WORKSHOP

How can National Public Health Institutes advance equity approaches to well-being to influence population health outcomes?

IANPHI Committee on Social and Public Health Inequalities

June 11–13, 2025, Saint-Maurice, France

Workshop report

INTRODUCTION

The workshop of the IANPHI Social and Public Health Inequalities Thematic Committee was held from June 11 to 13, 2025, at Santé Publique France in Saint-Maurice, France. It brought together representatives from 22 institutes and partner organizations, from all IANPHI regions, to explore the question: **How can National Public Health Institutes advance equity approaches to well-being to influence population health outcomes?**

This initiative is part of a broader project funded by the Public Health Agency of Canada's International Health Grant Program, which aims to promote well-structured exchanges on the role and experience of national public health institutes (NPHIs) in moving from observing and documenting inequalities to designing and implementing actions aimed at reducing those inequalities in health and well-being.

The meeting was opened by *Anne-Catherine Viso*, Director of Scientific and International Affairs at Santé Publique France, who presented the institute's overall mission and the importance for it to have a cross-cutting program which related to health inequities. Following the opening remarks, the workshop continued with a detailed overview from *Prof. Felix Rosenberg*, from FIOCRUZ, Chair of the IANPHI Thematic Committee on Social Inequalities and Public Health. He connected the individual sessions of the workshops with an overall framework of action. Prof. Rosenberg outlined how each session was strategically designed to address key approaches to advance health equity and ensuring that all discussions are aligned with the committee's overarching objectives. Finally, he focused on the project and the context of the Committee's activities, pointing out that this in-person meeting was a unique opportunity to turn years of conceptual discussions into concrete actions, and that their collective work would lay the foundations for a sustainable and funded work plan to effectively combat health inequalities.

SESSION 1 - THE ROLE OF NPHIS IN FOSTERING PRIMARY HEALTH CARE AND DEVELOPING COMMUNITY WORKERS CAPACITY

Chair: Prof. Felix Rosenberg, Director of Forum Itaboraí, Oswaldo Cruz Foundation (FIOCRUZ), Chair of the IANPHI Social and Public Health Inequalities Thematic Committee

The first session opened with *Prof. Rosenberg* presenting results of the "*Multicentric Territorial Diagnosis of Social Inequalities and Health Inequities through the Application of Social Technology*" project implemented in 2024 in Argentina, Mexico, Colombia, El Salvador and Paraguay. The project focused on promoting health equity through a territorial lens, integrating national and local public health systems. Prof. Rosenberg explained that this approach is underpinned by a conceptual model in

which territory is not just another epidemiological variable, but the structural basis where its communities or inhabitants interact, revealing significant social inequalities as determinants of health inequities, based on geography and social class. He advocated for territory-based public health interventions and highlighted the role of national public health institutes in developing localized policy responses.

Following his presentation, *Dr. Laura Recoder* from the Argentina's NPHI at the National Center for Endemic Diagnosis and Research – CENDIE/ANLIS, shared a case study, from the multicentric project, at the locality of Dock Sud, an environmentally vulnerable area near Buenos Aires. Their Participatory Rapid Diagnosis (PRD) process involved multiple stakeholders, including government, academia, and community groups, through interviews, mapping exercises, and workshops, and produced tangible outputs such as government reports, analog and digital maps, training sessions, and community screenings. These efforts not only generated new local health data but also strengthened community engagement and influenced municipal health policies.

The discussion then turned to more general reflections by participants on the use of PRD and participatory mapping, emphasizing the effectiveness of these tools in highlighting local health issues often overlooked by conventional surveys, and in promoting local ownership and engagement. PRDs were presented as a low-cost alternative to national surveys, providing real-time feedback to communities and ensuring the transparency and legitimacy of health data through community validation, making PRDs not only a methodological innovation but also a strategic approach to equity.

