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A Tailored Approach to Launch Community Coalitions Focused on Achieving Structural Changes: Lessons Learned from a HIV Prevention Mobilization Study

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Abstract

Public health HIV prevention efforts have begun to focus on addressing social and structural factors contributing to HIV risk, such as unstable housing, unemployment and access to healthcare. With a limited body of evidence-based structural interventions for HIV, communities tasked with developing structural changes need a defined process to clarify their purpose and goals. This paper describes the adaptations made to a coalition development model with the purpose of improving the start-up phase for a second group of coalitions. Modifications focused on preparing coalitions to more efficiently apply structural change concepts to their strategic planning activities, create more objectives that met study goals, and enhance coalition procedures, such as building distributed coalition leadership, to better support the mobilization process. We report on primary modifications to the process, findings for the coalitions and recommendations for public health practitioners that are seeking to start a similar coalition.

Keywords

HIV prevention; adolescents; community mobilization; structural change; coalition building

INTRODUCTION

Community coalitions have been a popular approach to affect community change related to complex public health priorities, such as teen pregnancy and substance use, because they

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provide the opportunity to bring together diverse groups (e.g., citizens, professionals and government) for collective problem solving and pooling of resources.[1–3] Historically, AIDS service organizations have created informal alliances and formalized coalitions to promote accessible medical and social services.[4] However, over the last decade, public health awareness of social and structural factors contributing to HIV risk, such as unstable housing, unemployment, and inadequate public health infrastructure, has prompted calls for pursuing structural changes as an intervention strategy.[5–7]

In contrast to HIV prevention interventions targeting skill or behavior modification, structural changes operate by modifying the environment where individuals live, work, socialize and seek care, there by making them an important complement to current HIV prevention approaches.[8,9] Among adolescents, research has demonstrated the difficulty of achieving long-term behavior change (e.g., consistent and proper condom use) to reduce HIV risk, underscoring the need for additional HIV prevention strategies.[10,11] In 2010, 26% of all new HIV infections were among 13–24 year olds and the number of new HIV infections among young men who have sex with men (13–24 years) increased by 22% between 2008 and 2010.[12] Moreover, sexual minority youth experience high rates of mental health issues, substance use and other psychosocial factors that increase their risk for HIV.[13–16]

A coalition model offers a platform for pursuing structural changes by supporting diverse groups of people working together to achieve mutually desirable goals and using their collective power to influence decision makers in a manner that a single organization could not achieve.[17,18] A significant body of literature explains the elements that contribute to a successful coalition, such as having a clear vision, defining coalition goals and recruiting a diversity of stakeholders.[19–21] Supported by the Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN), a National Institutes of Health research network, Connect to Protect (C2P) is a community mobilization research study focused on achieving structural changes via community coalitions with the goal of reducing HIV rates among adolescents 12–24 years old.

The purpose of this paper is to describe the adaptations made to the C2P coalition model following the launch of C2P coalitions (Cohort 1) with the purpose of improving the start-up phase for a second group of C2P coalitions (Cohort 2). In particular, the C2P research team wanted to examine whether Cohort 2 coalitions could more efficiently apply structural change concepts to their strategic planning activities, create more objectives that met study goals, and augment coalition procedures to enhance mobilization. We report on primary modifications to the process, findings for Cohort 2 and recommendations for public health practitioners that are seeking to start a similar coalition. This paper contributes to the literature by describing the tailored procedures that we assessed as being critical to the start-up of HIV prevention coalitions focused on structural change.

