Using Oral Histories:

A Methodology for Public Health Advocacy

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Foreword

I've often heard cultural organisations described as hospitals for the soul, and I rather like that analogy. It may sound fanciful, but during the pandemic lockdowns, its truth became strikingly evident. When people returned to museums and galleries after months of isolation, it wasn't just about seeing art – it was about healing. It was about being in familiar, collective spaces that were free, safe, and open to everyone, without the pressure to purchase anything. That sense of shared presence reminded us how vital these spaces are; not just for enjoyment, but for wellbeing.

Culture is a public good, but it doesn't exist in isolation. That's why we've developed a new theory of change for the museum – one that grounds us more fully in the social realities of our time. It begins with the people we serve: the citizens of Birmingham, who face stark health inequalities that are mirrored by inequalities in access to culture. How can we, as a museum that does not yet fully reflect the diversity of its audience, contribute meaningfully to problems even public health professionals are struggling to solve?

Because these issues are not separate. If we accept the idea of being hospitals for the soul, then we must also ask what else we can contribute, through our collections, our people, and our creativity.

Thankfully, we've had the great fortune of working with visionary public health leaders who understand that culture can play a real role in this space, and with Sophie Beckett, whose thoughtful research has pioneered this work with clarity and depth. This project began with a bold question: what if the museum's collections could be treated not just as objects, but as datasets; rich sources of knowledge that offer unique, qualitative insights into how people lived, what they ate, how they related to one another and to their own identities? This collaboration has done exactly that. It has allowed us to draw out new understandings about people's historical and emotional relationship with food, and in doing so, it's made our collections more relevant and resonant for today's audiences.

On a personal level, this project resonates with me in quiet but powerful ways. I was born in Pakistan and grew up in the UK, and food has always been one of the most enduring connections to my Punjabi heritage. At home, the meals we shared were rich with memory, meaning, familiarity, and full of care. I think often about my father, who tried, like many parents do, to encourage healthy habits, even as we all enjoyed second helpings of my mother's cooking. He was navigating the same tensions we all still do: how to eat well in a culture that doesn't always make that easy, and how to reconcile a love of traditional food with changing lifestyles. What this project surfaces, through community voices and historical stories, is how food is never just about nutrition. It's about identity, inheritance, joy, restraint, and belonging. Those are the stories museums should be telling, and it's a privilege to be part of that work.

Sara Wajid
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Public health is, by design, an unnatural occurrence, a system built to address unnatural inequalities. In contrast, arts, culture and heritage are what is natural to human life. We live, breathe and experience culture every day, it is how we understand who we are. For the future of public health, we must value these cultural experiences and embed them meaningfully within policy, practice and systems change.

Our museums are public assets. They hold our collective memory, help us understand the world around us, and invite us to imagine alternatives. When used with care and purpose, they can be powerful platforms for both healing and policy influence. This report isn't just about delivering a one-off project or simply 'making the case' for the arts. It was about doing the work to turn knowledge intoaction and policy and about creating a foundation for system-level change through culture.

Creative health, when done well, challenges the status quo. It introduces new voices, new languages, and new ways of seeing. In our collaboration with Birmingham Museums Trust, we engaged with artivism (art that acts as activism) to reflect on the past, call attention to structural injustice, and imagine alternative futures for our city. In this report you will learn how museums can help communities articulate the causes of ill health, not just the symptoms. Furthermore, it looks at how museums can be used to hold dialogue, promote empathy, and support the kind of values-led leadership needed for policy change.

This project has reaffirmed what we already suspected that creative health work is not linear, and it cannot be reduced to traditional logic models. It is complex, iterative, and deeply shaped by context. It is affected by relationships, organisational cultures, and wider socio-political conditions. It is as much about meaning and connection as it is about measurable outcomes. But that's also its power.

This is a landmark contribution to the field of Creative Health. It does more than summarise an innovative partnership, it offers a blueprint for how public health can evolve by integrating cultural institutions, creative methodologies, and community voice. It pushes beyond rhetoric and into structural insight. It shows that creative health isn't a soft add-on or 'nice to have', it's a strategic, systems-level approach to making public health more human, equitable and transformative.

If we are serious about tackling the root causes of health inequalities, then we must also take seriously the roots of culture, memory and identity. This report makes the case, with depth and urgency, fordoing exactly that.

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Executive Summary

This work is grounded in the belief that museums are not only spaces for learning and preservation, but also active agents in social change. Since the advent of neoliberal economics in the 1980s, museums have been increasingly forced to demonstrate their value to society, often through generating income and attracting tourists, and governed through new performance metrics. However, with social issues such as mental health, climate change, and displacement increasingly important to museum staff and visitors, the heritage sector is redefining its core values to reflect an ethos based on care, community and civic responsibility. In response, this research calls for museums to be seen as spaces for active participation in society and civic imagination, where communities can come together and shape a more inclusive and just future.

The public health sector has also faced increasing pressure to justify its value through cost saving metrics. Traditionally, the health system has been dominated by quantitative, positivist methods and data, often with an overreliance on Return on Investment and other economic indicators used to prove health interventions value. While these measures are effective in capturing intervention outcomes, these metrics neglect wider determinants of health and contextual lived experience, which do not align with neoliberal cost-benefit models. This focus on efficiency and reliance on big data often marginalises the experiences and needs of underrepresented populations, exacerbating inequalities in access to care. With growing interest in qualitative methods within healthcare, museums and the arts offer a unique space for mainstreaming lived experience into research, and shifting the focus onto the prevention and promotion domains of health. Developed through a collaborative partnership between Birmingham Museums Trust (BMT) and Birmingham City Council Public Health (BCCPH), this research presents an innovative, exploratory methodology that aligns museum collections with local health priorities. It demonstrates how heritage spaces can move beyond their traditional roles to actively contribute to health equity and public health literacy in cities like Birmingham. By embedding a Public Health Research Officer (henceforth 'the researcher') in a museum, this research aims to bridge the gap between the health and heritage sector, operating in a matrix way that supports shared outcomes.

Research question

How can oral histories contribute to improving health outcomes in Birmingham?

Value

This research offers a proof of concept for narrative-based health tools, illustrating how creative reinterpretations of heritage can capture lived experience and support health promotion. It introduces a new methodology for using oral histories strategically, explores the emotional mechanisms behind health literacy, and models a transdisciplinary, matrix approach to creative health. By combining social participation, behavioural science, and arts-based research, this work provides a blueprint for how museums can support better health outcomes across within their area.

Key findings – Creative health sector

1. **Oral histories can operate as a bridge between lived experience and local authority health strategy**
   This project piloted a new methodology to map local authority strategies onto existing oral history collections. This approach allows museums to align their assets with contemporary health policies, renewing static archives and using them as strategic public health resources.

Policy recommendation

- Public Health should recognise the value of oral histories and heritage objects more generally as a strategic public health resource, advocating for their reuse as a collective data set. This whole collection approach can strengthen system approaches to health and wellbeing in the city.

2. **Reimagining oral histories as dynamic, multipurpose tools for health**
   Oral histories should be treated as a dynamic resource for learning, dialogue and public health advocacy. Revisiting collections through a health lens supports food literacy, and health literacy more broadly, prompts emotional engagement and can support behavioural shift. As a contemporary data collection method, oral histories offer an effective tool for community health enquiry, well suited for understanding the wider determinants of health. With increasing focus on involving lived experience in health policy, they should be considered as a useful method in the public health toolkit.

Policy recommendation

- Consider oral histories as both a historic tool and a contemporary enquiry method for public health, recognising their potential to identify structural and cultural barriers and facilitators to health.
- Public health should recognise that heritage is well placed to innovatively use objects to improve health literacy. Heritage can work with public health to leverage heritage collections as pedagogical tools.

3. **Emotion as a health literacy pathway**
   Historic narratives have been shown to evoke emotional and cognitive responses, which in turn facilitates engagement and learning. This emotional pathway to influencing behaviour using museum collections can be applied to other health behaviours, such as smoking cessation, chest feeding practices and vaccine uptake.

Policy recommendation

- The heritage sector should invest in research exploring emotion as a mechanism for health literacy in heritage spaces, interrogating the pathway linking emotion, engagement, learning and behaviour.

4. **Museums as a viable space for public health advocacy**
   Museums strive to be considered trusted, inclusive spaces that can facilitate open dialogue. Their civic role in supporting life-long learning positions them well to consider health literacy and health promotion.
   This work moves away from museums facilitating arts for health sessions to sustained interaction around health promotion. This interaction can occur in several different heritage spaces, including exhibitions, programming and learning sites. In addition, museums are effective sites to pilot creative health initiatives that take lived experience and scale it up for policy recommendations, reinforcing their role in helping people participate in society.

Policy recommendation

- ICS and LA should formally integrate heritage institutions as delivery partners within local health and wellbeing, particularly within promotion and early intervention. Museums should be recognised as spaces of social participation and civic dialogue.
- Adopt shared evaluation frameworks across the sector (e.g. COM.B) to enable scalability and to find common language within creative health.

5. **Cross sectoral learning**
   This work models a matrix approach, linking heritage, health, behavioural science and community engagement. It highlights the potential of transdisciplinary collaboration, while also calling for greater recognition of creative, participatory and experimental methods as valid forms of data and evaluation.

Policy recommendation

- Both public health and the heritage sector should facilitate cross-collaborative work between arts and health, acting on resource sharing opportunities that are often not resource intensive.
- Public health bodies should embrace creative approaches to data collection and support heritage institutions in building research capacity, adding rigour and validity to creative health research.

Key findings – Birmingham Museums Trust

1. **Shift geographic focus for low attendance**
   Historically, BMT have tended to gravitate towards Nechells, given the proximity of 2 of its museum sites. However data from the gallery space indicates that other areas should be prioritised when considering low museum visitation, such as Tyseley and Hay Mills, Yardley East, Garretts Green, Frankley Great Park, Gravelly Hill, and Heartlands.

Key findings – Birmingham City Council public health

1. **Shift rhetoric towards food apartheid**
   Whilst food justice is a suitable lens for understanding inequalities in the city, 'food apartheid' more accurately captures the deliberate, systemic forces that have shaped these conditions. Emphasising this structural and historical context is crucial to achieving food sovereignty and understanding food inequality.
2. **Biggest barriers and facilitators for healthy eating**
   Using data collected from museum visitors, the physical environment, particularly around access, was the biggest perceived barrier to healthy eating. This calls for increased environmental restructuring and social planning, and aligns with a shift to consider structural barriers to access. The findings also reveal a need for systems approach to tackle complex issues, with local authorities working across departments to improve travel infrastructure, urban planning and create healthier food environments, aligning services at multiple levels. The contemporary oral history narratives echoed these concerns, with environmental accessibility, knowledge gaps perpetuated through lack of generational food education, and perceived inconvenience emerging as the biggest barriers to healthy eating. Key facilitators were belief around capabilities, with intention demonstrated through daily practices, and high levels of food literacy compelling belief around consequences. Positive familial experiences were key formative experiences in promoting positive food behaviours. Other narratives were able to emerge in this context, including a need to further investigate alternative medicines, a need for increased cultural competence in schools around disordered eating, and more accessible ways to breakdown UK nutritional targets for daily use.
3. **7 signifiers for Birmingham food**
   The themes that emerged in defining 'good food' should serve as signifiers for the city about what food should be: shared, cultural, tasty, healthy, caring, joyous, adventurous. Embedding these values into food policies ensures that initiatives are rooted in local perspectives and remain relevant to the needs of Birmingham.

Chapter 1.

Introduction

Chapter 1

Introduction

a. Background

This research represents an intentional and sustained partnership between the local authority health sector, Birmingham City Council Public Health, and the heritage sector, Birmingham Museums Trust (BMT). Centred initially around one oral history collection, this research aims to highlight the potential use of heritage objects in the improvement of health outcomes, specifically through engagement of emotions, facilitating learning and shifting behaviour. This work sits within a wider governance structure, with four researchers-in-residence embedded into arts organisations in Birmingham. This matrix structure has allowed the exchange of knowledge, data and methodologies across sectors, reinforcing the role of creative health in public health practice. It also provides a tangible space for BMT to make recommendations for local public health policy, ensuring they are heard and translated into action.

Museums, including BMT, have long been engaged in social change work. Recognised as spaces for civic engagement, learning, advocacy, and experimentation, they are uniquely positioned to respond to pressing societal challenges. With growing attention on health and wellbeing, particularly in response to climate change, non-communicable diseases and a mental health crisis, there is an increasing demand for meaningful, arts-based interventions. Interactions between arts and health have become increasingly frequent and deliberate, and this pilot initiative enables BMT to respond meaningfully to local health need through an evidence-based approach, informed by local strategy. Directly applying strategic health themes onto collections allows a new way of interpreting the data, reimagining it for the 21 century. In doing so, BMT fulfils its civic responsibility and advances its vision: 'a radical reinvention of the museum as a catalyst of cultural and social change'. Increasingly, the role of museums has expanded from curating and preserving objects to serving and enriching the people in the city. Breaking down health related barriers to accessing heritage also allows museums to become more inclusive and relevant for diverse audiences, ultimately increasing the potential for participation and visitors to our sites. By integrating public health theories and methods, BMT generates creative health evidence that can be scaled up to form recommendations for the city and the sector.

Museums and heritage sites offer potential as partners for public health departments in delivering health outcomes, particularly through alignment with local authority health priorities. By connecting specific museum collections with targeted health themes, there is an opportunity to engage new audiences, co-produce innovative methodologies, and pilot creative health interventions in trusted, accessible spaces. Heritage sites in particular have characteristics that make them well positioned to consider health outcomes. They are built around storytelling and identity, making them personal spaces where people can reflect, connect with their culture, and find solace during times of isolation and displacement. Artefacts and collections can serve as powerful catalysts for emotional and sensory engagement, supporting improved mental wellbeing and improving public engagement with health related topics. As spaces dedicated to learning, museums are well placed to support preventative health work in a non-clinical setting. This makes them especially effective for reaching individuals who may be reluctant to access traditional healthcare services. Their status as trusted institutions with strong community ties also places them in a powerful position to partner with local authorities, health sectors, and communities to address health inequalities, and it is this nexus that provides a case for museums to be considered part of the public health milieu. Whilst this research focuses on the subject of food, the methodologies are applicable to other aspects of health behaviour, such as vaccine uptake, smoking, exercise and more.

Whilst rooted in local authority priorities and museum's collections, this work also contributes to the wider literature of creative health. This research investigates the potential of heritage as a foundational tool in the design of health interventions, using oral histories as both a research methodology and intervention tool to understand health. The methods used are explorative, participatory and forefront lived experience. This research concludes that oral histories are an effective methodology for documenting lived experiences through community health enquiry, and serve as a springboard for conversation, learning and policy recommendation around health. By framing this historic oral history collection through a public health lens, collections can be transformed into an interactive learning tool, facilitating individual learning and enabling the potential for scaling up to form local authority recommendations.

This report offers a detailed, case study style report using one collection to see how heritage can improve health outcomes. It is designed as an educational resource for museum professionals, creative health practitioners, health care workers, oral historians and those working with communities on the subject of food. Due to the varying lengths of chapters, concluding remarks have been included where appropriate throughout.

b. Overview of literature

i. Health, arts and the museum

The relationship between arts and health has been explored for several decades, with early instances from the 1900s focused on 'arts-in-health' initiatives. These included bedside theatre performances, bringing artwork inside hospital walls, hospital collaborations with arts colleges and measuring specific outcomes, such as reduction in pain, blood pressure, cortisol and length of stay in hospitals (Gordon-Nesbitt, Restrepo and Woolf, 2024; Staricoff, 2004). Over time, this understanding of arts and health has expanded, encouraging sensory stimulation, emotional and cognitive engagement and wider social interaction as part of health promotion (Fancourt and Finn, 2019). These components are now the basis for many arts-based interventions into health, which can produce responses related to psychological, physiological, social and behavioural wellbeing. Once primarily focused on education, museums have been reimagined as restorative spaces that promote these wellbeing benefits.

