ESF-2023-HOMELESS

Deliverable

D5.2 Action Plan

EN version

SOLACE-CEE

Solutions for Overcoming Homelessness through Integrated Care in the CEE region

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Table of contents

Abbreviations, acronyms and descriptions

Abbreviation - acronym used in document	Description
SOLACE-CEE /Project	Solutions for Overcoming Homelessness through Integrated Care in the CEE region
GA	Grant Agreement
Coordinator (CO, COO) = Lead Partner (LP)	DEDO Foundation – Slovakia
Partner/-s Beneficiary/-ies (BEN)	VPR – Slovakia HCSOM/MALTAI – Hungary HESED – Bulgaria NMP – Poland Casa Ioana – Romania MRI – Hungary
Granting Authority (GA/EC)	European Commission
Coordinator	DEDO Foundation
WP/WG	Work Package(s)/Work Group(s)
Lead Beneficiary of WP	Lead partner responsible for individual WP from List of Deliverables from Grant Agreement
EC Portal, F and T Portal	Portal of European Commission where all documents and results will be sent and stored
PRD	Progress Report Document
PP	Project Partner
LP	Lead Partner
DEDO	Nadácia DEDO – DEDO Foundation
VPR	Všetci pre rodinu, n.o. – All for the Family NGO
MRI	Városkutatás - Metropolitan Research Institute
HCSOM/MALTAI	Magyar Máltai Szeretetszolgálat Egyesület (HCSOM/MALTAI) Hungarian Charity Service Of The Order Of Malta
CI	Asociatia Casa Ioana
HESED	Health And Social Development Foundation
NMP	Fundacja Najpierw Mieszkanie Polska Housing First Poland Foundation
IHaSC	Integrated Health and Social Care
TM & RM	Tele-medicine and Remote monitoring
TIC	Trauma Informed Care
ACE	Adverse Childhood Experiences
HFV	Housing First Values
NMP	Housing First Poland Foundation

PEH	People experiencing homelessness
DG EMPL	European Commission's Directorate - General for Employment, Social Affairs and Inclusion - formerly known as the DG for Employment, Social Affairs and Equal Opportunities
DD/MM/YYYY	Date/Month/Year format
DD-DD/MM/YYYY	Dates/Month/Year format
MM/YYYY	Month/Year format
PUB	Platform for Ending Homelessness

Short data sheet of the project

- **Project Name:** Solutions for Overcoming Homelessness through Integrated Care in the CEE Region
- **Project Acronym:** SOLACE-CEE
- **Project Number:** 101172625
- **Project Duration:** 36 months (01/10/2024 – 30/9/2027)
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- **Granting Authority:** European Social Fund Plus (ESF+)
- **Geographical involvement:** Poland, Slovakia, Hungary, Romania, Bulgaria
- **Coordinator:**
  - DEDO FOUNDATION (DEDO), Slovakia
- **Project Partners:**
  - Všetci pre rodinu, n.o. (VPR), Slovakia
  - MAGYAR MÁLTAI SZERETETSZOLGÁLAT EGYESÜLET (MALTAI), Hungary
  - HEALTH AND SOCIAL DEVELOPMENT FOUNDATION (HESED), Bulgaria
  - HOUSING FIRST POLAND FOUNDATION (NMP), Poland
  - Asociatia Casa Ioana (CI), Romania
  - VÁROSKUTATÁS (Metropolitan Research Institute) (MRI), Hungary

Introduction

The SOLACE-CEE Action plan serves as a strategic and operational framework supporting the implementation, communication, advocacy, dissemination, sustainability, and replication of Integrated Health and Social Care (IHSC) approaches for people experiencing homelessness in Central and Eastern Europe (CEE).

The document is based on the objectives and activities of the SOLACE-CEE project and builds on key project deliverables, including the Communication Manual, Needs Assessment findings, pilot HUB implementation experiences, and the overall Integrated Health and Social Care framework developed within the project. The Action Plan also reflects the principles of Housing First, Trauma-Informed Care (TIC), and Telemedicine, while taking into account the European and national policy context related to homelessness, healthcare accessibility, social inclusion, and integrated service provision.

The Action plan follows the overall two-tier approach of the SOLACE-CEE project, combining European/international and local/national levels. Particular emphasis is placed on cross-sector cooperation, accessibility of services, stakeholder engagement, and inclusion of the perspectives and experiences of people experiencing homelessness.

STRATEGIC ROLE OF COMMUNICATION IN SYSTEMIC CHANGE

This document is designed as a practical implementation and systems-change framework. It links communication, advocacy, dissemination, stakeholder engagement, policy influence, and sustainability activities with the broader goal of strengthening integrated and person-centred care systems for vulnerable groups.

The Action plan is intended to serve not only as an internal project coordination tool, but also as a transferable framework and source of practical recommendations for organisations, municipalities, policymakers, service providers, researchers, and other stakeholders interested in implementing integrated care approaches for people experiencing homelessness.

1. Strategic framework and context

The SOLACE-CEE project is based on the understanding that homelessness is a complex and multidimensional issue closely connected to health inequalities, social exclusion, housing instability, poverty, and limited access to essential services.

VISION
The SOLACE-CEE project aims to strengthen the understanding, legitimacy, sustainability, and transferability of Integrated Health and Social Care (IHSC) approaches for people experiencing homelessness in the Central and Eastern Europe (CEE) region.

MISSION

The mission of the project is to use communication and advocacy as strategic tools supporting:

- systemic integration of health and social care services,
- policy development and reform,
- reduction of stigma and discrimination,
- strengthening institutional and cross-sector cooperation,
- building public trust in integrated care approaches,
- and ensuring long-term sustainability of integrated service models.

CORE STRATEGIC PILLARS

The Action plan is structured around four interlinked strategic pillars:

- **DATA-DRIVEN LEGITIMACY** – using evidence from Needs Assessment, research, and pilot implementation to support credibility and policy relevance
- **IMPACT-ORIENTED NARRATIVE** – communicating real outcomes, system change, and human impact
- **CONNECTED CARE FRAMING** – promoting integrated, multidisciplinary and person-centred service models
- **MULTI-LEVEL POLICY ALIGNMENT** – ensuring coherence between European, national, and local policy frameworks

1.1. Context and Problem Definition

HOMELESSNESS IN THE CEE REGION
Complex and growing social issue influenced by structural inequalities, housing instability and exclusion, poverty, and limited access to coordinated support systems. It cannot be understood as an individual problem, but rather as a systemic challenge requiring cross-sector responses.

FRAGMENTATION OF SYSTEMS

One of the key challenges identified across countries is the fragmentation of:

- healthcare systems,
- social services,
- housing support,
- and employment services.

This fragmentation leads to discontinuity of care, inefficient service delivery, and repeated exclusion of people experiencing homelessness from mainstream systems.

BARRIERS IN HEALTHCARE ACCESS AND INCLUSION

People experiencing homelessness (PEH) face multiple barriers, including:

- administrative and structural obstacles in accessing healthcare,
- lack of coordination between services,
- stigma and discrimination in service provision,
- limited trust in institutions,
- and insufficient outreach and low-threshold services.

THESE BARRIERS ARE REFLECTED IN THE FINDINGS OF THE SOLACE-CEE NEEDS ASSESSMENT RESEARCH RESULTS, WHICH SHOW:

These experiences further reinforce exclusion and reduce engagement with mainstream services.

STRUCTURAL EXCLUSION AND STIGMA

Homelessness is often accompanied by strong social stigma, which reinforces exclusion from healthcare, housing, social services and employment systems. This leads to delayed access to care, deterioration of health conditions, and increased reliance on emergency services rather than preventive or continuous care.

THE NEEDS ASSESSMENT ALSO HIGHLIGHTS THE VULNERABILITY OF THIS POPULATION:

61 % REPORTING CHRONIC HEALTH CONDITIONS

80 % RESPONDENTS REPORTING EXPERIENCES AT LEAST OF ONE TRAUMATIC EXPERIENCE

These factors underline the importance of trauma-informed and integrated care approaches that address both medical and social needs in a coordinated way.

1.1.1. Importance of Integrated care

Integrated Health and Social Care (IHSC) approaches provide a response to these challenges by:

Key complementary approaches include Housing First, Trauma-Informed Care (TIC), and Individual Placement and Support (IPS), which together form **a holistic and person-centred service model.**

1.1.2. Policy relevance

The issue of homelessness and the development of integrated care approaches is highly relevant across multiple governance levels, each of which plays a distinct but interconnected role in shaping responses to homelessness.

AT EUROPEAN LEVEL, the topic is embedded in broader EU priorities, including homelessness reduction strategies, social inclusion policies, and efforts to strengthen access to healthcare and reduce inequalities across Member States. These frameworks increasingly emphasise the importance of integrated, cross-sectoral approaches, person-centered and evidence-based policy responses.

AT NATIONAL LEVEL, the relevance is reflected in ongoing reforms of health and social care systems, including efforts to improve coordination between sectors, strengthen community-based services, and address gaps in service accessibility for vulnerable populations. Integrated care is increasingly recognised as a mechanism for improving efficiency, continuity, and equity within public service systems.

AT LOCAL LEVEL, municipalities and regional authorities are key actors in the practical delivery of services, including housing support, social assistance, and community-based healthcare. Local systems are often the first point of contact for people experiencing homelessness and therefore play a critical role in implementing integrated, low-threshold, and outreach-based approaches.

Within this multi-level governance context, the SOLACE-CEE approach contributes to broader public health and social policy objectives. These include the prevention of homelessness, reduction of health inequalities, strengthening of continuity of care, and development of more coordinated and integrated service systems across sectors.

2. Communication, Advocacy and Dissemination objectives

The Action plan combines communication, advocacy, dissemination, and stakeholder engagement activities to support the implementation, sustainability, and transferability of Integrated Health and Social Care (IHSC) approaches for people experiencing homelessness in the CEE region.

The objectives presented below reflect the multi-level and cross-sector nature of the project and are aligned with the broader goals of strengthening integrated care systems, reducing barriers in access to services, improving institutional cooperation, and increasing awareness of homelessness as a structural and public health issue.

AWARENESS OBJECTIVES

- **increase awareness and understanding of homelessness** as a complex structural and public health issue,
- **strengthen understanding of Integrated Health and Social Care** (IHSC) approaches and their benefits,
- **promote person-centred, trauma-informed, and multidisciplinary approaches**,
- **increase visibility of the SOLACE-CEE project,** pilot HUBs, and project outcomes,
- **and contribute to stigma reduction** through evidence-based and non-stigmatising communication.

ADVOCACY OBJECTIVES

- **support policy dialogue and institutional cooperation** at European, national, and local levels,
- **strengthen recognition and legitimacy of integrated care** approaches within healthcare and social care systems,
- **advocate for improved accessibility and continuity of care** for people experiencing homelessness,
- **support multisectoral cooperation** between healthcare, social care, housing, and employment sectors,
- **contribute to discussions** on financing and long-term sustainability of integrated care models,
- **and strengthen institutional support** for integrated and person-centred service provision.

DISSEMINATION OBJECTIVES

- **disseminate project** results, methodologies, and evidence generated through SOLACE-CEE,
- **support knowledge sharing and exchange** of good practices among stakeholders,
- strengthen professional capacities through educational and dissemination activities,
- **promote the use of e-learning and practical implementation tools,**
- **support transferability and replication** of integrated care approaches in other contexts and regions,
- **and disseminate evidence, learning** outcomes, and implementation experiences from pilot HUBs.

SUSTAINABILITY AND STAKEHOLDER ENGAGEMENT OBJECTIVES

- **strengthen engagement and cooperation** between relevant stakeholders,
- **support institutional embedding** of integrated care approaches,
- **strengthen the legitimacy and sustainability** of the HUB model,
- **encourage long-term partnerships and multisectoral collaboration,**
- **include the perspectives and experiences** of people experiencing homelessness,
- **and contribute to the long-term sustainability and future development** of integrated service systems beyond the duration of the project.

These objectives provide the strategic foundation for the communication, advocacy, dissemination, and stakeholder engagement activities implemented throughout the SOLACE-CEE project. Their practical implementation requires coordinated cooperation between project partners, institutions, service providers, policymakers, and local communities across European, national, and local levels.

The following sections therefore focus on the identification of key stakeholder groups and the definition of targeted activities and engagement approaches supporting the implementation, sustainability, and transferability of integrated care models for people experiencing homelessness.

3. Target Groups and Stakeholder Mapping

Effective implementation of IHSC requires active cooperation and engagement of a broad range of stakeholders across **European, national, and local levels.** Due to the complex and cross-sector nature of homelessness, successful implementation depends on coordinated collaboration between:

- public institutions,
- service providers,
- healthcare professionals,
- researchers,
- civil society organisations,
- local communities,
- and people with lived experience of homelessness.

The SOLACE-CEE stakeholder framework reflects the project's two-tier approach, combining EUROPEAN/INTERNATIONAL and LOCAL/NATIONAL LEVELS. Different stakeholder groups play distinct roles in communication, advocacy, dissemination, implementation, sustainability, and policy development processes throughout the project lifecycle.

The stakeholder framework also supports targeted communication and engagement activities adapted to the needs, capacities, influence, and responsibilities of individual stakeholder groups.

3.1. European/International Stakeholders

This stakeholder group includes European institutions, international networks, researchers, academic institutions, and European-level policy and advocacy actors involved in homelessness, public health, social inclusion, and integrated care.

KEY STAKEHOLDERS INCLUDE:

- European institutions and policymakers,
- FEANTSA and European homelessness, housing, anti-poverty, social inclusion, public health and social innovations networks,
- European Platform on Combating Homelessness,
- researchers and academic institutions,
- other European advocacy organisations focusing on human rights, migration, child protection,
- and European media and dissemination platforms.