HISTORY AND CONTEXT

Study Framework

C2P is rooted in an ecological framework that considers multiple layers of influence, such as community, institutional and interpersonal, that contribute to an individual's overall health and well-being.[22,23] Based on the Community Empowerment Framework, the C2P model emphasizes seven factors for successful coalition development and function: (1) defining a clear vision and mission; (2) strategic planning; (3) coalition leadership; (4) providing resources to mobilizers; (5) documentation of coalition efforts and feedback on progress; (6) technical assistance and; (7) making outcomes matter.[24] In addition, C2P utilizes community-based participatory research principles through the promotion of local decision making and identification of structural change objectives.[25]

Core elements for organizing the coalitions are applicable to both cohorts and included the following. All C2P coalitions were required to focus on identifying and achieving locally relevant structural changes. The study defined structural change as new or modified programs, policies or practices that may directly or indirectly target individuals and do not rely on the C2P coalition to be sustained. Coalitions were instructed to serve as catalysts for change, not program implementers.[26] All C2P coalition held a series of four to five introductory meetings leading up to a formal strategic planning meeting. To generate their strategic plan, coalitions utilized the "VMOSA" (Vision, Mission, Objectives, Strategies, and Action Plans) framework.[27] In addition, a C2P logic model was integrated to illustrate primary determinants of HIV acquisition (i.e., number of sex partners, high-risk sex partners and sex partner concurrency) and transmission (i.e., condom/clean needle use, STI co-infection, and viral load) based on epidemiological models. [28] The logic model prompted dialogue of HIV risk factors.

All C2P coalitions had a paid coordinator located at each ATN research site. The C2P Coordinator filled a central role as the coalition convener, mobilizer and manager ensuring that coalition activities were aligned with study requirements. A National Coordinating Center (NCC) located at Johns Hopkins University supported the C2P Coordinators by providing in-depth technical assistance (e.g., monthly phone calls) and capacity building support (e.g., quarterly webinar trainings) to promote concepts and skills pertaining to coalition development, structural change and strategic planning.[29]

Start-up Procedures for Cohort 1

Cohort 1 coalitions launched at staggered times during 2006 and were located in Tampa, Miami and Ft. Lauderdale, FL; Los Angeles and San Francisco, CA; the District of Columbia; Philadelphia, PA; Chicago, IL; Bronx and New York, NY; New Orleans, LA; Baltimore, MD and San Juan, Puerto Rico. Eight of these coalitions received continued government funding in 2011 and exist today.

Cohort 1 procedures emphasized conducting a comprehensive review of potential partners and their organizational history, mission and current activities.[30] Specifically, C2P Coordinators distributed a brief survey to approximately 100 organizations to assess the organization's overall purpose and goals, including services offered to youth. A structured

face-to-face interview with a subset of approximately 20 local organizations followed. Partners were chosen based on their experience working with youth in geographic areas with high rates of HIV and STIs, strength in fostering community assent and time to devote to coalition work. All partners who completed a structured interview were invited to join the coalition and sign a Memorandum of Understanding (MOU).[31]

For the introductory coalition meetings, which were held every other month, C2P Coordinators developed their own meeting agendas with three study requirements: (1) provide an overview of HIV risk factors and local public health surveillance data (e.g., HIV and STI rates among youth); (2) conduct a structural change tutorial prior to starting strategic planning; and (3) host a workshop on youth involvement within six months of coalition start-up. Agendas often included discussion of HIV prevention activities in the community, the role of research and partners' upcoming events. Additional discussion topics (e.g., meeting facilitation, infrastructure building, leadership and conflict resolution) to enhance the coalition's internal capacity were optional.

To support the development of objectives within the VMOSA framework, partners were encouraged to think broadly about community sectors (e.g., schools, faith-based, government, social services) where youth may encounter HIV risk and consider the physical, social and emotional aspects of youth development using the "Youth Development: An Action Planning Guide for Community-Based Initiatives" as a resource.[32] Sector analysis was the central component for brainstorming objectives.

