GUIDELINES FOR BUILDING NATIONAL ALLIANCES FOR THE PREVENTION OF CARDIOVASCULAR DISEASES

A paper published in the context of the European Heart Health Initiative

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FOREWORD

In 1998 the European Heart Network (EHN), with the financial support of the European Commission, started the European Heart Health Initiative (EHHI). The EHHI aims at preventing cardiovascular diseases, mainly heart disease and stroke, by addressing known risk factors in the European population.

In its first phase the EHHI commenced the work of creating and strengthening alliances between organisations involved in CVD prevention at both national and European level. The alliances were to be instrumental in facilitating the exchange of information and in identifying and prioritising needs in CVD prevention. At the end of the first phase, the priority among the EHHI national coordinators and national alliances was quite clearly a focus on children and young people. At a major conference, "Winning Hearts", which took place on Saint Valentine's Day 2000, a declaration was adopted which has since been signed by many organisations throughout Europe:

"Every child born in the new millennium has the right to live until the age of at least 65 without avoidable cardiovascular disease"

Following this initial work, the second phase of the EHHI focused on children and young people and physical activity. A comprehensive overview of the existing science on children/young people and physical activity was merged with a stocktaking of programmes, campaigns, initiatives etc. based on the experience of the national coordinators. The coordinators used the knowledge they gained through their involvement with programmes and policy developments to create a publication called "Children and Young People – The Importance of Physical Activity". This paper was published in December 2001.

The purpose of the current study, which is an important part of the third phase of the EHHI, is to evaluate the process and impact of developing national alliances for cardiovascular disease prevention. The study is based on the experience of existing alliances set up within the framework of the EHHI. It analyses common principles, stages and functions necessary for constructing and maintaining national-level alliances.

The study also contains guidelines and principles of good practice on the development of national alliances for CVD prevention. Furthermore, it provides mechanisms for the dissemination of recent EHHI publications, particularly the report on "Children and Young People – The Importance of Physical Activity", and for the implementation of the recommendations set out in this document.

It is hoped that by publishing this study and thus sharing their experience, not only can the EHHI coordinators be helped to further strengthen their alliances and achieve their objectives, but that organisations in countries not hitherto part of the EHHI can also benefit.

Susanne Løgstrup
Director, European Heart Network

EXECUTIVE SUMMARY

The aim of these guidelines is to present principles of good practice for the development of national alliances for Cardiovascular Disease prevention. These principles have been developed from the European Heart Health Initiative (EHHI) national alliance coordinators' experience of designing, operating and evaluating their own national alliances. The guidelines represent a first step for future alliances.

Defining an alliance is vital, as it provides the starting point and the structure for future activity. An alliance is defined as:

- a group with a cooperative agreement between two or more individuals or organisations where:
  - a common purpose is agreed between all partners;
  - the pooling of the partners' resources provides a greater gain for all;the relationship between the partners is based on shared values, agreed aims and objectives, and honesty.

Two main types of alliance were found: action-oriented alliances working on collaborative projects and programmes, and advocacy-oriented alliances working on advocacy-related activities.

Four key working principles were found to be the essential foundations of a successful alliance: trust; openness; equality; and commitment. The coordinators found seven common functions of an alliance: management and coordination; information and publications; communication; administration; development and support; research and evaluation; and a strategy and business plan. Funding for the alliance came from four main sources: membership fees; products and services; fund raising and sponsorship; and national governments.

Evaluation of the alliance's work is essential. Results of process and/or outcome evaluations can be used to improve the alliance's work and to demonstrate the effectiveness of the alliance.

From over 50 collective years of running alliances, the EHHI coordinators identified a number of elements that are key to managing a successful national alliance for cardiovascular disease prevention. These elements were:

- core values and principles which are essential for working together;
- a clearly identified aim, a definite rationale and a business plan for the alliance;
- organisations that are involved in the alliance for the sake of goals that go beyond the alliance itself;
- a specified action or work programme that meets needs not already adequately addressed by other alliances or organisations
- constant communication in order to keep alliance members involved and motivated
- a strong national coordinator with a high profile

Successful alliances are not just 'talk shops', but are ready to turn opinion into action.

INTRODUCTION

1. Background

The prevalence and impact of cardiovascular disease (CVD) keeps it one of the largest public health problems throughout Europe. CVD causes four million deaths each year in Europe as a whole, and over 1.5 million deaths each year in the European Union alone (Rayner and Petersen, 2000). Unless more is done to develop strategies for CVD prevention, the cost of treating this chronic disease will continue to grow. Although behavioural risk factors for CVD, in particular smoking, poor diets and physical inactivity, are prevalent throughout Europe, they are not distributed equally across different countries and their populations. Environmental, economic and social approaches to the prevention of CVD are less well developed in some countries in Europe than in others.

In 1998 the European Heart Network (EHN) launched the European Heart Health Initiative (EHHI). This initiative had two aims:

- to strengthen European cooperation in order to promote effective action and interventions aimed at reducing the incidence of CVD throughout Europe;
- to create awareness among policy makers and health professionals – and in the longer term the general public – of the importance of fighting CVD and of ways and means to make its prevention possible.

National coordinators were appointed to set up new alliances for CVD prevention or to further develop existing alliances. In its first phase, the EHHI project focused on a pan-European action theme, mapping campaigns and interventions as well as developing national action plans and common projects, which included a survey of European politicians. In 2002, EHN published *Children and Young People – the importance of physical activity* (European Heart Network, 2002) as part of the second phase of the EHHI.

It was agreed that the implementation of the recommendations would require the support of alliances and, therefore, that a review of the principles of alliance work should be carried out. The result of the review is the present guideline document.

The guidelines present principles of good practice for the development of national alliances for CVD prevention. National alliances are a recent approach to the prevention of CVD. For the first time, these guidelines present the experiences of the national coordinators of the EHHI in developing and maintaining alliances for the prevention of CVD. They describe the theory behind alliance work, the different styles of alliances found within the EHHI, and the principles and processes of developing, implementing and evaluating alliance work.

New examples of good practice in alliance work will emerge as more is learnt about developing national alliances in different countries, cultures and settings across Europe. With this in mind, these guidelines should be considered as a starting point. It is hoped that the experiences and examples of good practice shared by the EHHI

participants will prove useful to their own further development as well as to the future work of others, especially in Central and Eastern Europe.

2. Who are these guidelines for?

These guidelines are aimed at people working at local, regional and national level who are part of any organisation for the prevention of CVD. Written with the help of the national coordinators, they are based on their experience of building alliances for cardiovascular disease prevention. The document includes examples of their perceptions of good practice, their reflections on their national alliances' strengths and weaknesses, other sources of published literature, and research on the theory and practice of alliance building. The aim of these guidelines is:

- to describe the principles and types of alliances while offering practical ideas for the development, implementation and evaluation of national alliances for the prevention of cardiovascular disease.

3. How has this guide been developed?

The guidelines are part of the developmental work of the EHHI. They are based on the results of research commissioned by the European Heart Network and conducted by the British Heart Foundation Health Promotion Research Group, from the University of Oxford. The contributors to the guidelines are representatives of fourteen heart associations which have set up national alliances:

- Austrian Heart Foundation
- Belgian Heart League
- Danish Heart Foundation
- Finnish Heart Association
- French Federation of Cardiology
- German Heart Foundation
- Irish Heart Foundation
- Italian Association against Thrombosis
- Netherlands Heart Foundation
- Norwegian Council on CVD
- Portuguese Heart Foundation
- Spanish Heart Foundation
- Swedish Heart-Lung Foundation
- UK National Heart Forum

In addition representatives of the following organisations also made contributions:

- Estonian Heart Association
- Hungarian Heart Foundation
- Slovenian Heart Foundation

The research had the following three phases of data collection:

- a self-completed questionnaire;
- an analysis workshop;
- country-specific post-workshop questions.

Representatives of the fourteen national alliances completed a 17-item questionnaire prior to the analysis workshop (see Appendix 1). The workshop data was generated via a series of facilitated activities, using researcher notes and participant notes. During the workshop, participants evaluated their own alliances and also provided additional materials including publications and reports. After the workshop, participants were asked to check and verify the analysis of their alliances. Additional data about the theory and practice of alliances was obtained via electronic literature searches.

4. How should these guidelines be used?

The examples of good practice for developing national alliances have been grouped into four sections.

Section 1 What is an alliance?

Section 2 Preparing for an alliance

Section 3 Making an alliance work

Section 4 Evaluation and alliance work

Each section contains key points and examples of good practice. A short discussion follows some points if experiences were different in other areas. At the end of each section key points are summarised.

Section 5 covers the common learning of the present national alliances of the EHHI.

Section 6 presents a series of questions suggested to help guide the development and action of any future alliance.

SECTION 1 – WHAT IS AN ALLIANCE?

The aims of this section are to define an alliance, to present the reasons for adopting working in alliances, to give examples of different types of alliances, and to cover the evidence that supports the advantages of working in alliances.

1.1 What is an alliance?

Examples of working through alliances can be found in every country across the world and throughout human existence. In prehistoric times, groups of people living and hunting together had a greater chance of survival than solitary individuals did. History also records alliances that were forged for military, economic, religious and political reasons.