These stakeholders play an important role in policy dialogue and advocacy, dissemination of project results and methodologies, strengthening legitimacy and

visibility of integrated care approaches, supporting knowledge exchange and replication, and connecting SOLACE-CEE with broader European policy and research frameworks.

3.2. National Stakeholders

National stakeholders include institutions and organisations involved in policy development, healthcare and social care systems, research, and implementation of services at national level.

KEY STAKEHOLDERS INCLUDE:

- ministries and governmental institutions,
- public health institutions,
- health insurance and health care providers,
- national NGOs and professional organisations focusing on housing, social services, employment, human rights, child protection, migration,
- researchers and universities,
- and national media.

Their role includes supporting policy and institutional cooperation, contributing to sustainability discussions, dissemination of evidence and research findings, strengthening professional capacities and supporting implementation and scaling of integrated care approaches.

3.3. Local Stakeholders

Local stakeholders represent key actors directly involved in practical implementation and delivery of integrated services within communities.

KEY STAKEHOLDERS INCLUDE:

- municipalities and regional authorities,
- healthcare providers,
- social service providers,
- Housing First and outreach teams,
- employers and employment support services,
- local communities,
- local media,
- and civil society organisations.

These stakeholders are essential for implementation of integrated and low-threshold services, coordination between sectors, outreach and community engagement, awareness-raising activities and long-term sustainability of local integrated care models.

3.4. PEH and Vulnerable Groups

People experiencing homelessness and other vulnerable groups represent a central stakeholder group within the SOLACE-CEE project. Their experiences, needs, perspectives, and feedback are essential for the development of accessible, person-centred, and effective integrated care approaches.

THE ACTION PLAN THEREFORE EMPHASISES:

- inclusion of lived experience perspectives,
- accessible and non-stigmatising, trauma informed communication,
- outreach and low-threshold engagement approaches,
- active participation and feedback mechanisms,
- and strengthening trust and accessibility within healthcare and social care systems.

3.5. Stakeholder Engagement

Effective stakeholder engagement is a strategic prerequisite for the success of SOLACE-CEE. The project aims to bring about systemic change in how integrated health and social care is delivered to people experiencing homelessness — a goal that cannot be achieved through service delivery alone. It requires active involvement of institutions, professionals, communities and decision-makers across multiple levels and sectors. Stakeholder engagement is therefore not a communication add-on, but a core implementation mechanism that supports institutional cooperation, sustainability and replication of integrated care approaches.

Stakeholders in SOLACE-CEE are segmented according to two key dimensions. The first is governance level — distinguishing between actors operating at European and international level, and those embedded in national, regional or local contexts. The second is the nature of engagement — differentiating between stakeholders who need to be informed about project progress and results, those who are expected to actively participate in implementation, and those whose institutional support is critical for long-term sustainability and policy change.

To support structured and consistent engagement across all partner organisations, SOLACE-CEE uses a Stakeholder Matrix as a practical planning tool. It serves as a shared reference point for all partners and should be reviewed and updated at key project milestones to reflect changes in the stakeholder landscape.

The following table provides the SOLACE-CEE Stakeholder Matrix.

3.5.1. Examples of stakeholder matrix from SOLACE-CEE

EUROPEAN LEVEL

STAKEHOLDER	INTEREST	INFLUENCE	MAIN OBJECTIVE	KEY MESSAGE	RISKS/ BARRIERS	CHANNELS	FREQUENCY
European Commission (DG EMPL, DG SANTE)	High	Very high	Position SOLACE-CEE as scalable social innovation	IHSC is evidence-based and transferable	Pilot perceived as local-only	Policy briefs, EU events, reports	Quarterly
FEANTSA	Very high	High	Dissemination and policy influence	CEE-specific integrated care model is needed	Fragmentation of messages	FEANTSA Forum, newsletters, webinars	Continuous
EPOCH Platform	High	High	Align with European homelessness agenda	Housing-led and integrated approaches work	Competing priorities	Policy discussions, conferences	Ongoing
European Parliament members / policy actors	Medium	High	Increase policy visibility	Homelessness is a public health issue	Low understanding of IHSC	Policy papers, meetings	Strategic moments
European research institutions	High	Medium	Strengthen evidence base	SOLACE-CEE combines practice and research	Academic-practic e disconnect	Conferences, publications	Ongoing
European networks (housing/public health/social innovation)	Medium	Medium	Dissemination and replication	IHSC can be adapted across contexts	Perceived complexity	Webinars, exchange events	Semi-annual

NATIONAL LEVEL

STAKEHOLDER	INTEREST	INFLUENCE	MAIN OBJECTIVE	KEY MESSAGE	RISKS/ BARRIERS	CHANNELS	FREQUENCY
Ministry of Labour	High	Very high	Support policy integration	Integrated systems reduce fragmentation	Siloed governance	Roundtables, policy briefs	Quarterly
Ministry of Health	Medium-high	Very high	Increase healthcare integration	Housing and health are interconnected	Healthcare conservatism	Expert meetings, HUB visits	Ongoing
Health insurance companies	High	Very high	Support sustainability financing	Integrated care improves outcomes and continuity	Concerns about costs	Bilateral meetings, data presentations	Semi-annual
Public Health Authorities	Medium	High	Public health framing	Homelessness affects population health	Narrow biomedical framing	Data dissemination	Strategic moments
Self-governing regions	High	High	Strengthen local integration	Multidisciplinary systems improve access	Budget limitations	Stakeholder meetings	Quarterly
National Platform for Ending Homelessness (PUB)	Very high	Medium	Advocacy coordination	Unified voice strengthens legitimacy	Capacity differences	Joint advocacy	Ongoing
National NGOs	High	Medium	Dissemination and alignment	Shared narrative strengthens sector	Different philosophies	Workshops, webinars	Ongoing
Universities and academic partners	Medium	Medium	Dissemination and research	Evidence supports systemic reform	Limited practical engagement	Conferences, publications	Annual

LOCAL LEVEL

STAKEHOLDER	INTEREST	INFLUENCE	MAIN OBJECTIVE	KEY MESSAGE	RISKS/ BARRIERS	CHANNELS	FREQUENCY
Municipalities	Very high	Very high	Institutional embedding	IHSC supports coordinated local response	Political shifts	Working groups, HUB visits	Monthly/ Quarterly
Local healthcare providers	Medium	High	Improve referrals and cooperation	Integrated care reduces barriers	Resistance to new models	Professional meetings	Ongoing
Hospitals	Medium	High	Improve continuity of care	Discharge coordination matters	Fragmented systems	Case discussions	Ongoing
Social service providers	Very high	Medium	Strengthen coordination	Shared responsibility improves outcomes	Competition for resources	Networking meetings	Monthly
Employers	Medium	Medium	Support IPS integration	Employment is part of recovery	Stigma toward PEH	Employer meetings	Quarterly
Police / emergency services	Medium	Medium	Improve crisis coordination	Integrated care reduces emergency burden	Enforcement-oriented approach	Coordination meetings	Semi-annual
Local public	Medium	Medium	Increase public support	Homelessness is systemic, not individual failure	NIMBY attitudes	Media, campaigns	Ongoing
Local media	High	Medium	Responsible narrative shaping	Evidence supports systemic reform	Sensationalism	Interviews, press kits	Ongoing
People experiencing homelessness	Very high	Medium	Service accessibility and trust	Dignified and evidence-based framing	Distrust toward institutions	Outreach, offline materials	Continuous

INTERNAL CONSORTIUM STAKEHOLDER´S LEVEL

STAKEHOLDER	INTEREST	INFLUENCE	MAIN OBJECTIVE	RISKS/ BARRIERS	CHANNELS	FREQUENCY
Consortium partners	Very high	Very high	Maintain unified communication	Fragmentation of messages	Internal meetings	Monthly
Communication leads	Very high	High	Consistency and visibility	Inconsistent branding	Coordination meetings	Monthly
HUB multidisciplinary teams	High	High	Practical implementation	Overload / operational focus	Internal communication	Continuous
Project management	Very high	Very high	Strategic alignment	Reporting pressure	PM meetings	Continuous

While the matrix presented here provides a consolidated overview across multiple project areas, the same tool can be applied independently for specific purposes — for example as an advocacy matrix focusing on policy actors and systemic influence, a communication matrix guiding visibility and messaging activities, or a dissemination matrix supporting knowledge transfer and replication.

Guidance on how to develop matrices and templates for use is provided in Annex A.

4. Key Messages and Narrative Framework in SOLACE-CEE

The SOLACE-CEE communication and advocacy approach is based on a consistent, evidence-based, and non-stigmatising narrative framework supporting the implementation and sustainability of IHSC for people experiencing homelessness. The project recognises that communication plays an important role not only in visibility and dissemination, but also in shaping public understanding, institutional trust, policy dialogue, and long-term systemic change.

The core narrative of the SOLACE-CEE project is based on the understanding that homelessness is a systemic and multidimensional issue requiring coordinated, integrated, and person-centred responses.

Core project narrative:
"Transforming lives, ending homelessness."

KEY MESSAGING THEMES

The SOLACE-CEE communication and advocacy activities are built around several key messaging themes:

- **HOUSING AS A DETERMINANT OF HEALTH** - housing stability is closely connected to physical and mental health, wellbeing, social inclusion, and long-term recovery.
- **HOMELESSNESS AS A STRUCTURAL ISSUE** - homelessness is not an individual failure, but a complex structural issue influenced by poverty, housing exclusion, health inequalities, trauma, and systemic barriers.
- **INTEGRATED CARE WORKS** - integrated and multidisciplinary approaches improve coordination between services, strengthen continuity of care, and support more effective and sustainable responses to homelessness.
- **TRAUMA-INFORMED AND PERSON-CENTRED APPROACHES** - trauma-informed and person-centred approaches improve trust, engagement, accessibility, and quality of service provision for vulnerable groups.
- **CONNECTED SYSTEMS AND CONTINUITY OF CARE** - better cooperation between healthcare, social care, housing, and employment systems reduces fragmentation and improves long-term outcomes for service users.
- **EMPLOYMENT AND HOUSING STABILITY ARE INTERCONNECTED** - access to employment, stable housing, healthcare, and social support are closely interconnected and should be addressed through coordinated approaches.

- **SUSTAINABILITY AND COST-EFFECTIVENESS** - integrated care approaches can contribute to more sustainable and efficient service systems by improving prevention, reducing emergency interventions, and strengthening long-term stability.

TONE OF VOICE

All communication activities within the SOLACE-CEE project follow a consistent and respectful communication style. Communication should be:

- respectful and person-centred,
- evidence-based and professional,
- non-stigmatising and non-discriminatory,
- accessible and understandable,
- impact-oriented,
- and focused on dignity, inclusion, and systemic solutions rather than charity-based narratives.

Particular attention should be paid to avoiding stereotypical or sensationalist representations of homelessness and vulnerable groups.

ETHICAL COMMUNICATION PRINCIPLES

The project recognises the importance of ethical and responsible communication, especially when communicating about vulnerable groups and lived experience.

Communication activities should therefore follow these principles:

- informed consent,
- dignity and respect,
- privacy and data protection,
- trauma-informed communication,
- accessibility and inclusiveness,
- non-discrimination,
- responsible storytelling,
- and avoidance of exploitative or sensationalist narratives.

The project also promotes active participation and inclusion of people with lived experience in communication, dissemination, and stakeholder engagement activities whenever appropriate and ethically possible.

The narrative and communication principles presented in this chapter create a foundation for consistent, ethical, and evidence-based communication within integrated care initiatives. Their application can support stronger stakeholder engagement, improved institutional cooperation, reduction of stigma, and greater public understanding of homelessness and integrated care approaches.

At the same time, the framework allows flexibility and adaptation to different national, regional, and organisational contexts while maintaining core principles related to dignity, accessibility, participation, trauma-informed communication, and person-centred approaches.

5. Communication Action Plan - SOLACE-CEE

Communication within the SOLACE-CEE project is understood as a strategic implementation tool supporting systemic change, institutional cooperation, sustainability, and transferability of integrated health and social care (IHSC) approaches for people experiencing homelessness.

The Communication Action Plan goes beyond standard visibility activities and connects communication, stakeholder engagement, dissemination, advocacy, implementation support, and replication. The strategic framework is based on the understanding that homelessness is closely connected to health inequalities, fragmentation of healthcare and social care systems, social exclusion, stigma, and barriers in access to coordinated services.

COMMUNICATION ACTIVITIES THEREFORE SUPPORT:

- visibility and legitimacy of integrated care approaches,
- policy dialogue and institutional cooperation,
- accessibility of integrated services,
- reduction of stigma and misinformation,
- and long-term sustainability and scalability of integrated care models.

The communication framework is closely connected to dissemination and advocacy:

COMMUNICATION explains and frames the project,
DISSEMINATION transfers learning and knowledge,
ADVOCACY supports institutional and system change.

THE COMMUNICATION APPROACH FOLLOWS SEVERAL CORE PRINCIPLES:

1. **DATA AND EVIDENCE-BASED COMMUNICATION** - communication should be grounded in evidence, implementation learning, monitoring results and practical experience. The project uses data-driven communication to strengthen credibility, improve understanding of integrated care and support informed stakeholder discussions.

2. **FOCUS ON IMPACT RATHER THAN ACTIVITIES ALONE** - communication should not focus only on describing activities, but primarily on explaining their relevance, practical value and contribution to system change, service improvement and integrated care development.
3. **CONSISTENT FRAMING OF INTEGRATED CARE** - communication across all countries and outputs should consistently present homelessness as a structural issue connected to health inequalities, housing instability and social exclusion. Integrated care, Housing First and employment support should be framed as interconnected and complementary elements of long-term inclusion and stability.

4. **ALIGNMENT ACROSS LOCAL, NATIONAL AND EUROPEAN LEVELS** - communication activities should remain coordinated across governance levels and partner organisations. While communication formats may be adapted locally, the overall

narrative, key messages and communication principles should remain consistent throughout the project.