Adaptation Rationale

Approximately one and a half years into the start of Cohort 1, the research team examined the progress and challenges that the C2P coalitions faced in trying to implement a study of this nature. A review of study documents found that most coalition partners (42%) represented HIV/AIDs service organizations or community-based organizations (CBOs) providing social services to youth,[31] one year after coalition formation, only 61% of coalition partners (n=170) felt that the coalition was in a position to "make this endeavor work" based on a survey administered semi-annually to coalition members (Table 3); more than 60% of the objectives being developed did not meet the study definition of structural change but instead focused on HIV prevention methods that targeted individual behavior change, such as sharing information about HIV risk or hosting group workshops on unprotected sex[33]; and based on a review of coalition meeting minutes, coalition members primarily fulfilled consultative rather than leadership roles.[34]

Recognizing that coalition development is a dynamic, non-linear process with multiple phases, the research team focused on modifying constructs that have a prominent role in coalition development.[35] Specifically, we focused on modifying three methods for Cohort 2: partner identification and coalition readiness, development of structural objectives and distributive leadership. We hypothesized that modifications to these components would contribute to a stronger and more efficient mobilization process by (1) recruiting partners who were primed to work on structural issues related to HIV and understood the coalition to be a community catalyst, (2) equipping partners to quickly develop a functioning coalition

structure, (3) highlighting the diversity of leadership roles, and (4) integrating new steps into the strategic planning training to prompt in-depth problem solving.

METHODS

In December 2011, five new C2P coalitions launched in Houston, TX; Detroit, MI; Baltimore, MD; Boston, MA and Denver, CO. Adaptations made to Cohort 2 start-up procedures are described below and summarized in Table 1.

Partner Identification and Coalition Readiness—Among the factors predicting effective coalition participation are commitment and investment of partners, suggesting a need to identify partners that have a clear understanding of coalition purpose and mission from the start.[1,36] Furthermore, when partners come to the coalition with an understanding of their function, they can more quickly identify opportunities for participation.[37] While partner diversity is valuable, the research team believed partner skills (e.g., advocacy experience), connections (e.g., relationship with decision makers) and content expertise (e.g., knowledge of system or issue) also needed to be considered during the partner identification process. For Cohort 2, steps were outlined to create a structured issue-identification process to guide partner identification.[38] Specifically, C2P Coordinators reviewed public documents (e.g., health department surveillance reports, local press releases and white papers); attended government, civic and professional association meetings, and met with stakeholders, community advocates, health providers and youth to assess the community landscape. Based on this review, C2P Coordinators developed a Community Assessment Memo that identified three core issues that were tied to contextual risk factors of HIV in the community and served as a launching pad for coalition planning. Issues identified included low income leading to ‘survival sex’ for shelter, food and clothing; safety of physical spaces where youth access medical care; and lack of inclusive sexual health education. The memo also identified people or organizations working on these issues (within and outside the field of HIV prevention), specific roles or skills, and a preliminary assessment of how this issue might influence partner recruitment. This was followed by identification of relevant systems, sectors and organizations that were involved in shaping the practices and policies impacting the core issues. A summary of this memo was condensed into an Issues Assessment Worksheet that was used to facilitate follow-up meetings with potential partners. The worksheet assessed questions such as ‘who is linked to this system’, ‘who will be an advocate for this issue’ and ‘who makes decisions related to this issue.’ These questions offered a way for C2P Coordinators to gain more insight into complex issues, as well as make final decisions regarding whom to invite to launch the coalition.

To promote coalition readiness, which meant having clarity of coalition procedures and purpose, the NCC provided structured agenda templates to guide the introductory coalition meetings, which occurred monthly. Required agenda items (in addition to the three requirements noted above for Cohort 1) included: review of factors that contribute to a successful coalition with emphasis on the differences between a coalition and program; a workshop on infrastructure building, including guidance on creation of by-laws, roles and

responsibilities, and decision-making models; an activity to promote shared leadership; and identification of new participants to invite to the strategic planning session. In addition, the NCC provided ideas of action steps to occur in between the meetings to promote partner involvement.

