reached, participation accelerates. Similarly, Noelle-Neumann's "spiral of silence"[11] suggests that minority or marginalised views often remain unexpressed until a tipping point renders them publicly viable, at which point wider consensus can shift rapidly. In the context of health communication, curated activity in civic spaces – which centres diverse experiences of health and concurrent narratives – can therefore play a role in making hidden concerns and alternative narratives visible, contributing to agenda-setting processes beyond the exhibition itself.

Social movement theory also demonstrates that popular consensus alone is insufficient to generate systemic change. Availability and mobilisation of resources, as well as political opportunity structures, determine whether collective sentiment translates into institutional response or policy reform. UK cultural policy history illustrates this pattern through extended periods of stagnation, incremental funding cuts, and technocratic management, which have been punctuated by moments of rapid reconfiguration, such as the post-war establishment of the Arts Council, emergency cultural recovery funding during COVID-19, and more recent place-based cultural strategies. These shifts have tended to occur when public sentiment becomes politically unavoidable and culture is reframed as essential socio-cultural infrastructure rather than a nice-to-have.

Within this context, curatorial practice assumes a critical narrative function. Creative health interventions remain unevenly embedded within public health systems, yet this emergent phase offers a strategic opportunity to shape how art, or creativity more broadly, is understood in relation to health. By framing creativity as essential across the life course, rather than as purely therapeutic or peripheral, curation can contribute to tipping-point dynamics in public perception. In this model, the intersection of art and health serves as connective infrastructure, supporting a modest redistribution of authority over health narratives, expanding participation in health authorship, and reconfiguring communicative loops through which health priorities are negotiated. In doing so, it contributes not only to individual wellbeing but to the broader democratisation of healthcare discourse and decision-making.

CAPACITY-BUILDING REQUIREMENTS FOR SYSTEMS SEEKING TO EMBED CREATIVE HEALTH COMMUNICATORS

Embedding novel health communication approaches – such as creative health communication – into healthcare ecosystems relies just as much on systems capacity as it does on available skillsets and evidence that it works. Key features of the capacity-building process include navigating *legitimacy, remit*, and *strategic positioning*.

In Birmingham, legitimacy was catalysed through the authority of Dr Justin Varney-Bennett[4] – during his time as Director of Public Health – who enabled a Creative Public Health programme[12] to move from aspiration to action. His leadership helped to maintain momentum for innovation that

did not sit neatly within established conventions. Drawing on Rogers' "Diffusion of Innovation" theory[13], Varney-Bennett can be understood as an "innovator," with programme participants acting as "early adopters" within his system.

At a national level, the Creative Health Champions Network[14] – hosted by the National Centre for Creative Health (NCCH) – has played a complementary role, extending early adoption to other systems by providing both peer legitimacy and a protected space for shared learning. In this context, legitimacy is not passively granted by systems, but actively leveraged by a knowledgeable minority who are able to navigate entrenched norms and mobilise collective authority to advance change. The intension is for this infrastructure to become the foundations on which NCCH can attract "the early majority" of creative health advocates moving forward.

Directors of Public Health from this network identify remit as a barrier for their creative health leadership. Where large public health teams – like that in Birmingham – are able to enforce novel creative health workstreams, other places – like Herefordshire[15] – have required cross-departmental partnerships between culture and health teams to enable creative health to be funded and delivered. Where only leisure is within the remit of a council, rather than culture, leaders have faced greater barriers to progression within their public health workstreams.

Measurement of the long-term impact of health communications – both creative and otherwise – remains a persistent challenge. However, creative health communication holds a particularly strong logic for how it is able to engage "hard to reach" and disengaged communities; with the PHROiR work at Ikon providing a rich example of good practice. In this context of limited measurability, knowledge transfer roles, like the PHROiRs, locally, and NCCH, nationally, are important in translating the potential of creative health communications work into something that is legible to leaders responsible for addressing health inequalities.

IMPLICATIONS FOR THE HEALTH COMMUNICATION WORKFORCE

Having explored the competency and capacity requirements for embedding a creativity into health communication, we envisage a growth in the health communication workforce – one which includes both artistic and hybrid roles:

Within this model, artistic stakeholders are not as peripheral contributors, rather they are actors with distinct communicative power. Their skills in narrative construction, aesthetic mediation, and affective engagement enable forms of health communication that operate beyond instruction or persuasion alone. Positioned outside statutory authority, they occupy a different social and relational space to health institutions – often one in which trust, curiosity, and voluntary engagement are more readily negotiated. Creative health approaches can diversify how health messages are authored, shared, and received, redistributing power away from top-down models and toward values of plurality and public participation.

Complementing the role of artistic stakeholders, a PHROiR brings specialist training in health communication, population-level insight, and the interpretation of epidemiological and inequalities data. This enables targeted decisions to be made about design, grounded in an understanding of who is most affected and least reached. This role facilitates partnerships with organisations that work directly with priority populations and accesses valuable datasets to thicken public health insights.

This approach supports two-way health communication, attempting to balance public empowerment with scientific accuracy. It positions itself within *complex* health domain[16] – that is, a space where public trust, cultural relevance, social determinants of health, and self-actualisation are recognized as equally important to advancing quality communication about healthy behaviours. The Cynefin framework[16] recognizes this as ground for *emergent practice*. Here, it is proposed, creative health communication functions not as a simplification of health knowledge, but as structured spaces for sense-making, dialogue, and negotiated meaning between healthcare leaders and members of the public. This is designed to pay recognition to the conditions that render some groups "hard to reach," including historical exclusion, institutional mistrust, competing life pressures, and limited cultural resonance with official health narratives. Creative health approaches grant space to challenge misaligned health messaging – placing relevance and co-presence at the centre of communication strategy.

Finally, for health systems and cultural organisations alike, organisational readiness for creative health delivery begins with open – and at times uncomfortable – conversations. Mutual understanding of disciplinary norms is essential; as is explicit acknowledgement of cross-system inequalities in resource, status, and risk. Without this groundwork, partnerships risk reproducing the same health gaps and imbalances they seek to address. Conversely, when these conversations are prioritised and sustained, creative health becomes a powerful tool in the health communicators toolkit.

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