Participants identified local-level strategies for addressing health inequities:

1. Rethink how public health success is measured, moving beyond biomedical indicators toward new metrics that reflect well-being, equity, and systemic transformation, and advocate for the integration of social science expertise into public health institutions, as the dominance of clinical models often limits the scope of action. These approaches require methodological changes and institutional shifts, including educational reforms, long-term capacity building, and shared authorship with communities involved in research and planning.
2. Close the gap between centralized systems and local realities. NPHIs must support local actors through training and resources, while also acting as conveners that align community needs with national strategies. This territorial lens is key to understanding how structural inequalities manifest differently across places, and how localized responses can be more effective when co-created with those most affected.
3. Address challenges around inclusion and trust, particularly in settings where participatory practices are new or where power imbalances between institutions and communities remain strong. Intersectoral collaboration is a success factor.

Participants all reported success using participatory tools such as health mapping and community diagnostics to generate relevant data and mobilize joint responses. However, there was also acknowledgment that without structural support, such as funding, institutional mandates, and political will, these practices risk becoming isolated projects without long-term impact. Participants called for participatory diagnosis to be recognized as a tool for community empowerment and policy transformation, and for stronger institutional commitment with social and environmental justice and long-term investment.

SESSION 2 – FOOD AND NUTRITION SECURITY: HOW TO INTEGRATE NATIONAL PUBLIC HEALTH INSTITUTES TO INTERSECTORAL FOOD AND NUTRITION SECURITY POLICIES?

Chair: Dr. Ivalda Macicame, National Director for Surveys and Health Observation, National Institute of Health of Mozambique

Dr. Macicame gave a presentation on the critical role of NPHIs in addressing food and nutrition security, highlighting global disparities in undernourishment and food insecurity, especially in Africa and in low- and middle-income countries, where the burden is highest and exacerbated by armed conflicts, climate change, and economic challenges. She then presented the collaborative model of the NPHI network for Portuguese-speaking countries, which aims to integrate NPHIs into national food and nutrition councils, share best practices, and overcome challenges such as weak surveillance systems and fragmented data. She concluded by proposing strategies for NPHIs to strengthen food and nutrition security through data analysis, policy guidance, intersectoral coordination, capacity building, and advocacy for equity.

Following this presentation, participants proposed concrete recommendations that could be implemented to integrate NPHIs into intersectoral food and nutrition security policies:

1. Expand NPHIs' role in nutrition, beyond obesity prevention and control, and individual behaviors in order to address hunger and food insecurity as public health priorities. NPHIs must actively engage in national commissions and intersectoral bodies to break down silos and promote collaboration between the food, health, and environment sectors.
2. Share and promote best practices: Leverage proven models, such as Nutri-Score in France, free school meals in England, and community-based approaches in Quebec, to guide policy and encourage international collaboration. Focus on adapting existing resources rather than creating new solutions.
3. Coordinate multi-level action: At the local level, use participatory methods to create culturally appropriate dietary recommendations, influence food offer by limiting licensing of food outlets selling unhealthy foods, and support community food production and nutrition programs. At the regional and national levels, address structural issues such as poverty and inequality, while advocating for evidence-based regulations to gain political support.
4. Strengthen monitoring and research: Regularly evaluate nutrition interventions using indicators such as undernutrition, food insecurity, and socioeconomic disparities. Develop research on the impact of climate change on food systems and nutritional quality to inform policy.
5. Address both undernutrition and obesity by adapting strategies to local realities, striking a balance between improving the food environment and interventions aimed at changing individual behaviors, and recognizing the dual burden of undernutrition and obesity.
6. Address commercial determinants of health: NPHI must strengthen their capacity to counter the influence of the food industry on public health and use international tools to protect health interests. Build public trust by ensuring that health comes before corporate profits and critically evaluating public-private partnerships.
7. Shift from behavioral to structural approaches: Coordinate structural and behavioral interventions across all sectors, regardless of funding structures. Policy recommendations must be flexible in order to effectively address all aspects of the food environment.
8. Build capacity and skills: Invest in nutrition training across all sectors, such as public health, education, and family agriculture. Intergenerational programs can preserve food knowledge and culinary skills, promoting sustainable eating habits.