Development of Structural Changes—To develop structural changes, a broad scope of societal and contextual issues must be examined to address HIV risk from a socio-ecological perspective and to complement ongoing clinical efforts.[9] This presents a paradigm shift for community members who are accustomed to targeting individual-level HIV risk factors, such as HIV knowledge or skills, when planning interventions. Understanding the underlying conditions that contribute to HIV risk, which may be far outside the control of an individual, is critical to effectively identifying structural changes.[39] For Cohort 2, two specific changes were made to prompt comprehensive thinking of community-based HIV risks. First, the Issues Assessment Worksheet was re-visited after the structural change tutorial to facilitate preliminary problem-solving and practice applying structural change concepts. Second, a root cause analysis method was integrated into the strategic planning process to engage in a more in-depth exploration of risk conditions within the community. The modified strategic planning steps included: (1) framing the individual risk factor (e.g., number of sex partners) as an actual problem or behavior in the community; (2) asking why this problem exists by probing several layers deep to identify fundamental contextual factors (e.g., exchanging sex for shelter); (3) identifying the systems/structures with influence over or related to the issue; (4) identifying and engaging key stakeholders and powerbrokers who have influence within the targeted system; and (5) developing structural changes (e.g., more shelter beds for youth).[33]

Broadening Concepts of Leadership—Distributive leadership is a model of shared influence based on skills that group members are able to contribute. It can affect coalition productivity and sustainability, as well as overall member satisfaction.[3,40–41] This concept acknowledges that leadership emanates from a diversity of skills and capabilities (e.g., content expertise, strategist, negotiator, etc.) that no one person is likely to possess. For Cohort 2, a broad definition of “leader” was introduced early in the coalition start-up process and used to promote acceptance of multiple leadership roles, thereby encouraging partners to find a niche that suited their interests and skills. Within the first three months of coalition start-up, Cohort 2 was required to facilitate a leadership assessment and identification activity using a SWOT (strengths, weaknesses, opportunities, threats) analysis framework.[42] Each coalition partner identified his or her strengths in the context of the coalition’s mission and the group collectively assessed leadership gaps.

Facilitated Sharing Between Cohorts—In addition to procedural changes described above, the NCC facilitated communication between the C2P Coordinators in Cohorts 1 and 2. For example, coordinators from Cohort 1 assisted with capacity building trainings, hosted open forums on designated topics, such as meeting planning, and mentored Cohort 2 coordinators as needed.

Data Analysis

We reviewed study records to examine the modifications for Cohort 2 and how findings differed compared to Cohort 1. To assess partner composition, the research team built on the coding process described by Straub et al.[31] to determine the type of organization (e.g., medical care, social or cultural) the partner represented. For Cohort 1, a check list was used during the interview with partner agencies to assess type; for Cohort 2, the research team used the same checklist to code partners based on memos submitted by the C2P Coordinators. Once coded, partner agencies were grouped by traditional partners (i.e., having experience in HIV prevention, clinical care or related support services) and non-traditional partners (i.e., having no or limited expertise in these areas). Within these broad categories, we assessed the primary purpose of each partner organization to create sub-categories of partners (e.g., advocacy) and assist with understanding whether partners were more likely to be associated with proximal or distal issues related to HIV. Memos submitted by Cohort 2 assisted the NCC with this assessment by describing the rationale for selecting a partner, the role the partner filled and the link between the partner and issues identified during the community assessment phase.

Second, the types of objectives initiated by the two cohorts were examined. All objectives (n=299) developed by both cohorts during the first 21 months, including those that may have ultimately been discontinued, were reviewed and classified by research team members as either “structural” or “non-structural” using the study definition. The process involved independent review of objectives by two team members. If there was disagreement, a third team member reviewed the objective.

Finally, we analyzed data from the Healthy Coalition Questionnaire (HCQ), completed semi-annually by coalition members rating statements derived from the Wilder Collaboration Factors Inventory utilizing a five-point scale from strongly agree to strongly disagree to assess coalition growth and development.[43] For this paper’s assessment, percentage of respondents answering ‘strongly agree’ and ‘agree’ were combined. We examined a subset of questions from the HCQ associated with coalition purpose and process and compared responses at two time points during the coalitions’ first year, referred to as T1 and T2. In addition, two questions were added to the HCQ for Cohort 2 to assess the extent that leadership was shared between staff and coalition members.