Museums use a greater range of materials than 'the arts' as traditionally defined, enabling users to engage with historical and natural objects as well as art works. Research on the benefits of this wider engagement in museums is captured in the first monograph dedicated to the subject by Chatterjee and Noble (2013). Their work demonstrates that museums can enhance health and wellbeing through: positive social experiences, leading to reduced social isolation; opportunities for learning and acquiring news skills; calming experiences, leading to decreased anxiety; increased positive emotions, such as optimism, hope and enjoyment; increased self-esteem and sense of identity; increased inspiration and opportunities for meaning making; distraction from clinical environments, including hospitals and carehomes; and increased communication between families, carers and health professionals.

These heritage and health interventions and responses can be broadly categorised into two categories. Firstly, the evidence of health benefits of participating in heritage, which can provide improvement in physiology, emotional state and relation. These activities target support for specific health conditions such as dementia, COPD, and Parkinson's disease, as well as more general wellbeing practices like yoga in heritage spaces or volunteering. For instance, as part of the 'Not So Grim Up North' research project, the 'Self and Recovery' initiative was developed. It used object handling sessions and personal items to help adults with acquired brain injuries and stroke survivors share their recovery stories (UCL, 2018). Broader wellbeing projects may also focus on specific communities, such as exploring how volunteering in museums can enhance the wellbeing of individuals from economically disadvantaged areas in Manchester (Garcia and Winn, 2016).
These interventions usually revolve around participatory arts programmes, social prescribing and arts in health and care environments.

Secondly, heritage has a role as a communication, engagement and research tool for health.
These interventions primarily revolve around facilitating discussions about health, bridging of potential communication gaps, such as food literacy and providing an emotional prompt to discuss health behaviours. Drama and theatre have been used to improve children's nutritional knowledge (Bush et al., 2018), increase awareness of the dangers of illegal drugs (Starkey and Orme, 2001), and increase testing for sexual transmitted infections (Orozco-Olvera et al., 2019). However, the use of heritage to influence preventative health behaviours is less common and is typically limited to awareness raising inexhibitions. A local example is Black Country Lungs, an exhibition aimed at increasing awareness of COPD and provide a way to empower people with lung conditions to share their experiences (Feetham, 2018). One programme that has used heritage to directly address behaviour and learning is 'Live Today, Think Tomorrow' (Dodd and Jones, 2014). This programme tackles smoking behaviours in Nottingham by using objects from the tobacco industry to have conversations with young people to reduce smoking prevalence. Using surveys and long form feedback, Nottingham City Museums and Galleries were able to capture both qualitative and quantitative data to measure learning. While some interventions report positive changes in health seeking behaviours, these are often secondary outcomes rather than the primary focus of the research. This research looks to build on this literature by exploring this function of heritage for health, positioning collections as a tool for public health advocacy and learning.

BMT have facilitated health and wellbeing work, including providing cognitive and social stimulation for veterans, creating a supportive space for carers outside of medical space, facilitating gardening activity to those living with mental health at Sarehole Mill and hosting death cafes to encourage open ended conversations around end-of-life matters. These activities can be mapped across the continuum of healthcare, covering promotion, prevention, management and treatment of health. Building on this work, BMT aims to explore heritage as a tool for public health advocacy. With a focus on lifelong learning, museums are well suited for this role, and BMT is well placed to help develop a strong methodology to enhance health and wellbeing across Birmingham.

This research focuses on the role of oral histories within the health landscape and develops a methodology to use them as a public health resource, specifically in the context of public health advocacy and the prevention aspects of health. Given its role within historic discourse to represent the 'voice from below', oral history naturally aligns with public health initiatives and social change.

ii. Why oral history?

Oral history is a powerful methodology traditionally associated with museums and the heritage sector. It involves recording historical information, through personal recollection, capturing narratives of those frequently excluded from mainstream historical records, effectively offering a 'voice from below' (Frisch 1990; Thompson 2000). By centering on stories that may not be present in conventional archives (Thompson, 2007), oral history is especially well suited to exploring topics such as disability, illness, cultural nuances, and gendered professions. It is widely used in museums to include first-person narratives in displays, to promote empathy and understanding of diverse lives, to challenge dominant narratives and to introduce multiple perspectives (Cento Bull and Reynolds, 2021).

Oral history has been used in the health field for many years. In a scoping review by Tsui and Starecheski (2018), oral histories have been used to: a) understand lived experiences of either particular conditions or identities, b) to understand experiences of healthcare professionals, c) as educational resources for populations and professionals, d) to improve the provision of health service. To document and understand particular conditions, oral history has been central. In the case of AIDS, perspectives from religious leaders (House, 2012), caregivers (MacKay, 2022) and those with lived experience (Brier, 2018) are documented through oral histories, working to inform person-centred approaches to care. For experiences of healthcare professionals, Venkatesh (2019) documents the role of women doctors in nation building in post-colonial India having to fight for equality in relation to their male counterparts. Similarly, Simpson (2014) uses oral history in conjunction with visual sources to reintegrate history of migration into narratives around the NHS. Increasingly, participatory methods such as oral history are being used in health education interventions; centering lived experience of sex work, an educational 28-minute narrative recording was compiled as an education resource for sex workers (Rickard, 2003). There is also existing work that uses lived experience to inform public health practice and policy; HIV and AIDs work by Rockwell and others (2006) contributed to harm reduction work, and Stebbins and Vukotich (2010) looked to improve public health provision for disease outbreaks, producing a range of educational resources. However, the translation of research into recommendations for health policy remains limited.

In terms of their research philosophy, oral histories are an interpretivist and subjectivist approach well equipped to understand the complexities of health. By valuing lived experience, they provide detailed insights that can inform culturally sensitive health policies and programmes; this is particularly important in food related research, where universal approaches often fall short. Given their nuance within healthcare, this work offers a scalable framework for embedding learnings from oral histories, both historic and contemporary, into policy.

iii. Why Birmingham?

As the second largest city in the UK and the youngest major city in Europe, with nearly 40% of its population under the age of 25 (Harris, 2018), Birmingham presents a unique case for studying food systems. The city's demographic diversity, with over 50% of its residents coming from global majority backgrounds, is reflected in its vibrant food culture, which includes a wide array of restaurants, markets, and food outlets offering cuisines from around the world. However, Birmingham faces significant challenges within its food system. For example, the city is below the national average in meeting the recommended five portions of fruit and vegetables per day (Meelu, Smith and Blair, 2018). Additionally, high levels of childhood tooth decay, largely linked to poor dietary habits, remain a persistent public health issue (Office for Health Improvement and Disparities, 2024), and food insecurity is prevalent, exacerbating health inequalities across the city.

To combat these issues, the city has implemented several initiatives aimed at transforming its food system. Central to this process is the Food System Strategy aimed at creating a bolder, healthier, and more sustainable food system, supporting vulnerable communities, and empowering citizens to make healthier food choices (Birmingham City Council, 2023). Additionally, Birmingham is home to innovative projects like the Edible Eastside urban garden and the Birmingham Food Council, which works to create a sustainable food city. Globally, the city is involved in the Milan Urban Food Policy Pact and has developed a Global Food Justice Toolkit following Covid-19 (Birmingham City Council, 2021).

Situated within this literature and context, this work focuses on positioning oral histories as a public health tool in Birmingham, using historic narratives as educational interventions, springboards for conversations around healthy habits and as a form of community health enquiry (see logic model for this research in figure 1). These elements collectively inform recommendations for both public health practice and the heritage sector. This work provides a new, exploratory methodology for using heritage collections in a systematic and rigorous way for health intervention.

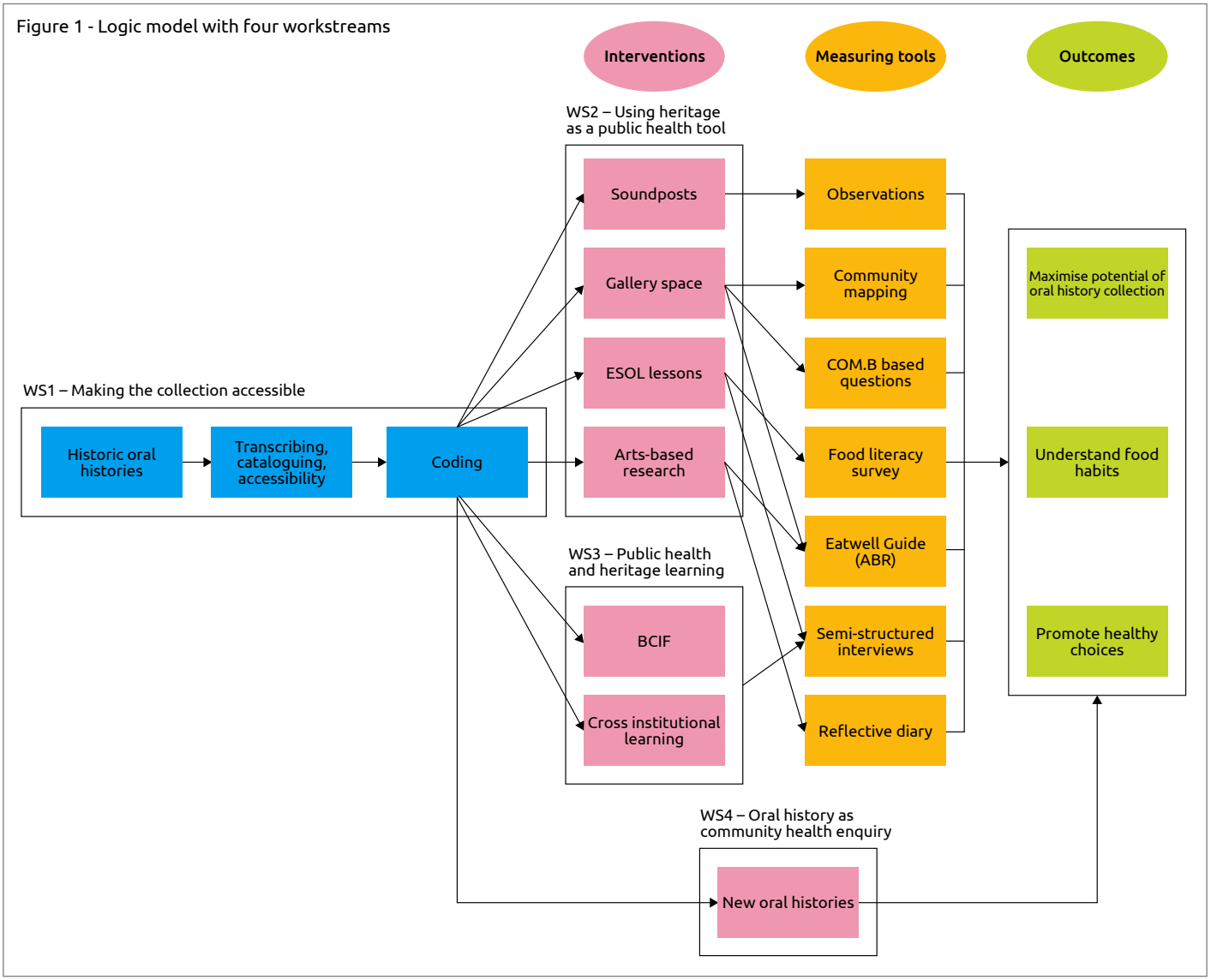
The city's demographic diversity, with over 50% of its residents coming from global majority backgrounds, is reflected in its vibrant food culture, which includes a wide array of restaurants, markets, and food outlets offering cuisines from around the world.

This report is organised into 4 chapters, grounded in the 4 distinct workstreams;

1. Making the collection accessible
2. Using nostalgia as a public health tool
3. Public health and heritage learning
4. Oral history as community health enquiry

These workstreams follow the chronology of the project. The oral histories needed to be processed in away that allowed them to be analysed as a complete collection before any health aspects of the data could be drawn out, addressed through the distinct coding methodology designed for this research in chapter 1. Next, the historic data is used as the basis for health interventions, drawing on emotions asa tool to improve engagement and learning around food in chapter 2. Next, the distinct governance structure gave rise to cross-sectoral learning opportunities, explored in chapter 3. Finally, chapter 4 unpacks how new oral histories can be used as a community health enquiry method, reflecting thelived experience of food in the city onto local health policy.

Figure 1 - Logic model with four workstreams



Chapter 2.

(WS1) Making the Collection Accessible

Chapter 2

(WS1) Making the Collection Accessible

This research in grounded in an oral history collection recorded in 1984, titled 'Food and Drink'. It was recorded as part of a wider collection titled 'Change in the Inner City', which explored 5 key themes: Immigration, Childhood, Public Baths, Birmingham Gun Quarter and Food and Drink. This wider collection was funded by the Inner-City Partnership Programme, a collaboration between national government, local authorities and private sector partners which aimed to revitalise economically and socially deprived areas. The project looked to capture inner city life through both recordings and photographs, documenting the changes in social and working conditions over the century, and work to restore confidence in the inner-city area, making it a more liveable area. The Food and Drink collection consists of 100 interviews, and explores the change in food consumption, highlighting the shift from traditional foods like tripe, cow heel and calves' heads to curries, pizzas and burgers. It also tracks the rise of diet culture, changing eating patterns through the movement away from a hot lunch and the impact of new technologies on eating practices. The rise of international migration during this time also lends itself to discussions around hybridisation, cultural tolerance and the significance of food in cultural identity and heritage. The collection offers an everyday insight into cultural, economic and social change over this period, through the lens of food. Among those interviewed are the restaurant owners and workers, health inspectors, union officers, equipment manufacturers, butchers, fishmongers, school meal servers, and pub owners of Birmingham at the time. The full interviews are available here, and a selection of snippets are available here.

Re-use of oral histories

This work advocates for the repurposing of historic oral histories, specifically re-analysis as outlined by Corti and Thompson (2004). The re-use of oral histories for a health remit is relatively underdeveloped, but has included the comparative analysis of health policy over time (Berridge, 2010), combining archives with contemporary recordings to improve access to treatments (Scalvini and Parkes, 2016), re-examining archives with new themes (Mullin, 2022) and training caregivers (ibid.). This work draws on this field and combines multiple creative uses of an oral history collection, re-examining historic data to generate health related insights. Fundamental to this project is the reanalysis of the 1984 oral history collection, reinterpreting it through Birmingham's Public Health Food System Strategy (Birmingham City Council, 2023). In this case, the data is not only recontextualised in the present time, but also through a new thematic lens. Some practical and epistemological considerations around re-use are outlined by Jackson, Smith and Olive (2008), and applied in this work by incorporating full transcripts that capture both interviewer and interviewee and using direct quotations in excerpts to maintain contextual integrity (Söhner, 2022). Yet a wider question is around the application of a different thematic lens; If the interviewees had known that the research had health-related objectives, would they have consented to be interviewed? Would their responses have differed? In addition to these ethical considerations, there were also practical challenges around re-use. Significant portions of the recordings were unrelated to health, and therefore not directly relevant to the project. This created frustration during the documentation process, as the researcher had to process data that would ultimately not be used. Despite this, the decision to re-use this data allows historical records and data to be porous and reimagined in light of contemporary social challenges. Considering the high cost associated with primary data collection, using historical data offers a sustainable approach, preserving past stories and linking them to contemporary stories. The re-analysis of these records more generally is a useful reflective practice, as history offers important lessons that can inform current and future decisions and policy.

a. Priming the data

The initial phase of this project involved transcribing and cataloguing the oral history collection. Preliminary transcripts were generated using Otter.AI, which automated much of the verbatim transcription, making the process more efficient. These drafts were then carefully reviewed and edited by the lead researcher and a team of volunteers to ensure accuracy and clarity. This approach introduced a new system of remote volunteer management, which has since been adopted across BMT. Offering remote volunteering opportunities improves potential audience engagement, allowing volunteers to work within their own time and physical restrictions.