9. **Frame food production as a health issue**: Public health planning must address agricultural practices, particularly agrochemicals and pesticides. Support agroecological approaches for a healthier population and planet.
10. **Integrate climate and sustainability**: Policies and research should link climate change and nutrition, promoting collaboration between the North and South. This area offers opportunities for joint action and mutual learning.
11. **Improve communication strategies**: Adapt messages so that they resonate with diverse groups and promote traditional food practices as cultural and nutritional heritage. Effective communication creates momentum and a sense of collective ownership in favor of healthier food systems.

SESSION 3 - THE ROLE OF NPHIS IN WORKFORCE CAPACITY BUILDING TO FACE SOCIAL, ECONOMIC AND ENVIRONMENTAL INEQUALITIES AS DETERMINANTS OF HEALTH INEQUITIES

Chair: Dr. Bernardo Hernandez Prado, Dean of the Public Health School, National Institute of Health of Mexico

In his introductory presentation, *Dr. Hernandez Prado* stated that the availability of an adequate public health workforce (qualitative and quantitative) is probably one of the most striking inequalities between countries and regions worldwide. There is expected to be a shortage of 11 million health professionals by 2030, mainly in low- and lower-middle-income countries, contributing factors being chronic underinvestment in the education and training of health professionals and the mismatch between education, health systems and the needs of the population. Although there has been work defining competencies for the workforce in public health, there is need for a more specific definition of required competencies to face inequalities as determinants of health disparities.

According to *Dr. Hernandez Prado*, prospective estimates of supply and demand for health resources, interprofessional training focused on social responsibility, including community work, education, and research, and the use of new educational models are key aspects of capacity building to address health issues.

The session then shifted to participants describing their experiences and challenges in the needs and training of the workforce. A call was made to try to focus on workforce capacity building to face social, economic and environmental inequalities as determinants of health inequities, and the role that NIPHs should play. Based on this, some proposals for action were advanced to recenter the focus on equity:

1. **Reframing the definition of the public health workforce:** Emphasize interdisciplinary and multisectoral approaches (e.g., inclusion of professionals from social services, education, urban planning), highlight the need for diverse representation, lived experience, and anti-racist/cultural competencies, explicitly linked to the ability to address root causes of inequities, and reference to primary health care as an equity mechanism, drawing attention to first-level access and social gradient. This reframing helps ensure that capacity building is not just about technical skills but about equipping a workforce that understands and can act on inequities.
2. **Defining competencies that directly target inequities:** Include political analysis, health systems organization and coverage, strategic communication, and community engagement as essential equity-related skills, and call for alignment between training and real-world public health system needs, considering the context of social determinants of health in specific places. These additions shift the focus from generic public health training to capacity that directly supports action on social, economic, and environmental inequalities.
3. **Strengthening the role of NPHIs in equity-oriented training:** Although there is a substantial heterogeneity in the mandates and activities of different NPHIs, it is necessary to acknowledge that NPHIs may not formally oversee training but can influence, support, and assure quality, with a clear equity lens, and consider secondments, mentorship, and peer learning as flexible

tools for applied equity learning. This reaffirms a broader responsibility of NPHIs in fostering workforce development for equity, not only through direct training mandates but also by role modeling best practices and offering training and continuous professional development opportunities for their staff, even trainings for external organizations.

4. NPHIs as structural enablers for equity: NIPHs are in a good position to call for long-term, multidisciplinary investment in training that addresses root causes of inequities, support the institutionalization of Schools of Public Health with a clear focus on equity and sustainability. These structural approaches will help ensure that equity is not an add-on but embedded in how the system supports the workforce.
5. Forward Directions with an Equity Lens: In order to reduce health inequalities, it is necessary to emphasize training as a lever for long-term change: today's trainees as tomorrow's equity leaders, highlight the need to embed SDH into core curricula and promote cross-sector communities of practice, especially involving marginalized professionals, and include foundational competencies like epistemic humility, listening, and political literacy, skills critical for equity work. These reinforce the idea that public health transformation toward equity requires a deeper shift in mindset, skills, and structures.