COMMUNICATION SHOULD AVOID:

- sensationalism,
- charity-based framing,
- oversimplification of homelessness,
- fragmented messaging across partners.

The Communication Action Plan is intentionally structured as a transferable framework and practical implementation example for future integrated care initiatives, municipalities, NGOs, Housing First programmes, and EU-funded projects.

5.1. Two-Tier Communication Approach

The model ensures alignment between policy-level communication and operational implementation while allowing adaptation to different institutional and local contexts.

5.1.1. European/International Level

The communication plan at European level is based on 3 strategic objectives:

- **INCREASE VISIBILITY OF THE SOLACE-CEE** - position SOLACE-CEE as an innovative and evidence-informed model of integrated health and social care for people experiencing homelessness.
- **HIGHLIGHT EUROPEAN COOPERATION** - communicate how the project contributes to broader European objectives related to homelessness, integrated care, Housing First, social inclusion and reduction of health inequalities.

- **SUPPORT REPLICATION AND TRANSFERABILITY** - share project learning, methods and implementation experience in formats that can support adaptation and replication in other European contexts.

5.1.2. Local/national level

Local communication activities should support implementation realities in each partner country. Main objectives include:

- **SUPPORT LOCAL IMPLEMENTATION** - increase understanding of the project among local stakeholders, institutions and communities.
- **ENGAGE LOCAL STAKEHOLDERS** - strengthen cooperation between municipalities, healthcare providers, NGOs, Housing First teams, employment services and other actors.
- **RAISE AWARENESS** - improve understanding of homelessness as a structural issue connected to health, housing and social systems.
- **SUPPORT ACCESSIBILITY OF SERVICES** - provide clear and understandable information about available support systems and integrated services.

European and local communication activities are mutually interconnected and support both local implementation and European-level dissemination and replication.

5.2. Communication Governance and Coordination

Communication activities are implemented through coordinated cooperation between the Lead Partner and communication representatives of all consortium partners.

THE GOVERNANCE FRAMEWORK IS BASED ON:

- shared communication planning,
- coordinated content production,
- regular exchange of communication outputs,
- unified visual identity,
- and continuous monitoring of communication indicators.

LEAD PARTNER RESPONSIBILITIES

- Strategic coordination and quality control of communication outputs
- European-level communication and dissemination
- KPI monitoring and reporting
- Compliance with EU visibility requirements
- Maintenance of Communication manual and visual identity standards
- Approval of key communication materials

COMMUNICATION TEAM RESPONSIBILITIES

Communication representatives of partner organisations are responsible for:

- Implementation of local communication activities
- Content production and localisation
- Local stakeholder engagement
- Adaptation of communication materials to local contexts
- Contribution to dissemination activities and reporting

Communication Task	Lead Partner	Partners
Strategic communication planning	P[1]	S
European-level dissemination	P	S
Social media – LinkedIn	P	S
Social media – Facebook/Instagram/LinkedIn/X	S	P
Newsletter production	P	S
Local stakeholder events	S	P
Content production (articles, infographics)	S	P
Website management	P	S
KPI monitoring and reporting	P	S
EU visibility compliance[2]	P	P

All communication outputs must comply with the SOLACE-CEE Communication Manual, project visual identity guidelines, and EU visibility requirements. Any communication or dissemination activity anticipated to have a major media impact must be notified to the European Commission in advance, in accordance with GA. The Lead Partner is responsible for coordinating such notifications

INTERNAL COORDINATION TOOLS

Coordination is supported through regular meetings, shared planning tools, cloud storage and KPI monitoring systems.

5.3. Main Communication Areas and Channels

1. PROJECT IDENTITY AND BRANDING - the purpose is to ensure recognisable, professional and coherent communication across all countries and outputs.

- Logo and visual identity consistent across all materials
- Templates and presentation materials
- Communication guidelines and tone of voice
- EU visibility requirements (including publication) - specific rules for the European flag and emblem in line with GA:
    - the European emblem must appear on all communication materials and must remain distinct and separate — it cannot be modified by adding other visual marks, brands or text,
    - apart from the emblem, no other visual identity or logo may be used to highlight EU support

[1] *P = Primary responsibility; S= secondary responsibility*
[2] *While all partners bear primary responsibility for EU visibility on their own outputs, the Lead Partner (DEDO) has oversight and quality control responsibility for ensuring compliance across all consortium outputs, in line with Article 7 of the GA.*

- for publications, the action name, European flag and funding statement must appear on the cover or on the first pages following the editor's mention.
- Consistent use of SOLACE-CEE framing and terminology

2. WEBSITE AND DIGITAL COMMUNICATION

The project website serves as the main public communication and dissemination platform and includes project information, news and updates, publications and outputs, learning resources, e-learning materials, and contact information.

Digital communication also includes social media channels, newsletters, partner websites, and online articles and multimedia content.

3. CONTENT PRODUCTION - content production supports visibility, dissemination and stakeholder engagement through:

- Articles and opinion pieces
- Infographics and visual explainers
- Fact sheets and policy briefs
- Newsletters
- Videos and visual materials
- Campaign materials
- Presentations and reports

4. EVENTS AND STAKEHOLDER COMMUNICATION

Communication activities support stakeholder engagement, dissemination of findings, networking, replication and partnership-building through:

- Conferences and professional events
- Webinars and online workshops
- Stakeholder roundtables
- Guided visits to HUB sites
- EU-level networking activities

MAIN COMMUNICATION CHANNELS OVERVIEW:

Channel	Main Purpose	Primary level
Project Website	Central repository for outputs and learning	Both
Partner Websites	Local dissemination and stakeholder engagement	Local/National
LinkedIn	Professional and European-level communication	Both
Facebook / Instagram /X	Public awareness and community engagement	Local/National
Newsletters	Regular updates and dissemination	Both

Conferences and Events	Networking and professional dissemination	Both
FEANTSA and EU Networks	European-level visibility and replication	European
Publications and Outputs	Knowledge transfer and credibility	Both

5.3.1. Stakeholder Communication Framework

The following table sets out communication objectives, main channels, frequency and practical formats for each stakeholder group.

Stakeholder Group	Communication Objective	Main Channels	Frequency
European institutions and policy actors	Increase policy visibility and support dissemination	Policy briefs, conferences, stakeholder meetings	Quarterly / strategic moments
NGOs and professional networks	Support dissemination and cooperation	Workshops, webinars, newsletters	Ongoing
Healthcare and social care providers	Support implementation and coordination	Professional meetings, trainings, HUB visits	Ongoing
Municipalities and regional authorities	Support institutional embedding and sustainability	Stakeholder meetings and working groups	Quarterly
Researchers and universities	Dissemination of evidence and methodologies	Publications, conferences, webinars	Ongoing
Local communities and media	Awareness raising and visibility	Campaigns, media communication, events	Ongoing
People experiencing homelessness	Accessibility, outreach and trust-building	Outreach communication and offline materials	Continuous

COMMUNICATING WITH PEOPLE EXPERIENCING HOMELESSNESS (PEH)

People experiencing homelessness are not only a target group for service delivery – they are also key stakeholders in the communication process. Communication directed at this group requires specific approaches:

- Use plain, accessible and non-stigmatising language in all materials
- Develop offline and outreach-based materials for those with limited digital access
- Ensure information about available services is clear, practical and regularly updated
- Involve peers and lived experience voices in the development of communication materials where possible
- Prioritise dignity and trust-building in all communication approaches

Communication about this target group at other levels (policy, professional, public) must also maintain a non-stigmatising and structural framing, avoiding charity-based or individualising narratives.

5.4. Communication activities by phase

Communication activities are organised across three implementation phases: **Initial Phase (project setup and launch), Implementation Phase (core delivery period), and Final Phase (closure, dissemination and sustainability).** The following tables present planned activities separately for the European/international level and the local/national level.

The three phases correspond to the overall project timeline and should be aligned with the project work plan. Specific timing for each activity is coordinated by the Lead Partner in consultation with each partner.

EUROPEAN LEVEL

Tools/ channels	Target group	Timing		
		Initial Phase (Month 1-6)	Implementation Phase (Month 7-30)	Final Phase Month (30-36)
INTERNAL COMMUNICATION	**Project partners**	Setup of tools and coordination mechanisms and communication channels	Coordination and monitoring	Final coordination and monitoring
PROJECT IDENTITY AND BRANDING	**All target groups**	Development of logo, claim, templates, tone of voice and rules for using	Consistent use and adaptation across outputs and countries	Continued use in final outputs and sustainability materials
WEBSITE & E-LEARNING	**All target groups**	Establish the objective of the website, create its structure, and prepare content for the website.	Launch of the official website + create a structure, content and finally launch a e-learning as a part of website	Final update with key results and outputs
PUBLICATIONS & OUTPUTS (fact sheets, guidelines, documents)	**EU stakeholders, policymakers, professionals, researchers**	Planning and initial drafting	Development and dissemination of deliverables	Final report, legacy materials, publication and promotion of outputs
EVENTS	**Professionals, policymakers, stakeholders project partners**	Planning of project events and identification of relevant external events (conferences, seminars, webinars) for participation and presentation, kick-off event communication	Organisation of project internal events and active participation in external events, including presentations of the project and its results	Organisation of final internal project event(s) and continued participation in external events to present final results and support dissemination and replication at European level
MEDIA & PUBLIC RELATIONS	**Media on european level, general public**	Creation and dissemination of the Initial press release announcing the project	Press releases about milestones and its results	Press release focused on final results and key project outcomes
NEWSLETTER	**All target groups** (subscribers from multiple target groups)	Establishment of newsletter, including selection of distribution tools, development of contact database, definition of frequency (biannual and event-based), preparation of initial content plan, and creation and dissemination of the first newsletter	Regular distribution with updates and results from both international and national levels	Final edition/editions summarising key outcomes

SOCIAL MEDIA	**All target groups**	**Setup of communication on social media**, including selection of platforms, definition of communication approach and posting frequency, preparation of initial content plan, and launch of channels with first posts	Regular dissemination of project updates, milestones and outputs;	Focus on results, impact and dissemination of final outputs
CONTENT PRODUCTION (articles, blog, visuals or multimedia outputs)	**All target groups**	Creation of a content plan for multiple channels and sharing initial content introducing the project and its objectives	Ongoing production and dissemination of content, including online campaign articles, case studies, infographics, and multimedia materials reflecting project activities, pilot progress, and interim results	Production and dissemination of final content summarising project results, impact with a focus on supporting replication and sustainability

LOCAL/NATIONAL LEVEL

Local communication activities mirror and complement the European-level plan, adapted to national and community contexts. The following activities are expected from each country partner in coordination with the Lead Partner.

Tools/ channels	Target group	Timing		
		Initial Phase (Month 1-6)	**Implementation Phase (Month 7-30)**	**Final Phase Month (30-36)**
PROJECT IDENTITY AND BRANDING	**All target groups**	Adding the project identity to the partner identity and aligning it with the created guidelines for SOLACE-CEE communication	Consistent application of branding across all local outputs and events; localisation of templates where needed	Continued use of project identity in local sustainability and handover materials
WEBSITE & LOCAL DIGITAL CONTENT	**All target groups**	Contribution to project website content; preparation of local language section about SOLACE-CEE	Regular contribution of local news, updates and case studies to the project website and partner websites. Each project´s website and social media accounts must include: project summary, coordinator contact details, full list of participants, the European flag and funding statement, and project results, as required by GA.	Final local content updates; contribution to e-learning and legacy materials

PUBLICATIONS & OUTPUTS (fact sheets, guidelines, documents)	**Local professionals, municipalities**	Planning and initial drafting	Development and dissemination of local-language materials: fact sheets, practice guides, case studies from HUB pilots	Final local publications; contribution to European-level outputs with local evidence and results
EVENTS	**Local professionals, municipalities, NGOs, communities**	Mapping of relevant local events; planning of local stakeholder activities and HUB presentations	Organisation of local stakeholder workshops, roundtables and HUB visits; participation in national conferences and events	Organisation of local dissemination events; presentation of local results; support for replication discussions at national level
LOCAL MEDIA & PUBLIC RELATIONS	**Local and regional media, general public**	Identification of local media contacts; preparation of initial local translation of press release	Regular local media communication about project progress, HUB activities and results, regular press releases, HUB guided tour	Local translation of the press release on final results; local visibility activities supporting sustainability
OUTREACH AND COMMUNITY COMMUNICATION	**PEH, local communities**	Development of plain-language and accessible materials about HUB and available services and the project	Continuous outreach communication; distribution of accessible materials through HUBs and partner organisations	Final update of service information materials; contribution to local legacy and sustainability communication
SOCIAL MEDIA (local channels)	**All target groups**	Setup or alignment of local social media presence; coordination with European-level channels	Local communication of HUB activities, implementation progress and outcomes.	Focus on HUB results, impact and visibility of integrated care outcomes
CONTENT PRODUCTION (articles, blog, visuals or multimedia outputs)	**All target groups**	Creation of a content plan for multiple channels and sharing initial content introducing the project and its objectives	Ongoing production and dissemination of content, including online campaign articles, case studies, infographics, and multimedia materials reflecting project activities, pilot progress, and interim results	Production and dissemination of final content summarising project results, impact with a focus on supporting replication and sustainability

5.5. Practical Communication Process

Before preparing any communication activity or output, the following steps should be followed to ensure strategic and audience-oriented communication:

Step	Question to answer	Why it is matters
1. Define the message	What should be communicated? What is the key message?	Ensures clarity and focus
2. Define the audience	Who are we communicating with? At which level (European / local)?	Enables appropriate framing and channel selection
3. Select the format	What format best serves this message and audience?	Ensures accessibility and relevance
4. Select the channel	Which channel will best reach this audience?	Maximises reach and engagement
5. Define the outcome	What should the audience know, feel or do after this communication?	Enables evaluation of effectiveness
6. Plan follow-up	How will we track reach and engagement? What follow-up is needed?	Supports monitoring and learning

This framework ensures that communication remains strategic, audience-oriented and connected to implementation and project objectives throughout the duration of SOLACE-CEE.