FINDINGS

In general, findings differed across the two cohorts across all areas assessed. The structured issue identification process resulted in 80% of C2P Coordinators in Cohort 2 citing unstable housing as a core issue followed by comprehensive sexual health education (60%) and culturally-responsive resources and services for youth (40%). Partners associated with at least one of these core issues. Traditional partners (n=67; 74%) represented a diverse mix, including CBOs (21%), medical (18%), local government agencies (14%), coalitions (9%), cultural/social institutions (8%), faith/spiritual (3%) and planning councils (1%). The remaining partners (n=23; 26%) were categorized as non-traditional (see Table 2). Of non-traditional partners, 26% represented youth development (e.g., City Department of Social Services program); 26% housing (e.g., a city-wide shelter for sexual minority youth); 17%

advocacy (e.g., transgender coalition); 9% health education (e.g., Department of Elementary and Secondary Education); and 9% substance abuse facilities (e.g., recovery home). The remaining 27% was split among partners representing foundations, law enforcement and non-affiliated individuals. Cohort 2 partners included management level staff (e.g., Bureau Deputy, Development Director, Vice President), and specialists (e.g., Senior Policy Analyst).

For Cohort 2, high levels of coalition readiness were demonstrated at T2 across several indicators related to coalition process, structure and communication. Table 3 shows 85% to 98% of Cohort 2 coalition members (n=65 at T2) responded favorably to statements in the HCQ related to the coalition process, communications and belief that the work could be achieved, an increase from Cohort 1 findings of 61%-79% (n= 171 at T2).

Both cohorts developed the same average number of objectives during the first 21 months (n=16 objectives per coalition; range 5 to 34 objectives). However, the percent of objectives coded as structural for Cohort 2 was 93% compared to 69% for Cohort 1. While the diversity of sectors targeted by Cohort 2 was less than Cohort 1, Cohort 2 objectives more often targeted changes within a system with broader reach (e.g., a school system). Objective examples are provided in Table 1.

For Cohort 2, the percent of coalition members who felt the C2P coalition was led by a combination of C2P Coordinators and ‘a small group of coalition members’ or ‘large group of coalition members’ ranged from 54% to 72% across the five coalitions approximately one year after Cohort 2 started. Leadership was not assessed as part of the start-up phase for Cohort 1.

DISCUSSION

Much is known about factors that contribute to the success of coalitions including having clear goals, creating an infrastructure with defined roles and having a sense of purpose.[1] However, few coalitions have undertaken a mission focused specifically on achieving structural change in the field of HIV prevention for youth. Through our assessment of the process, structure, focus and content expertise of the coalitions’ membership, we examined modifications made to the start-up phase of five C2P coalitions based on lessons learned from a previous group of C2P coalitions. Recommendations are below.

Recommendation #1: Define Core Issues to Facilitate Partner Identification and Coalition Readiness

The structured issue identification process provided a focused method for identifying partners with mobilization skills and expertise needed to pursue structural changes. For Cohort 1, partners were selected by casting a wide net and invitations were extended widely to agencies providing sexual health related prevention, education and/or outreach to youth. In contrast, partner selection efforts for Cohort 2 were guided by the identification of locally-defined community issues fueling HIV risk. Rather than coming to the table to broadly address HIV prevention for youth, Cohort 2 partners were identified through a systematic process of assessing underlying contextual issues contributing to HIV risk.

Although an approximate70% of Cohort 2 partners represented “traditional” entities, their roles (e.g., policy manager) were more closely aligned with C2P being a catalyst for community change rather than a manager of a HIV prevention program. The required meeting content for Cohort 2 and monthly schedule of meetings had the benefit of allowing partners to become familiar with new terminology, to practice key planning concepts, and to build camaraderie with partners. The Community Assessment Worksheet provided a resource for synthesizing root causes, stakeholders, systems and organizations to facilitate partner recruitment and to launch coalition plans. For example, the C2P Coordinator in Boston (Cohort 2) recruited two high-level partners from the Boston Public Schools Health and Wellness Department to work toward the adoption of age-appropriate comprehensive health education in all public high schools, an issue identified early in the community assessment process. The C2P coalition formed a subcommittee, developed an action plan and after a year of work, the policy was approved. The C2P coalition in Boston was publicly acknowledged by city officials for their contribution to the effort.