SESSION 4 - BUILDING TRUST, BRIDGING DIVIDES: SUPPORTING NPHIS IN EQUITABLE AND EFFECTIVE PUBLIC HEALTH COMMUNICATION

Co-Chairs: Jalpa Shah (Santé Publique France), Giri Shankar (Public Health Wales)

Giri Shankar opened the session by emphasizing the importance of equitable public health communication, particularly in the context of growing misinformation and social division. He explained that NPHIs must serve as trusted sources of accurate, timely information, especially during crises. Equitable communication should be accessible to all segments of the population, inclusive of marginalized groups, and tailored to empower communities to take meaningful action. He stressed that health communication must not only inform but also promote health literacy, build trust, and ensure that no one is left behind.

Jalpa Shah then presented a case study from France, developed with *Stéphanie Vandentorren*, on co-producing COVID-19 communications for marginalized populations, particularly people experiencing homelessness. The initiative, which ran from 2021 to 2023, produced 22 newsletters and became a trusted source of information, widely disseminated via email, WhatsApp, printed materials, and social media. It also influenced policy discussions, highlighting structural barriers like address requirements in vaccination systems. She concluded by stressing the value of co-production in bridging the gap between the health and social sectors, while noting challenges in evaluating communication impact, given the increasingly widespread dissemination of information online through private channels (i.e. WhatsApp), and combating misinformation.

The following key messages then emerged from the ensuing discussion with participants:

1. NPHIs must lead the way by developing evidence-based messages, creating communication tools and platforms, and coordinating strategic responses to misinformation, promoting collaborative networks that foster the dissemination of reliable health information and ensuring the effective use of resources. Fake news must be rapidly confronted with evidence-based facts. NPHIs) have a responsibility to actively ensure that their communications do not perpetuate or exacerbate existing health inequalities. One effective approach is to develop communications that address and challenge structural discrimination and power imbalances,

ensuring that marginalized communities have agency—for example, through co-production, community-engagement, community-based approaches and so forth.

2. Importance of co-production: Effective public health communication requires genuine collaboration with communities, built on trust. These relationships, cultivated during non-crisis periods and maintained over time, enable rapid mobilization during crises, and support community resilience. Breaking down bureaucratic barriers and building bottom-up networks also helps ensure that communication is relevant, especially for marginalized groups who may not prioritize specific health concerns given the prioritization of urgent, basic needs that dominate their daily lives.
3. Ensuring community engagement: Listening to communities and acknowledging uncertainties is just as important as sharing evidence-based information. Establishing effective pathways to developing shared understanding is also key, as is recognizing and addressing power dynamics between institutions and communities. Each of these elements help build trust and ensure that messages are received and understood as intended. Morever, caution must be taken to ensure that messages do not increase stigmatization of already marginalized groups.
4. Benefits of community-based approaches: Bottom-up strategies involving local leaders and trusted intermediaries have proven more effective than centralized communication alone. Aligning communication with community values and cultural nuances is essential.
5. Contextual sensitivity: Public health messages must go beyond technical accuracy to address structural barriers such as language barriers, stigma, discrimination, and marginalization. Addressing these barriers directly is essential to improve health equity and ensure that messages reach and resonate with all segments of the population.
6. Rapid and reliable communication, particularly during public health emergencies: Speed should not come at the expense of trust, messages must be carefully timed and adapted to the local culture to avoid coming across as condescending or overly prescriptive. To combat misinformation and disinformation, communicators should anticipate the types of misinformation that are likely to emerge and plan accordingly.
7. Tensions between local and central authorities: Inconsistent messaging can undermine trust and effectiveness. The fragmentation of health information not only causes confusion among health professionals and field workers, but also erodes the trust of marginalized populations, particularly those with limited health literacy.
8. Training and capacity building: Training public health professionals in communication techniques, and integrating communication experts, including students and social scientists into teams is essential. Similarly, communicators need to be trained in public health principles and equity frameworks to ensure that messages serve the entire population. National public health institutions are encouraged to adopt more proactive digital strategies to reach diverse audiences.
9. Putting equity at the heart of messaging: Health literacy levels, cultural beliefs and linguistic diversity must all be considered when designing and disseminating public health communications.