The Ottawa Charter reinforced the need for alliances in the health field (World Health Organization, 1986). The Charter emphasised that health promotion and the prevention of disease would be best served by developing health-promoting policies and environments and by working with communities. This approach of working together led the World Health Organization (WHO) to call this process 'intersectoral/multisectoral collaboration', or in other words 'alliance work' (Naidoo and Wills, 2000).

An alliance is a group with a cooperative agreement between two or more individuals or organisations where:

- a common purpose is agreed between all partners;
- the pooling of the partners' resources provides a greater gain for all;
- the relationship between the partners is based on shared values, agreed aims and objectives, and honesty.

Working in alliances was recognised by the WHO as a key element in tackling the broader determinants of health which could not be approached effectively through health systems alone.

> 'Multisectoral cooperation is the only way of effectively ensuring the prerequisites for health, promoting healthy policies and reducing the risks in the physical, economic and social environment' (World Health Organization, 1985).

Other descriptions of alliances include (Naidoo and Wills, 2000):

- *Multi-agency*: an alliance formed between organisations that belong to the same sector, such as industry, health, social services, education;
- *Intersectoral*: an alliance that goes beyond any one sector and mixes organisations from public, private and voluntary organisations;
- *Partnerships*: an alliance that could be multi-agency or intersectoral and that implies joint action between partners and an equal sharing of power.

1.2 Why work in alliances?

Building an alliance increases the capabilities of all partners to achieve a common aim. An alliance is formed to achieve specific goals and objectives of the partners involved. The alliance becomes a new single organisation, made up of different partners, which can work together on specific actions to achieve the goals that all the partners share. The formation of the alliance should increase the likelihood of achieving an aim via action, so that the alliance should be more efficient and effective than the member organisations are when working alone.

1.2.1 Advantages of an alliance

Alliances and collaborations create 'additionality' (Naidoo and Wills, 2000), that is, the overall effect of the alliance is greater than the individual effects of its members. An alliance will:

- be more effective in its activities;
- share knowledge among members;
- delegate and share tasks and responsibilities;
- save money by collaboration;
- offer greater public and political recognition for the individual organisations and the alliance itself;
- provide a forum for discussion and debate;
- provide a forum for scientific agreement;
- build a consensus on key issues;
- offer a collective power and voice to its members.

1.2.2 Disadvantages of an alliance

There are very few disadvantages to alliances, but there are some problems associated with working in alliances. These problems relate to the way an alliance operates or the way it is perceived. An alliance that is not functioning effectively might:

- include only certain organisations like multi-agency groups whilst ignoring voluntary or public organisations;
- become a 'talk shop' – only discuss action rather than actually taking action;
- rely on certain members of the alliance to deliver results without equal support from other members of the alliance;
- be perceived as a single-issue alliance, as one issue dominates the alliance's actions, while ignoring other aims of the alliance;
- be perceived as too close to or include member organisations that may not share the aims of the alliance, e.g. industry;
- lack visibility at national, regional or local level with its stakeholders, supporters and/or target group.

1.3 Types of alliances

An alliance can be defined by the way it operates. The functions of an alliance will be determined by its aim, its membership and its actions. Often alliances emerge from informal relationships between organisations, perhaps as part of collaboration or as part of joint work, rather than being created from nothing.

The workshop participants identified two related types of alliance: action-oriented alliances and advocacy-oriented alliances. These definitions emphasise the main focus and aim of the alliance itself, whether it is work on collaborative projects and programmes or work on advocacy-related activities.

1.3.1 Action-oriented alliance

An action-oriented alliance focuses on bringing together different partner organisations with the aim of working together to support and implement programmes and projects. Examples of these could include participation in national health days through issuing press releases, producing a series of professional or patient information resources, or commissioning a scientific review of evidence to support or develop new areas of work. Action-oriented alliances could aim to:

- coordinate prevention-related campaigns and projects for CVD prevention;
- develop and implement national campaigns and projects;
- develop resources and products for use in projects;
- support the development of a research and best practice evidence base for the prevention of CVD.

Two examples of Action oriented Alliances

The Netherlands Heart Foundation
The Netherlands Heart Foundation leads a number of non-governmental organisations and charities in concerted actions and co-funds activities, campaigns and organisational structures. The Netherlands Heart Foundation sponsors a great number of prevention campaigns and represents heart health in many different organisational bodies.

The Spanish Heart Foundation
The Spanish Heart Foundation brings together different groups (governmental and non-governmental) by organising common activities. For example, in order to create awareness amongst women about the risk of CVD the SHF set up an alliance with the Ministry of Agriculture, Fishery and Food, the Spanish Society of Cardiology, several women's associations, pharmaceutical companies and fruit producers to develop an information campaign. The positive response from female participants and the echo in the national media showed the success of cooperation trough this alliance.

1.3.2 Advocacy-oriented alliance

An advocacy-oriented alliance aims to speak out and make a case for its agenda. For example, EHN advocates that a population-wide approach to promoting heart health yields better results than a high risk approach alone. An alliance will target its advocacy activities in two ways: first by listening, understanding and formulating the views of its members, acting as an 'advocate'; secondly by presenting these views to institutions or groups that influence what happens or hold influence over their members, 'lobbying' or 'educating'. Lobbying is not the same as advocacy; it is one action of an advocacy-oriented alliance. Lobbying is used to influence local or national governments which create legislation or regulations at their respective levels.

Advocacy-oriented alliance – Aims and objectives – Irish Heart Foundation
Aim – To advocate for environmental, political and legislative changes to create a supportive environment for children to be or become physically active
Objective 1 – To compile a position paper on physical activity and young people
Objective 2 – To disseminate this paper to members and other organisations that can influence the process
Objective 3 – To organise a conference on this topic to disseminate to Government and other key players, such as media.

Alliances advocate for their particular causes or for individuals affected by their causes. The action of advocacy remains central to the aims of the alliance. Many types and levels of advocacy exist. An example of how an alliance can actually provide advocacy on a daily basis are presented in Appendix 1 – An Advocacy Fitness Plan (OMB Watch, 2002).

An advocacy-oriented alliance can advocate for increasing political recognition and appropriate resources to prevent CVD and perform the functions of an action-oriented alliance.

Advocacy-oriented alliance – German Heart Foundation
The Coalition against Smoking (COS) promotes and supports non-smoking among the public, makes the public aware of the risks of smoking, and tries to combat the tobacco industry while strengthening its own political influence within the German government. The COS writes letters to the members of parliament, participates in congresses focused on smoking prevention, organises and does lobbying work. Its target groups are the national media to raise awareness about smoking, politicians to strengthen political influence within the Bundestag, physicians to work more effectively with patients, opinion leaders such as German celebrities to get the attention of the public, health journalists and other cardiovascular disease prevention groups.

1.4 Evidence base for alliance work

Very little empirical evidence exists about the effectiveness of working in alliances. Calls for alliance work can often be found as recommendations for the future in reports and studies into current public health problems; however, the nature, processes and effectiveness of working in alliances remain largely unstudied.

Nonetheless, working in alliances continues to be a popular approach to public health improvements. One recently published study examined the characteristics of 'successful' alliances, from the Community Care Network, in the USA (Shortell et al., 2002). This work conducted a process evaluation of 25 community-based alliances, supported through a central funding organisation. The study identified the common strengths and weaknesses of these alliances, using quantitative and qualitative methods. It found that three key factors determined whether an alliance was a success or a failure:

- a shared vision;
- strong governance; and
- effective management.

The research also identified six main characteristics of the more successful alliances. These characteristics related to the way the alliance was able to:

- manage its size and diversity;
- attract and rely on different types of leadership;
- focus on its aims;
- manage and channel conflict;
- decide when to take the lead and when to let others develop a common area of work;
- reposition its skills, resources and efforts to respond to changing needs and priorities.

The first four main characteristics were related to the working principles, structure and management capabilities of the alliance, while the final two related to the development of the alliance and its capacity to handle growth and change.

This evaluation offers a useful reference point for developing and managing an alliance. In spite of differences between the USA and Europe, the study reinforces the importance of common working principles, clear management practices and a shared vision of goals to make a successful alliance.

SECTION 2 – PREPARING FOR AN ALLIANCE

The aim of this section is to describe the typical steps taken before an alliance is formed, various designs that can be chosen, working principles, terms of reference, and the process of recruiting new partners.

2.1 How does an alliance start?

Alliances begin with a common idea or interest, with individuals from key organisations expressing a shared concern or identifying a mutual goal. To achieve this goal they will combine their efforts. The type of alliance formed generally reflects how it started and the common interests of the original organisations. The preparation of an alliance is crucial to its future success, and any weaknesses at this stage will become more troubling as an alliance grows and starts its work. An alliance may start its life focusing on action-oriented work before moving into more advocacy-oriented work.