5.6. Communication monitoring and evaluation

Communication activities are monitored continuously throughout the project duration. Monitoring includes analytics, KPI reporting, stakeholder engagement tracking and periodic evaluation of communication effectiveness.

MAIN MONITORING INDICATORS INCLUDE:

- website traffic,
- social media reach and engagement,
- newsletter performance,
- number of dissemination outputs,
- media mentions,
- participation in events,
- stakeholder engagement activities,
- and dissemination of project deliverables.

The monitoring system allows continuous optimisation of communication activities and supports strategic adaptation of communication approaches where necessary.

The following indicators from the GA are directly linked to communication, dissemination and outreach activities and form part of the project's approved monitoring framework. Partners are expected to contribute to reaching these targets through their WP5 activities. Organisations adapting this framework should replace these with targets derived from their own funding agreement.

GA Indicator	GA Target	Related WP5 Activity	Monitoring Tool
People reached by campaign	29,000	Awareness campaigns, social media, media outreach at European and local level	Social media analytics, media monitoring
Partnerships for Advocacy	26	Stakeholder engagement, advocacy activities, network building	Stakeholder tracking log
Awareness of available services	3,650 individuals	Outreach communication, accessible materials, HUB communication	Outreach records, service data

Progress against these indicators is tracked as part of regular project monitoring and included in progress reports submitted to the European Commission.

5.7. Communication Risks and Mitigation Measures in SOLACE-CEE

The following table identifies key communication risks, their potential impact, and concrete mitigation measures. Each risk is assessed in terms of likelihood and potential impact on project communication objectives.

Risk	Likelihood	Impact	Potential Impact	Mitigation Measure	Responsible
Fragmented communication between partners	Medium	High	Inconsistent project visibility	Central coordination and communication guidelines	LP
Low stakeholder engagement	Medium	High	Reduced dissemination impact	Tailored stakeholder communication	All partners
Stigmatising communication	Low	High	Reputational and ethical risk	Use of non-stigmatising communication principles	LP+ CT member
Inconsistent branding across outputs	Medium	Medium	Reduced project recognition	Continuous monitoring of communication outputs	LP
Limited media visibility	Medium	Medium	Reduced public awareness	Evidence-based communication	All partners
Operational overload of partners	High	Medium	Delays in communication activities	Shared templates and coordinated planning	LP

Political or institutional sensitivity	Medium	High	Reduced cooperation potential	Evidence-based and neutral communication approach	All partners
Staff turnover affecting continuity	Medium	Medium	Delays and loss of institutional knowledge	Documentation of communication processes, onboarding materials for new team members	All partners

5.8. Connection to Dissemination and Advocacy

AREA	MAIN FOCUS	TOGETHER, THESE AREAS SUPPORT:
COMMUNICATION	Visibility, engagement and understanding	• visibility of integrated care, • stakeholder cooperation, • dissemination of implementation learning, • policy dialogue, • sustainability and replication of the SOLACE-CEE model.
DISSEMINATION	Transfer of knowledge and learning	
ADVOCACY	System influence and policy change	

Communication, dissemination and advocacy are interconnected but have different functions.

COMMUNICATION CONTRIBUTION TO SUSTAINABILITY AND REPLICATION

Communication activities within SOLACE-CEE are designed not only to support visibility during implementation, but also to strengthen long-term sustainability and replication potential of integrated care approaches.

Special emphasis is placed on:

- dissemination of practical implementation experiences,
- visibility of pilot HUB outcomes,
- transferability of methodologies,
- strengthening institutional legitimacy,
- stakeholder trust-building,
- dissemination of educational outputs,
- and support for future replication of integrated care models in other regions and institutional environments.

The Communication Action Plan therefore supports the broader objective of strengthening integrated, multidisciplinary and person-centred care systems for people experiencing homelessness in Central and Eastern Europe.

6. Advocacy Action Plan - SOLACE-CEE

Advocacy in SOLACE-CEE functions as a system-change mechanism that translates evidence from integrated service delivery into institutional decisions, policy development and long-term structural transformation of homelessness responses.

The project addresses homelessness as a structural issue linked to health inequalities, fragmented service systems, housing instability and social exclusion. **Advocacy therefore does not aim only to raise awareness, but to enable concrete system-level change at local, national and European levels.**

It builds on the communication principle that integrated care should be understood not only through activities, but through the changes it produces in systems, services and people's lives. Advocacy builds on this same principle and focus on:

- institutional change (not only awareness),
- decision-making processes,
- funding and financing structures,
- service design and integration,
- long-term sustainability.

It is therefore closely connected to implementation and is grounded in real operational experience from HUBs, outreach services, Housing First and integrated care models.

A PRACTICAL DEFINITION FOR IMPLEMENTERS:
Advocacy is the process of transforming evidence, implementation learning and lived experience into informed decisions, institutional commitment and sustainable system improvement.

6.1. Advocacy System in SOLACE-CEE (integrated framework)

ADVOCACY IS IMPLEMENTED THROUGH THREE INTERCONNECTED TOOLS:

- **ADVOCACY MATRIX (WHO and WHY)** - defines stakeholders, their influence, position and engagement strategy.
- **ADVOCACY PATHWAY (HOW CHANGE HAPPENS) -** defines the progression from evidence to system change.
- **THE ADVOCACY CALENDAR (WHEN and WHAT ACTION)** Defines operational activities over time linked to policy windows and project outputs.

HOW THESE TOOLS WORK TOGETHER:

Question	Tool	Output
Who should be engaged?	**Advocacy Matrix**	Stakeholder prioritisation
How can stakeholders move towards action?	**Advocacy Pathway**	Logic of system transformation
When and through which activities should engagement happen?	**Advocacy Calendar**	Operational plan

Used together, these tools support more strategic, coordinated and consistent advocacy planning across different contexts and implementation phases.

Matrix defines priorities, pathway defines sequencing, calendar defines operational execution.

6.1.1. Advocacy Matrix - Practical implementation tool

Practical planning tool used to map stakeholders according to their relevance, influence and relationship to integrated care. **Its purpose is not only to identify stakeholders, but also to understand:**

- their institutional role,
- level of influence,
- current position towards integrated care,
- possible support or resistance,
- and the most appropriate communication or engagement approach.

The matrix should be updated regularly throughout the project, especially after policy changes, stakeholder meetings, elections, funding discussions or important implementation milestones.

STAKEHOLDER CATEGORIES

Suggested stakeholder categories	Description	Role in Advocacy	Examples stakeholders	Focus of engagement
Decision-makers	Stakeholders with formal authority related to policy, financing or service planning.	Set policies, funding, system rules	Ministries, municipalities, insurers	financing, legislation, sustainability

Implementation partners	Stakeholders involved in direct service delivery or coordination.	Deliver services	healthcare providers, outreach teams, shelters, Housing First teams, employment services,	multidisciplinary cooperation, operational integration
Knowledge and legitimacy actors	Stakeholders supporting evidence, expertise and credibility.	Provide evidence and credibility	universities, research institutes, evaluators, public health experts, professional associations	evidence, evaluation, methodological quality, transferability, wider learning
Public influence actors	Stakeholders influencing public understanding and social narratives.	Shape narratives	media, civic platforms, public campaigns	stigma reduction, public understanding
PEH	People with lived experience should not be included only as symbolic participants, but as important contributors to understanding barriers, services and practical needs.	Experts by experience	PEH representatives	informed consent, trauma-informed principles, dignity-based communication, protection of privacy and safety

HOW TO USE THE ADVOCACY MATRIX:

1. step: Identify stakeholder at EU / national / local level

Identify all relevant actors across governance levels to ensure a complete advocacy scope.

Examples may include: municipalities, ministries, health insurance companies, healthcare providers, NGOs, Housing First teams, professional associations, universities, FEANTSA and other European networks, media, funders, and representatives of people with lived experience.

Purpose: ensure no key system actor is missing.

2. step: Assess influence and interest

Each stakeholder can be assessed through several practical questions:

- What influence or mandate does the stakeholder have?
- What resources or cooperation can they provide?
- What is their current level of understanding of integrated care?
- Are they supportive, neutral or hesitant?
- What message or evidence is most relevant to them?
- What action or commitment is expected from them?

Purpose: prioritise engagement strategically.

3. step: Identify current position (support / neutral / resistant)
Classify stakeholders based on their current stance towards integrated care.
Purpose: adjust advocacy intensity and approach.

- Supportive → deepen cooperation
- Neutral → build awareness and evidence
- Resistant → focus on dialogue and trust

4. step: Define key message per stakeholder - tailor messages to stakeholder roles and priorities.
Purpose: ensure relevance and clarity of advocacy.

5. step: Define engagement approach- select appropriate format for interaction.
Examples: meetings, roundtables, HUB visits, workshops, policy briefs, conferences, working groups.
Purpose: translate strategy into action.

6. step: Assign responsible partner - define who is responsible for engagement and follow-up within the consortium.
Purpose: ensure accountability and coordination.

EXAMPLE MINI-MAPPING LOGIC

Ministry of Health → high influence / medium support → policy brief + expert meeting

Municipality → high influence / high interest → HUB visits + working group

Health insurer → high influence / cautious → cost-effectiveness evidence + bilateral meetings

6.1.2. Advocacy Pathway

This tool helps structure advocacy as a gradual and relationship-based process rather than a series of isolated activities. **It supports implementers in moving from:**

- evidence and problem identification,
- towards stakeholder engagement,
- policy dialogue,
- institutional cooperation,
- and sustainability discussions.

The pathway also reflects the logic of SOLACE-CEE, where advocacy is closely connected to implementation learning, dissemination and replication.

STAGES OF THE ADVOCACY PATHWAY

Stage	Purpose	Tools	Output
Stage 1 - Evidence and define problem	Define problem and identifying key barriers and challenges	• NA findings, • service data, • implementation experience, • stakeholder feedback, • lived experience insights	• Clear description of the problem • Who is affected • Consequences of fragmentation • Case for why integrated care is relevant
Stage 2: Stakeholder Mapping and Prioritisation	Identify and prioritise key actors based on role, influence, and relevance	Advocacy Matrix	• List of key decision-makers • Potential allies • Stakeholders needing awareness • Implementation/legitimacy stakeholders
Stage 3: Message Framing	Translate evidence into clear, stakeholder-specific messages focused on impact	Communication Manual	Impact-oriented messages per stakeholder
Stage 4: Relationship Building	Build trust and long-term cooperation with stakeholders	• Bilateral meetings • Roundtables & workshops • Study visits • Informal exchanges • Presentations of findings	Stakeholder understanding of integrated care and their role within it
Stage 5: Policy Ask and Proposed Solutions	Move toward concrete, actionable proposals once relationships are established	Evidence base + implementation learning	• Inclusion in local strategies • Referral agreements • Sustainability plans • Healthcare access improvements • Financing discussions
Stage 6: Commitment & Institutionalisation	Secure formal engagement and sustainability mechanisms	• Working groups • Policy consultations • Pilot agreements • Dissemination partnerships	• MoUs, • policy commitments, • financing discussions
Stage 7: Monitoring & Adaptation	Ensure advocacy remains relevant and responsive	Monitoring framework, stakeholder feedback	• Updated advocacy strategy, • improved stakeholder alignment

Guidance on how to develop an Advocacy Pathway and an example from SOLACE-CEE are provided in Annex B.

6.1.3. Advocacy Calendar

The calendar helps translate advocacy priorities into concrete and time-bound activities linked to:

- project phases,
- dissemination outputs,
- policy opportunities,
- stakeholder engagement,
- public events and conferences.

The calendar should support coordination between local, national and European advocacy activities while still allowing flexibility for local adaptation.

WHAT THE CALENDAR SHOULD INCLUDE

Core structure:

- Timeframe (timeline or frame) - when activity happens
- Advocacy objective - what we want to change,
- Stakeholder - who we target and on which level,
- Key message - core argument,
- Evidence - supporting data
- Planned activity,
- Responsible partner,
- Expected outcome - realistic results,
- Follow-up - next step.

The calendar should connect advocacy activities with important project outputs such as:

- needs assessment findings,
- awareness campaigns,
- methodology guidelines,
- HUB implementation learning,
- dissemination events,
- policy discussions.

SUGGESTED TYPES OF ADVOCACY ACTIVITIES

- **BILATERAL MEETINGS** - useful for decision-makers, ministries, municipalities, regional authorities, health insurers, and institutional partners. These meetings should be prepared with a short briefing note, clear ask, and proposed next step.
- **ROUNDTABLES** - useful for building shared understanding across sectors.
- **STUDY VISITS AND GUIDED VISITS** - useful when stakeholders need to understand how the integrated model works in practice. These are especially effective for municipalities, health insurers, public institutions, and potential replication partners.
- **POLICY BRIEFINGS** - useful when project findings need to be translated into concise recommendations.

- **PUBLIC ADVOCACY EVENTS** - useful when the objective is to increase broader legitimacy, public support, or visibility. These events should be carefully aligned with communication ethics and avoid sensationalising homelessness.
- **TECHNICAL WORKING MEETINGS** - useful when advocacy has already moved into a practical implementation stage.
- **EUROPEAN-LEVEL ADVOCACY** -useful for connecting findings with broader EU debates, FEANTSA networks, EPOCH, ESF+ priorities, and replication opportunities across the CEE region.

PRACTICAL GUIDANCE: CONNECTING THE 3 TOOLS

First, use the **Advocacy Matrix** to map stakeholders and prioritise who should be engaged.

Second, use the **Advocacy Pathway** to define where each stakeholder currently stands: Do they need awareness? Evidence? Relationship building? A policy ask? Follow-up?