SESSION 5 - THE ROLE OF NPHIS IN PROMOTING THE SYSTEMATIC INCLUSION OF GEOGRAPHICAL AND INEQUALITY INDICATORS.

Co-Chairs: Andrew Hayward (UKHSA), Stéphanie Vandentorren (Santé Publique France)

The session focused on how health inequality indicators can be made more meaningful and actionable, especially for local actors and marginalized populations.

Andrew Hayward emphasized the importance of using health equity data for actionable decision-making, not just reporting. In the UK, despite a wealth of data and interactive tools like Fingertips and Health Inequalities Dashboard, there is still a gap in translating data into impact. He stressed the need for simple, targeted data, better data visualization, and inclusion of socially excluded groups (e.g., homeless, migrants) who are often invisible in routine datasets.

Stéphanie Vandentorren shared a French perspective where social data is scarce, limiting response capacity during crises like COVID-19. France is now systematically integrating key social determinants (e.g., housing, employment, origin) into national surveys. She highlighted the shift from using composite deprivation indices to more specific structural indicators to better inform policy and intervention. Case studies on heatwaves and tuberculosis showed how focusing on housing conditions (overcrowding, poor ventilation) rather than broad indices better guided targeted, effective public health measures. She stressed the need for training, methodological clarity, and collaborative communities to turn social data into systemic change.

A few key recommendations were then formulated during discussions with participants:

1. Moving beyond merely describing inequalities toward using indicators to challenge them, addressing the question of whether the priority should be generating more indicators or translating existing data into real-world action. Concerns were expressed about repeated data collection efforts that fail to influence policy or service delivery, but it was also recognized that robust and transparent indicators are vital tools for accountability, planning, and community engagement, particularly when designed with clear purposes and target populations in mind.
2. Value of granular, small-area data for revealing local inequalities and supporting targeted interventions, while also acknowledging ethical and practical challenges related to confidentiality when dealing with highly disaggregated data. Reframing spatial data by focusing less on disease-specific mapping and more on analyzing structural and environmental fragilities that underlie health disparities, to support proactive public health strategies addressing root causes rather than symptoms.
3. Importance of co-producing indicators with communities affected by inequalities. Using qualitative research with local health workers to redesign dashboards that better support decision-making. Need for diverse data collection approaches, and involvement of communities from planning through to interpretation.
4. Improving data literacy, especially at the local level, to ensure indicators are understood and used effectively, as inequality metrics tend to be more complex than traditional health data.
5. Looking beyond conventional data sources, for example, poison center databases, wastewater analysis, and community asset inventories, which can offer timely, context-specific insights often overlooked in routine surveillance. The ethical and political dimensions of data production are a major concern, particularly the phenomenon of "statistical genocide," where marginalized groups are rendered invisible by their absence in official statistics or their dilution in average indexes, which impacts their rights and access to resources. This shows the role of data in making invisible problems visible and amplifying excluded voices.
6. Integrate ethical safeguards throughout the indicator of development and reporting processes to avoid undesired outcomes, paying attention to the misuse of data, which is never neutral and can be used as a weapon to stigmatize or justify harmful policies.

Overall, participants called for a paradigm shift toward co-produced, context-sensitive indicators that reflect lived realities and serve as tools not only for measurement but for advocacy, collaboration, and meaningful change.

SESSION 6 - HOW TO BUILD CAPACITY AND RECOGNITION ON THE ROLE OF NPHIS IN INTERSECTORAL EFFORTS AND PROJECTS TO FACE HEALTH AND WELLBEING INEQUALITIES

Co-Chairs: Beth Jackson (Public Health Agency of Canada), Marianne Jacques (National Collaborating Centre for Healthy Public Policy, Institut national de santé publique du Québec)

During this rich and multifaceted discussion, *Marianne Jacques* and *Beth Jackson* explored the role of NPHIs in promoting intersectoral action to address health inequalities and act on the social, economic, environmental and structural determinants of health, based on the WHO's four pillars, governance, leadership, working methods and resources, as a framework for strengthening the NPHIs' capacity to act in an intersectoral manner.