2.2 Designing the alliance

Once the overall goal of the alliance has been set, new potential members of the alliance need to be identified. This stage of identifying new partners shapes the possible strengths and weaknesses of the future work of the alliance. New partners should contribute or add to the alliance:

- a commitment to the overall goals of the alliance;
- an increase in the knowledge base of the alliance;
- a wider sphere of work in different fields or disciplines with partners that do not usually work within health;
- the chance of funding opportunities;
- improved access, communication, influence and stronger relationships with different public, professional and political bodies;
- more efficient use of overall resources and delivery of services;
- a unique set of skills, e.g. information technology.

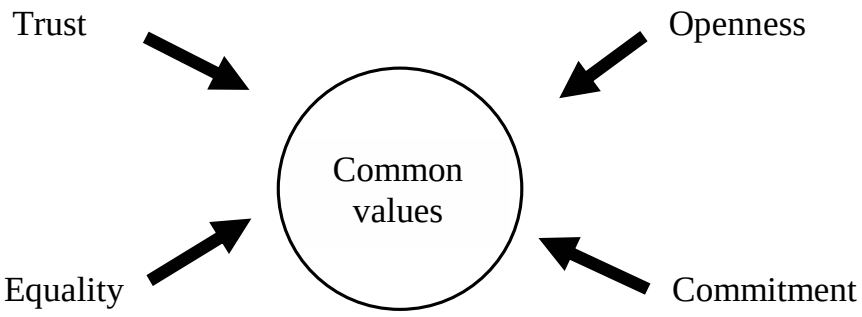
This list is not exhaustive, but it does illustrate the key principle of ‘additionality’. Running a successful alliance in practice is built on hard work, not theory.

Sometimes an alliance already exists and the best use of resources is to join this alliance and work to support its activity in CVD prevention. For example, the EHHI coordinator in Sweden joined existing networks in the field of children and physical activity.

2.3 Principles of alliance work

An alliance bonds its members together around a shared common interest. Alliances do not build themselves overnight, but take time to develop their own working principles. Figure 1 illustrates the principles that are essential for effective work in alliances.

Figure 1 Key principles of alliance work



The principles of how the alliance will function can be established through a series of initial meetings or events.

2.4 Terms of reference

The working principles and the goals of the alliance should be embodied in the alliance's terms of reference. This is a document that outlines the agreed aims of the alliance; its membership; and its working principles and communication and decision-making processes.

Healthy Alliances – Terms of reference – UK

In 1993, the Department of Health in the UK produced a handbook on health alliances, which identified a number of factors as important in developing good alliances. These factors have been adapted into examples of statements that could be included in a 'terms of reference' document.

- The alliance should have a full or part-time coordinator.
- All members should have a shared vision and concept of the influences and determinants of health.
- All members of the alliance should have sufficient and protected time within their host organisations to devote to their alliance work.
- All members must have sufficient status and authority in their own host organisations to influence decisions, including social, economic and environmental influences on health.
- All members of the alliance should share common goals and targets for promoting health.
- The alliance should have its resources and mechanisms to produce actions and results.
- The successes and achievements of the alliance need to be shared by all its members.

2.5 Selecting potential partners

The process of selecting potential partners is about sharing a vision of what the alliance is aiming to achieve, assessing how potential partners can contribute, and clarifying what they will gain in return. Mapping the potential range of partners who do or could work on the prevention of CVD could present a huge range of possible partners. In many cases the alliance seeks out member organisations, but sometimes organisations take the initiative and ask to join the new alliance.

Potential partner organisations, leaders and projects all have their own personalities and unique culture. An alliance might work with NGOs, different government departments, the media and academics, among others. By understanding these different organisational cultures an alliance could anticipate possible difficulties and plan strategies to deal with differences, conflicts and possible failures. In each case, the alliance ought to ask what the new partner offers as a contribution to achieving the goals of the alliance. The following factors could be considered at the start in selecting new partners for a CVD health alliance:

- a shared vision of health;
- recognition of their role in the prevention of CVD;
- history of the organisation – examples of previous work – action-oriented/advocacy-oriented work;
- specialist knowledge;
- resources (individuals, experts, money, communication materials);
- skills;
- access to policy makers, professional groups, public, target group within the populations;
- the level of representation that will be offered to the alliance (executive, senior manager)
- possible conflicts of interest/ethics (links with possible conflicting groups, e.g. the tobacco industry).

An alliance can only be as good as its members. Examples of national alliances are presented for reference in Appendix 2.

2.6 Recruiting partners

The process of recruiting partners requires that the alliance have its goals and terms of reference in place. The mechanisms of recruitment could take many forms, including exploratory meetings with individual organisations, a conference to attract interested parties, or a launch event to generate media interest. A small committee could be tasked with identifying and planning the recruitment of new members to the alliance. A new policy initiative, expert report or popular concern over a health issue could also prompt the need for a new or different slant to an alliance. Indeed, many of the members of the EHHI work with a number of different alliances focused around different health determinants and policies. Using experience gained in other areas by other alliances is helpful in shaping the composition of the members for an alliance.

Establishment of the National Heart Forum – UK
The National Heart Forum (NHF) was established in 1986, following a national conference. Currently there are over 45 institutional members concerned with the prevention of coronary heart disease in the UK. Member organisations represent the medical and health services, professional bodies, consumer groups, and voluntary organisations. Many individual experts in cardiovascular research are also included in the membership. Government departments have observer status and also provide the NHF's core funding.

Recruiting partners takes time, effort and patience, but is necessary because there is a danger that an alliance that is too small might not be able to achieve any useful action beyond talking about the difficulties.

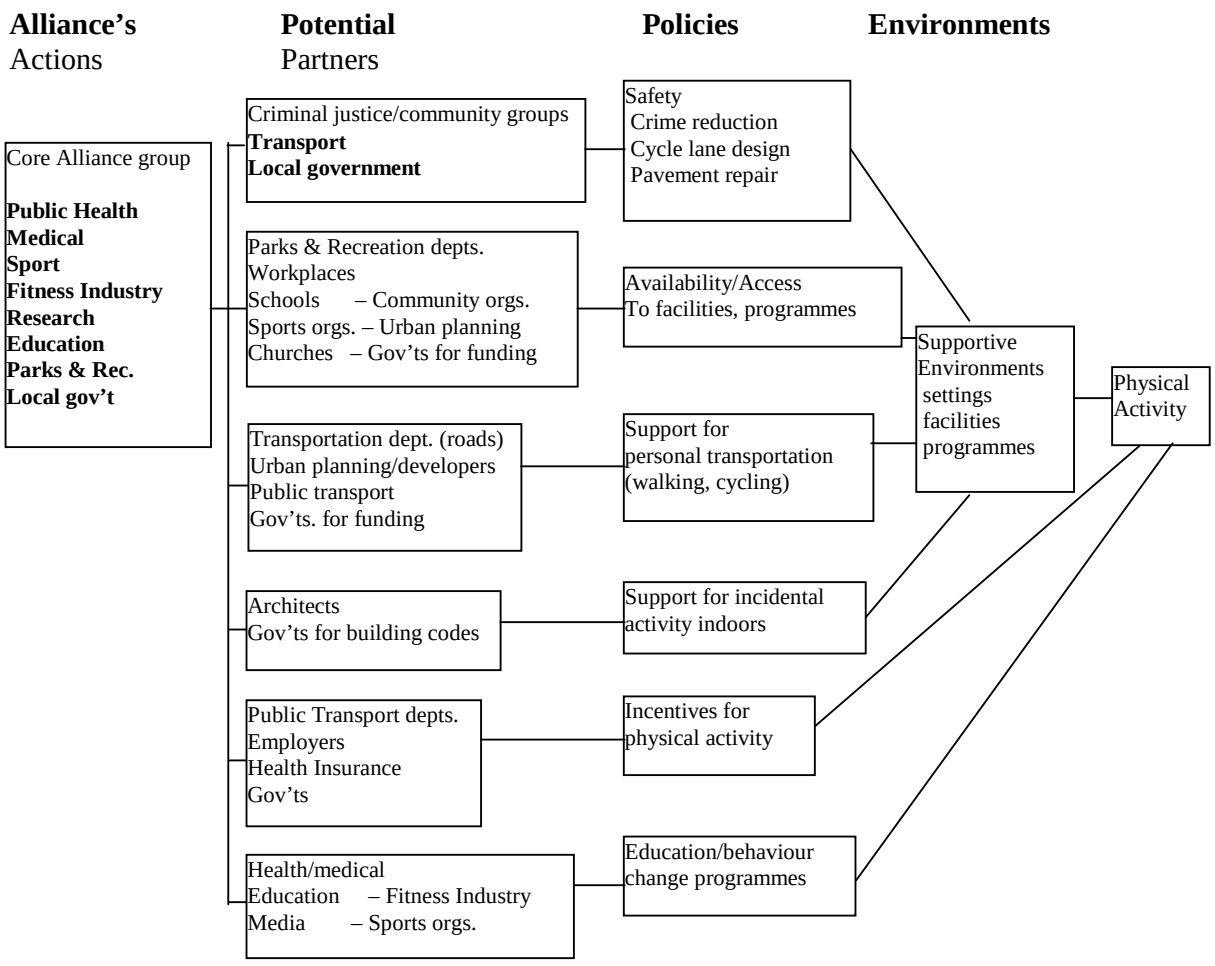
Recruiting potential partners – Irish Heart Foundation
Proposed participant organisations were approached during 1998 with a series of formal meetings or presentations. These organisations included the Health Promotion Unit of the Department of Health, the National Consultative Committee on Health Promotion, the Institute of Public Health, the Association of Health Promotion, and Health Education Officers. Informal contacts were also made with individual Directors of Public Health, Health Promotion Officers, the Healthy Cities Network, Health Promoting Hospitals and Schools Networks. All of these networks and organisations are supportive of the initiative and the establishment of a National Alliance. The Irish Heart Foundation selected the Chairperson in advance.