The researcher developed transcription guidelines based on Smithsonian transcription practice, which were implemented by volunteers. Each completed transcript was subsequently reviewed by the researcher to ensure accuracy. The value of verbatim transcription in research has been a subject of debate (Portelli, 2010, Halcomb and Davidson, 2006), particularly given its time-intensive nature and the challenges of fully capturing oral narratives in written form. Drawing on Sandelowski's (1994) question: is a transcript necessary to achieve the research goals?, the researcher determined a complete written transcript was necessary to analyse the data for public health policy. This decision aligns with oral history practices that emphasise preserving the unabridged narrative of lived experiences. In addition, creating full transcripts ensures that future researchers can access the collection in a neutral and comprehensive format, minimising interpretive bias.

b. Coding the data

The researcher designed a method for importing the transcripts into Excel, to allow them to be fully searchable. Once the data was cleaned and organised, the next step was analysis. Due to the sensitivity of the data and the prohibitive costs of third-party coding systems, the primary researcher devised a line coding method using Excel. This approach combined both deductive and inductive coding, with reference to the 10 themes outlined in the Public Health Food System Strategy. These themes are: food production, food sourcing, food transformation, food waste and recycling, food economy and employment, food safety and standards, food skills and knowledge, food behaviour change, food security and resilience, food innovation, research and data. Before coding, the researcher developed some line codes using the 10 themes and the Food System Strategy document. Then, using the first 20 oral histories, additional line codes were developed based on the data. The outcome is a fully searchable, coded collection that is accessible to other researchers. This methodology provides a framework for the oral history data to be re-examined in new contexts. This process of aligning strategic objectives with oral history data to inform public health policy can be used with other collections, both historic and contemporary, and strategy documents. The step by step guide for importing transcripts and the fully coded transcripts are available in the appendices (Appendix A and B).

c. Researcher reflections

Key findings:
The recontextualisation of oral histories has a distinct role within health work, aligning strategic documents and themes with historic collections, and using lived experience as a basis for intervention design. This coding methodology allows a deep and thematic investigation of oral histories that is appropriate for local museums financial means.

Challenges:

The work of transcribing and coding the collection was time consuming, and it often felt difficult to see the bigger picture. However, the use of Otter.AI sped up the process significantly, and the ability to engage with an entire collection as opposed to individual stories offered a fuller and more detailed picture of food in Birmingham. This holistic approach was vital to the research and arguably without it, the data would remain fragmented and far less useful to other researchers.

Implications for future work:

This work has contributed a practical methodology that can support the wider museum sector in (re) using oral histories. Using this framework will hopefully bring these often overlooked stories to the forefront and allow them to be seen as contemporary resources for engagement.

This methodology provides a framework for the oral history data to be re-examined in new contexts.

Chapter 3.

(WS2) Using Heritage as a Public Health Tool

Chapter 3

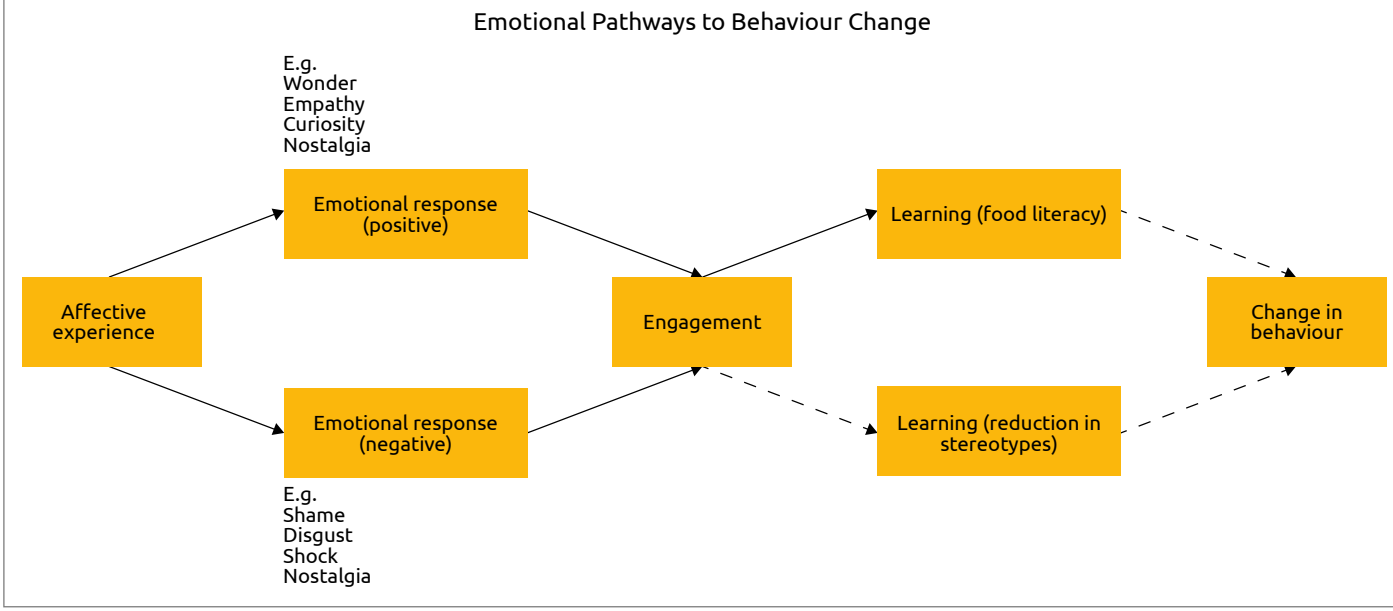
(WS2) Using Heritage as a Public Health Tool

Museums and heritage sites are places where people go to feel, regulate and experiment with emotions and can therefore be considered sites of affect. Affect is the unconscious, underlying state or feeling a person experiences, while emotions tend to be more specific and intense. Using affect as a way of thinking about museum spaces is to understand the relational nature of bodies and environments, and how these spaces are intentionally designed to promote certain emotional responses.
Since the 19th century, museums have aimed to instil emotions in visitors, historically with the goal of promoting national and civic identities, which reflected the patriarchal and imperial ideologies of the time (Varutti, 2022). However, the turn to the affect has reframed emotions, including nostalgia, as integral to our reasoning and cognition, rather than merely unreliable and subjective (ibid.). Research such as that by Anders and others (2013) documents the affective potential of heritage experiences, emphasising that affect and emotion are essential in meaning making and engagement in heritage objects (Hoare, 2020). For example, emotional interest theory posits that positive emotions arouse emotional interest, which subsequently increases our enjoyment (Dahl et al., 2013; Harp and Mayer, 1997). Similarly, cognitive interest theory (ibid.) suggests that objects become more interesting when we understand them or can relate to them.

One emotion closely associated with museums and heritage is nostalgia. The connotations of nostalgia have shifted over time, considered in the 18 and 19 century as a psychiatric disorder, associated with anxiety, sadness, and in some cases fatality. In the 20 century, nostalgia was linked to right-wing nationalism and was critiqued as portraying a dangerous and sanitised view of history (Smith and Campbell, 2015). Now considered a more complex emotion, nostalgia can be understood as a negotiation between past and present, a way of recontextualising the past through the lens of the present. Often mobilised as a political tool (MAGA), nostalgia could be reframed as a mechanism for social change. Additionally, the rhetoric around looking back being a distinctly 'backwards' position must be challenged; nostalgia can strengthen feelings of connectedness, increase creativity and be an effective motivator, positioning it as an emotion well primed to consider behaviour change.

These affective states, motivation and emotion have been shown to be essential drivers of behaviour (Ferrer and Mendes 2018). Research in the heritage sector by Falk and Gillespie (2009, p. 112) tracks the role of emotion in enhancing learning at a science museum and suggests 'there is a relationship between emotional arousal and positive changes in visitor long-term cognition, attitudes and behaviors'. This research looks to contribute by considering the pathway linking emotion, engagement, learning and behaviour (see Figure 2). Museums are well placed to elicit emotions and have long been considered a space for life-long learning; gaining insight into the mechanisms of learning and engagement in these settings is essential for enhancing visitor enjoyment. In the long term, this understanding can contribute to repeat visitation and engagement with heritage sites.

Figure 2 – Explorative theory diagram. Solid lines represent a cause-effect relationship proved in this work. Dotted lines represent a relationship not proven in this work, but in wider literature.



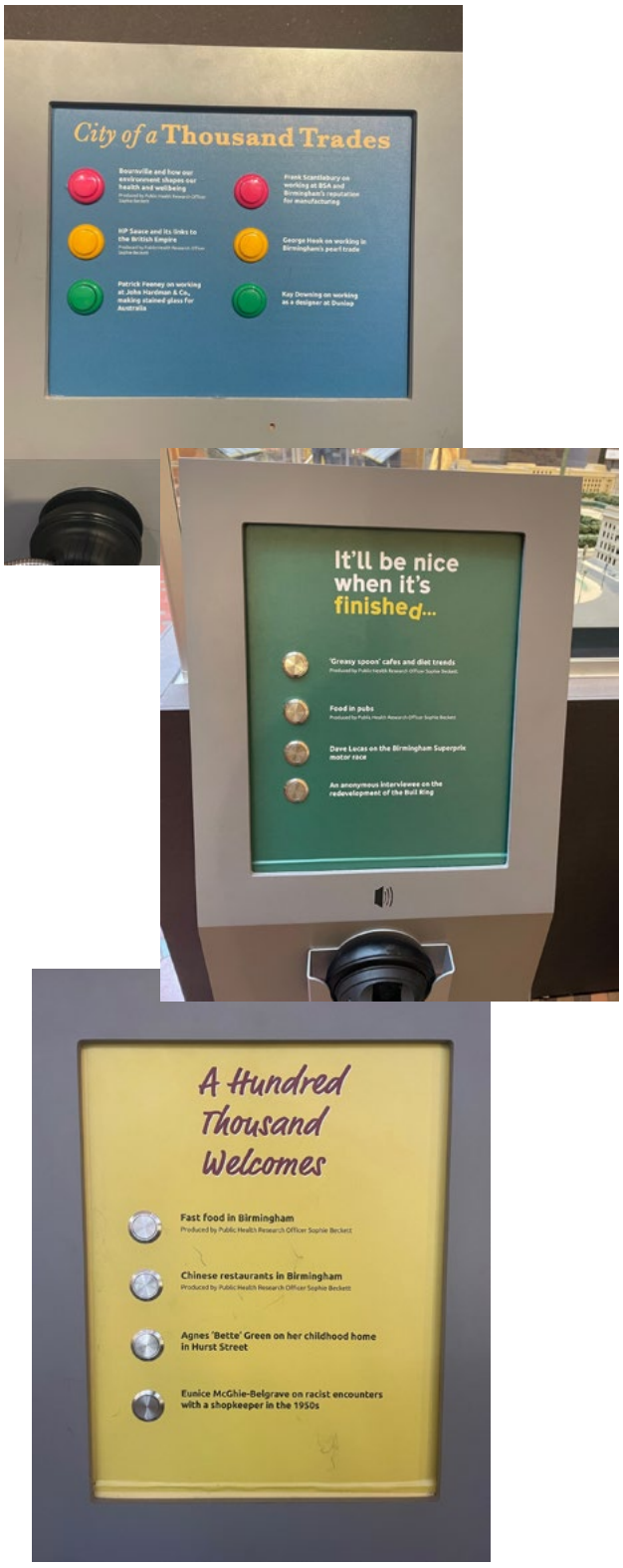
This chapter takes on this call for more exploratory methods as a way of testing how we can use oral histories to invoke emotion and subsequently shift behaviour. In order to do this, this project looks to new interpretative strategies, forms of community engagement and participatory methods (Simon, 2010). In this context, oral histories bring the topic of food to life, supporting visitors in engaging with the object and subject. They serve as a powerful tool for starting conversations, facilitating adult learning, and deepening meaning of the subject.

a. Exhibitions

i. Soundposts

To offer a new form of interpretation for visitors, the researcher created a set of sound posts themed around the subject of 'Food and Health', linking to six objects in a gallery space at one of BMTs museum sites, Birmingham Museum and Art Gallery (BMAG). Due to renovations and building works, this site had been closed since 2020. When it reopened in October 2024, it offered a useful site to test new forms of interpretation, such as soundposts. The sound posts developed by the researcher used audio from the 1984 collection to tell an alternative story of the object, creating a thematic 'mini exhibition' that overlays the primary display, mediating understanding and offering alternative access to the physical display. The researcher began with the long list of objects in the gallery space, and identified objects which may have links to food or health. These objects were then researched for narratives, and then the coded Excel document was searched for relevant themes and audio clips. For example, the text interpretation for the Cadburys chocolate box detailed how the company profited from resources and labour during the British Empire, so the soundpost narrative was framed around Quakerism and the role of environmental determinants of health, referencing the large village built for factory workers in South Birmingham. Written interpretation of a potato cart explains the reception of Italian migrants during the war, whilst the soundpost was designed around the evolution of fast food, with the baked potato one of the original fast foods in Birmingham. Each of the six narratives included a question e.g. 'how far do you have to travel to get to green or blue space?' And 'how do you see fastfood changing in the future?'. This gives the visitor an alternative narrative, whilst simultaneously using the oral history collection to supplement physical objects. Research suggests that audio guides are well suited to communicating public memory, with the narrative voice possessing emotional impact (Bertens and Polak, 2019). Embedding the 1984 narrative voice in the soundposts contributes to the affective potential of these posts, providing an intimate and authentic representation of cultural memory. These narratives worked to highlight the emotional impact of the audio guide, and their ability to a) improve accessibility to the oral history collection and b) provide new perspectives to the objects to enhance visitor experience.

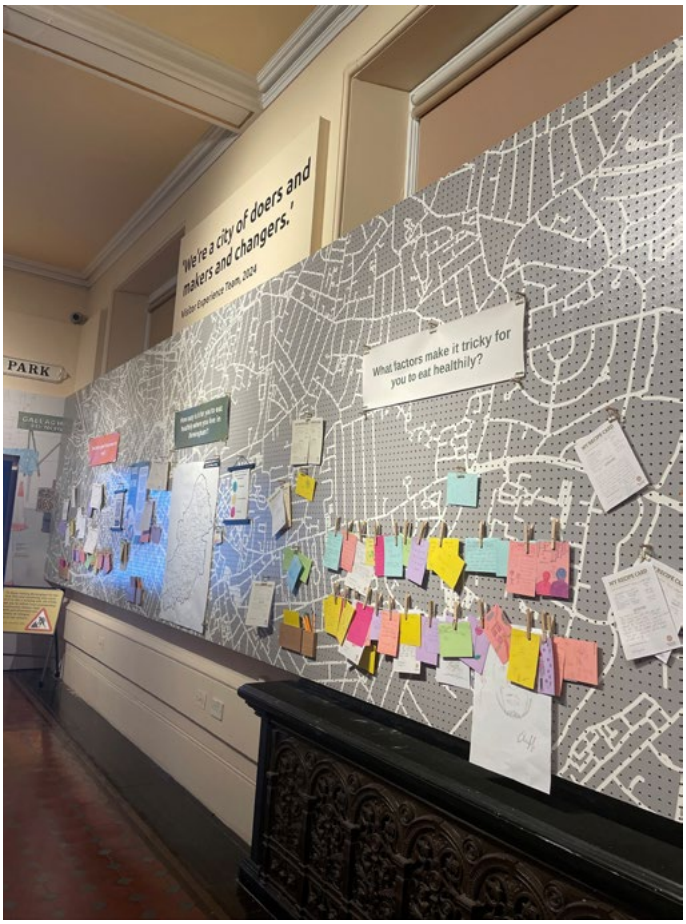
Figure 3 – Soundposts with embedded oral history narratives



ii. Embedding COM.B into the gallery

The newly opened Museum and Art Gallery space offered an opportunity to test a participatory data collection approach. The researcher wanted a way of engaging the public directly in shaping policy recommendations; however, asking people to propose new food policies requires abstract and critical thinking, a process that is complex and resource intensive. What was needed was a quick, accessible way of facilitating these conversations, in a way that was mediated for a museum going cohort. Ensuring everyone's voices could be heard was executed in two ways; making the language in the questions asked more accessible and framing them from the first person. This approach aimed to individualise the questions and dismantle the idea that individuals must be 'clever enough' to contribute. By grounding these questions in a well-established behavioural science framework, the collected data can be extrapolated and scaled up to policy recommendations. This framework for scalable, participatory research in a museum setting can be applied to other health related phenomena.