Recommendation #2: Tailor Strategic Planning Steps to Create Systems-Focused Structural Changes

Addressing risks that are distally related to HIV transmission and acquisition, such as unstable housing or unemployment, requires a different planning approach than modifying risk behaviors.[44, 45] A framework, such as root cause analysis, is needed to understand the layers of influence that impact HIV risk conditions within a community. The modifications made to the C2P strategic planning process facilitated development of different types of objectives for Cohort 2. More objectives were structural (i.e., the objective was written to make a policy or practice change) and targeted large systems. We assert that the combination of partners at the table and the modified strategic planning process contributed to more focused framing of structural issues. The root cause analysis process was especially critical in coming up with structural ideas related to HIV prevention, given the challenge of thinking about HIV as a disease that is perpetuated by community factors, not just behavior. This was in contrast to the process used by Cohort 1, which relied heavily on considering individual-level risk behaviors, such as lack of condom use, and sector analysis to develop objectives. More often, Cohort 1 objectives focused on distributing information, such as a brochure or website link, to youth; creating a periodic event, such as a health fair or workshop, or distributing condoms passively, such as having a bowl of condoms on the counter of a local business. Cohort 1 did achieve structural changes that targeted systems and made broad-reaching policy or practice changes but it took many of them longer (i.e., more than two years) to do this.[46]

Recommendation #3: Equip Partners to Participate through Shared Leadership and Capacity Building

Our findings reinforce the importance of establishing coalition purpose, process and communication early in coalition development. Quickly establishing a course of action and intentionally engaging in skill-building activities that promote distributive leadership, shared knowledge and goal-setting, and identification of roles and responsibilities is beneficial.[47, 48] Cohort 2 actively engaged their partners in a leadership activity within the first three months and used techniques early in the process to promote partner participation.

With the exception of two coalitions that discussed decision making models and collaboration strategies, Cohort 1 did not include the optional discussion topics on their meeting agendas within the first six months. It was promising to see that across Cohort 2 more than 50% of the partners within each coalition perceived that there was shared leadership.

The data presented indicate that start-up procedures for Cohort 2 were better aligned with the goals of the C2P study. However, we are limited in quantifying the extent to which the study modifications contributed to the change versus the influence of other known and unknown factors. Given the disparate number of coalitions and individuals involved within each cohort, comparisons are limited. As with any multi-phased study, tremendous insight was gained from the experiences of Cohort 1 that aided Cohort 2. Cohort 2 benefited from talking with Cohort 1 coordinators who had “been there” and could share advice. The HCQ survey relied on self-ratings, which may contribute to social desirability bias. Finally, as with any community mobilization study, it’s impossible to control external factors that influence coalition efforts.

Despite these limitations, our experience indicates that coalitions seeking to build a structural change agenda to address a challenging public health issue, such as HIV, would benefit from adopting tailored practices to guide the initiation of their work. Important approaches include identification of underlying issues contributing to the defined health problem as a means to recruit partners, a strategic planning process inclusive of root cause analysis, and an early focus on leadership growth.