Beth Jackson explained that well-being frameworks, such as Canada's Quality of Life Framework, open new doors for intersectoral collaboration by providing a common language and objectives that transcend traditional health silos. She also emphasized the importance of putting these principles into practice by integrating equity, engagement and evidence into core public health functions, and positioning the Public Health Agency of Canada not only as advisor but also as catalyst for systems-level change in policy environments focused on population well-being.

Marianne Jacques then introduced the Canadian Network for Health in All Policies, created to foster cross-sector collaboration and peer learning among public health professionals across Canada. Although many people are working towards similar goals, their efforts often remain siloed. By facilitating knowledge sharing, this network aims to support governance structures that promote holistic and collaborative approaches to health and well-being.

Discussions with participants concluded that progress depends on institutional models that place equity and collaboration at the heart of fundamental public health functions. In this context, there is a need for robust support for professional networks that can navigate the impasses and conflicts that arise when public health responsibilities and priorities diverge across agencies at a national, regional, and local level. These networks are essential for fostering alignment and addressing the tensions that can impede progress. This also ties into the group's critical reflections on leadership, autonomy, and concepts such as "resilience" and "Health in All Policies", emphasizing that these terms must be used with caution to avoid reinforcing structural limitations. The discussion also revealed the tension between the autonomy of NPHIs and their dependence on government funding or mandates, highlighting the need for a clearer and more supportive framework that balances independence and effectiveness in public health leadership.

The following key points also emerged from the discussions:

- Importance of realistic target-setting to reduce health inequalities and the need for robust data infrastructure to guide policy.
- Role of informal and formal leadership, cultural shifts within institutions, and the potential of diagnostic tools to enhance collaboration.
- Need for stronger advocacy within public health institutions and accountability focused on long-term, process-oriented collaboration.
- The lack of comprehensive national health inequality strategies is a significant gap.

Some strategies suggested included:

- Strengthening local intersectoral actions.
- Involving representatives from other sectors in governance.
- Maintaining institutional independence with resilient leadership capable of navigating political changes.
- Advocating for modern public health legislation.

The session concluded with reflections on the importance of building intersectoral traction within institutes through committees engaging both internal and external stakeholders.

PLENARY DISCUSSION – CONCLUSIONS AND NEXT STEPS FOR THE IANPHI THEMATIC COMMITTEE ON SOCIAL INEQUALITIES AND PUBLIC HEALTH

Chair: Felix Rosenberg (FIOCRUZ), Chair of the IANPHI Social and Public Health Inequalities Thematic Committee

General conclusions and recommendations regarding health inequities as a central issue in NPHIs

The discussions allowed the participants to identify different mechanisms by which NPHIs can contribute to reduce heath inequalities, including those listed below:

- Place health inequities as a central institutional issue and avoid isolation of equity work within institutes: Health inequities are often isolated in specialized units and not mainstreamed within NPHIs, risking marginalization and limited impact. Advocate for integrating health inequities across all institute programs rather than isolating them. Share knowledge widely and support those working on inequities to avoid isolation.
- Focus on action and intersectoral collaboration: Many NPHIs perform studies on the impact of different types of social and economic inequalities on health inequities. Practical activities are needed to effectively act to reduce such inequities. NPHIs should also get involved in cross-sector collaboration, including education, agriculture, environmental development, housing, among others.
- Assess current institutional positions; Institutes vary widely in their mandate, capacity and maturity regarding health equity. Tailoring goals and timelines acknowledges these differences, ensuring realistic expectations and fostering incremental progress without discouraging less advanced institutes.
- Leverage existing resources and best practices, including work on inequities in other institutional programs within the NPHIs.
- **Set realistic goals,** National Institutes vary greatly; interventions must be adaptable and goals realistic to ensure effective progress.
- **Make health equity impact assessments mandatory** for institutional activities (e.g. health promotion activities, capacity building, training or research), to promote accountability and measurable change.
- **Present equity analysis is essential to scientific validity** to strengthen its acceptance among researchers. This positions equity not only as a moral imperative, but also as an essential factor in achieving credible and effective public health outcomes.
- **Involve communities in their priorities to ensure more relevant, accepted, and effective interventions**. Ignoring local concerns creates a risk of ineffective solutions and wasted resources. The applications of Social Technology instruments are necessary to listen and work towards community-based concerns and priorities.