Figure 4 – Evaluative gallery space



In the gallery space, the researcher positioned a QR code containing ten curated oral history snippets, each paired with a health-related prompt, alongside three questions to the visiting public. The researcher spent time in the gallery space engaging with visitors and encouraging them to listen to theoral history snippets and to share their thoughts. The aim here was to use oral histories as thought-provoking prompts to encourage visitors to answer questions, which were responded to through comment cards or by placing a sticker on a map. In total, visitors contributed 134 comment cards and 830 stickers in response to the following questions:

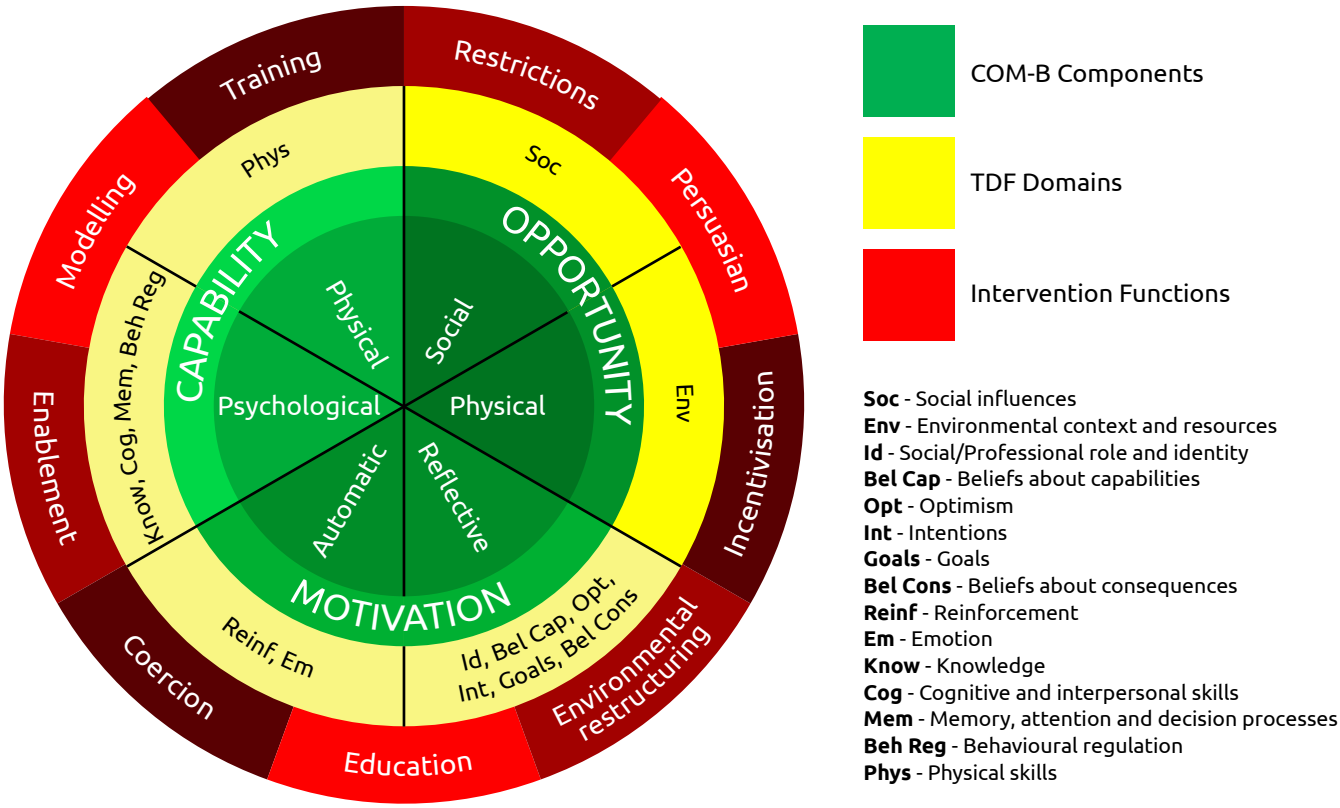
What does good food mean to you?

How easy is it for you to eat healthily where you live in Birmingham?

What makes it tricky for you to eat healthily?

These questions are based on the three domains of the COM.B behaviour change theory, capability, opportunity and motivation. Following desk-based research, this framework was deemed most appropriate to apply in a heritage setting. COM.B is an evidence-based model developed through a comprehensive literature review and has been widely used in behavioural interventions. Its simple structure allows for application at multiple different levels and across different contexts, making it a valuable framework for use in the heritage sector. Additionally, COM.B maps on to the behaviour change wheel (BCW) and both frameworks are recommended by Public Health England for local authorities to structure decision making (West et al., 2019). The researcher selected one question to represent each domain, adapting the language to be more inclusive for the heritage setting. The responses were either written comment cards (Q1 and Q3) or placing coloured dots on to a map (Q2). Each of these questions is considered in turn.

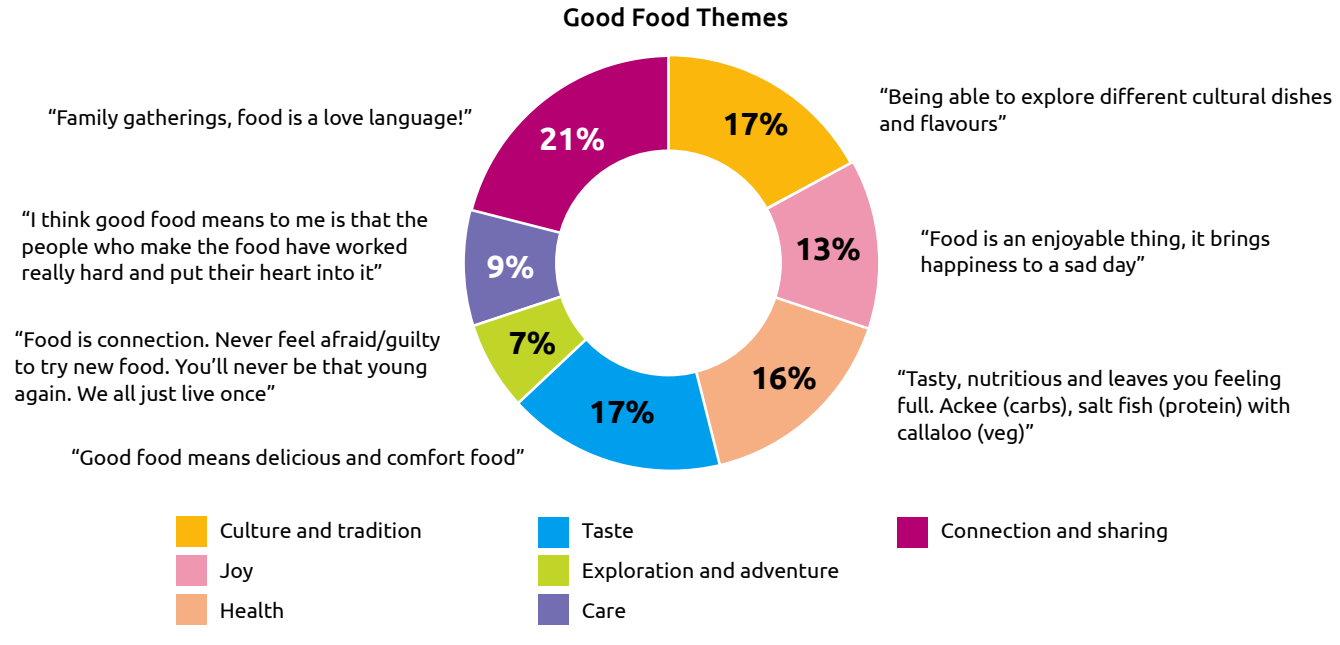
Figure 5 – the three levels of the Behaviour Change Wheel (BCW) (Michie et al., 2011).



Question 1: What does good food mean to you?

This question was used to encourage individuals to reflect on food and their personal priorities, expanding the discussion beyond a purely health framing. Aligning with the concept of museums as spaces for 'meaning-making' (Hein et al, 1999) it asks visitors to construct their own personal understandings of 'good food'. Responses, both written and drawn, allowed for personal expression and dialogue. The phrasing of the question echoes the psychological capability aspect of COM.B, focusing on knowledge and decision making. By framing the question in an open and inclusive way, it created an accessible entry point for participants of all backgrounds to engage, with visitors as young as 3 years old contributing.
This data gives an understanding of the priorities of the Birmingham population and what might influence their decision making around food. Seven themes arose during the process: connection and sharing, culture and tradition, joy, health, taste, adventure and care.

Figure 6 – Good food themes and quotes

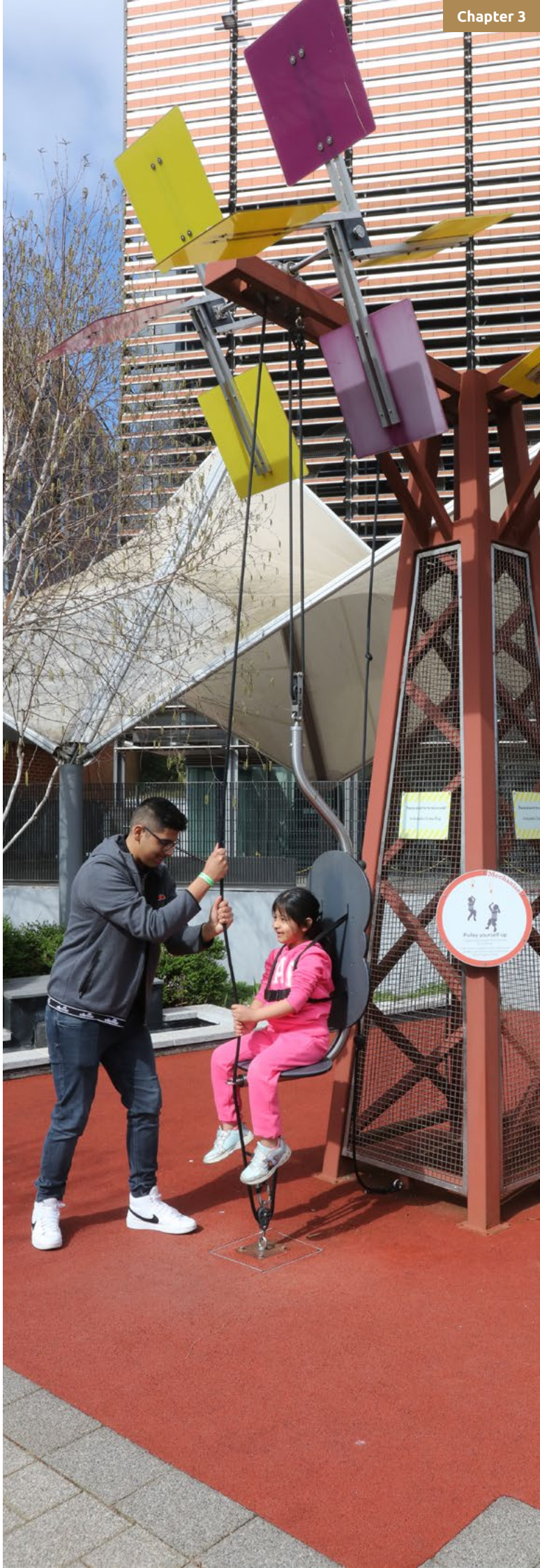


The emphasis on familial networks and relationships positions food as a medium for encouraging social bonds and meaningful interactions: 'it's not about the food you eat. It's about the people you share it with', 'Good food = good conversations, excellent company, riveting stories, and warmth from friends, family, and strangers'. Food has long been a way of bridging communities, with a strong relationship between communal eating and increased sense of belonging and social cohesion (Dunbar, 2017). In familial contexts, parental practices shape food behaviours, with parents who model healthy diets more likely to encourage healthy eating habits in children (Scaglio ni et al., 2008).

This relationship can be investigated to understand how these familial networks either encourage or discourage patterns of food behaviour. The celebration of different cultural foods in response to this question e.g. 'dal chawal, sarmale, murcian paparajote' reflects Birmingham's diversity, with food serving as a strong indicator of cultural identity. Exposure to culturally diverse food as a child has proven to enhance food familiarity, improve their diet variety and help children develop relational competencies (Ares et al., 2024; Monterrosa et al., 2020). Substantive evidence suggests childhood dietary habits and adult food preferences are closely linked, and therefore the childhood diet inevitably contributes to the long-term health of the individual, an influence that could be explored to improve healthy eating (Venter and Harris, 2009; Horovitz, 2024; De Cosmi et al., 2017). Within the heritage sector, the preservation of cultural phenomena such as eating practices represents an acknowledgement of the significance of local culture and traditions, and a key aspect of history to preserve. Drawing on this rich diversity, Birmingham public health could develop initiatives grounded in cultural eating practices designed for children, aimed at promoting food literacy and cultural exposure from an early age. Such an initiative could involve collaborations between schools, community organisations and local cultural groups.

Many responses positively correlated good food and nutrition; 'For me, good food means a healthy and balanced diet.' 'Healthy, happy kids! Fruit! Veg. Grains, nuts, pulses'. However, a few comments touched on the perceived contradiction between consuming nutritious and good food; 'Feel not guilty to taste what we love, even if it's not always healthy'. This remark reflects the broader challenge of navigating food preferences that prioritise taste while adhering to nutritional guidelines. Addressing this tension requires reframing the conversation around diet and nutrition to focus on balance rather than categorising foods as inherently 'good' or 'bad.' Research indicates that individuals who experience guilt or shame around their food choices are more likely to engage in irregular eating patterns, which can undermine long-term health goals (Grossniklaus et al., 2010). Neutralising food within education settings, can help to break these binaries and work towards fostering a healthy relationship with food.

These themes come together to form a food identity for people in Birmingham and can be considered as signifiers for good practice within food: sharing, cultural, tasty, healthy, caring, joyous, adventurous.



Question 2: How easy is it for you to eat healthily where you live in Birmingham?

This question invited individuals to place a coloured dot on a map where they lived, corresponding to how easy it was to eat healthily in their area. Red indicated it was difficult, yellow that it was complicated, and green that it was easy. This community mapping process works to articulate local knowledge and experience, a response to conventional, elitist cartography that forefronts Euclidean space and comes preloaded with power imbalances (Parker, 2006). It is a visual and relational data gathering technique that intends to be both participatory and empowering, supporting both community dialogue and individual expression (Amsden and VanWynsberghe, 2005). This question looked at opportunity within the COM.B framework, with the aim of identifying areas with low perceived food security. In particular, this work looks to the accessibility and utilisation pillars of food security. Accessibility covers both economic and physical access to a reliable food source, and utilisation refers to how effectively people can meet their nutritional needs (FAO, 2006). As this data will not indicate the causes of food insecurity, it cannot recommend exact interventions. However, its city-wide scope highlight areas that would benefit from additional research and resources while also identifying the general category of intervention, such as accessibility, stability, and affordability, that may be most appropriate.

A scoping review by Fagerholm and others (2021) synthesizes various analysis methods for participatory mapping techniques and has developed a 3-step approach: **explain** (describing the data), **explore** (overlaying the data) and **predict** (extrapolating the data). Since the data collected was not GIS-based, modelling is challenging; instead, the predict section section will consider future research locations for food insecurity in Birmingham.