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Table 1

Cohort 1 vs. Cohort 2 Coalition Start-up Procedures

COHORT 1	COHORT 2
Partner Identification & Coalition Readiness	
Utilized structured face-to-face interviews	Utilized structured issue-identification worksheets
Conducted three required trainings (overview of HIV risk factors & local HIV/STI surveillance data, structural change workshop, and youth involvement workshop)	Conducted six required trainings (Cohort 1 trainings plus workshops on building a successful coalition, creating coalition infrastructure and leadership development)
Meeting agendas focused on HIV prevention activities in the community, partner events and role of research	Structured meeting agendas focused on community factors contributing to HIV risk, coalition development and
Development of Structural Changes	
Utilized Youth Development Guide concepts during strategic planning to consider HIV risks and affecting youth behavior	Utilized Issue Assessment Worksheet *prior to* strategic planning to gain familiarity with structural change concepts and problem-solving strategies
Utilized sector analysis	Utilized root cause analysis
Objective examples: • Public school system to begin providing health alert notices regarding HIV/STI and other youth related issues to parents and students. • Local book store to distribute free condoms and educational materials • An AIDS service organization to create a website with information on local services, activities and a chat room to link service providers. • Community based organization to begin providing quarterly educational workshops around dating and domestic violence.	*Objective examples:* • Public school system to revise wellness policy to include comprehensive health education appropriate for all students in schools. • Department of Children and Families to begin tracking LGBT-affirming foster homes to ensure proper placement of LGBT homeless youth. • Ryan White Part A program to amend tool to include assessment of staff's knowledge of policies and procedures that pertain to patients. • Transportation Authority to shorten application process for HIV+ youth who need public transportation to get to medical appointments
Creating Distributive Leadership	
No structured coalition activities in first six months	Within three months, conducted activity using SWOT framework to identify personal and group leadership attributes and skills

Table 2

Types of Partners: Percent Recruited by Cohort

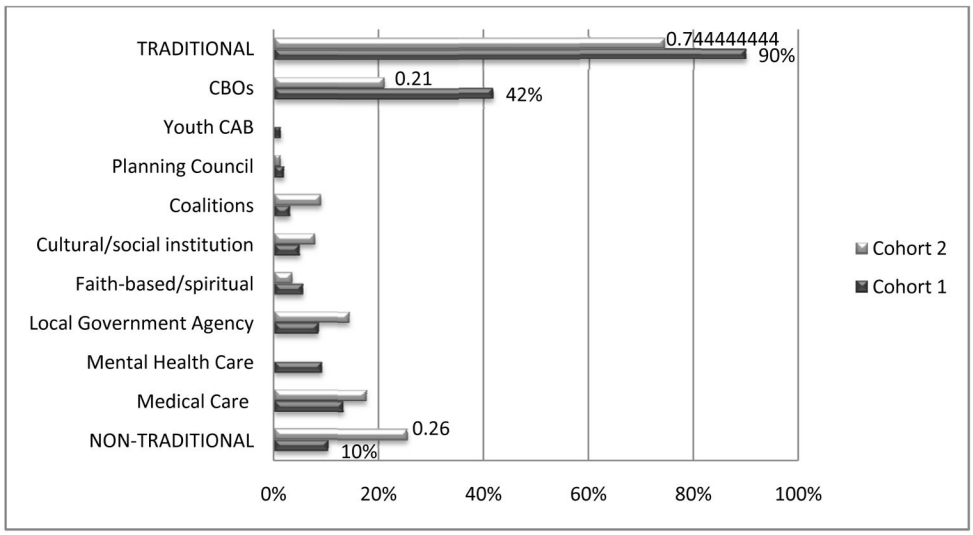

Table 3

Coalition Growth and Development - Time 1 and Time 2: Percent responded ‘strongly agree ‘and ‘agree’

	Cohort 1 T1 N = 181	**Cohort 1 T2 N = 170**	**Cohort 2 T1 N = 56**	**Cohort 2 T2 N = 65**
Purpose				
People in this coalition are dedicated to the idea that we can make this endeavor work.	72	61	95	98
My ideas about what we want to accomplish with this coalition seem to be the same as the ideas of others.	76	71	89	86
Process				
There is a clear process for making decision among partners in this coalition.	78	76	68	85
People in this coalition communicate openly with one another.	73	79	88	94
I am informed as often as I should be about what goes on in the coalition.	79	78	95	95
The people who lead this coalition communicate well with the members.	67	74	96	97