- Frontline health workers are essential to effectively implement equity initiatives. The involvement of Primary Health Care workers at local level studies and practices recovers the original feelings of the Alma Ata Declaration on Primary Health Care and Health Promotion enabling deep community engagement in rapid territorial diagnosis and feasible solutions to reduce health inequities.

Concrete actions for the committee

- **Strengthen the committee as a supportive community**, encouraging regular interaction, momentum and collective action, to expand the committee's influence and knowledge sharing.
- **Hold quarterly virtual meetings** to maintain engagement, share regular updates, and produce guidance for policymakers and the public.
- **Develop a concrete plan of action** for the Committee's activities and on how to integrate health inequities into existing institutional structures and projects.
- **Organize smaller, regional or contextually similar support groups** to address diverse country-specific contexts effectively and foster mutual support.
- **Draft a short position paper to engage Directors** of Institutes, timed for when the committee's goals mature, for greater impact.
- **Ensure equity is integrated across all IANPHI Thematic Committees** work plans, organize joint meetings to align strategies
- **Ensure equity is embedded in all projects, as well as key institutional frameworks** and tools, like the IANPHI Framework for the Creation and Development of National Public Health Institutes.
- **Establish a Community of Practice**, develop a platform to share best practices, benchmarks, and tools for integrating health equity.
- **Map and leverage existing resources,** asking each institute to report on how equity is structured and organized to inform collective improvement via a committee-led questionnaire

ANNEX I: PARTICIPANTS

Country	Name	Institute / Organization	Position
Argentina	Laura Recoder	National Center for Diagnosis and Research in Endemic Epidemics (CENDIE) - ANLIS-Malbran	Researcher
ASPHER	Alison Mc Callum	Association of Schools of Public Health in (WHO) European Region (ASPHER)	Visiting (Hon) Professor of Public Health, Centre for Population Health Sciences, Usher Institute, University of Edinburgh.
Austria	Marion Weigl	Austrian National Public Health Institute (GÖG)	Head of Department Health, Society and Equity
Belgium	Aline Scohy	Sciensano	Researcher and project manager
Brazil	Felix Rosenberg	Oswaldo Cruz Foundation (FIOCRUZ)	Director Forum Itaboraí
Burkina Faso	Seydou Barro	Institut National de santé publique du Burkina Faso	Director of the institute
Cambodia	Vannarah Te	National Institute of Public Health	PhD program coordinator
Canada	Beth Jackson	Public Health Agency of Canada	Manager and Senior Scientific Advisor in the Health Equity Policy Division
France	Anne-Catherine Viso	Santé Publique France	Director of the Scientific and International Division
France	Jalpa Shah	Santé Publique France	Research officer for the Social and Territorial Inequalities in Health programme
France	Stéphanie Vandentorren	Santé Publique France	Coordinator of monitoring, surveillance, prevention and intervention activities
Germany	Digo Chakraverty	Bundesinstitut für öffentliche Gesundheit (BIÖG)	Scientific Officer
Germany	Julia Waldhauer	Robert Koch Institute	Researcher in the Social Determinants of Health Department
IANPHI	Ines Ferrer y Fernandez	IANPHI	Project Coordinator
IANPHI	Marie Le Roy	IANPHI	Programme Manager
IANPHI	Sarah Fernandes	IANPHI	Events and Project Officer
IANPHI	Yi Shang	IANPHI	Project and Programme Assistant
Ireland	Roger O'Sullivan	Institute of Public Health in Ireland	Director of Ageing Research
Italy	Ornella Punzo	Istituto Superiore di Sanitá	Senior Researcher
Jordan	Ala'a B. Al-Tammemi	Jordan Center for Disease Control	Director of Research, Health Policy, and Training Directorate
Kenya	Sophia Michael	Kenya National Public Health Institute (KNPHI)	Community health and social intelligence