Figure 7 – Raw data in gallery

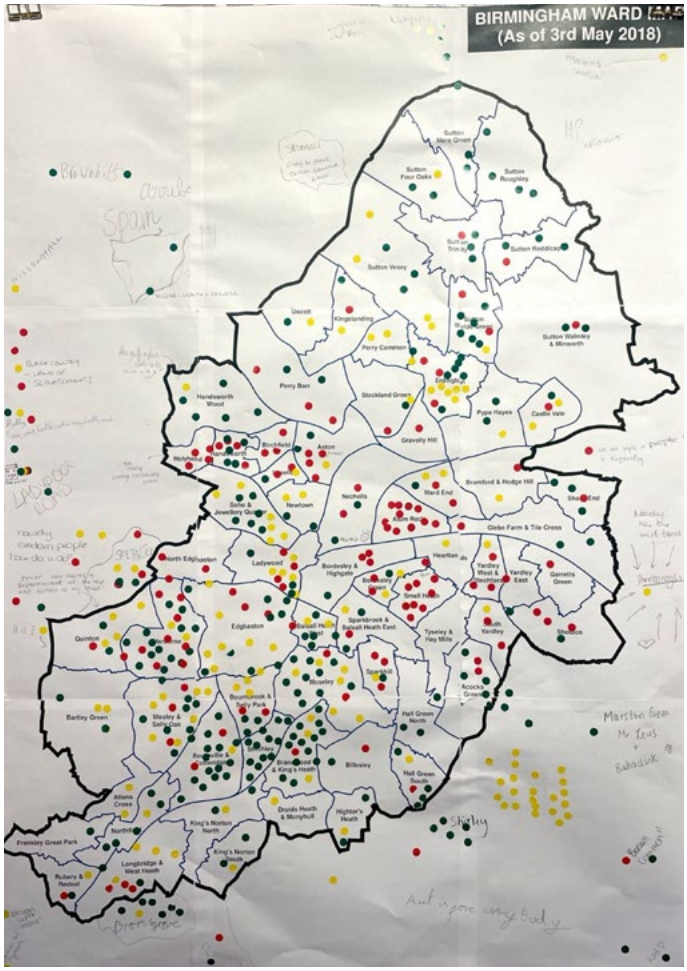
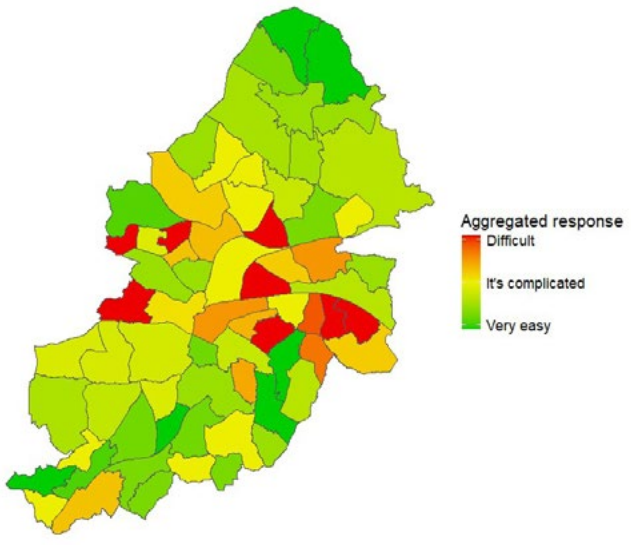


Figure 8 – Aggregated heat map of raw data. The map on the left indicates ward level data, extrapolated from the raw data map above, using a value assigning process to aggregate the data. The map on the right indicates the number of respondents per ward. Data produced by BCC Public Health Knowledge Team.

How easy is it for you to eat healthily where you live in Birmingham?



Number of respondents per ward

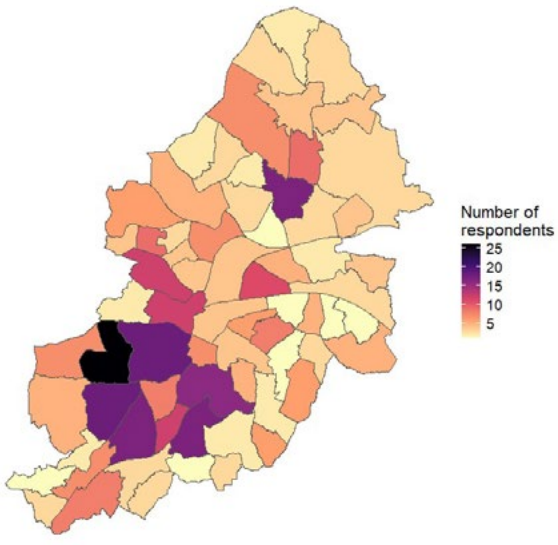
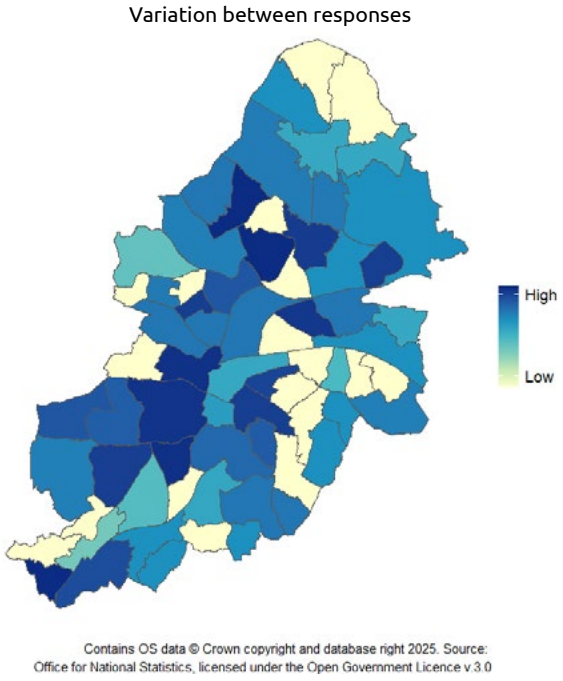


Figure 9 – This map indicates disparity in responses within a ward, e.g. having red, yellow and green stickers in the same ward gives a high variance score. Data produced by BCC Public Health Knowledge Team



Explain

From the raw data alone, several trends emerge. The most significant areas of difficulty are concentrated in the central band of the map, with Alum Rock, Small Heath, and Holyhead the wards with the lowest food security. Other areas that depict low levels of food security are North Edgbaston, Gravelly Hill, Yardley East, Birchfield and Garretts Green. These areas had limited data availability, but consistency amongst results.

The peripheries of Birmingham in the North and South had better perceived food security. The areas on the map where it is deemed easiest to eat healthy were Stirchley and Sutton Roughley. These areas had a high response rate, with a clear trend towards food security. Other areas of high perceived food security were Sutton Mere Green, Hall Green North, Tyseley and Hay Mills and Frankley Great Park. Some of these areas had a low response rate making the data less reliable for those locations.

The areas with the lowest engagement were Tyseley and Hay Mills, Yardley East, Garretts Green, Frankley Great Park, Gravelly Hill, and Heartlands, each with only 1 sticker placed. Regardless of the colour of the sticker, these low levels of engagement indicate a lower percentage of visitors visiting from these areas. This city-wide snapshot of visitor geography would be a good starting point for further research for BMT.

Whilst the researcher was in the space, they overheard people discussing putting stickers directly onto the neighbourhoods within their respective wards. This is most clearly seen in Edgbaston, where there is a banding of yellow, red and green dots within the ward.

These wards with variance in results (Figure 9) are areas for further research, potentially indicating contrast in food security at a neighbourhood scale. These areas are most notably Handsworth, Nechells, Erdington, Edgbaston and Harbourne, Weoley and Selly Oak, Perry Barr, Kingstanding.

As well as the dots located on the map, individuals replied to the question around the map. Areas such as Weston-Super-Mare (yellow), Farmborough (yellow), Brownhills (2 green), Lichfield (4 green, 1 yellow) were added and coded. Others annotated the map with wards in the Birmingham Metropolitan area, such as Smethwick, (3 green, 2 yellow, 3 red), Bromsgrove (6 green, 1 yellow) and Redditch (1 green, 1 red). There were also some annotations depicting the reasoning behind their colour coding - 'easier now there's a supermarket at the top and bottom of my street!', (Quinton) 'too many yummy takeaway places' (Holyhead), 'has quite a few allotments, and is easier with a car' (Handsworth Wood), 'easy to steal carrots from the fields' (Stannall).

Viewing the data at a city level through the lens of food apartheid provides a critical perspective on the unequal access to nutritious and affordable food within Birmingham's constituencies, with Hodge Hill and Yardley emerging as areas with the highest levels of perceived food insecurity. This aligns with data from the Priority Places for Food Index data, which ranks Hodge Hill as the constituency with the worst access to affordable food in the UK (Pontin et al., 2024). Food apartheid is a political, placebased approach for understanding inequitable food access, emphasising the deliberate actions and policies that have created and continue to sustain disparities, which are often rooted in race, class, and socioeconomic exclusion (Walker, 2023). It replaces the term food desert, which implies a natural phenomenon, with a condition that is deliberate and political. This term is particularly relevant in Birmingham, where racial disparities have existed in housing, access to green space and transport infrastructure for decades. The seminal work of Rex and Moore in the 60s highlights how public housing policies in Sparkbrook created tension for newly arrived migrant communities and pointed to the role of structural equalities in shaping racial conflict (Rex and Moore, 1967). Understanding how the historic policies have shaped the food landscape today is essential to addressing food inequity and to prioritising equitable resource allocation. Food apartheid also gives a space to consider the impact of welfare reforms, and how these might disproportionately affect global majority populations. Benefit freezes, tightening criteria for PIP and welfare cuts will all be exacerbated for global majority populations, further limiting access to essential resources.

Adopting this approach deepens understanding of food inequities, by focusing on structural causes rather than symptoms such as food insecurity or food deserts. Local Authorities and Health organisations such as NHS Trusts could use this data to inform targeted interventions through a placebased approach to help address the inequalities in food accessibility. The term food apartheid is an appropriate evolution of the social justice discourse and is imperative for describing Birmingham's experience of food.

Figure 10 – Obesity levels in Children. Data from 2022/23 National Child Measurement Programme (NCMP)

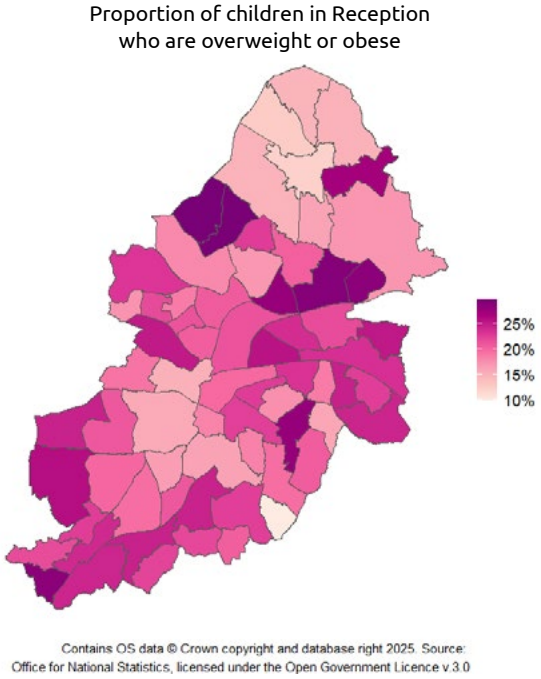
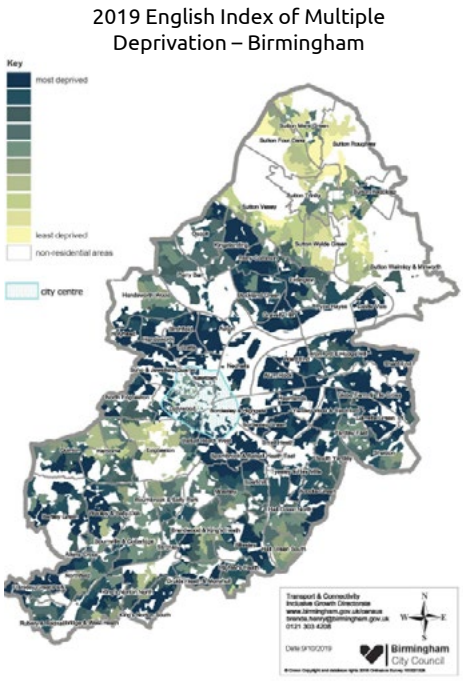


Figure 11 – Social deprivation levels across neighbourhoods in Birmingham



Explore

In this section, the raw data generated will be overlaid with existing data. Identifying overlaps between indices may give insight into which domain of food insecurity should be prioritised in specific wards, such as a focus on accessibility or affordability. This approach allows for more strategic and effective resource allocation. While these remain broad recommendations, integrating lived experience with large scale national data provides a nuanced picture of food insecurity, and points to what resources might be needed to address it. This approach therefore combines spatial, statistical and qualitative data to inform interventions.

Overlay of heat map with obesity map (Figure 10)

Exploring the relationship between perceived food insecurity with childhood obesity (figure 10) may highlight issues such as reliance on calorie dense, low nutrient foods.

Areas with high obesity and perceived food insecurity: Gravelly Hill, Alum Rock. Interventions may include:

- Conducting supermarket basket analysis for affordability and availability of fruit and vegetables (The Food Foundation, 2024).
- Working with local schools to decrease sugary snacks in vending machines (Park and Papadaki, 2016).
- Forming local partnerships e.g. partnering with transport departments to understand and improve local transport networks (Davies, 2018).
- Developing fresh fruit and vegetable initiatives (Gonçalves, 2021).

Areas with high levels of food insecurity, but low obesity: Birchfield, Holyhead, Small Heath, North Edgbaston, Yardley East, Garretts Green. In these areas, the issue may not be nutritionally diverse access to food but may be a result of a different challenge e.g. the affordability of food.

Area with high obesity and high variance amongst perceived food insecurity: Castle Vale, Kingstanding, Rubery and Rednal, Perry Barr. These areas may require a more nuanced approach, as varying levels of food insecurity suggest diverse challenges that need tailored solutions.

Overlay of heat map with social deprivation map (Figure 11)

Areas with high perceived insecurity and high deprivation: Alum Rock, Garretts Green, Small Heath, Yardley and Stechford, Birchfield, Holyhead, areas of North Edgbaston. Interventions may include:

- Localised agricultural schemes e.g. seed provision, community gardens (Stroud Community Seed Bank, 2025).
- Skills and knowledge training around food provisioning (e.g. nutritional education for mothers, food literacy programmes around choosing affordable vegetables, food prepping etc) (Huwaikem and Campa, 2021).

Notably in this comparison, all the areas with high perceived food insecurity also have high levels of deprivation.

Areas with high deprivation and low perceived food insecurity: Soho and Jewellery Quarter, Balsall Heath West. These areas stand out as exceptions where deprivation is high, but food insecurity appears to be relatively low. This would be an important area to research further, to see if the positive features could be replicated in other deprived areas.

Areas with high deprivation and high variance amongst perceived food insecurity: Castle Vale, Ward End, Stockland Green, Sparkbrook and Balsall Heath East, Bordesley Green, Kingstanding, Erdington. One area of interest is Erdington, where the placement of dots accurately reflects neighbourhood level deprivation within the ward, highlighting a strong correlation between these two indices.

Predict

Recommendations for Public Health and Local Authority:

Perceived food insecurity variance within a ward at a neighbourhood level: To better address the perceived variance in food insecurity within specific wards, targeted research is recommended in the following areas: Handsworth, Nechells, Erdington, Edgbaston, Harborne, Weoley and Selly Oak, Perry Barr, and Kingstanding. Given the high level of disparity in these wards, ward level projects mapping the food security in these neighbourhoods should be the focus for research, identifying hotspots for resource allocation.

Accessibility focused interventions: Ward such as Gravelly Hill and Alum Rock would benefit from strategies aimed at improving food accessibility.

Affordability focused interventions: Interventions addressing affordability challenges should focus on Alum Rock, Garretts Green, Small Heath, Yardley and Stechford, Birchfield, Holyhead, and parts of North Edgbaston.

All these areas could benefit from integrated, skills-based approaches designed to build food literacy. Such interventions are most effective when they are community-based and participatory, empowering residents to play an active role in addressing food insecurity. Programs should include practical workshops and collaborative initiatives that foster long-term solutions and promote community ownership.

Recommendations for BMT:

Attendance gap: To address gaps in visitors from different wards, focus efforts on Tyseley and Hay Mills, Yardley East, Garretts Green, Frankley Great Park, Gravelly Hill, and Heartlands.

Food security initiatives: Weoley and Selly Oak: Given the high levels of food security variance, leverage BMT sites such as Weoley Castle and its associated green spaces to foster community-based agricultural projects and workshops (Horniman Museum and Gardens, 2025). Yardley and Stechford: Similarly, Blakesley Hall could host localised agricultural schemes and skills training, focusing on affordability interventions (see the work of the Women's Environmental Network, 2025).

By embedding local demographic insights into programme design, BMT can enhance its impact on food security while strengthening its connection to the communities it serves.

Question 3: What makes it tricky for you to eat healthily?