2.7 Focusing on the alliance's potential partners

The style of alliance should be shaped by its aims; however, there are many potential partner organisations that could become part of the work. Taking physical activity as an example, Figure 2 presents the range of different organisations and agencies that could be involved in an alliance. This figure could be used as a basis for planning activities for an action or advocacy-oriented alliance. It assumes that a core alliance of key organisations such as public health, medical, sport, fitness industry, research, education, parks and recreation and local government can influence policies related to physical activity. These core groups can expand to link into policy for physical activity promotion for children and help to construct supportive environments for physical activity. Such supportive environments could be reinforced via campaigns and programmes using the same potential partner organisations. The impact of the alliance would thus move from its core partners through to new potential partners, with the overall goal of improved promotion of physical activity and increased access to space and resources for participating in sport and recreation activity.

Figure 2 is based upon the work of the New South Wales Physical Activity Task Force, and shows the different stakeholder organisations that could contribute to an alliance for physical activity promotion for children due to their ability to influence relevant policies (Sallis et al., 1998).

Figure 2 A framework of potential partner organisations for an alliance to influence policies to promote physical activity for children



Source: Sallis et al. (1998)

This example highlights a key decision which a new alliance needs to take – what will its relationship with government be? Does the alliance want the government to be part of the alliance or not? This decision should be made in discussion with the partners within the alliance and be based on the experience of the host organisation for the alliance.

Young@heart – National Heart Forum – UK

The young@heart project aimed to lobby the UK government to ensure that children should be able to live to the age of 65 free of avoidable heart disease. Experts in children's health, welfare, and public policy, as well as a stakeholder conference, produced recommendations for government and other key agencies.

The NHF is partly funded by the UK government's Department of Health. In this case the NHF used government funds to lobby the government.

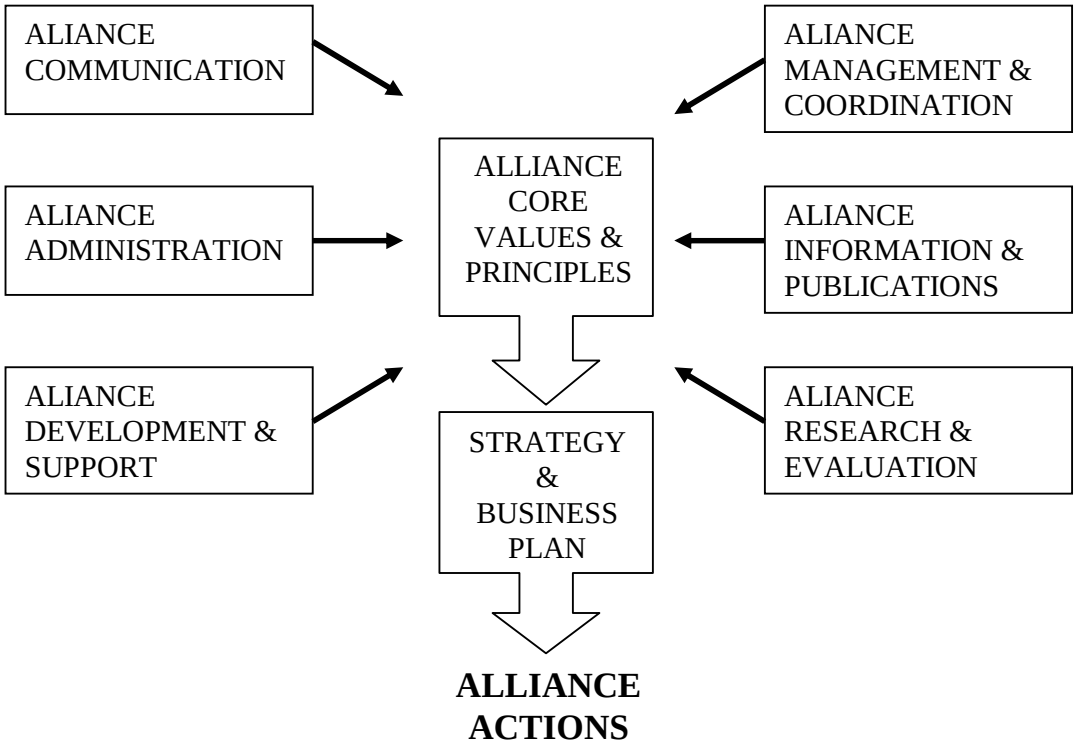
SECTION 3 – MAKING AN ALLIANCE WORK

The aim of this section is to describe the decisions an alliance will take to develop a structure, a strategy and a work programme. It will also identify mechanisms to sustain and grow an alliance and strategies for dealing with an alliance that only 'talks' and does not 'act'. It covers issues concerning developing the alliance's management and operational capabilities, e.g. communication, action and advocacy-oriented work. It also includes details of potential weaknesses and challenges to alliance work and the options for managing an unsatisfactory alliance.

3.1 A working model of an alliance

A number of elements combine to create a successful and effective alliance. These include alliance management, finances, resource allocation, and delivery on the alliance's aims and objectives. These key functions are linked with the central values of alliance work (described in Section 2) and can shape the potential model of an alliance outlined in Figure 3. In this model an alliance's key functions work via its core principles and values, through its strategy and work programme, to carry out the action it selects.

Figure 3 Common alliance functions



The alliance will need to decide whether these functions are to be served centrally by one organisation or shared by several or all the alliance partners. Other internal or external groups, such as external consultants or academic groups, could provide certain specified services. This framework assumes that there is a central coordinator for the alliance, based within a core organisation. The EHHI initiative chose such an approach, working through a central coordinator within EHN and national coordinators based in national organisations, with specific tasks outsourced as necessary.

With a coordinator at the heart of the alliance, it is tempting to presume that this person has to fulfil all the functions of the alliance. Unlike a commercial company, which would perform all functions (or buy them), an alliance is unlikely to have the capacity to do everything that needs to be done, especially at the beginning of its development; hence it relies on its coordinator for everything. The danger in this is that the coordinator could be left running the alliance, in effect becoming the alliance, rather than the alliance being run in partnership with all its members.

The growth of an alliance takes time and will parallel the development of the relationships of the partner organisations. Initial actions for an alliance include developing the essential mechanisms for building longer-term plans and actions.

3.2 Management and coordination

The management of the alliance is perhaps the most important function for determining the success or failure of the alliance's work. Central to the alliance should be a paid coordinator, with administrative support. The style and relationship between this coordinator and the alliance members should reflect the alliance's core values and principles. Day-to-day running of the alliance should be the responsibility of the coordinator, but key decisions that might shape or direct the work of an alliance should be left to the alliance members themselves. The coordinators should establish a system of communication with the members of the alliance for taking decisions, perhaps through chaired meetings. As mentioned previously, the skill of good management of the alliance by the coordinator consists in delegating and supervising the delivery of tasks by all the alliance members. Adapting the work of the alliance to the work of its members will take time, so during the early stages of a developing alliance it might be useful to work with the existing plans and actions of the alliance members (if they fit the aims of the alliance), rather than constructing new actions too early.

Alliance Structure – Irish Heart Foundation
National part-time coordinator – 20 hours per week
Chairperson – Non-executive voluntary

The steering group for the alliance provides support to the National coordinator, gathers information, identifies key issues, puts forward proposals to all the alliance's members and monitors and supports the delivery of the alliance's actions and proposals

If a new alliance is part of a broader cardiovascular disease prevention alliance, the management and structure of the main or host organisation should be reflected within the new alliance's structure. This may involve using a director or executive body of the host alliance to support future work. Helping a new alliance develop is a key role for any host organisation. The host organisation can provide experience and a process for building a consensus about new areas with local and existing partners.

3.3 Funding

Funding is a key area for any alliance. It determines the potential impact of an alliance and reflects the alliance's operating style. A number of different sources of funding have been used throughout the EHHI national alliances.

For the first years of the EHHI, four main sources of funding were identified by the national alliances. These were in addition to part funding from the European Commission. The most common source of funding was the use of membership fees of individuals and organisations. These annual fees were part of the conditions of membership of the alliance. Often these fees provided core mechanisms through which other revenue could be generated, especially dedicated fund-raising activity. This second source of funding was often tied into particular products or outputs of alliance work. These might be funds generated by a particular programme of work or actions. Examples included revenues from conferences, the provision of training programmes, selling of health promotion materials, resources, reports and other publications.