Mexico	Bernardo Hernández Prado	National Institute of Public Health of Mexico	Dean of the Public Health School of Mexico
Mozambique	Ivalda Macicame	National Institute of Health	National Director for Surveys and Health Observation
Quebec	Marianne Jacques	National Collaborating Centre for Healthy Public Policy and Institut national de santé publique du Québec	Scientific lead for the National Collaborating Center for Healthy Public Policy (NCCHPP)
Quebec	Olivier Bellefleur	Institut national de santé publique du Québec	Head of the Psychoactive Products and Substances Scientific Unit
Serbia	Milena Vasic	Institute of Public Health of Serbia Dr Milan Jovanovic Batut	Head of Department for Scientific Research and Projects Coordination
United Kingdom England	Andrew Hayward	UK Health Security Agency (UKHSA)	
United Kingdom England	Noor Saeed	UK Health Security Agency (UKHSA)	Head of Health Equity Intelligence
United Kingdom Scotland	Rishma Maini	Public Health Scotland	Consultant in Public Health Medicine
United Kingdom Wales	Giri Shankar	Public Health Wales	Director of Health Protection

ANNEX II: AGENDA

Day 1 – Wednesday, June 11th		
8:30am – 9:00	Welcoming and registration	
9:00am – 12:00pm (30-minute coffee break at 10:45am)	<u>Session 1</u> The Role of NPHIs in fostering Primary Health Care and developing community workers capacity. Presentation on 'Implementing Social Technology tools to identify fragile / vulnerable populations and build Community engaged proposals (Project in 5 Latin American countries)'	**Chair: Felix Rosenberg** (Fiocruz)
12:00pm – 1:00pm	*LUNCH BREAK*	
1pm – 2:45pm	<u>Session 2</u> Food and nutrition security: How to integrate NPHIs to intersectoral food and nutrition security policies? (The RINSP/CPLP model).	**Chair : Ivalda Macicame** (National Institute of Health Mozambique)
2:45pm – 3:15pm	*COFFEE BREAK*	
3:15pm – 5:00pm	<u>Session 3</u> The role of NPHIs in workforce capacity building to face social, economic and environmental inequalities as determinants of health inequities	**Chair : Bernardo Hernandez Prado** (Instituto Nacional de Salud Publica Mexico)
Day 2 – Thursday, June 12th		
8:00am - 9:45am	<u>Session 4</u> Building trust, bridging divides: supporting NPHIs in equitable and effective public health communication	**Co-Chairs : Jalpa Shah** (Santé Publique France), **Giri Shankar** (Public Health Wales)
9:45am – 10:15am	*COFFEE BREAK*	
10:15am – 12:00pm	<u>Session 5</u> The role of NPHIs in promoting the systematic inclusion of geographical and inequality indicators.	**Co-Chairs : Andrew Hayward** (UKHSA), **Stéphanie Vandentorren** (Santé Publique France)
12:00pm – 1:00pm	*LUNCH BREAK*	
1:00pm – 4:00pm	<u>Session 6</u>	**Co-Chairs : Beth Jackson** (Public Health Agency of Canada),

With a coffee break from 2:45 to 3:15pm	How to build capacity and recognition on the role of NPHIs in intersectoral efforts and projects to face health and wellbeing inequalities	**Marianne Jacques** (National Collaborating Centre for Healthy Public Policy and Institut national de santé publique du Québec)
Day 3 – Friday, June 13th		
9:00am – 12:30pm (30-minute coffee break at 10:45am)	**<u>Plenary discussion:</u>** • Draft recommendations • Committee's Plan of Action to edit the Recommendations and to support and promote its implementation by IANPHI member Institutes • Alternatives for publishing the results of the workshop	**Chair : Felix Rosenberg** (FIOCRUZ)
12:30pm	***LUNCH***	