Third, use the **Advocacy Calendar** to schedule concrete actions and assign responsibility.

Guidance on how to develop an Advocacy Calendar and a template for use are provided in Annex C.

6.1.4. KPI Framework for Advocacy

Advocacy success is measured through system influence, not only activity volume. Example of KPIs (key performance indicator):

QUANTITATIVE KPIs

- number of policy meetings
- number of stakeholders engaged
- policy briefs produced
- partnerships established
- consultations participated in
- replication requests

QUALITATIVE KPIS

- shift in stakeholder position (resistant → neutral → supportive)
- references to SOLACE-CEE in policy documents
- inclusion in strategic frameworks
- creation of cooperation mechanisms
- evidence of policy dialogue initiation

SYSTEM-LEVEL KPI (MOST IMPORTANT) evidence of integrated care being embedded in:

- funding systems
- municipal strategies
- healthcare pathways

- institutional cooperation structures

6.1.5. Risks and Ethical Considerations

Advocacy in SOLACE-CEE is strictly data-driven, evidence-based and system-focused. Communication is based on aggregated findings, implementation evidence and system-level analysis. No individual stories, personal narratives, images of people, or case-based storytelling are used.

POTENTIAL RISKS INCLUDE:

- oversimplification of complex structural drivers of homelessness,
- fragmented or inconsistent messaging across stakeholders,
- politicisation or misinterpretation of data,
- unrealistic expectations regarding system change timelines,
- misuse or decontextualisation of evidence.

All advocacy activities must ensure that data is interpreted in its proper context and that findings are not decontextualised or used in isolation from methodology and system conditions.

ADVOCACY ACTIVITIES MUST AVOID:

- any form of storytelling or narrative-based communication,
- use of personal cases, testimonies or individual examples,
- visual or textual identification of individuals,
- any content that could indirectly lead to identification of service users,
- emotionally framed or sensational communication.

ALL ACTIVITIES MUST FOLLOW:

- strict data protection and confidentiality standards,
- ethical use of aggregated and anonymised data,
- accuracy and methodological transparency,
- informed consent only in relation to data collection processes,
- institutional ethical and research governance standards.

More about Risks and Ethics in Communication can be found in the Communication manual.

6.1.6. Practical Use of Advocacy Tools

The Advocacy Matrix, Advocacy Pathway and Advocacy Calendar should support continuous advocacy planning throughout implementation.

A PRACTICAL ADVOCACY CYCLE MAY INCLUDE:

1. reviewing evidence and implementation learning,
2. updating stakeholder mapping,
3. selecting advocacy priorities,

4. defining key messages and expected outcomes,
5. planning activities,
6. recording follow-up and learning.

Used together, these tools help ensure that advocacy remains strategic, coordinated and connected to the broader goals of sustainability, replication and systemic change.

Advocacy and dissemination in SOLACE-CEE should function as complementary and interconnected processes. While advocacy focuses on influencing institutional commitment and policy environments, dissemination supports learning, transferability and wider uptake of integrated care approaches across different contexts.

7. Dissemination Action Plan

Dissemination in SOLACE-CEE is not understood as a simple act of sharing project outputs after they have been produced. It is a strategic process through which project learning, evidence, methods and practical experience are made available to those who can use them for improving services, influencing policy, replicating integrated care models, and strengthening systems responding to homelessness.

The purpose of dissemination is not only visibility of project activities, but transfer of usable knowledge that can support:

- improvement of services,
- adaptation of integrated care models,
- strengthening of professional practice,
- policy learning and system development,
- replication across different contexts in the CEE region and beyond.

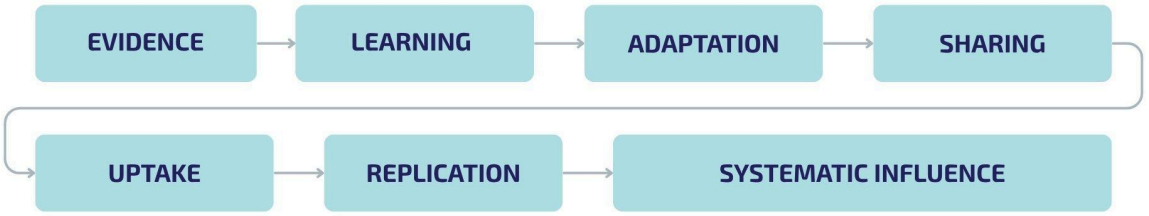
Dissemination is therefore directly linked to implementation and advocacy, but focuses primarily on learning transfer rather than decision-making influence.

The project is based on a complex intervention combining outreach, Housing First, integrated health and social care (IHSC), mental health support, employment integration and cross-sector coordination. Dissemination therefore ensures that this complexity is translated into clear, usable and context-sensitive knowledge for different target groups.

7.1. Dissemination logic

The dissemination logic of SOLACE-CEE follows a structured process in which evidence and implementation experience are gradually transformed into transferable knowledge, stakeholder learning, replication opportunities and broader systemic influence.

The purpose of dissemination is therefore not only to share outputs, but to support understanding, adaptation and practical uptake of integrated care.



This means that dissemination should not start from communication products, but from project learning.

THE PROJECT GENERATES EVIDENCE THROUGH:

- needs assessments,
- pilot implementation,
- monitoring and evaluation,

- stakeholder engagement,
- operational experience,
- service utilisation data,
- implementation feedback.

THIS EVIDENCE IS THEN TRANSLATED INTO PRACTICAL LEARNING:

- what worked,
- what barriers appeared,
- what adaptations were necessary,
- what conditions enabled implementation,
- what can be replicated in other contexts.

Only afterwards should dissemination formats and audiences be selected.

FOR EXAMPLE:

- implementation lessons may require methodology guidelines or practitioner webinars,
- policy-relevant findings may require policy briefs or stakeholder roundtables,
- transferability lessons may require study visits or peer exchange,
- academic findings may require publications or conference presentations.

> The goal is not only visibility, but practical uptake and replication.

7.2. Dissemination Audiences

Different audiences require different types of dissemination. The same output cannot be shared in the same form with all stakeholders.

PROFESSIONAL AUDIENCES

(service providers, NGOs, health & social care teams, case managers, Housing First teams, employment specialists and service managers)

Dissemination should focus on practical knowledge:

- how integrated care can be organised,
- how multidisciplinary teams can work,
- how trauma-informed care can be embedded,
- how outreach and outpatient care can be connected,
- how to build referral pathways,
- how to use data for service improvement,
- how to adapt the model to different organisational capacities.

Formats: methodology guidelines, webinars, case studies, peer-learning sessions, study visits and training materials.

POLICY AND INSTITUTIONAL AUDIENCES

(municipalities, ministries, self-governing regions, health insurers,EU institutions, local governments and decision-makers)

Dissemination should focus on systemic relevance:

- integrated care implementation models,
- coordination mechanisms between sectors,
- referral and continuity-of-care pathways,
- financing and sustainability considerations,
- integrated care workflows,
- system barriers and enabling conditions.

Formats: policy briefs, stakeholder action plans, roundtables, advocacy sessions, guided visits, data summaries and high-level presentations.

ACADEMIC AND RESEARCH AUDIENCES

(universities, research institutes, public health experts, social policy experts,..)

Dissemination should focus on evidence, evaluation and methodological learning:

- needs assessment findings,
- pilot implementation data,
- monitoring and evaluation results,
- qualitative findings,
- ethical and methodological challenges,
- transferability across CEE countries.

Formats: peer-reviewed articles, conference papers, research presentations, datasets where appropriate, and collaboration with European research networks.

PUBLIC AND MEDIA AUDIENCES

(local communities, media, civil society, supporters, donors and the broader public)

Dissemination should focus on accessible, non-stigmatizing and dignity-based communication:

- homelessness as a structural issue,
- housing as a determinant of health,
- integrated care as a practical solution,
- real impact of services,
- human dignity and rights,
- public value of coordinated systems.

Formats: short articles, videos, infographics, social media posts, media briefings and campaign materials.

7.3. What Is Disseminated

Dissemination should not be limited to final deliverables. The project should disseminate different types of learning throughout implementation.

Project outputs	Implementation knowledge	Evidence and data	Transferability knowledge
Communication Manual	how partners established HUBs	needs assessment findings,	minimum conditions for integrated care
Methodology Guidelines	what barriers appeared during implementation	service utilisation data	core principles that should not be lost
Awareness Toolkit	how teams adapted to local contexts	outreach data,	elements that can be adapted locally
Action Plan for Stakeholders	how outreach was connected to outpatient services	training participation data	risks in replication
Policy briefs	how multidisciplinary cooperation developed	stakeholder engagement data	stakeholder roles
Reports	what helped or hindered stakeholder cooperation	evaluation results	financing and sustainability considerations

7.4. Dissemination Channels and Activities

The project should use a combination of channels. Each channel has a different function.

Channel	Main function
Project website	Central repository for outputs, news, publications and learning resources
Partner websites	Local-language dissemination and local stakeholder engagement
LinkedIn	European-level professional and institutional dissemination
Facebook / Instagram	Local public communication and community engagement
FEANTSA channels	European professional and policy dissemination
Conferences	Expert exchange, credibility and networking
Webinars	Capacity-building and replication support
Guided visits	First-hand understanding of HUB implementation
Policy events	Connecting evidence with advocacy and institutional change
Peer-reviewed publications	Academic credibility and knowledge transfer
ESF+ Project Results Platform	Formal European-level dissemination of project results

DISSEMINATION ACTIVITIES:

1. PUBLICATIONS AND KNOWLEDGE PRODUCTS: the project should prepare publications in different formats for different users. Recommended formats:

Format	Best used for
Fact sheet	Quick summary of one finding or message
Policy brief	Policy problem, evidence and recommendations
Case study	Practical implementation experience
Methodology guideline	Replication and professional use
Infographic	Public or stakeholder-friendly data
Toolkit	Practical use by stakeholders
Academic article	Research and credibility
Newsletter article	Ongoing visibility and updates

2. PROFESSIONAL DISSEMINATION: should help understand how integrated care works in practice.

Examples of activities:

- webinars on IHSC implementation,
- practitioner workshops,
- case-based learning sessions,
- presentations of HUB experience,
- peer exchange between project partners and external organisations,
- dissemination of e-learning modules,
- train-the-trainer sessions,
- professional conference presentations.

Goal: support practical uptake of integrated care approaches.

3. POLICY DISSEMINATION: policy dissemination should translate project findings into arguments that are relevant for decision-makers.

Examples:

- policy briefs on healthcare access,
- presentations for municipalities,
- briefings for health insurers,
- national stakeholder events,
- public health roundtables,
- guided visits to HUBs,
- evidence summaries on cost-effectiveness,
- recommendations linked to national reforms or local strategies.

Goal: translate implementation evidence into policy-relevant arguments.

The project proposal explicitly includes annual policy advocacy sessions in each project country and guided visits to pilot locations for policymakers, professional organisations and potential multipliers.

4. EUROPEAN DISSEMINATION: should position SOLACE-CEE as a relevant model for integrated care in the CEE region and as a contribution to wider European debates on homelessness, health inequalities, Housing First and social innovation.

Mandatory compliance requirement:

- ESF+ Project Results Platform upload — all public project results must be uploaded via the Funding & Tenders Portal, as required by Annex 5 GA.

Recommended activities:

- FEANTSA Forum presentations,
- European Research Conference contributions,
- FEANTSA newsletter articles,
- European webinars,
- exchange with EPOCH-related stakeholders,
- dissemination through European networks,
- peer-reviewed publication.

The project proposal foresees FEANTSA newsletter articles, press releases, a peer-reviewed publication, and active participation in FEANTSA Forum and the European Research Conference on Homelessness.

5. LOCAL DISSEMINATION - should make project learning accessible in the language, context and reality of each pilot location.

Examples:

- local website articles,
- local-language infographics,
- community events,
- municipal presentations,
- local media work,
- HUB open days,
- partner newsletters,
- local professional meetings.

Goal: ensure accessibility and relevance within local contexts.

7.5. Quality Standards for Dissemination

All dissemination outputs should meet the following standards:

- **CLARITY** - the message should be understandable to the intended audience. Technical terms should be explained.

- **CONSISTENCY** - outputs should use the shared SOLACE-CEE framing: integrated care, Housing First, trauma-informed care, dignity, evidence, system change.
- **EVIDENCE** - claims should be supported by data, project experience, evaluation findings or clearly described practice-based learning.
- **ETHICAL COMMUNICATION** - dissemination should avoid stigma, sensationalism and charity-based narratives. People experiencing homelessness should be presented with dignity and agency.
- **VISUAL IDENTITY AND EU VISIBILITY** - SOLACE-CEE materials should use the unified visual identity, include the SOLACE-CEE logo and EU funding visibility elements, and remain consistent in tone of voice and key messaging across materials.

7.6. Monitoring Dissemination

Dissemination should be monitored both quantitatively and qualitatively.

QUANTITATIVE INDICATORS (examples)

- number of publications,
- website visits,
- downloads,
- social media reach,
- newsletter opens,
- media mentions,
- conference presentations,
- webinar participants,
- guided visit participants,
- stakeholder meetings,
- replication requests.

QUALITATIVE INDICATORS (examples)

- stakeholder feedback,
- references to project outputs in policy discussions,
- new partnerships,
- improved understanding of IHSC,
- requests for methodology support,
- invitations to present,
- evidence of local adaptation,
- changes in public or institutional narrative.

The calendar should therefore not only record what was published, but also what happened afterwards.