The responses to this question did not fit neatly into the category of motivation but instead addressed broader barriers to healthy eating. As a result, they were coded across all three COM-B domains. These findings were then mapped onto the Theoretical Domains Framework (TDF) and the Behaviour Change Wheel (BCW) to systematically identify and design interventions in Birmingham.

Table 1 – Mapping the BCW onto oral history data

COM.B	TDF	Example	Rank	Frequency of mentions	Intervention function and BCT's	Policy category
Automatic motivation	Emotion	'Junk food makes me happy especially in front of some good tv. It tastes better!'	1	20	5.3 - Information about social and environmental consequences 5.1 - Information about health consequences	Regulation
Physical opportunity	Environmental context and resources (access)	'There should be less fried chicken shops in Birmingham, it has become a pandemic'	2	19	Environmental restructuring; 12.5 - adding objects to the environment 12.1 - restructuring the physical environment	Environmental and social planning
Physical opportunity	Environmental context and resources (cost)	'Environment, finances, accessibility. MAKE HEALTH FOOD AVAILABLE FOR EVERYONE'	3	6	Environmental restructuring 12.1 - restructuring the physical environment	Environmental and social planning
Reflective motivation	Intentions	'None - if you cook your own food from scratch and ignore fast food outlets your body and your pocket will be richer. EAT LOTS OF VEG'	4	4	5.1 - information about health consequences, 5.3 - Information about social and environmental consequences	Education
Psychological capability	Knowledge	'knowledge of how to cook - I had food tech lessons in school but that was it'	4	4	Education, training, enablement 4.1 - instruction on how to perform the behaviour	Communications and marketing
Automatic motivation	Reinforcement	'I am 64 and have been vegetarian since 14. I've no problem eating heathily. It's simple! I cook everything from scratch. No junk food ever.'	5	3	6.2 - social comparison, 13.2 - Framing/reframing, 13.1 - identification of self as role model	Guidelines
Social opportunity	Social influence	'We try to eat healthily but Simon keeps buying sour watermelons from Spar!'	5	3	Enablement; 3.1 - social support (unspecified) 1.1 - goal setting behaviour	Service provision
Psycological capability	Behavioural regulation	'eat less practice often. Fried foods - 'X' eat less!'	6	2	Education, training, enablement; 1.1 - goal setting (behaviour)	Environmental and social planning
Psycological capability	Environmental context and resources (time)	'Time'	7	1	Enablement; 1.4 - action planning	Environmental and social planning

Cummins and others (2016) have noted the lack of evidence of the effectiveness of population-wide interventions for tackling obesity in their pilot programme 'Tackling Obesities'. Their findings suggest that to address a complex problem such as obesity meaningfully, it is essential to understand the multiple and interconnected barriers to healthy behaviours across the whole city. Similarly Go-Golbourne, a community-based whole-systems approach to obesity highlighted the need for local initiatives to be reinforced by supporting action at a regional and national level (Gadsby, 2020). Building on these findings, this small qualitative study is an explorative start to understanding broadly what interventions the city needs, based on the perceived barriers to healthy eating. Operating a systems approach to intervention development and deployment that goes beyond individual level changes is essential for effective policies. Furthermore, it prioritises community values and lived experiences, fostering a stronger sense of belonging, community engagement, and local heritage; key metrics for the UK Levelling Up agenda (2022).
By involving community members' lived experience in policy recommendations, trust and cooperation are built, facilitating greater buy-in for initiatives aimed at improving local areas. This data set also reveals a need for cross-sectoral working to tackle complex issues, with local authorities working across departments to improve travel infrastructure, urban planning and create healthier food environments, aligning services across multiple levels. This whole city behavioural diagnosis provides a critical evidence base to design and implement coordinated interventions.

Conclusion

For public health, the value of this work is the engagement of people through a neutral, nonhealthcare space that opens up space for dialogue. Involving community members in policy decision making is crucial for making health care systems more equitable, relevant and effective.
This bridging of everyday experiences and strategic planning follows ideas of participatory health governance, grounded in social participation (De Ruysscher et al., 2024).
This process works to ensure that health services are addressing the issues that matter most to the community that it serves, building legitimacy and trust, impact, social justice and ownership (ibid.).

For the heritage sector, this work highlights the role of the museum as a vital community asset that facilitates civic engagement. They offer accessible, friendly spaces for the public to participate in public discourse and develop opportunities for critical thinking (McElheny, 2024). The act of individuals adding narratives around the map indicates an appetite for these participatory spaces and using these as a way of self-expression. The wards identified for museum engagement present opportunities to adopt asset-based community approaches, such as Asset-Based Community Development (ABCD). This model views communities through a lens of abundance, recognising and building upon existing resources and connections, rather than framing deficits or deprivation as problems to be solved by external intervention. Using this in low attendance areas can help museums see how we can use our resources to catalyse existing community assets (Longhenry, 2023). Given that the research shows that systems-based approaches are necessary to address complex structural issues like obesity, this research indicates that museums can be part of such an approach, and that working in this integrated way will make their engagement activities much more likely to be effective. In policy terms museums should prioritise integrating activities designed to achieve social change into wider systems working towards the same goal.

b. Community engagement

i. ESOL lessons

Co-curating lessons using oral histories

This section explores the use of heritage as a way of adding meaning in education, and as a tool for health literacy.
Oral histories have been widely used in educational settings, offering an alternative to traditional textbook based learning (see English, 2021). Within this, language learning as a specialisation has been explored; the process of recording an oral history reinforces language skills whilst also acting as a tool to forefront community experience in education, serving both a linguistic and a pedagogical function (Burgo, 2016). Similarly, Montero and Rossi (2012) used oral history as a methodology for culturally responsive pedagogy, recording and interpreting the English learners' migration stories to support writing development. Research suggests that educators implementing oral history projects in their ESOL classrooms report increased student engagement, cultural responsiveness and a notable enhancement in learners' confidence in using the target language (Olmedo, 1993; Voice of Witness, 2025).

BAES

For this work, the researcher collaborated with Birmingham Adult Education Services (BAES) to devise, deliver and evaluate the use of historic oral histories in an educational capacity. BAES is a centre that educates around 7,000 adults each year. English Language courses (ESOL) run across the city in 9 different locations and are free of charge. Proficiency in the host country's language facilitates social inclusion and therefore has great capacity to improve integration (Beißert et al., 2006).

Learning objectives

In this work, historic oral histories were used as a foundation for learning English, drawing on the collections' distinct form, content and historical context to provide a meaningful learning experience.

These three aspects tie directly into the learning objectives agreed by the researcher and the BAES teachers:

1. To improve English literacy
2. To improve food literacy in a UK context
3. To improve knowledge of the city of Birmingham

The researcher curated a set of 18 oral history snippets for the teachers to choose from. The teachers then met 4 times over the course of a month to put together sessions that would work for their groups, using the evaluation form set out by the researcher. The output of this work was 15 hours of lessons developed by 12 ESOL teachers, who worked in collaboration to deliver the lessons to over 100 students at an Entry 3 level.

Developing evaluation

Studies indicate that individuals with limited food literacy are less likely to engage in preventive health behaviours (Bennett et al., 2009) and are more prone to varying patterns of healthcare use and increased mortality rates (Berkman et al., 2011). To evaluate how these lessons might affect food literacy, the Short Food Literacy Questionnaire (SFLQ) was chosen based on the findings of the systematic review by Yuen and others (2018). This tool was selected for its balance across functional, interactive, and critical literacy domains while remaining accessible for ESOL learners.
The researcher ordered the questions based on a repeated F/I/C domain formula and included a mix of Likert scales (1-5) and multiple-choice. The same questionnaire was administered at the conclusion of the 15-hour course.
The evaluation form was adapted to a British context and simplified by ESOL teachers to ensure clarity for learners.
By using a rigorous evaluation, this methodology for using oral history as a tool for pedagogical interactions is clearly defined and evaluated. In addition, two semi-structured interviews were carried out with groups of ESOL teachers for their feedback on the experience of planning and delivering the lessons. See Appendix C for full questionnaire.

Results

Figure 11 – Pre and post data for recommended salt intake in the UK

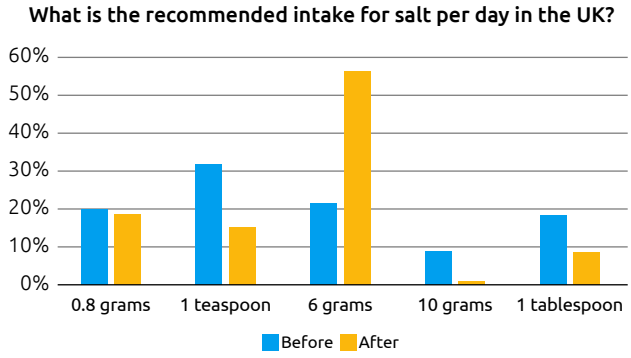
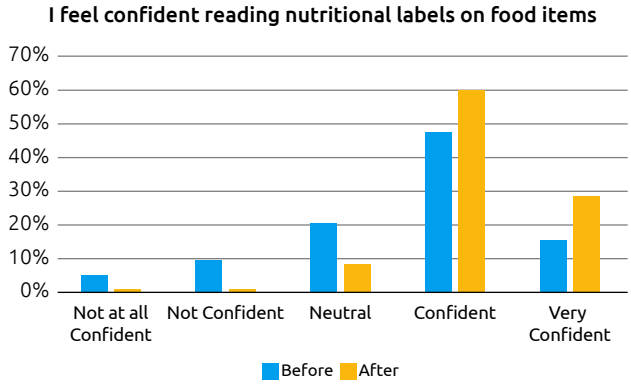


Figure 12 – Pre and post data for confidence in reading nutritional labels



As this study was a non-parametric study, and there was a disparity in the number of respondents on the survey, likelihood ratios were the best way to understand this data. A likelihood ratio compares how much more (or less) likely a response is to occur after an intervention than before. If a likelihood ratio is greater than 1, it means the response became more common after the intervention. The higher above 1, the stronger the effect of the intervention, in this case on food literacy.

Likelihood ratios between the pre and post survey data suggest that this intervention successfully improved overall food literacy levels. The most considerable positive changes were in functional aspects, with the most significant increases being in identifying the UK recommendation for salt intake (6 grams, likelihood ratio of 2.67); the proportion of individuals who selected 'strongly agree' in their understanding of the Eatwell guide (likelihood ratio of 2.2); level of individuals choosing 'very confident' when reading nutritional labels (likelihood ratio of 1.81). For the interactive domain, participants were 1.31 times and 1.25 times as likely to report feeling 'confident' and 'very confident' respectively when identifying foods that are healthy for their identity following the intervention. In the critical domain, individuals choosing 'strongly agree' when considering the ease of understanding the long-term impact of their diet for their health improved considerably (likelihood ratio of 2.7).

Aspects of food literacy with more variation in improvement were helping friends with nutritional issues; those who answered 'agree' had a likelihood ratio of 0.95, yet those who answered 'strongly agree' had a likelihood ratio of 1.5. When considering the functional aspect of knowing where to find information on healthy nutrition, individuals were 1.5 times as likely to select 'strongly disagree', yet also 2 times as likely to select 'strongly agree'. Participants were 0.96 times as likely to choose 'agree' when considering their understanding of media information and adverts on nutrition but were also 1.67 times as likely to choose 'strongly agree'. See Appendix D for full survey results and graphs.

Feedback from ESOL teachers

Teacher feedback was overwhelmingly positive, with all respondents noting the lessons' beneficial impact on students. Engagement levels were consistently high, with students displaying equal or greater involvement compared to other lessons and actively expressing their views.
One teacher mentioned a sense of solidarity between historic interviewees and learners, particularly around children not wanting to eat foods from within their culture and instead gravitating towards Western food.
This shared experience across generations and cultures was further reflected in students' reactions to the challenges of procuring food in the 1980s; some expressed surprise, solace and comfort, recognising similar struggles in their own lives. Teachers adapted the oral histories to suit their classes, with one specifically highlighting the financial barriers to healthy eating. This teacher emphasised that economic constraints, both historically and in contemporary contexts, often determine food choices more than personal preference, a perspective that resonated with students.
Additionally, a teacher emphasised the difficulty of finding suitable resources for adult learners, noting that the oral histories were particularly valuable as they featured adults discussing relevant issues with other adults. The main issue reported was lack of time to cover all the resources.
One teacher mentioned that the audio was too advanced for her learners, so she slowed it down and used the transcript to follow along.

Conclusion

Oral histories are an underdeveloped resource for ESOL settings and for adult learners, offering both linguistic and contextual dimensions that can shape meaningful learning experiences. In this work, the historic food memories were reconstructed by the teachers and the learners in ways that felt meaningful and relatable to them.
By intentionally creating learning material that resonates with students' experiences, engagement increased, as reflected in improvements in food literacy.
These improvements were seen across all functions of food literacy, but were most pronounced when targeting functional aspects, and could be tailored moving forward to target specific food literacy concerns. This tentatively suggests that emotional resonance and active engagement play a role in how effectively individuals learn and retain food literacy concepts.

ii. Arts-based research evaluation

The Eatwell Guide, a pictorial resource used to represent UK guidelines for nutritional consumption, was used as the basis for an arts-based intervention. Criticisms of this guide highlight a lack of cultural nuance, difficulties for those from a lower income household to meet guidelines, and an overemphasis on carbohydrates. This intervention developed a project specific version this guide, enabling participants to design their own guide based on their self-identified needs. Participants were recruited in the gallery space at BMAG and in community spaces, where the researcher was invited to run the activity. Participants in community spaces and gallery spaces were given a blank A3 Eatwell Plate, a sheet of culturally diverse food graphics (developed from the appendix of the Birmingham Eating Guidance Exploration Report, 2024) and invited to collage their own Eatwell Guide from scratch. Please see Appendix E for the Eatwell Guide resource pack. By inserting themselves into the healthy eating narrative directly, participants are able to challenge and re-imagine the Eatwell guide in relation to their own identity (dual heritage, stage of life, health conditions, dietary requirements).
This process has two primary functions within this project:

1. Identify food literacy concerns within the city
2. Reflect everyday food experiences in the city

Grounded in art-based research (ABR), this approach uses artistic processes to intuitively explore human experience, giving space to data not solely controlled by the researcher (Smith et al, 2021). These methods provide a set of tools that can unpack and give voice to perspectives on issues otherwise missing from policy and research. Through the process of identifying, cutting and sticking, participants reframed the Eatwell Guide in a way that reflected their lived everyday experience of food whilst asserting agency over their own cultural narratives. Creative approaches to engagement tap into the affective domain of learning (Friedman, 2013) and may be more effective than approaches that are purely cognitive (Moser and Dilling 2011).

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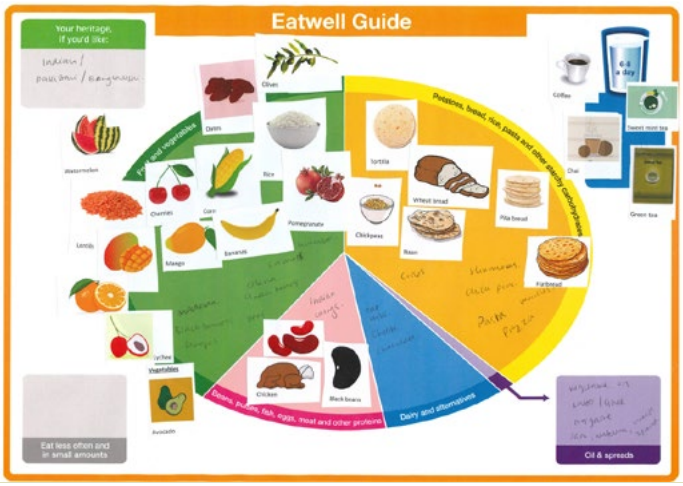
Figure 13 – Participants taking part in the Eatwell Guide activity

Results

This work primarily engaged two key audiences: individual community groups with local residents in community centres and children with their parents on a Saturday morning at BMAG. These groups differed in their engagement; the community groups were a more captive audience, focusing more intently on their individual work. Conversely, the sessions on the Saturday morning in the gallery allowed a greater extent of cross cultural and generational sharing. During these sessions, the researcher engaged with participants individually, asking each whether they had encountered the Eatwell Guide before, to grasp familiarity across the different groups. These results draw on the collaged Eatwell Guides and the researchers' reflective journal.