The third source of funding came from in-house fund-raising activities. Often these activities became part of the actual work of the alliance, e.g. sponsored events but focusing upon the public or specific participation of a target group. Fund raising could also focus on obtaining sponsorship or donations from the commercial sector for activities or programmes of work. There have been many successful examples of commercial sponsorship within the EHHI national alliances.

Partnership with commercial sponsors – Danish Heart Foundation
The Schools Fitness Day project aims to teach children about the positive impact of exercise on personal well-being. The funding from The Danish Heart Foundation and Kellogg's is used to provide materials for the Schools Fitness Day. The total number of participants comes to around 600,000 pupils each year.

However, some EHHI coordinators pointed out the dangers of involvement with commercial sponsors. For example the public face of an alliance might suffer if it were seen to be funded by commercial organisations. Another worry for coordinators was the difficulty of assessing a potential commercial partner in regard to their connections or relationships with other commercial sectors, as a parent company producing healthy products might have interests in less healthy areas. An assessment of the expected benefits of any partnership or agreement with industry and the alliance should be thorough and open, and should start as early as possible, in order to prevent any future problems. The knowledge of other members of the alliance, particularly

other NGOs, could be used in this process, and any involvement of a commercial organisation requires the full agreement of existing alliance members.

The fourth source of funding for national alliances thus far has been national governments. Some alliances have used government funds to support their structure and administration, while others have created partnerships with government departments for specific programmes of work.

Coordinators have stressed that sustaining and finding new sources of funding has been a constant challenge for their alliances.

3.4 Administration

An alliance needs administrative and financial support. Administrative support is central to the communication requirements of the alliance. Strong administration will allow a coordinator to delegate work, facilitate communication and also provide another point of contact for an alliance. Ideally an alliance should aim to have a paid secretary for its work, although this function might be hosted by a larger alliance (as in the EHHI model). Other administration functions such as report production, desktop publishing and IT support could be sourced externally or provided by a partner organisation. For example, in Italy the alliance relies on the human resources (administrators, directors and secretaries) of each alliance member. Then the national coordinator of the EHHI project operates as a pivot between EHN and all the alliance members' representatives.

Administration and resources enable an alliance to operate and achieve its aims and objectives. Without money an alliance can only be a 'talk shop'. Resources must be split into those for the internal running of an alliance (salaries for staff, non-staff costs, consumables and travel) and external costs (costs of carrying out the alliance's strategy and projects).

3.5 Communication

If the actions of an alliance are based on the collective actions of its members, the alliance must create its own internal and external communication. Effective communication will contribute to efficient alliance work and establish and maintain a positive external profile.

Regular meetings and communication will strengthen the alliance's internal activities. Communication within an alliance should always have a specific purpose. Possible purposes include sharing information, seeking feedback on issues, consulting on future actions and asking for opinions. The degree of urgency of response to each of these types of communication should be decided and conveyed to the partners by the coordinator of the alliance, as this will allow the partners to act and to prioritise their responses.

Media liaison is a crucial task of a health alliance, and one which must be handled carefully. An alliance must be able to respond to the media with an appropriate opinion for coverage of issues related to CVD prevention. Ideally any media response should be agreed with members in advance, but in practice, because a quick response is required to take advantage of media opportunities, this is often impossible. An agreed policy setting the alliance's position on certain issues could be part of the alliance's core principles and terms of reference.

All media responses should be reviewed regularly by the alliance. A poor media profile can develop immediately while a good profile takes time and effort to maintain and grow.

Often an alliance for CVD prevention will find that an opposing alliance exists which does not support its actions. Some of these opposing alliances may be very open in their hostility (e.g. the tobacco companies) whilst others may be more subtle. An alliance will need to decide if it is willing to have its representative appear in media interviews with representatives from such opposing alliances.

In the case for physical activity it is less obvious what types of organisations might oppose promoting physical activity to children, but alliances should be aware that their actions aimed at preventing CVD may have a cost for another group. Some suggestions of groups opposed to the promotion of physical activity include the motor industry, organisations that promote car use, and beneficiaries of children's leisure time spent in sedentary behaviour such as watching TV or playing computer games. This issue needs greater consideration for alliance work in the future as broad environmental influences continue to reduce opportunities for children to be active.

3.6 Development and support

Developing an alliance requires careful planning, with suggestions for new actions for the alliance coming from a variety of sources. The alliance must support its members and seek their input into future plans. Brainstorming, open agenda meetings, expert days, policy analysis and partner contributions are all suggested mechanisms for generating ideas for developing an alliance.

Evaluation offers an alliance an opportunity to identify the strengths and weakness of its present actions and approaches. The results of a thorough evaluation can help the alliance to improve its next steps. An audit of the strengths and weaknesses of present alliance actions and organisations should also be conducted to identify any common areas for development and support. This review should also cover the central structure and functions of the alliance, the coordinator and administration, etc.

3.7 Information and publications

Information and publications are ways an alliance can create a profile. An alliance can develop different types of materials, e.g. information leaflets, training packs, videos, either on its own or more often in collaboration with partner organisations. The

alliance can share examples of different resources within its partner organisations and identify any information gaps. Development of any publications should involve the target group for the publication and technical experts. Ideally any materials should be tested with the target group, and in the case of public or patient information, any professional groups who will disseminate the materials.

The alliance should have a clear name, logo and key sentence that will explain what it is trying to achieve. This will help it to create its own unique identity and help develop recognition for what the alliance is about. The alliance needs to discuss with partner organisations the use of alliance logos and partner logos in relationship to future alliance work, as there might be a danger of inclusion of existing partners' logos at the expense of the alliance's identity.

3.8 Research

Using research is an important function of an alliance. Research helps make the case for a particular recommendation. It offers a possible model for an alliance action, or it exposes gaps in knowledge about a particular issue. Theoretical research using modelling can be used to illustrate the possible consequences of not taking action to cut down on the incidence of CVD. Whatever the aim of this work, it is vital that the alliance is clear that any research and evidence is aimed at a particular group and that it meets the needs of that group.

An alliance should identify any relevant national or regional surveys of CVD-related behaviours amongst adults and children. Results of these surveys could be used to support a case for more work in a priority area as well as to track trends in population behaviours. This information is important to see what priorities remain in tackling existing (e.g. lack of physical activity) or recent population changes in behaviour (e.g. obesity rates). An alliance will not be able to directly link the impact of its activities to changes in CVD risk behaviours, but its activity might contribute to shifts or changes.

Using research evidence for advocacy – Italian Position Paper on Physical Activity for Children and Young People

The EHHI position paper aiming to promote physical activity among children and young people was translated and produced for national policy makers. The paper was endorsed by all the alliance members and sent to concerned authorities including the Minister of Health, the Minister of Education and the Minister of Sport. After being informed about how important it is for children to participate in physical activity of moderate intensity (at least one hour per day) the Ministers and the equivalent authorities on the local level were urged to:

- Develop policy to promote health-enhancing physical activity amongst young people;
- Ensure that high quality physical education programmes will be an integral element of every school education programme;
- Ensure that long-term capital funding will be available to set up initiatives aiming to promote physical activity among young people and children;

- Ensure that all those who work with young people (teachers, coaches, youth workers, etc.) are appropriately trained and qualified for their role and are also aware of health-enhancing physical activity issues.

One suggested theoretical and descriptive model that may be useful to help make the function and role of different types of research easier to understand for both an alliance and its audience is presented in Appendix 3. This model shows how different types of evidence, research and evaluation can fit together for CVD prevention, using physical activity and children. This model is helpful in explaining what types of evidence can be useful for advocacy and action-oriented alliance work.

Using national surveys – Finnish Heart Association
Evaluation of national lifestyle and health changes are monitored via annual surveys e.g. Health Behaviour among Finnish Adult Population and Adolescents Health and Lifestyle Survey.

3.9 Developing a strategy for the alliance

An alliance should have an idea of where it wants to be by a particular time. Its strategy should be formulated in a document that outlines the direction and details of this goal. Within the strategy will be a work programme.

The first suggested steps for an alliance are to relate its goals to that of national policy. By assessing the potential areas for future work within an existing policy framework the alliance can sense best where its future direction should be.

For example getting physical activity into a wide range of different national strategies might be a first goal of an alliance. Where there is no recognition of the importance of physical activity for children within health, education or sports policies, an alliance would aim to make the case for children and physical activity. The alliance would use a broad range of evidence to support its case on the benefits of CVD prevention. Certainly members of the alliance would have their own ideas of priorities and evidence sources. Evidence about physical activity would also need to be tailored to the type of organisation it is aimed at. The use of a variety of types of evidence for appropriate audiences adds impact and a wider value to the case for physical activity promotion. Examples of these types of evidence could include:

- the prevalence of inactivity within children and population sub-groups;
- the fitness levels of the children and population sub-groups;
- the benefits of physical activity for health;
- the benefits of walking and cycling as means of transport;
- the benefits of physical activity in improving quality of life, e.g. reducing crime, improved academic performance and social behaviour;
- the economic benefits of active children.

The most common type of evidence used in this area is applied in publications exploring or presenting problems, called ‘problem definition’, i.e. documents that

describe the extent of a problem within a particular group, the health consequences of this problem and the benefits of change.