7.7. Common Risks in Dissemination

Risk	Explanation	Mitigation
Activity-focused communication	Sharing what happened, but not why it matters	Always connect activities to impact

Too much technical language	Outputs are understandable only to experts	Adapt language to audience
Fragmented partner messages	Each partner communicates separately without shared framing	Use common key messages and templates
Weak follow-up	Outputs are published but not used strategically	Define follow-up actions in the calendar
Ethical risks	Use of sensitive information, decontextualised data or potentially identifiable content	Use anonymised and aggregated data, follow ethical communication and data protection standards.
Low visibility of outputs	Publications are uploaded but not actively shared	Use targeted dissemination lists and events
No link to policy	Evidence remains descriptive	Translate findings into recommendations
Poor timing	Outputs are shared when no stakeholder is ready to act	Connect dissemination to policy windows and events

7.8. Connection Between Dissemination and Advocacy

Dissemination and advocacy are interconnected but distinct processes.

Dissemination	Advocacy
What have we learned?	What should change because of it?
Knowledge transfer	System influence
Sharing evidence	Using evidence for institutional change

Dissemination often creates the foundation for advocacy by:

- strengthening legitimacy,
- improving understanding,
- building stakeholder engagement,
- supporting policy dialogue,
- creating replication interest.

The strongest dissemination activities are those that lead to partnerships, policy discussions, training requests, implementation support and replication opportunities.

7.9. Practical Process for Implementation

At first it is recommended to go through following thinking process:

Step	Key Question	Practical Guidance

Step 1 – Identify what is ready to be shared	What learning, evidence or result is already mature enough for dissemination?	Dissemination should be based on validated findings, implementation learning or practical experience. Teams should assess whether the information is understandable, evidence-based, ethically safe and useful for external audiences.
Step 2 – Define the audience	Who needs this knowledge and why?	Different audiences require different formats, language and levels of detail. The main audience may be professional, policy, academic, public, local, European or internal consortium stakeholders.
Step 3 – Define the message	What is the one main thing the audience should understand or remember?	Each dissemination activity should communicate one clear and impact-oriented message linked to integrated care, system change, evidence or implementation learning.
Step 4 – Choose the format and channel	What is the most useful way to share the information?	The format should match the audience and objective. Examples include policy briefs, webinars, methodology guidelines, conference presentations, infographics, study visits or social media communication.
Step 5 – Plan follow-up and uptake	What should happen after dissemination?	Dissemination should create opportunities for action, such as stakeholder meetings, replication discussions, training requests, partnerships, policy dialogue or implementation adaptation. Follow-up responsibilities should be clearly assigned.

HOW TO USE THE DISSEMINATION DIAGRAM AND CALENDAR

The dissemination diagram should help understand the overall logic:

what we learn → how we translate it → who needs it → how we share it → what changes because of it

The dissemination calendar should then turn this logic into a concrete plan:

When → what output → which audience → which channel → who leads → what follow-up

Together, these tools help ensure that dissemination is not random, fragmented or output-driven, but strategic, audience-specific and connected to advocacy, replication and sustainability.

SOLACE-CEE dissemination diagram is provided in Annex D and dissemination calendar template is provided in Annex E.

Dissemination in SOLACE-CEE is not only about making project outputs visible. It is about transforming project evidence and implementation experience into knowledge that others can understand, use, adapt and scale. Through strategic dissemination, SOLACE-CEE supports the transfer of integrated, trauma-informed and housing-led responses to homelessness across the CEE region and beyond.

8. Sustainability and Long-term Impact

Sustainability within SOLACE-CEE is understood as the project's ability to create long-term structural impact beyond the formal implementation period. The project is designed not only as a temporary pilot intervention, but as a transferable and scalable model supporting IHSC approaches for people experiencing homelessness in Central and Eastern Europe.

8.1. Sustainability Areas

INSTITUTIONAL EMBEDDING

SOLACE-CEE supports long-term cooperation between healthcare providers, social services, municipalities, NGOs, Housing First teams and employment services. The project strengthens multidisciplinary cooperation, referral pathways and integrated care workflows that can remain functional after project completion.

FINANCING PATHWAYS

The project supports discussion on sustainable financing mechanisms for integrated care, including municipal funding, healthcare financing, ESF+ opportunities and integration into existing service budgets. Sustainability depends on combining social, healthcare and local financing approaches.

POLICY INTEGRATION

Project learning and implementation experience are intended to contribute to local, national and European discussions on homelessness, integrated care, Housing First and health inequalities. Dissemination and advocacy activities support integration of project findings into policies and strategies.

CONTINUED DISSEMINATION

SOLACE-CEE outputs, methodologies, educational materials and implementation learning are designed for continued use after the project ends. Knowledge transfer is supported through publications, e-learning, stakeholder cooperation and dissemination through European and national networks.

8.2. Replication After Project End

SOLACE-CEE aims to create transferable implementation models that can be adapted in other institutional and regional contexts. Replication potential is strengthened through:

- dissemination of implementation learning,
- visibility of HUB outcomes,
- support for replication and sustainability,
- strengthening institutional cooperation.

Together, these sustainability measures support the long-term objective of strengthening person-centred, multidisciplinary and coordinated support systems for people experiencing homelessness across Central and Eastern Europe.

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Neither the European Union nor the granting authority can be held responsible for them.

The Deliverable's quality review was carried out by the official QAA

Annexes

LIST OF ANNEXES

Annex A: Stakeholder Matrix - Manual and Template

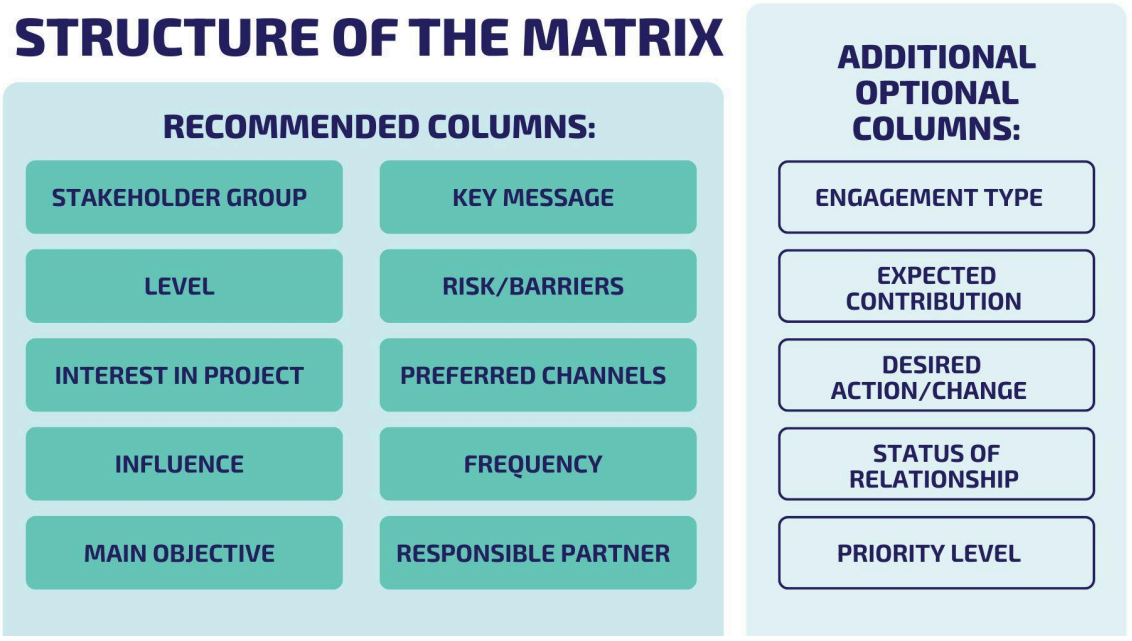
Different stakeholder groups have different levels of influence, responsibilities, interests, and engagement needs within the implementation of integrated care approaches. The stakeholder engagement approach therefore combines tailored communication, dissemination, advocacy, and cooperation activities adapted to the specific role of each stakeholder group.

PROPOSED STAKEHOLDER MATRIX – SOLACE-CEE example

The matrix is designed according to the SOLACE-CEE two-level communication model, advocacy priorities, HUB implementation logic, IHSC systemic approach, Communication Manual (recommendations on stakeholder mapping), multi-level policy alignment.

THE STRUCTURE INTENTIONALLY COMBINES:

- communication,
- advocacy,
- dissemination,
- sustainability,
- implementation support.



EXAMPLE OF THE MATRIX COLLUMS:

STAKE-HOLDER	INTEREST	INFLUENCE	MAIN OBJECTIVE	KEY MESSAGE	RISKS/ BARRIERS	CHANNELS	FREQUENCY

Stakeholder Prioritisation and Risk Considerations

Due to the broad and cross-sector nature of integrated care implementation, different stakeholder groups require different levels of engagement, communication approaches, and coordination intensity. The Action plan should therefore apply a prioritisation approach based on stakeholder influence, level of interest, operational relevance, and potential impact on implementation and sustainability processes.

STAKEHOLDER PRIORITISATION MODEL

Stakeholders can be grouped into four main categories according to their level of influence and engagement relevance.

Category	Description	Approach
Strategic decision-makers	High influence + high interest	Intensive engagement
Strategic allies	Medium/high influence + high support	Partnership building
Operational stakeholders	Medium influence	Practical coordination
Public/environmental stakeholders	Lower direct influence	Awareness and narrative work

STAKEHOLDER RISK PROFILE

Different stakeholder groups may also present different implementation, communication, or sustainability risks. **Key risk considerations include:**

- level of support,
- level of resistance,
- political sensitivity,
- reputational risks,
- misinformation risks,
- risk of narrative fragmentation.

RECOMMENDED ADDITIONAL MATRIXES

The Action Plan could contain several complementary matrices:

A. ADVOCACY STAKEHOLDER MATRIX

Focused on: influence, policy leverage, legislative relevance.

B. DISSEMINATION STAKEHOLDER MATRIX

Focused on: transferability, learning, replication, professional dissemination.

C. COMMUNICATION STAKEHOLDER MATRIX

Focused on: narratives, messaging, channels, visibility.

FOR SOLACE-CEE it is important that matrix should explicitly reflect:

- **MULTI-LEVEL GOVERNANCE** (EU → national → local)
- **CROSS-SECTOR INTEGRATION** (health + social + housing + employment)
- **DIFFERENT COMMUNICATION GOALS** - not every stakeholder needs: awareness, advocacy, dissemination, partnership, sustainability discussions equally.

RECOMMENDED VISUAL VERSION

To support strategic coordination and stakeholder engagement, the Action Plan may be complemented by additional stakeholder mapping and visualisation tools, including:

- stakeholder influence-interest map,
- ecosystem diagram,
- policy ecosystem map,
- stakeholder journey,
- advocacy pathway diagram.

These tools can support better understanding of stakeholder relationships, communication flows, decision-making structures, and opportunities for long-term cooperation and replication of integrated care approaches.

STAKEHOLDER MATRIX - SOLACE-CEE

Use this matric to identify key stakeholders, understand their nterests and influence, and plan engagement, communication, and advocacy actions.

STAKEHOLDER GROUP	LEVEL (who we want to influence)	INTEREST IN PROJECT (L/M/H)	INFLUENCE (L/M/H)	MAIN OBJECTIVE (what we want from them)	KEY MESSAGE (what we want them to understate)	ENGAGEMENT TYPE (awareness/partnership/ advocacy/support/coordi nation/funding)	PREFFERED CHANNELS (what works best)	FREQUENCY (of engagement)	RESPONSIBLE PARTNER	NOTES (optional)

INTEREST: **L** - Low; **M** - Medium; **H** - High **INFLUENCE:** **L** - Low; **M** - Medium; **H** - High

LEVELS: **EU** - European level; **National** - National level; **Local** - Local level; **Internal** - Consortium/Project team

ENGAGEMENT TYPES: **Awereness** - raise awareness; **Partnership** - build collaboration; **Advocacy** - influence policy/systems; **Support** - gain support; **Coordination** - operational coordination; **Funding** - secure financing

STAKEHOLDER MAP - SOLACE-CEE

Map stakeholders by their level of interst and influence to prioritize engagement strategies

INSTRUCTIONS:

1. Place each stakeholder group in the map based on their level of interest and influence
2. High interest + high influence = priority engagement
3. Low interest + low influence = minimal monitoring
4. Use different colour or symbols to represent levels (EU/National/Local/Internal)

LEVEL LEGEND (use colours and symbols)

- EU - European level
- National - National level
- Local - Local level
- Internal - Consortium/Project team
- Other (specify)

NOTES/IDEAS/KEY INSIGHTS

SOLACE CEE

Annex B: Advocacy Pathway Diagram - example from SOLACE-CEE

The advocacy pathway for SOLACE-CEE should visually demonstrate that the project is not only delivering services, but intentionally transforming: narratives, institutional cooperation, policy understanding, financing approaches, integrated systems in the CEE region.

The pathway should connect evidence, implementation, communication, stakeholder engagement, policy influence, systemic impact.

1. RECOMMENDED STRUCTURE OF THE DIAGRAM

The pathway can be visualized as:

DATA & EVIDENCE
↓
PILOT IMPLEMENTATION
↓
COMMUNICATION & NARRATIVE CHANGE
↓
STAKEHOLDER ENGAGEMENT
↓
ADVOCACY & POLICY INFLUENCE
↓
SYSTEM CHANGE & SUSTAINABILITY

2. DETAILED ADVOCACY PATHWAY

STAGE 1 — DATA & EVIDENCE

Inputs:

Needs Assessment (5 countries), European Homelessness Counts, HUB implementation data, Case studies, Lived experience insights, Service utilization data, Housing stability outcomes, Healthcare access barriers, Employment outcomes

Main Goal: Build legitimacy and credibility.

Advocacy Function

Demonstrate:

- homelessness as structural issue,
- fragmentation of systems,
- need for IHSC,
- impact of integrated approaches.

Outputs

- reports,
- infographics,
- policy briefs,

- evidence summaries,
- presentations.

STAGE 2 — PILOT IMPLEMENTATION

Inputs:
Partner HUBs, multidisciplinary teams, Housing First, TIC, IPS outreach services

Main Goal:
Demonstrate practical feasibility.