Figure 14 and 15 – Examples of Eatwell Guides



Food literacy

Of the 36 plates created by participants, 20 had the additional 'your heritage, if you'd like' box filled in. This mostly occurred in the community settings and was avoided by children. The levels of food literacy varied across these populations; some completed guides signalled strong food literacy, with written agendas and goals 'I eat fermented sauerkraut beetroot, kefir, probiotics, prebiotics for good gut health' and 'cut back on carbs as they turn into sugar'. The ability to differentiate between pre and probiotics indicates a very high level of food literacy and understanding of how food impacts health. However, the level of food literacy was lower in the community spaces compared to the family audience; on average, there were 3.6 misplaced items per plate in the community setting, and 1.2 misplaced items per plate in the museum visitor population. Multiple individuals colour coded the food according to the guide, and the majority of participants in community spaces had not seen the Eatwell Guide before. [comments from the researchers reflective diary on these sessions]: 'A lot of guidance was needed from myself to explain what sorts of foods went where on the Eatwell Guide; this may reflect food literacy but may also have been compounded by the varying levels of English literacy'. In contrast, over 85% of children reported having seen the Eatwell plate in school settings, and many demonstrated the ability to navigate and complete the guide effectively. However, some interactions revealed literacy challenges. For instance, younger children (around age seven) often relied on their parents to prompt them for the placing of foods. On average, children displayed the strongest understanding of the fruit and vegetable section and the greatest uncertainty regarding the 'eat less of' section.

Engagement and connectivity

In the Saturday sessions, children often initiated work on an Eatwell Guide but struggled to maintain focus, frequently abandoning their projects. Consequently, several incomplete guides were excluded from the final dataset of 36. One of the most significant outcomes of these gallery sessions was the conversations between parents and children. The activity provided a structured space, supported by visual resources, for open discussions about food and eating habits. These discussions frequently revealed surprising insights for parents about their children's eating preferences or behaviours. In many cases, this led to verbalised commitments from parents [comments from the researchers reflective diary on these sessions]: 'parents learning about children's food habits from their plates often led to some sort of action - one parent stated "well I'll make flatbreads at home!" after seeing them on their child's plate'. Additionally, many parents expressed interest in taking the resources home, wanting to engage with children who exhibited challenging eating habits and to extend the activity into a home setting. These findings align with research highlighting the importance of household food practices in shaping food habits, with the transference of food behaviours and values within families being widely acknowledged (Davis et al., 2018). The discussion of food outside of mealtimes, particularly around food preparation, has been shown to positively impact children's food behaviour (Norton et al, 2022), and this activity can act as a tool for intergenerational discussion, without the pressures of being sat at a table.

Conclusion

This activity served as both a process and an outcome; not only about the act of 'doing', but the collaborative effort of 'doing together', proving to be a valuable tool for opening dialogues about food in a neutral context, allowing a process of exchange. It offered parents insights into their children's eating habits while providing a non-judgmental space to explore these topics collaboratively. Implementing this activity as a school assigned homework task could further support food literacy by engaging families in conversations about current eating habits at home. Another key insight from this work was the notable difference in how adults and children understood the Eatwell Guide. In community settings, many adults demonstrated a lower level of comprehension, which may stem not from general food literacy challenges but rather from a limited familiarity with UK dietary guidelines. This gap may be attributed to arriving in the UK after completing formal education elsewhere, highlighting the need for targeted support in this area.

c. Schools

i. Idea formulation and initial research

Alongside the expansion of oral histories into adult education settings, the researcher planned a set of lessons deliverable in school environments. After initial consultations with teachers both at KS2 and KS3, an overall framework and draft lesson plan was created. Though later dropped due to capacity, teachers gave positive feedback, highlighting its potential to integrate local objects into education and foster critical thinking.

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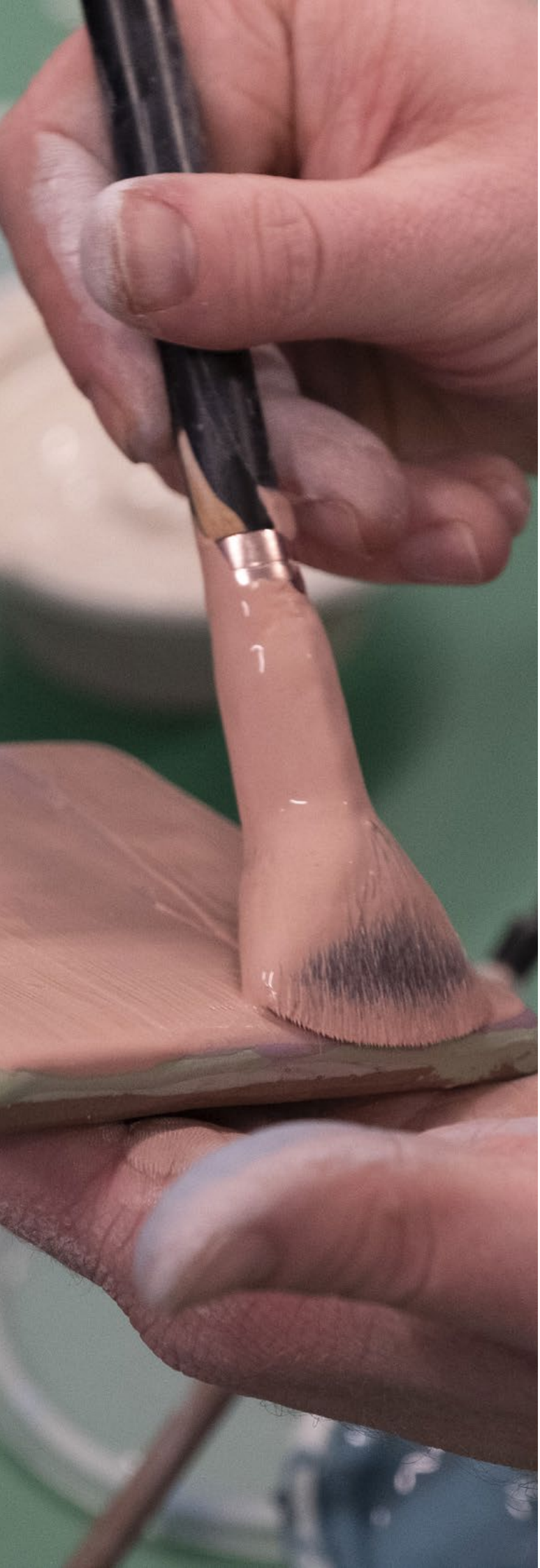

d. Researcher reflections

Key learnings:

A key takeaway was the success of using a standardised framework to frame an evaluative data gathering space – it provided a structured and inclusive way to integrate lived experience into recommendations for policy. Oral histories were a fantastic tool for adult learning – their strength lay in being a resource by adults for adults. This made them relatable for the students, whereas many resources around food literacy available are aimed at children. Involving the teachers in this process was essential for success – necessary to involve those who knew and understood the needs and ability of the class. For the process to feel fully co-created, there might have to be a bit of nervousness for the researcher about what is actually produced! The arts-based research was a neutral way to have conversation about food habits, particularly with children.

Challenges:

Initially, comment cards seemed abstract and difficult to decode, but a simple coding strategy revealed consistent themes. The 2nd question in the gallery space evolved from a written comment card response to a map format, due to very little interaction, possibly due to it being more abstract. This change reflected the importance of adapting methods in real time – flexibility is essential (do not be afraid to change!) when the data itself signals a need for change. Maintaining matched before and after surveys was near impossible – despite all the support from BAES, still a drop off in 2 sample. Considering this, I opted for ratio analysis instead of a statistical test. Because this is not a controlledvenvironment, need to be flexible with data analysis. Simple way of manipulating numerical data. Arts based research is messy! Not getting full Eatwell Guides in the gallery space felt like the data collecting was a failure. However, it became clear that the value of this activity was the participatory process as opposed to the output.

Implications for future work:

There is clear potential for further exploration into how emotions influence learning environments. Particularly, which emotions are most effective in prompting meaningful engagement and retention.

Chapter 4.

(WS3) Public Health and Heritage Learning

Chapter 4

(WS3) Public Health and Heritage Learning

Whilst there is significant encouragement for partnerships across the public and nonprofit sector, the practice of working collaboratively can be problematic, due to different working cultures, imbalances in power and sustainability of interactions (Cairns and Harris, 2011). The embedded researcher way of working in this project allowed a bridging of some of these issues, working on two pilot cross-sectoral interventions. These pilots highlight the potential for historic objects to be used as community-based assets and have conversations around identity and historic representations of diversity. They also reveal possibilities for easily implementable initiatives for both museum education and local authority, improving health outcomes through mutual learning.

a. BCIF

Outline and selection of oral history snippets

The Birmingham Cultural Intelligence Framework (BCIF) is designed to develop individuals' and organisation's ability to develop their understanding of cultural communities, and to ultimately empower communities of identity and experience (Birmingham City Council, 2024). This framework consists of 7 domains: curiosity, understanding, allyship, anti-discrimination, game changer, advocacy, and conscious decision maker. As part of this initiative, a resource library was developed for each domain. Participants use these resources to think critically about their understandings of cultural communities, and write reflective responses. For the domain 'understanding', concerned with pushing understandings of communities and stereotypes, some of the oral histories were incorporated. The recordings chosen with the Public Health team were based on their engagement potential for learners. In some cases, the language used was discriminatory, highlighting the hardship and racism faced by communities in Birmingham. The intended emotional responses were expected to increase learner engagement with the resources and the learning.

Results

For the pilot phase of BCIF, 100 participants from 4 organisations across Birmingham took part. Each participant was asked to fill in a reflective practice feedback form that tracked their own learning journey and skills development. The questions asked: How did I feel about what I learnt or experienced? Why did I feel this? What was good about the experience and what was bad about the experience? How will what I experienced change the way I behave in the future? In addition, each participant completed a pre and post survey for each module, to show progression of the BCIF intervention. This included behavioural changes towards particular community groups, e.g. 'In the past month, how often did you use insights from your reflections to adapt your approach towards the [specific community]?'.

This pilot project is ongoing, and given the other resources in the library, causality cannot be definitively attributed to the oral histories based on the current data. However qualitative insight can be gained through the reflective passages. One reflection on these oral history resources mentioned the value of the recording, and the inequalities the interviewee might have faced:

"There was an immense warmth about this interview, and I feel really grateful that Una had openly shared so many of her insights into Caribbean food in so much detail. She seems like a lovely lady and provides so much honesty, with a very gentle nature. I am also grateful that the recording had been made, preserved, and become publicly available. I also feel a bit disappointed in myself for never having explored Caribbean food previously, despite having an active interest and experimenting with cooking foods from other parts of the world."

"It is likely that Una (and the people around her) would have endured substantial inequalities during her time in the UK, which is worth reflecting upon. Also, it was sad when the interview ended. I think there are plenty more insights and valuable cultural knowledge that Una could have provided 2025 with."

In discussions following the implementation of the oral histories, both the Public Health team and the researchers appreciated the use of these localised materials as an emotive resource to consider stereotypes and cultural competency.

b. Cross institutional learning

Museum learning and education departments are cornerstones of children's and young people's learning experiences. They offer high value educational experiences and alternative ways to learn that are often difficult to achieve in traditional classroom settings, particularly those with limited resources. Successful collaborations between schools and museum services have led to museum staff developing strategies and concepts, improved social inclusion and powerful learning outcomes for students (Hooper-Greenhill et al., 2007). BMT delivers workshops, shows and hands on experiments to nearly 50,000 children in Birmingham each year. One of these shows, 'Under Your Skin', which takes place at one of BMT's sites, the Thinktank Science Museum, educates students about the Eatwell Guide, the digestive system and dental health. Following discussions with the learning team at this site, the BCCPH's Food team was brought into advise on the content of the show. A team representative observed a session and provided feedback on aligning language with public health messaging.

Results

The outcomes of this two-hour session for BMT included revisions to the workshop script and the introduction of a new evaluation survey option for schoolteachers.
By using similar vocabulary across the curriculum, educators can provide a cohesive experience for learners. For the Public Health team, they were offered practical guidance from the learning team on their future public Full of Beans lesson resources and offered to use the strategic network of schools in connection with BMT. This cross-institutional way of working allows for mutual learning across civic institutions, leveraging in house knowledge and reducing reliance on external consultants. Future resource sharing partnerships could enhance efficiency and highlight more potentials for collaborative work.

c. Researcher reflections

Key learnings:

Oral histories can also be used as prompts to understand concepts beyond their original intended use. Many of BMT's and other museums' oral history collections would be suitable starting points for conversations around the representation of global majority communities, gender, disability and more.

Challenges:

Despite both parties seeming interested and engaged during the facilitated session, there was a hesitancy or uncertainty about continuing the collaborative work after the allocated time with the researcher. Subsequently as my methods have developed, there has been interest from the food team in exploring how my approaches could support efforts to improve health literacy.
This indicates a growing openness to incorporating mixed methodology approaches into health practice.

Implications for future work:

There is still work to be done to demonstrate the potential value of mutual exchange between the organisations for both parties.

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Chapter 5.

(WS4) Oral History as Community Health Enquiry

Chapter 5

(WS4) Oral history as community health enquiry

In this final section, the use of oral history as a tool for community health enquiry is examined, through the recording of 11 new oral histories that mirror the 1984 collection.

Oral histories for health research lend a detailed, interviewee led dialogue that allow agentic and nuanced accounts. Rather than reinforcing an objective, top-down definition of what it means to be 'healthy,' they shift the focus toward subjective, culturally informed understandings of health. The open-ended exploration of themes raised by the interviewer allows unexpected insights that may not have been captured in a more structured format, and they allow space for different cultural conceptions of health behaviours, and how these fit into daily life.
Birmingham City Council have demonstrated leadership in this area through the development of Community Health Profiles (CHPs). These CHPs were created in collaboration with local communities, to deepen understanding of specific needs and contexts. Used in combination with these profiles, oral histories can provide a path to more culturally appropriate policies and programmes.

It is postulated by Tsui and Starecheski (2018) that oral histories may be particularly effective in revealing how wider determinants of health shape health experience over a lifetime. As the health sector increasingly focuses on understanding and addressing these factors, oral histories may reemerge as a valuable methodology to consider the complex interplay of social, economic, structural and environmental factors on overall health.

a. Guide and recruitment

An oral history guide for the recording of new interviews was developed by the researcher. The guide both mirrored the 1984 collection to allow continuity across data sets, and used the COM.B framework to shape questions that could later be analysed. The guide started with some overview and background questions, and then moved into questions themed around capability, opportunity and motivation. Please see the appendix for the interview guide.

In oral history research, representativeness is not the primary concern; instead, emphasis is placed on the depth, richness, and contextual nuance of the narratives. Rather than aiming to produce generalisable data, this approach seeks to capture diverse and meaningful perspectives grounded in lived experience. Based on this methodology, this work used purposive participant selection to recruit participants. Whilst seeking a true representative sample for this work would have not been appropriate, the researcher still wanted the data to be reflective of the diverse communities in Birmingham. To encourage this, the researcher used both a voluntary response method, doing callouts on the museum website and radio, and also a more targeted approach, reaching out to specific community groups. Within these groups, opportunity sampling was subsequently used to pick out interviewees. In total, 11 oral histories were recorded.

b. Results

Coding of the collection

The same themes were used to code the collection as the 1984 collection, derived from the BCC Food Strategy. The line codes generated from the interviews however differed, reflecting the types of questions asked and the people interviewed.

Alongside thematic coding, the collection was also coded with barriers and facilitators to healthy eating. The open-ended nature of these interviews enabled open and often intimate dialogue, allowing topics to emerge that were not anticipated by the researcher. This follows an abductive approach, which is well suited to exploring complex social experiences. The researcher maintained flexibility in the research process, iteratively engaging with the data and adjusting it for future interviews. Please see Appendix F for the interview guide.