3.10 Developing an action plan

Once a strategy is in place an action plan will describe the process to achieve the aims and objectives of the strategy. Whilst the strategy provides a framework, the action plan describes the allocation of tasks and the timetable of actions to achieve the various goals. The action plan should be based on the capabilities and resources of the alliance. The action plan should be 'SMART', specific, measurable, achievable, realistic and time-specific.

Setting a specific aim – Netherlands Heart Foundation
The Netherlands Heart Foundation developed a project for young people aiming to establish what the best method is for communicating healthy heart messages to young people. An expert meeting was held with health promotion professionals, a trend forecaster, a PR consultant and representatives from the industry with proven experience in communicating with the young. The main result of this meeting was the decision that any message for young people should be simple, clear, 'cool' and feasible. Working with partners in the industry will enable the project to use their expertise and brand name to promote healthy messages to young people. The next part of the project aims to develop a lifestyle campaign for youngsters.

The action plan should describe how the activities of the alliance would use the different functions of the alliance to achieve its goals. Alternative plans and solutions should also be made in response to particular situations or scenarios where circumstance might change. The action plan should include time and resources for evaluation of the alliance's actions and the efficiency of the alliance itself.

3.11 Common features of an ideal alliance

The features of an ideal alliance develop over time. These features can be found in the common functions of an alliance shown in Figure 3 (p. 17).

Core values and principles
- A common interest in the prevention of CVD on health and other social welfare fronts (e.g. transport, education, commerce, law)
- A commitment to deliver on this interest – 'don't just talk about it; do something'
- Agreed aims and objectives

Communication and coordination
- Active participation within and outside the alliance
- Strong profile with government, NGOs and the commercial sector
- Strong profile with opposing organisations, e.g. anti-car and pro-car lobbies in the transport sector
- Regular internal communication using different media (e.g. e-mail, e-newsgroups)

- Communications graded for importance to alliance members (e.g. information only, feedback needed, action as soon as possible)
- Able to react to breaking stories to maintain media profile

Administration
- Broad sources of funding including core central funding, donations, memberships, grants and fund raising
- A clear and open policy about sources of funding and potential conflicts of interest
- Unique contact point for alliance information and activity

Development and support
- Seeks to educate partner organisations in the importance of CVD prevention
- Always seeks to broaden membership to potential partner organisations
- Is clear about its relationship with the commercial sector
- Advocates for more resources for their own and other alliances

Management
- Strong shared leadership
- Able to make quick decisions

Information and publications
- Produces information that is needed by target groups (e.g. government, other organisations, professional and public bodies)

Strategy and business plan
- A broad plan including advocacy, campaigns and programmes
- Synergy of action

Research and evaluation
- Able to access academic and public opinion on key issues
- Has expert reference group for topic areas
- Production of research-based documents
- Production of research-based reports and recommendations that fit alliance strategy
- Able to evaluate the actions of the alliance and develop based on results

3.12 Symptoms of weak alliances

Symptoms of a weak alliance are indications that one or a number of the functions of the alliance are failing. These symptoms are presented in Table 1 within each of the functions of the alliance.

Table 1 Symptoms of a weak or dysfunctional alliance

Alliance functions	Symptoms of weak areas
Core values and principles	Poor partner selection CVD prevention seen as the preserve of the medical sector
Core values and principles	Health education is the only approach needed for CVD prevention Partner organisations that wish to dominate the alliance Jealousy and conflict of interest between partners Fear of losing identity within alliance
Communication and coordination	Alliance not partner gets recognition for actions
Administration	Lack of finances – cannot do what you want or need to do Danger of large financial contributors to the alliance dominating decision making because they bring more money to the alliance – have more say in affairs
Development and support	Work overload of partner organisations so they are unable to develop their role in an alliance or contribute Actions always take more time to plan and deliver than thought Trying to be too radical in approach too early so alienate potential future partners
Management	Partners that do not contribute to the alliance Failure of collaboration, e.g. 'some partners always do more work than others' Different levels of representation of partner organisations at the alliance, e.g. some are allowed to make decisions, others are not.
Information and publications	Different public information messages about CVD prevention come from partner organisations
Strategy & business plan	Too dependent upon central government so unable to challenge present policy Poor planning and task allocation 'Too much talk, not enough action'
Research & evaluation	Assuming that an expert report will be enough to win over policy makers Lack of evidence of effectiveness and cost effectiveness of population-based CVD prevention interventions Alliances not confident about evaluation of themselves and their actions

3.13 Sustaining the alliance and motivating unwilling partners

All the EHHI coordinators have described occasions where they had to tackle partner organisations that appeared to be unwilling to contribute to their alliance. One common approach has been for the coordinator to raise his or her concerns off the record with the representative of the partner organisation, then with the organisation itself. Problems often lay with the individual representative of the organisation not understanding or sharing the core principles and terms of reference of the alliance. Reviewing these terms of reference and the reasons for joining the alliance would help an organisation to decide if it wants to remain part of the alliance. All the coordinators agreed that in some circumstances it was better that an organisation that did not contribute to the alliance be asked to leave. However, the coordinators were very reluctant to do this, as it was against the spirit of alliance work. A system for dealing with failing organisations should be developed within the alliance's terms of reference.

Coordinators have also recognised and described the difficulties of having a failing alliance. They agree that it would be very painful to scrap an alliance, but this might be the only option. Any new alliance would have to adopt aims and objectives very different from those of its predecessor.

SECTION 4 – EVALUATION AND ALLIANCE WORK

This section can be used to guide an alliance through the evaluation process. Its aim is to emphasise the importance of evaluating alliances and alliance work, to describe three different types of evaluation and to give examples of how they relate to alliance projects and to the evaluation of the alliance itself.

4.1 Commit to evaluation

Evaluation is an important task for the future of any alliance. Appropriate evaluation can help demonstrate the value, impact and efficiency of an alliance for itself, its members, funders and the public.

The purpose of evaluation is to:

- determine whether aims and objectives have been achieved;
- find out what went well and what could be improved;
- provide information to improve the development of the alliance;
- provide feedback to alliance stakeholders, funders and supporters.

Recent WHO guidelines for the evaluation of health promotion clearly stress the need for evaluation and propose the case for allocation of suitable resources (World Health Organization, 1999).

'Policy-makers should require that a minimum of ten percent of the total financial resources for a health promotion initiative be allocated to evaluation.'

Securing adequate resources provides a wider choice about which components of an alliance's work can be evaluated. An alliance (assuming it has the resources) needs to decide what type of evaluation it wants for its activities.

The extent to which an evaluation is important or valuable to an alliance will be shaped by the attitudes and values of the alliance members. What they value is important as it will shape:

- what they feel defines success;
- what is seen as a strength or weakness of the alliance or its work;
- how these are 'measured';
- who does the 'measuring';
- who pays for the evaluation;
- who analyses the information;
- how the results are shared.

4.2 Types of evaluation

Three different types of evaluation could be used by an alliance: formative, process and outcome evaluations. Each type of evaluation will answer different questions about an alliance's activities and produce information of potential value to those who fund, deliver and participate in the alliance's actions. Table 2 illustrates this.

Table 2 Evaluation types

Evaluation types	Application to alliance work
Formative evaluation	A method of evaluating programmes or materials while activities are under way. For example, while developing health education materials the materials would be tested with the target group.
Process evaluation	An evaluation that focuses upon what has happened in the process of delivering an alliance action. This type of evaluation is often used to assess what happened during a project and to identify any factors that helped the work succeed.
Outcome evaluation	An evaluation that focuses upon the impact or effect of the action upon its target group or area. This type of evaluation is often used to assess the success or failure of a project in accordance with criteria set before the work occurs.

The type of evaluation that is chosen will then determine the evaluation questions that will be asked by the alliance about its activities.

Each type of evaluation question will have an evaluation indicator. An evaluation indicator is a measurable factor that provides an answer to your evaluation question. Hence indicators point to the answer to an evaluation question. For example, an outcome evaluation of a project to encourage children to cycle more to school would have the cycling rates of children to/from school as its evaluation indicator. Only after the evaluation question and indicators are established should the evaluation method be selected, for example questionnaires, interviews, observations or others.

The evaluation method should not shape the evaluation. Once the decision is taken as to what is being evaluated, and the questions and indicators are selected, the appropriate evaluation method will be chosen.

4.3 Evaluating the activities of the alliance

It is possible to ask any question about an activity of the alliance. The evaluation has an audience, which could include funders, staff and/or working partners in the alliance. The decision as to the best evaluation question to ask is based upon a number of factors. These factors include:

- the ability of the alliance to conduct the evaluation with its own staff;
- the ability of the alliance to supervise external experts who would carry out the evaluations;
- the resources available for the evaluation (skills, money, time scale, evaluation tools and measures);
- the values of participants (see Section 4.1).

Whatever the evaluation design, every evaluation should have an evaluation plan. This plan will mimic the action plan of the activity it is evaluating. It should include details on:

- the aim of the activity;
- how the plan will work;
- the evaluation questions and indicators;
- how information will be collected (evaluation method);
- how the information will be analysed (analysis);
- what will happen with the results (who, what to say, what next);
- a detailed plan for who does what, by when, how, and how much it will cost.