Advocacy Function
Show that:

- integration works in practice,
- multidisciplinary care is possible,
- local systems can cooperate,
- CEE-adapted models are viable.

Outputs

- operational examples,
- implementation lessons,
- good practices,
- transferability evidence.

STAGE 3 — COMMUNICATION & NARRATIVE CHANGE

Activities
media communication, social media, storytelling, impact communication, public campaigns, conferences, newsletters, publications.

Main Goal
Shift the public and institutional narrative.

Advocacy Function - move framing:
FROM:
charity, emergency response, individual failure.

TO:
public health, systemic response, housing stability,
integrated care, rights-based approach.

Key Messages

- Housing is a determinant of health.
- Homelessness is systemic.
- Integrated care reduces fragmentation.
- Stability improves outcomes.
- Trauma-informed approaches increase engagement.

STAGE 4 — STAKEHOLDER ENGAGEMENT

Stakeholders
municipalities, ministries, insurers, healthcare sector, NGOs, FEANTSA, EPOCH, EU institutions, academia, employers.

Activities
- roundtables,
- policy dialogues,
- HUB visits,
- workshops,
- conferences,
- bilateral meetings,
- strategic partnerships.

Main Goal
Build alliances and institutional trust.

Advocacy Function
Create:
cross-sector cooperation, policy legitimacy, ownership, institutional buy-in.

STAGE 5 — ADVOCACY & POLICY INFLUENCE

Advocacy Areas
integrated financing, healthcare access, Housing First, medical respite, hospital discharge pathways, prevention systems, multidisciplinary care, integrated local systems.

Activities
- policy briefs,
- recommendations,
- consultation participation,
- legislative discussions,
- expert advisory participation,
- dissemination of evidence.

Main Goal
Influence: policy, financing, strategic planning, service design.

Desired Outcomes
- stronger institutional support,
- inclusion in strategies,
- sustainable financing pathways,
- replication interest.

STAGE 6 — SYSTEM CHANGE & SUSTAINABILITY

Long-Term Outcomes
- integrated care embedded in systems,
- stronger coordination between sectors,

- improved healthcare access,
- reduced fragmentation,
- prevention-oriented approaches,
- stronger Housing First ecosystem,
- transferability across CEE.

Sustainability Areas

- institutional embedding,
- financing,
- political support,
- professional capacity,
- replication,
- long-term partnerships.

3. VERY IMPORTANT CROSS-CUTTING ELEMENTS

These should visually run THROUGH the entire pathway:

A. Trauma-Informed Approach

- dignity,
- trust,
- ethical communication,
- non-stigmatizing language.

B. Multi-Level Governance

- local,
- national,
- European level.

C. Data-Driven Legitimacy

Evidence supports every stage.

D. Connected Care Framing

Housing + health + social + employment interconnected.

4. RECOMMENDED VISUAL LAYOUT:

OPTION A - LINER PATHWAY
FROM EVIDENCE TO SYSTEM CHANGE

1. DATA AND EVIDENCE
- Needs Assessment, counts
- Service and outcomes data
- Lived experience insights
- Case studies, reports

Build legitimacy and credibility with evidence.

2. PILOT IMPLEMENTATION
- HUBs
- Multidisciplinary teams
- HF, TIC, IPS
- Integrated health and social care

Demonstrate feasibility and real-world impact.

3. COMMUNICATION AND NARRATIVE CHANGE
- Media, social media, campaigns
- storztelling, impact communication
- Publications, events, newsletter

Shift public and institutional narratives.

4. STAKEHOLDER ENGAGEMENT
- Roundtables, policy dialogues
- HUB visits, workshops
- Partnership and alliances

Build alliances and institotional trust

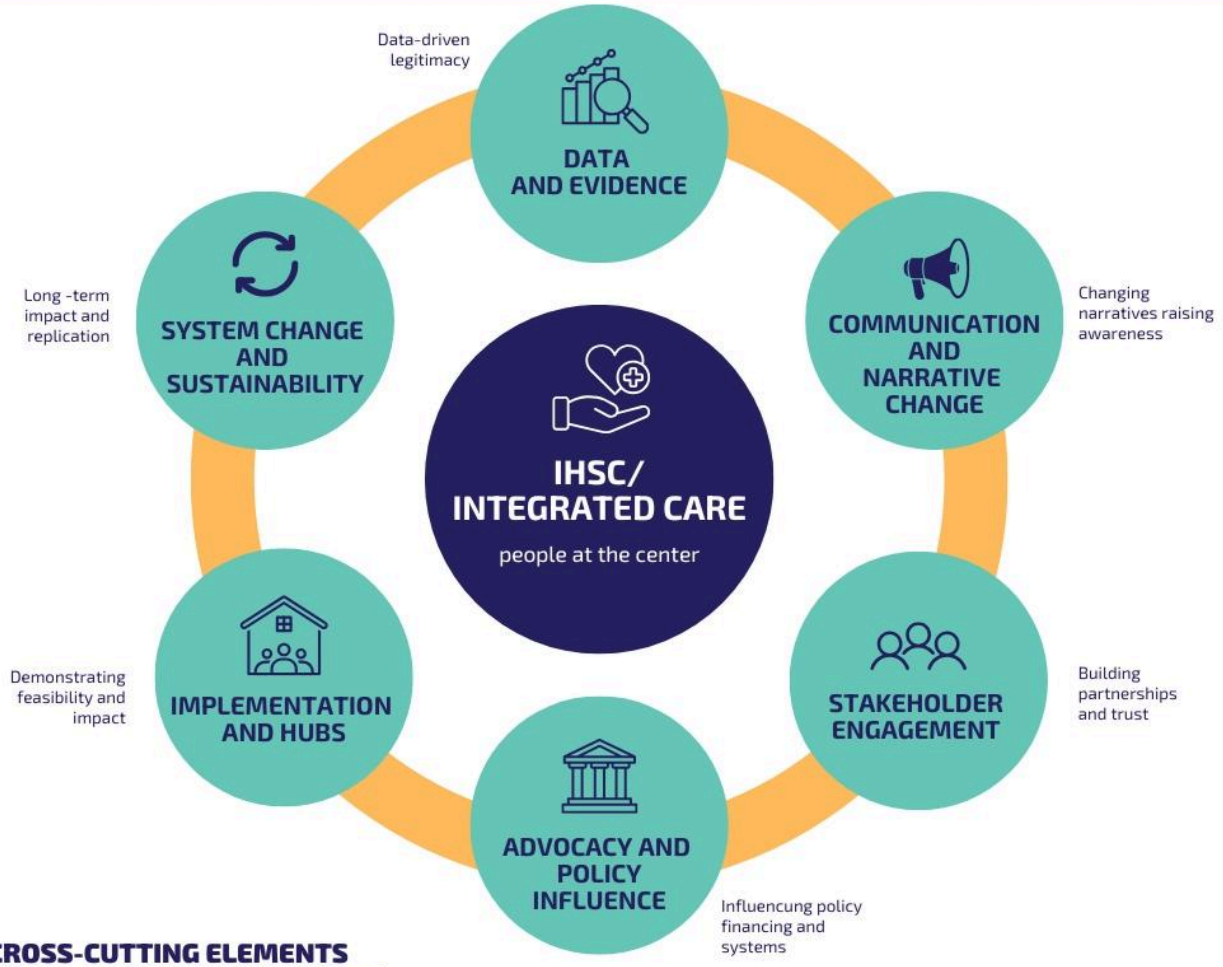
5. ADVOCACY AND POLICY INFLUENCE
- Policy briefs, recommendations
- Consultations, legislative discussions
- Influencing policy and financing

Influence policy financing and strategic planning

6. SYSTEM CHANGE AND SUSTAINABILITY
- Integraated care embedded in systems
- Stronger coordination across sectors
- Improved access, prevention, stability
- Transfebility across CEE

Achive lasting systematic change and impact

OPTION B - ECOSYSTEM CIRCULAR MODEL
INTEGRATED ELEMENTS FOR SYSTEMIC CHANGE



CROSS-CUTTING ELEMENTS (ACTIVE THROUGH ALL STAGES)

TRAUMA-INFORMED APPROACH
Dignity, trust, ethical communication

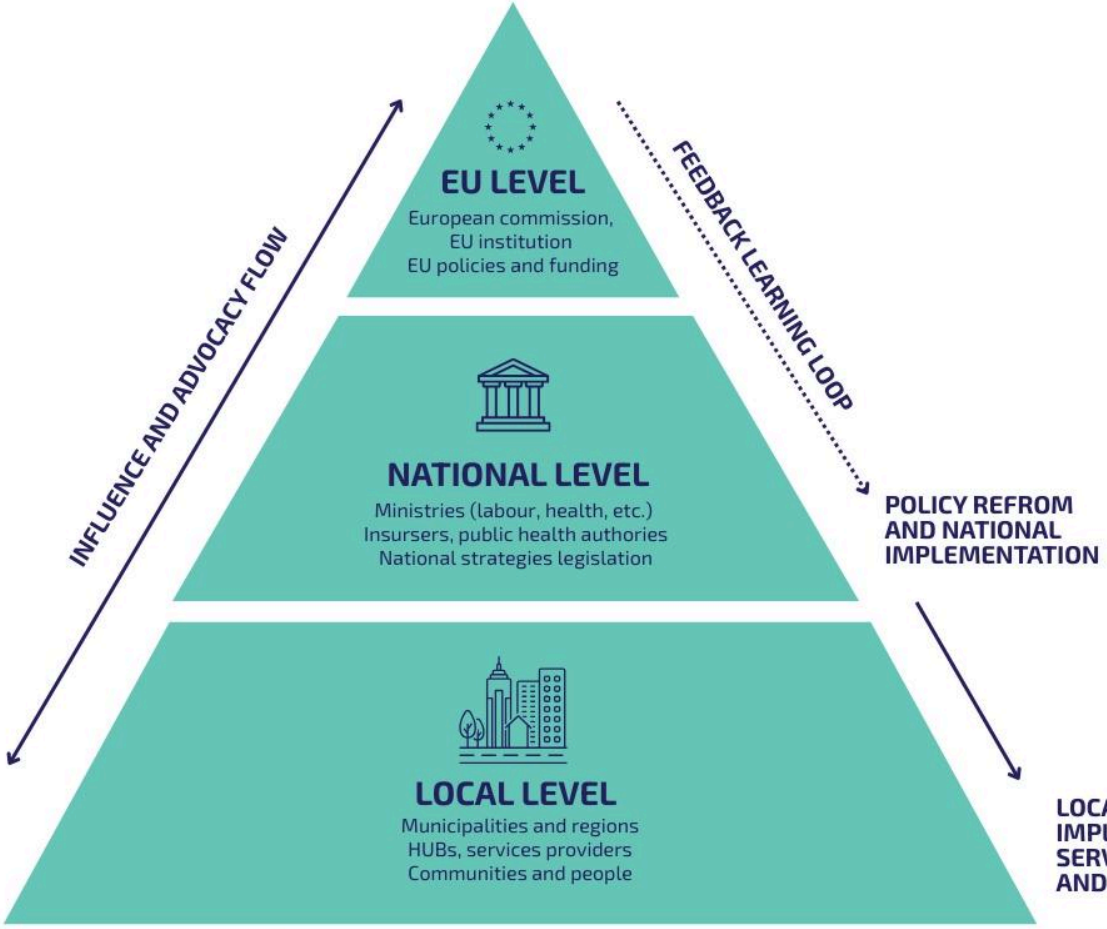
MULTI-LEVEL GOVERNANCE
Local, national, european level

DATA-DRIVEN LEGITIMACY
Evidence supports every stage

CONNECTED CARE FRAMING
Housing + Health + Social + Employement

OPTION C -MULTI-LEVEL GOVERNANCE PYRAMID

INFLUENCING CHANGE ACROSS LEVELS



CROSS-CUTTING FOUNDATIONS

- EVIDENCE AND DATA
- COMMUNICATION AND NARRATIVE
- PARTMERSHIPS AND COOPERATION
- TRAUMA-INFORMED APPROACH

CREATING COORDINATED SYSTEMS THAT WORK FOR PEOPLE

STRONGEST MESSAGE

SOLACE-CEE is not only a service project. It is a systematic transformation pathway that uses evidence, integrated pilots, communication and advocacy to influence long-term structural change in homelessness response in the cee region.

SOLACE CEE

Annex C: Advocacy Calendar Framework

Below is an advocacy calendar framework that can be used by implementers of integrated services projects (e.g. IHSC HUBs, Housing First programmes, outreach and integrated prevention systems).

The purpose of the calendar is not only to plan activities, but to:

- connect advocacy with real implementation,
- identify policy windows and opportunities,
- coordinate stakeholders,
- link evidence, lived experience and systemic change,
- monitor progress and follow-up actions.

1. ADVOCACY CALENDAR

FULL TEMPLATE	2. SIMPLIFIED VERSION FOR OPERATIONAL TEAMS
Month/Period	**When?**
Advocacy Goal	**What do we want to change?**
Target Stakeholder	**Who do we need to influence?**
Opportunity/Trigger	**What is happening in the system?**
Key Message	**What will we do?**
Evidence/Data	**Responsible Person**
Activity Type	**Status**
Lead Person	
Allies/Partners	
Expected Outcome	
Follow-up Needed	

3. EXPLANATION OF THE COLUMNS

Advocacy Goal

What exactly are we trying to achieve?

Examples:

- secure municipal support for an integrated HUB,
- change funding rules,
- establish cooperation with health insurers,
- create referral pathways,
- include homelessness in strategic plans, influence legislation,

- gain political support.

Target Stakeholder

Who has influence or decision-making power?

Examples:

- municipalities,
- regional authorities,
- ministries,
- public health authorities,
- health insurers,
- hospitals,
- MPs,
- media,
- universities,
- FEANTSA,
- local communities,
- donors,
- professional chambers.