Table 2 – Key barriers, themes and quotes

COM.B	TDF	Subtheme	Quote
Opportunity	Environmental context and resources	Limited access to culturally specific foods	"Yes, some of them is too long way. I should go to the Kurdish stores or the Iranian store. I cannot find them there in normal shops. Same Aldi, Lidl, Morrison, Asda, I cannot find them."
Opportunity	Environmental context and resources	Accessibility of culturally appropriate food	"for example, we didn't have lots of meat shops or local shops that were catered for Asian food."
Capability	Knowledge	Food knowledge	"You know, because they don't know how to how to start with basic ingredients and make an edible meal, because it got taken out the curriculum, cooking."
Capability	Physical skills	Practical cooking skills	"I think all those practical skills are necessary because I know my son wouldn't know doesn't know things because he didn't learn them at school."
Opportunity	Environmental context and resources	Influence of takeaway culture	"I know there's a lot of takeaways now along Springfield, Dixie chicken and all that. So, I think probably the young people are more prone to eating unhealthy food."
Capability	Knowledge	Lack of clear food labelling	"You know, they talk about food labels and so on. None of it makes sense to anybody."
Motivation	Emotion	Stress related eating	"I think I used to eat too much, particularly where I was stressed."
Motivation	Beliefs about capabilities	Lack of confidence	"And as an adult now, I don't have the confidence to cook on my own, I feel as though I need a supervisor."
Opportunity	Social influences	Early exposure to diverse foods	"I can remember having yoghurt and things before my friends did, and it was ski yoghurt, I think I was very lucky, really, because we just had anything, you know, my mum and dad would try everything."
Opportunity	Social influences	Role of family and upbringing in diet	"If your elders aren't familiar with that, that's just not something that you're going to be exposed to at home."
Motivation	Identity	Strong personal values on diet	"People bring a box of chocolate to my house. I say, 'Why have you bought this? We don't eat this.'"
Opportunity	Environmental context and resources	Financial constraints on food choices	"It literally just comes down to money at the moment."
Capability	Knowledge	Cultural differences in food education	"A lot of those women had never seen that [food plate] either, because their initial education wouldn't have been here."
Motivation	Emotion	Issue with relationship with food	"I had a very tricky relationship with food, and I still do a little bit, but not as bad as I used to."
Capability	Knowledge	Limited food education in school	"I don't remember anything from food tech, really, other than the stress of buying the ingredients."
Capability	Memory, attention and decision processes	Time restraints	"Time and exhaustion, sometimes when I'm busy, I think can't be bothered. But even then, I try and make something quick, like an omelette. It's time and tiredness."

Barriers to healthy eating were distributed across all domains of the COM-B model. The most frequently cited barriers included environmental context and resources, knowledge, emotion, social influences, and beliefs about capabilities. Among these, environmental context and resources were the most commonly referenced, particularly in relation to food accessibility. Interviewees highlighted the distance to culturally relevant supermarkets and the prevalence of fast-food establishments; these findings point to the usefulness of considering the foodscape in Birmingham through a food apartheid approach.

Knowledge based barriers often stemmed from disrupted or lack of generational food education, including limited school instruction and a lack of parental guidance. Emotional barriers included experiences of stress, unhealthy relationships with food, and a diminished sense of enjoyment in eating. This was particularly evident when considered over time, and how this relationship with food had changed and influenced current eating habits. Beliefs about capabilities revolved around perceived inconvenience and time constraints.

Table 3 – Key facilitators, themes and quotes

COM.B	TDF	Subtheme	Quote
Opportunity	Social influences	Mealtimes as opportunities for connection	"They're asking about the recipe. I'm asking them their recipes, their favourite foods."
Capability	Physical skills	Importance of cooking education in schools	"I know that sometimes I would close the door and I'd teach an old-fashioned cookery lesson."
Motivation	Intention	Growing food as a rewarding activity	"Because I can do it, and I want to do it, and I know it's fresh, and I feel as I've achieved something basically."
Motivation	Beliefs about capabilities	Learning a new skill	"Onions, I wasn't very good at cutting because my mum used to just slice them in her hand as though she was peeling a potato and into the finest, thinnest slices, which is a lovely skill to have, which I've shown off to a friend recently. And I was like, Oh, I can do it! [laughter]."
Motivation	Behavioural regulation	Limiting food	"If it's not there, we won't eat it. We don't buy fizzy drinks. We've got one of those fizz machines, which we don't use that often anymore. So I'm a bit more if it's not there, you won't eat it. It's quite simple."
Opportunity	Environmental context and resources	Access to international ingredients	"I think it's amazing. I think, I think the availability and variety is just phenomenal. You know, you go, you get the Caribbean, to the Bangladeshi, to the Pakistani, to, you know."
Opportunity	Environmental context and resources	Access to ingredients	"Because I live in Birmingham, and I've got access to all these wonderful ingredients very easily."
Capability	Knowledge	Parental guidance in childhood	"Because of my background where there was no sort of parental relationship with food that I was able to participate in."
Motivation	Intention	Interest in alternative food sourcing practices	"I've been reading a lot more about alternative sort of foraging and things like that. I've always had an interest in it, and it's been there for a while."
Motivation	Belief about capabilities	Food preparation and planning	"I'll do things like, when I know that there's a really busy period coming up, I'll make a big veggie lasagna and stick it in the freezer, or I'll make some [pathia] Just, just the sauce for the [pathia], because it's so easy to make at home and you're not putting 10 tons of oil in it."
Capability	Behavioural regulation	Dietary changes based on experience	"I don't think I had the menopause, but by taking those medicines, I think it was bringing on menopausal symptoms. So I think it's just a question of using natural things. For eating I've started using I eat lots of nuts and seeds, and I've tried making things like sourdough bread and trying to reduce my ultra processed food products and cooking homemade, homemade foods from scratch."
Opportunity	Social influences	Family mealtime traditions	"Some of the most, like fondest mealtime memories, I'd say, would be with my nieces and nephews, actually, when they used to come round, and they still all come round now, and it's still some of my favourite times to sit down and meet with people."
Motivation	Reinforcement	Receiving praise	"And so I cooked quite a lot then... when I do get a chance, I enjoy it because of the sense of accomplishment that I've completed this thing, and then when everybody eats it and they enjoy it, and I'm like, yeah, praise me more, praise me more. I've done a good job."
Motivation	Belief about capabilities	Food preparation and planning	"I did the prep earlier. I'm good at- I kind of do my prep- say if I go home today at one o'clock. I'll do the prep for the meal, uh, later on, and I'll do it, and then I'll go and do whatever I want, because then I can come down at whatever time and have you, bang, bang, bang, done."

Facilitators of healthy eating also spanned all COM.B domains, with motivation and opportunity emerging as the most prominent enablers. Most common were facilitators around belief about capabilities, belief about consequences, environmental context and resources, social influences. A strong belief in individuals' capabilities, particularly in food preparation and planning, was a key driver, as was intention, often demonstrated through active engagement in alternative food practices like foraging or home cooking. Belief about consequences was also a key motivator for participants to eat healthily, with high levels of food literacy among interviewees frequently associated with childhood exposure and food literacy. Social influences, such as family traditions and shared meals, further supported positive food behaviours. Conversations also moved to health more generally, with discussions around green space being a facilitator for improved mental wellbeing.

Aside from the barriers and facilitators, several compelling narratives emerged through the interviews. One interviewee discussed the culturally diversity of education around eating disorders in schools. This is not a topic that was raised through a specific question but came up through the abductive process. The interviewee mentioned that they felt eating disorders were portrayed as a 'white' illness in school education, making it difficult to have conversations with their parents about the subject. This points to a need for improved cultural competence training in school-based education, to ensure topics such as disordered eating and mental health are inclusive. In addition, it is important to consider how ethnic identity and acculturative stress might be a risk factor for disordered eating habits (Acle et al., 2021).

Another key theme concerned food literacy, and the difficulty communities might face with UK based guidelines. For example, the interviewee discussed individuals not being able to conceptualise how much 6 grams of salt is per day, suggesting a need to diversify and contextualise public health messaging. Unpacking abstract nutritional targets into tangible amounts, such as through the Eatwell Guide activity, can lead to innovative and more accessible ways to improve food literacy.

Natural, holistic and traditional medicines featured significantly in this collection. One interviewee expressed uncertainty about whether this content was the sort of topic the interviewer would be interested in. The non-medical setting and the style of interview likely encouraged more honest sharing, helping to reduce social desirability bias and allowing real practices to emerge. Globally, the WHO recognise traditional medicines as essential for achieving universal health coverage, and for many global majority communities, traditional medicine is often used alongside or in place of conventional treatments. To align with their recommendations, the UK should be recognising these practices as being complementary to current healthcare services, exploring pathways for their integration with national care such as the NHS. As the healthcare system continues to embrace culturally sensitive interventions, there is scope to include these traditional medicines as part of an inclusive model of care.

Conclusion

The result from this research creates a behavioural diagnosis for healthy eating practices, identifying that all three domains of COM.B can be levers for change. While this sample is small, it gives insight into the complex nature of food habits. The open-ended questions allowed detail to come up that enriches the narrative, revealing underlying reasons and motivations behind their eating behaviours. For many participants there was a reflective aspect to this work, prompting them to consider their food identity in ways they had not previously. Understanding what domains are most significantly linked to facilitating or hinder healthy food behaviours is a starting point for developing subsequent interventions and evaluation.

c. Researcher reflections

Key learnings:

This work successfully demonstrated the ability of oral histories to bridge heritage and health. Strong relationships with interviewees were important in this, often opening up conversations beyond the original scope of questions. This revealed a rich tapestry of the daily interactions and emotional complexities surrounding food.

Challenges:

Recruiting participants proved difficult, particularly within the constraints of a 9–5 working schedule and the one-to-one format. In response, some interviews evolved into more informal group conversations, which were not officially documented.

The process of conducting oral history can be emotional and intense, and it is key to practice selfcare as a researcher as you are absorbing other people's stories, and sometimes trauma. To manage this, the researcher only conducted one interview per day and found keeping a reflexive diary helpful for separating my own feelings and interviewee narratives. In any future project a formal mechanism of support should be considered, akin to supervision for psychologists.

Implications for future work:

Future research might benefit from focusing on a specific community or demographic group. While a broad approach here offered a wide diagnosis, focusing on particular diets or cultural practices could provide deeper understanding to the intricacies and conflicts of health management.

Chapter 6.

Conclusions

Chapter 6

Conclusions

Returning to the research question: 'How can oral histories contribute to improving health outcomes in Birmingham?' this work has explored the topic through a range of creative methods. The findings highlight the diverse and significant ways oral histories can be leveraged as a promotive health tool. Below are the key insights that emerged:

With the breakthrough of AI enabling affordable transcription and therefore making oral histories more accessible, museums and public health both need to treat oral histories as a collective and dynamic resource, moving away from isolated stories. The re-use of historic narratives by interpreting them through a contemporary strategic lens allows for new conceptualisations and ways of knowing. This new methodology developed allows a consideration of an entire data set for themes across the whole city to occur and can provide a powerful resource for a systems approach to behavioural diagnosis, not by examining the data in itself, but by using it as a prompt for contemporary conversations. The use of historic narratives in schemes such as BCIF indicates a use of the data as a learning and engagement tool for food literacy, facilitating conversations, and critical reflection on the representation of communities.

Underpinning the use of museum objects, such as oral histories, to enhance health literacy is the exploration of emotion as a pathway to learning within museum spaces (figure 2). Museums are inherently emotional spaces with a civic responsibility to promote learning, positioning them as meaningful environments to prioritise and advance health literacy. Given the limited existing literature on the use of museum objects as tools for public health advocacy, this work contributes to establishing a foundation for this more sustained interaction between heritage and health. Developing this pathway between emotion, engagement, learning and behaviour in heritage contexts could be the basis for future research.

One way to explore this pathway is by using oral histories as an affective tool to bring visitors closer to objects and subjects. The application in this work in a set of soundposts allows a mediated interaction between the object on display and the visitor, transforming the oral history interviewee into a contemporary tour guide. Listening to the oral history allows visitors to reflect on others' pasts, facilitating both a personal and interpersonal experience.

Moving along figure 2, oral histories offer a distinct pedagogical tool for adult English learners, a powerful way to support not only language development but also food literacy and a sense of belonging. Their real-life, relatable content makes oral histories especially valuable for individuals who are new to the country and may be curious about its history and the diverse experiences of migration over time. Similarly, arts-based research can offer unique, grounded insight into behaviours and provide unique opportunities for improving health literacy. This indicates an opportunity for adoption of arts-based methods into health settings, particularly for learning and literacy outcomes.

As a contemporary data collection method, oral histories offer an effective tool for community health enquiry, that focuses on the everyday experience of food. It is well suited for understanding the wider determinants of health, and with increasing focus on involving lived experience in health policy, it should be considered as a useful method in the public health toolkit.

Moving away from oral history specific interactions, museums and heritage can effectively investigate behavioural aspects of health by integrating behavioural frameworks such as COM.B into exhibitions, evaluation and programming. Applying this framework worked particularly well through the community mapping process. This approach could be applied to other spatialised aspects of health, such as mapping where chestfeeding is most difficult or where access to green space is limited. This could be extended further to understand areas of social capital, such as neighbourhood helpfulness, sense of local belonging and civic engagement. By embedding frameworks such as these, museums can generate insights that are scalable for public health discourse. More generally, other methods informed by social participation can be piloted in museum spaces to involve the general public in policy making.

Finally, there is still a need to be more ambitious with cross sectoral collaboration and learning, and for both the health and heritage sectors to be more open to adopting and adapting more diverse data and methods. To allow this, there needs to be a system adjustment to allow heritage to be porous to more rigorous methods, and public health to be open to research led by rich, often messy and complex, lived experience. Acceptance and experimentation with more creative methods, such as oral histories and art-based research can be an asset to health discourse and be easily implemented in cultural institutions.

a. Implications

For the local authority health department, this work shows that when treated as an entire dataset, oral histories can be used to uncover city-wide patterns and themes, allowing a systems approach, moving beyond individual factors to understand structural and cultural factors. Next, it demonstrates that engaging with objects can encourage critical reflection and support healthy behaviours, key for health promotion. Innovative strategies such as these developed improve health literacy and provide a rich experience of food behaviours in Birmingham. Given their association with learning, museums offer distinctly unique opportunities to consider health literacy across many different health behaviours. Finally, this work highlights the need for more politicised language around food in Birmingham, advocating for the use of 'food apartheid' as a framework to understand inequality in the city.

For the heritage industry, this work reframes museums as distinct spaces for dialogue and learning about health, and also as a space where citizens can actively participate in society. It is important to reimagine museums spaces as community driven hubs that are dedicated to inquiry and dialogue, responding to local need. Using frameworks such as COM.B gives museums a structured way to contribute visitor experience to policy conversations, strengthening their relevance and credibility to health authorities and funding bodies. Oral histories have also shown to be powerful tools for learning, enabling museums to better serve migrant communities.

For the wider creative health sector, this work offers proof of concept for narrative-based health tools, using creative interpretations of heritage as a way of capturing contemporary lived experience, reinforcing the role of storytelling in health promotion. By bringing together public health, behavioural science, heritage and community engagement, it models a matrix, transdisciplinary way of working that is essential to the future of creative health.

b. Future research

Looking forward, further research is needed to explore the pathway between emotion, engagement learning and behaviour in museum settings, as a mechanism for understanding how museums can promote health. These insights may also benefit museums beyond health-focused initiatives, offering strategies to enhance long-term visitor retention. Additional work could examine the integration of audio and objects, investigating how objects can be effectively integrated with oral histories to facilitate both individual and collective connections to history. This layering approach encourages self reflection and may improve visitor engagement and satisfaction. Finally, more work could be done on cross pollination of frameworks, methods and data between the sectors. Building on this report's application of COM.B into a gallery space, other frameworks and strategies can be embedded in a similar way to generate scalable insights.

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Appendices

Appendices

Appendix A:
Crib Sheet for Importing Transcripts

Appendix B:
Coded Transcripts File

Appendix C:
ESOL Evaluation Survey

Appendix D:
ESOL Food Literacy Survey Results

Appendix E:
Eatwell Guide Resource Pack

Appendix F:
Interview Guide

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