Two examples of Evaluation:

- *the Swedish health education project in schools - Swedish Heart-Lung Foundation*

The Pelle Pump project aimed to give 10-year-old children health education to help them understand how their body works and the importance of physical activity, healthy food, not using tobacco and avoiding stress. The aim of the project's evaluation was to investigate how teachers reacted to the Pelle Pump material, what materials could be changed, and how useful the project was for the schools. In addition, it evaluated whether the students had learned something while working with Pelle Pump and whether they had changed their attitudes and actions regarding smoking, physical activity and diet. The evaluation used a range of different methods – a questionnaire for the students and for the teachers, face-to-face interviews both with teachers and students, and focus groups.

- *The Spanish nutrition project in schools – Spanish Heart Foundation*

The campaign is targeted at children aged 6 to 12 years old, parents associations and teachers of public schools. It tries to encourage healthy nutritional habits in children and young people. In 8 years time, the campaign has reached more than 280 cities and over 60.000 children. Via a questionnaire an evaluation process has been set up to test the children's knowledge on healthy eating habits before and after the activity. This evaluation also helps to study and follow the nutritional habits of school children. The evaluation is performed by a professional agency and the results are analysed by the Spanish Heart Foundation and Spanish Society of Cardiology.

4.4 Evaluating the alliance itself

Similar evaluation questions can be asked about the alliance itself. Typical evaluation questions of alliance work would examine the way the alliance functions (a process evaluation) or how well it is achieving its aims (an outcome evaluation). Table 3 shows examples of evaluation questions, evaluation indicators and possible suitable methods for evaluating the alliance, for both process and outcome evaluations.

Table 3 Evaluation questions, indicators and methods for evaluating an alliance

Process Evaluation		
Evaluation questions	**Evaluation indicators**	**Evaluation methods**
How popular/credible is the alliance?	Public perceptions of the alliance	Cross sectional survey of public's attitudes to the alliance and to CVD prevention
What is the image/profile of the alliance?	Examples of media coverage	Analysis of media coverage
What are the most satisfying aspects of participating in the alliance?	Experiences of the members participating in the alliance	Semi-structural interviews with representatives of the alliance
What are the strengths, weaknesses and threats to the alliance?	Experiences of alliance staff and members External views of the alliance	SWOT analysis of alliance using staff and members experiences
Outcome Evaluation		
Evaluation questions	**Evaluation indicators**	**Evaluation methods**
Has the alliance achieved its annual aims and objectives?	Performance indicators of alliance	Progress audit with reference to business plan
How equal is the contribution of alliance members to the alliance?	Input of alliance members to alliance work (resources, time, actions)	Evaluation of alliance records and plans and comparison of relative contributions between members

SECTION 5 – SHARING WISDOM

The aim of this section is to share the learning of the EHHI members about their alliances.

5.1. What have the EHHI alliances learnt?

The accumulated experience of the EHHI alliances, if measured in absolute terms (adding together the number of years each alliance has been running), is over 50 years!

As part of the development of these guidelines, all the national coordinators were asked to reflect upon their own and their organisation's experiences and prioritise the key points each would share with other people planning to start an alliance. Table 4 collects this 'alliance wisdom' under several key themes and also provides a rationale for each theme.

Table 4 Wisdom gained from the EHHI national coordinators

Theme	Rationale
Core values and working principles are essential.	Be absolutely sure that the partners to be chosen for the alliance share its aims in CVD promotion. There are important differences in perspectives and emphasis about what constitutes success for CVD prevention!
Identify a clear aim, rationale and business plan for the alliance.	The aim of the alliance should be measurable, defined, planned and financed before starting the programme. Keep the alliance's goals and interests as clear as possible, so that membership is self-evident. Draw up a business plan for the forthcoming years (at least three, possibly five years) identifying the potential sources of funding.
Keep it simple.	Only a common project for organisations with a common interest will work.
No organisation will be involved in an alliance just for the sake of the alliance itself.	There are costs and benefits for organisations that are involved in an alliance. When recruiting organisations to join the alliance, try to anticipate what these could be and emphasise the benefits of the alliance to each organisation.

Identify a specified action or area of work possibly not already covered by other alliances or organisations.	By focusing on a specific area of CVD prevention an alliance can have a greater impact. For example, an advocacy-oriented alliance might be more of a priority than an action-oriented alliance where there are already many stakeholders engaged in prevention through information, education and skills training.
Shape the alliance structure to give each member a specific role.	Every member must contribute to the work of an alliance, but try to adapt members' contributions both to their capacity and to the needs of the alliance. Match their contributions to their strengths, not their weaknesses. The alliance members should agree the management structure of the alliance.
Envisage potential barriers and drawbacks which might occur concerning the alliance's activities.	As part of developing a strategy for the work of the alliance, anticipate any potential problems or barriers to the work. Try to plan suitable solutions and use the expertise of the alliance members to resolve problems.
Communicate constantly in order to keep all alliance members involved and motivated.	Good communication is the key to keeping alliance members informed of present activities and their contribution to the alliance. Media could include a web site, an intranet connection, a newsletter, a bulletin, workshops and meetings to be held at least once a year.
A strong national coordinator, with a high profile, is key.	Every alliance needs a central point, just as a wheel needs a central hub to connect its spokes. A coordinator is the heart of an alliance, and therefore must have the ability to manage the alliance actions on behalf of its members, as well as having the appropriate resources available.
Engage the key experts in the area of the alliance.	Key experts will allow the alliance to use members organisations' knowledge and networks for the benefit of the alliance. Use experts to produce a review of evidence to lobby for resources.
The alliance should plan things step by step and set achievable goals and	The success of an alliance will come slowly, and there is a danger of achieving

milestones.	very little by trying to reach an impossible aim. Include plans for evaluation from the very beginning.
Your network should consist of different members from different societies.	All interests should be represented, and the alliance should work with the interests of all its members in mind. Representation of advocacy groups in the alliance should be especially encouraged.
Don’t be just a ‘talk shop’.	An alliance is not just an open platform for information and conversation; be sure that there are not too many members in the alliance. Avoid passengers who never contribute to the journey! Be sure that you have enough powerful people in the group to make it easier to implement decisions.
Turn opinion into action.	An alliance can use the knowledge of leading experts, but it can only act on this knowledge if it can use advocacy and action-oriented people to deliver action.

SECTION 6 - KEY QUESTIONS FOR BUILDING AN ALLIANCE

This section presents a series of key questions that EHHI coordinators thought were important for the development and working of an alliance.

The questions are posed to stimulate thinking about preparing and designing an alliance for CVD prevention. Although not comprehensive, they provide a starting point for discussion and will help in seeking options for building an alliance.

1. What are the core stakeholder organisations in the alliance?

2. What is the aim of the alliance?

4 What are the working principles of the alliance?

5 What are the terms of reference for the alliance?

6 How will the alliance be funded?

7 What are the potential new partner organisations for the alliance?

8 What information is needed to convey the importance of an alliance for CVD prevention with potential recruits to the alliance?

9 What additional contributions will a potential new partner bring to the alliance?

10 What are the gains and costs to the potential recruit of participating in the alliance?

11 What area of expertise in CVD prevention does the alliance need/have?

12 How does the aim of the alliance fit within existing policy and practice?

13 Where are the gaps in terms of policy and practice for CVD prevention?

14 How will the alliance decide on its strategy with its new partners?

15 What is the alliance's strategy?

16 Which groups should the alliance work with or target?

17 What is the alliance's organisational structure?

18 How will the programme develop ownership with all its participants?

19 How will the alliance communicate within and outside of its network?

20 How will the alliance identify whether it is working effectively?

21 How will the alliance coordinate with national, regional and local activities?

22 How will the alliance monitor the responsiveness to its work within different geographical and cultural groups?

23 How will the alliance evaluate its actions?

24 How will the alliance identify its strengths and weaknesses?

25 How will the alliance disseminate evaluation, good practice and learning?

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APPENDICES

Appendix 1 - An Advocacy Fitness Plan (OMB Watch, 2002)

Becoming politically fit is a lot like becoming physically fit. Team sports and exercise classes have their place, but sometimes it is just you and the TV – and nothing you can do about it. Even if others are theoretically available to run or shoot baskets, they may not be available on the same schedule. One way or another, being on your own (living in a rural area, leading a busy life, or just being shy) is no reason not to keep your advocacy fitness level high.

Physical fitness is a useful analogy to keep in mind for another reason. Just as your flesh-and-blood muscles need regular use and increased activity over time, so do your political muscles. Stop using them altogether and you will quickly become politically flabby; use them regularly and your level of advocacy fitness will soar.

So, what follows is a quick and easy, 10-step advocacy fitness plan, a kind of aerobics for advocates. And, like those aerobics workouts on early morning TV, it has three levels: low, medium and high impact (impact on you, that is, not on your issue or cause).

LEVEL l

Low Impact -Every MONTH do at least one of the following:

1. Get on the mailing list of an advocacy group that focuses on an issue you care about.

This is good because it supports advocacy efforts monetarily (usual annual costs run between $10 and $40). At the same time, you will become better informed about the issue, and you will learn when citizen action is most needed.