Opportunity/Trigger

What creates a good "window of opportunity"?

Examples:

- elections,
- municipal budget planning,
- new funding calls,
- public incidents,
- publication of new data,
- conferences,
- European Commission visits,
- hospital pressure,
- legal reforms,
- audits,
- EPOCH reporting processes.

Key Message

What is the one main thing we want stakeholders to remember?

Examples:

- "Integrated care reduces pressure on emergency services."
- "Housing and health systems must work together."
- "People experiencing homelessness face discrimination in healthcare access."
- "Prevention is cheaper than crisis response."

Evidence / Data

What evidence supports our advocacy?

Examples:

- needs assessments,
- pilot results,
- emergency room data,
- patient stories,
- economic modelling,
- Housing First retention rates,
- service utilization data,
- qualitative interviews,
- testimonials.

Activity Type

What advocacy format or action will we use?

Examples:

- bilateral meetings,
- workshops,
- roundtables,
- advocacy letters,
- public events,
- media interviews,
- policy briefs,
- site visits,
- stakeholder breakfasts,
- conference presentations,
- campaigns.

Expected Outcome

What realistic result do we expect?

Examples:

- follow-up meeting,
- memorandum of cooperation,
- public endorsement,
- funding commitment,
- inclusion in a strategy,
- pilot approval,
- partnership agreement,
- legislative discussion.

Follow-up Needed

Advocacy is a process, not a one-time event.

Examples:

- send meeting summary,
- prepare additional data sheet,
- follow-up call,
- involve experts by experience,
- prepare draft MoU,
- invite stakeholders for a HUB visit.

4. IMPLEMENTER THINKING PROCESS

STEP 1 — WHAT ARE WE TRYING TO CHANGE?

Implementers should ask themselves:
What systemic barriers currently exist?
What do we need for sustainability?
What must change in the system, not only within the project?
Where is the bottleneck?

Examples:

- lack of sustainable financing,
- barriers to clinic registration,
- weak referral pathways,
- discrimination in healthcare,
- lack of homelessness data.

STEP 2 — WHO HAS INFLUENCE?

The person with formal authority is not always the key actor.

Differentiate between:

- decision makers,
- influencers,
- blockers,
- allies,
- neutral actors.

STEP 3 — WHERE IS THE "WINDOW OF OPPORTUNITY"?

Advocacy works best when:

- the system feels pressure,
- a crisis emerges,
- new evidence becomes available,
- elections are approaching,
- reforms are underway,
- funding opportunities open.

STEP 4 — WHAT IS OUR STRONGEST ARGUMENT?

Strong advocacy combines:

- DATA,

- HUMAN STORIES,
- ECONOMIC ARGUMENTS,
- RIGHTS-BASED ARGUMENTS,
- SYSTEM EFFICIENCY.

STEP 5 — WHAT IS REALISTIC?

Not every advocacy activity needs to change legislation.

Success can also mean:

- building partnerships,
- increasing trust,
- opening discussion,
- creating a working group,
- organizing a site visit,
- securing pilot support.

5. RECOMMENDED ADVOCACY CYCLE

MONTHLY

- update stakeholder mapping,
- monitor opportunities,
- review political context,
- identify risks and barriers.

QUARTERLY

- evaluate progress,
- revise messages,
- review alliances,
- identify wins and losses.

ANNUALLY

- review advocacy strategy,
- assess policy impact,
- evaluate stakeholder relationships,
- plan scaling and sustainability.

6. OPTIONAL TEAM REFLECTION TABLE

Question	Reflection
What worked well?	
Which stakeholders became more supportive?	
Where did we face resistance?	
Which arguments resonated most strongly?	
What surprised us?	
What should we stop doing?	
What should we scale up?	

7. KEY PRINCIPLES FOR IMPLEMENTERS

Advocacy is not only communication

It is also:

- relationship building,
- strategic influence,
- timing,
- credibility,
- persistence.

Advocacy must be connected to implementation

The strongest advocacy comes from:

- real services,
- real evidence,
- lived experience,
- practical solutions.

Different stakeholders require different language

- politicians → public impact,
- insurers → cost-effectiveness,
- hospitals → reduced pressure,
- municipalities → social stability,
- donors → measurable impact.

Follow-up is critical

Many advocacy efforts fail not because of weak messages, but because there is no structured follow-up.

Experts by experience must be part of the process

Not only as storytellers, but as:

- co-designers,
- consultants,
- evaluators,
- representatives,
- decision-making participants.

Annex C.1: Advocacy Calendar Template

MONTH/ PERIOD (when)	ADVOCACY GOAL (what we want to achieve)	TARGET STAKEHOLDER (who we want to influence)	OPPORTUNITY /TRIGGER (why now?)	KEY MESSAGE (what we want them to hear)	EVIDENCE /DATA (what supports our message)	ACTIVITY TYPE (how we engage)	LEAD PERSON (who is responsible)	ALLIES/ PARTNERS (who supports us)	EXPECTED OUTCOME (what we expect)	FOLLOW/UP NEEDED (next steps)	NOTES (optional)

2. COLUMN EXPLANATIONS

MONTH/PERIOD When will the activity take place? Be specific (month/quarter)	**OPPORTUNITY/TRIGGER** What creates the right moment or urgency for action?	**LEAD PERSON** Who is responsible for leading this activity?	**FOLLOW-UP NEEDED** What will we do after the activity? (e.g. send materials, next meeting, request data, site visit, etc.)
ADVOCACY GOAL What change or decision are we advocating for? Keep it specific and measurable.	**KEY MESSAGE** One clear, simple message that our stakeholder should remember	**ALLIES/PARTNERS** Who will strenghten our voice and join the effort?	**NOTES** Any additional context, links, or important information
TARGET STAKEHOLDER Who has the power or influence to make the change happen	**EVIDENCE/DATA** What data, research, stories or examples support our message? Include sources	**ACTIVITY TYPE** What format will we use to engage? (e.g. meeting, roundtable, policy brief, media event, etc.)	**EXPECTED OUTCOME** What result do we expect from this activity? (e.g. commitment, meeting, public support, etc.)

3. KEY PRINCIPLES FOR EFFECTIVE ADVOCACY

PEOPLE FIRST Include people with lived experience meaningfully in planning and decisions	**EVIDENCE DRIVEN** Use reliable data and stories to build credibility and trust	**RELATIONSHIP BASED** Invest time in building and maintaining strong relationships	**TAILOR YOUR MESSAGE** Different stakeholders need different information and arguments	**PERSISTENT & FLEXIBLE** Different stakeholders need different information and arguments	**SYSTEM CHANGE FOCUS** Look beyond services - influence policies, systems and structures

4. ADVOCACY CYCLE (ONGOING)

SCAN
Monitor context, identify issues and opportunities.

PLAN
Set goals, mapstakeholders and design activities.

ACT
Implement activities and engage stakeholders.

EVALUATE
Assess outcomes and what we learned.

ADAPT
Adjust strategy and repeat the cycle.

1 DEFINE THE CHANGE
What systemic change do we want?
What barrier are we trying to remove?
What decision or action do we need?

2 WHO CAN INFLUENCE IT?
Map stakeholders: decision makers, influencers, blocker, allies, neutrals. Choose priority stakeholders.

3 IDENTIFY THE OPPORTUNITY
What is happening now that creates a window of opportunity? (Policy cycle, budget, election, crisis, new data, event, etc.)

4 BUILD YUOR CARE
What is the strongest argument?
Use a mix of data, stories, economic, right-based and practical solutions.

5 PLAN THE ACTION
Choose the best activity and partners.
Define key message, materials and roles.

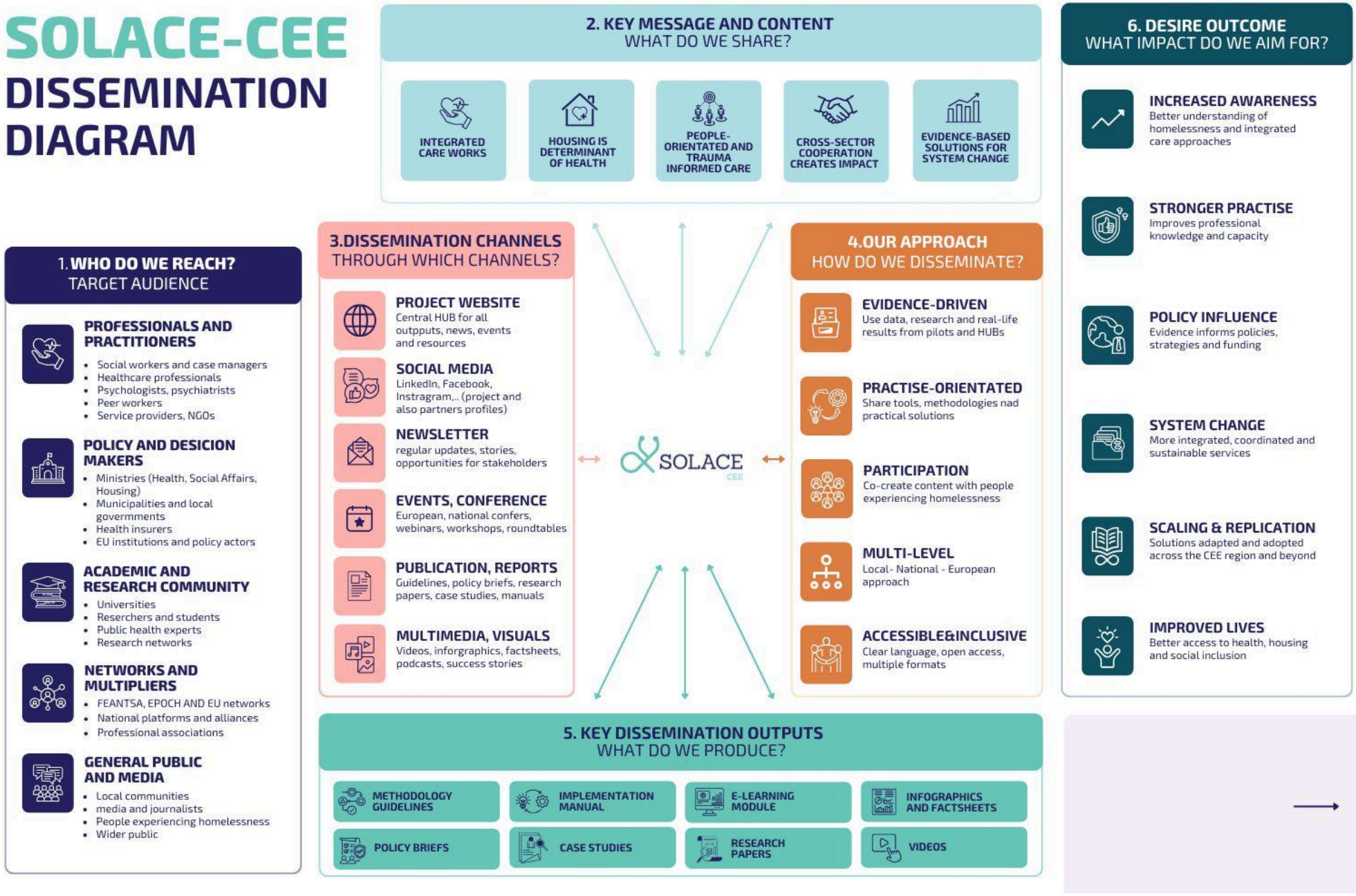
6 ENGAGE & FOLLOW UP
Implement the activity. Follow up, nurture the relationship and move the conversation forward.

7 REVIEW & LEARN
Track outcomes, reflect on what worked, update strategy and repeat the cycle.

QUICK START - THINKING PROCESS

SOLACE CEE

Annex D: Dissemination Diagram - SOLACE-CEE example



7. DISSEMINATION PROCESS
OUR FLOW

8.SUCCESS FACTORS

- CLEAR MESSAGE AND CONSISTENT BRANDING
- STRONG PARTNERSHIP AND STAKEHOLDER ENGAGEMENT
- RELEVANT, HIGH-QUALITY AND ADAPTABILITY
- TWO-WAY COMMUNICATION AND FEEDBACK
- MONITORING, LEARNING AND ADAPTABILITY
- SUSTAINABILITY AND LONG-TERM IMPACCT FOCUS

9.FEEDBACK LOOP

FLOW OF INFORMATION TWO-WAY ENGAGEMENT LINK TO IMPACT

Dissemination is more than sharing information - it is a strategic process that builds knowledge, drives colllaboration and creates lasting change.

SOLACE CEE

Annex E: Dissemination Calendar - template

PROJECT PERIOD	DISSEMINATION FOCUS	KEY CONTENT/ OUTPUT TO DISSEMINATE	MAIN CHANNELS	TARGET AUDIENCE	LEAD CONTRIBUTORS	EVIDENCE/KPI

NOTES:

- Be audience-oriented: think who needs this information and in what format
- Link dissemination to impact: every activity should contribute to awarness, uptake, replication or policy change.
- Use multiple channles: combine digital, in-person and network channels.
- Ensure EU visibility in all materials and activities.
- Track and document results for learning and reporting.

HOW TO USE THIS CALENDAR

1. Identify kez moments in the project (milestones, outputs, events, policy windows)
2. Define the dissemination focuus and main message for each period.
3. Choose the most appropriate channels and formats for your audiences.
4. Assign responsibilities and set indicators to track results.
5. Review regularly and adjust based on feedback and outcomes.

DISSEMINATION PROCESS - OUR FLOW

KEY PRINCIPLES

AUDIENCE FIRST
Tailor messages and formats to audience needs.

EVIDENCE-BASED
Use data and results to build credibility.

CONSISTENT& CLEAR
Keep messages simple, consistent and aligned.

COLLABORATIVE
Work with partners and stakeholders to amplify impact.

SUSTAINABLE
Plan for long-term use and replication.