2. Enlist a friend.

Get someone you know interested in your issue and excited enough to do something – anything – about it (learning more counts, as does attending a meeting or showing up to volunteer on a one-time basis). Do not worry about what they do; once hooked they will figure out for themselves what is most comfortable.

3. Inform a stranger.

You can have an impact just by carrying on a conversation in a place where others are sure to hear: the subway, a checkout line, or elevator. You could post a Fact Sheet on the bulletin board in your apartment complex or local grocery store, put an informative bumper sticker on your car, or post something on a computer bulletin board for other subscribers to read. Or, you could ask that a group you belong to (e.g.,

Rotary Club, church, mosque, or synagogue, PTA, professional association) consider forming a task force on the issue you care most about.

This level is like the exercises where your feet do not leave the floor and your movements are quite gentle. But even if you get no further than Level I, by the end of a year you will be better informed, and will have gotten a few more people thinking about others in your community.

LEVEL 2

Medium Impact -Every WEEK do at least one of the following:

4. Write a policy-maker (federal, state or local).

Practice what you already know; exercise those political muscles. Once you have done it a few times, it will get easier. As with most things in life, the first time is usually the hardest. If your elected officials like getting messages by e-mail, use it.

5. Call a policy-maker (federal, state, or local).

Ditto. It helps that U.S. Senators and Representatives all have local offices with local telephone numbers, and some have toll-free lines as well. You may find yourself talking to a machine, but that is easier for some people, and your message will be conveyed.

6. Visit a policy-maker (federal, state, or local).

Ditto again. It is not enough to read about making a visit; sooner or later you need to use what you learned. Try it, you may like it. Those who start out feeling the most timid, the most reluctant, frequently turn out to be the best converts once they try. Sometimes novice lobbyists use words like ‘seductive,’ ‘addictive,’ and ‘intoxicating,’ to describe the experience.

This level is comparable to those exercises where the body movements are more energetic, the pace is faster, and a lot more bending and stretching is involved. But the impact can also be far more dramatic. If everyone who claimed to care about others wrote, called, or visited a policy-maker every week, their issues would fare very differently in the political process. So long as most of the people who claim to be concerned keep their concern to themselves, social issues/the environment/the arts will continue to get only a fraction of the public dollars and political attention afforded to just about everything else.

LEVEL 3

High Impact -Every WEEK, in addition, do at least one of the following:

7. 8. 9. Write, call, or visit other voters.

Every week, automatically re-cast your letters, calls, and visits for use with a larger audience: the voting public. Every time you write, call, or visit a policy-maker, think of a way to get the same message across to other voters. Re-write the letter to your legislator as a letter-to-the-editor; call a radio call-in show with the message you left on your council member's message machine; repeat what you said to the mayor at the Rotary Club or with your exercise group. That way you will double (or triple) your impact with only a fraction more investment of energy and time.

This level is like the exercise routine where you jump up and down, fling out your arms and legs, and quickly work up a sweat. At this point you will be a true citizen activist, with advocacy muscles that are taut and working at their peak. Go for it.

BONUS POINTS

10. Work for a visionary goal.

While every effort counts, groups still have a greater chance of success than individuals working on their own. That said, even very effective groups can sometimes get so caught up in responding on an immediate, practical level that they lose perspective. It is essential, as the old civil rights refrain goes, to ‘keep your eyes on the prize.’

So, for the greatest impact, join with the advocacy group of your choice to work for at least one visionary goal. It is important for people organising food drives to think of ending poverty, not just alleviating hunger; important that domestic violence advocates work toward creating a less-violent society, even as they fight for increasing the sensitivity of police, or expanding shelter capacity.

Management objectives, organization charts, and inter-agency agreements all have their place, but good advocates must never forget that a better world, not the next annual report, is what these efforts are all about.

Appendix 2 - Examples of members of national alliances

Swedish Heart Foundation

The Swedish Cardiac Society
Department of Public Health
The Commission of Public Health
The Karolinska Institute (a research foundation)
Swedish Heart-Lung Rehabilitation Association
Association of Doctors against Tobacco
National Board of Health and Welfare
Swedish Heart Lung Foundation
Association of Physical Activity
National Cooperation of Swedish Pharmaceutics
Swedish Sports Federation
Swedish Diabetic Association
Swedish Association for Immigrants
A Non-smoking Generation (Alliance)
Swedish Association for the Study of Obesity

Irish Heart Foundation

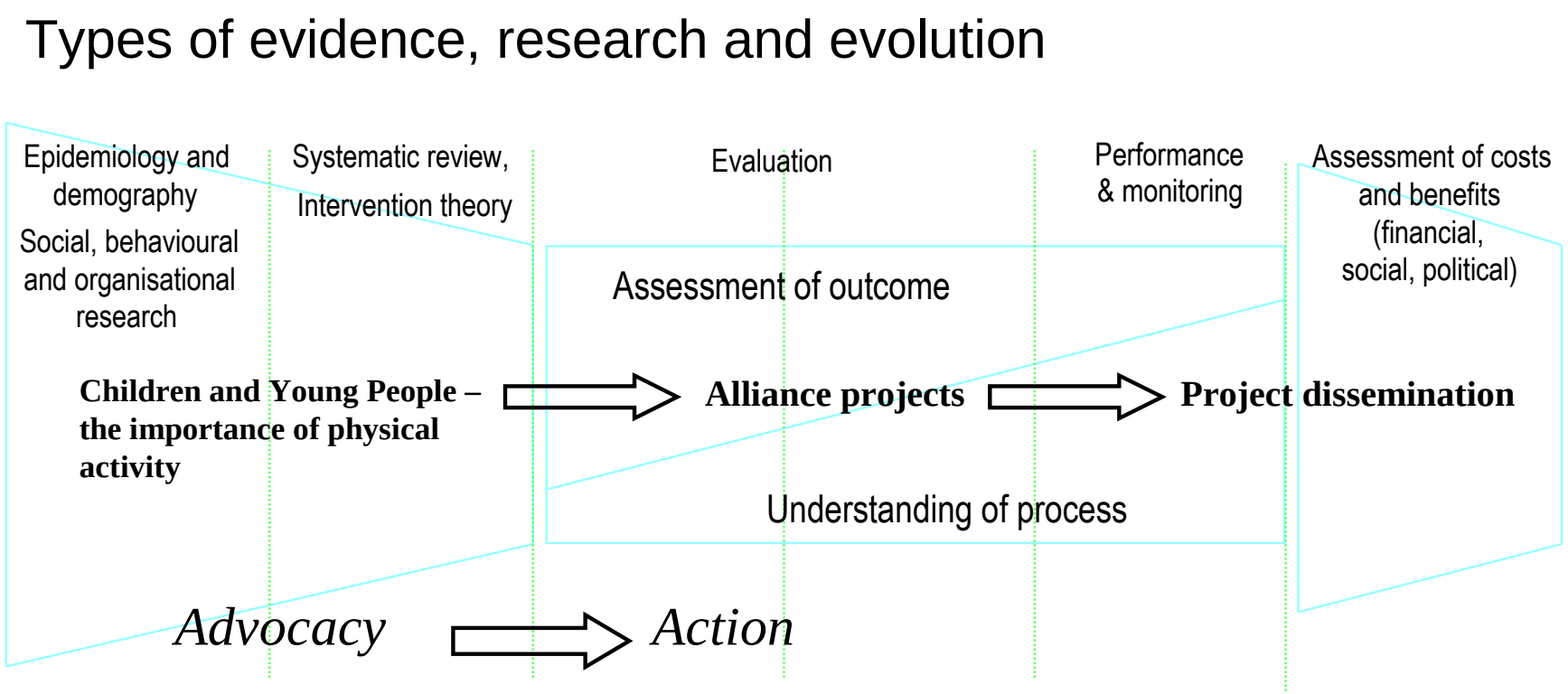
The following organizations nominated representatives to the National Alliance:

Directors of Public Health/Specialists in Public Health Medicine
Institute of Public Health Medicine
Office for Health Gain
Association of Health Education and Health Promotion Officers
National Consultative Committee on Health Promotion
ICGP
Health Promotion Department of national university
Representatives from IHF Councils on Cardiology/Stroke
College of Surgeons/Physicians
Institute of Public Health Nurses
Occupational Health Physicians/Nurses
Irish Nurses Organisation
Institute of Nutrition and Dietetics
Irish Cancer Society/ASH
Health Promoting Schools and Hospitals Networks
Healthy Cities Network
Department of Health & Children – Health Promotion Unit
Department of Health & Children – Community Care Section
Other participants included the Sports Council, Congress of Trade Unions, Irish Business Employers Congress

The Danish Heart Foundation

The Danish Heart Foundation and the National Council for Physical Activity has now been established. The members of the Council are;
The Danish Ministry of Education
Danish School Sport
University of Southern Denmark – Institute of Sports Sciences and Clinical Biomechanics
University of Copenhagen – Institute of Sports Sciences.
The Danish School Sports Association
Kellogg's

Appendix 3 - Stages of research and evaluation in health promotion



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