ORIGINAL RESEARCH

The Trans Accountability Project: Community Engagement to Address Structural Marginalization and Health Inequities

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ABSTRACT

Background:
Black and Latina Transgender women face systemic marginalization and harm, increasing vulnerability to social stress and poor health outcomes. These communities have limited access to resources to mobilize and create paths toward health equity.

Objectives:
In this paper we report on the results of a community partnership to engage Black and Latina transgender communities on the South and West Sides of Chicago and establish service priorities for collective empowerment.

Methods:
The Trans Accountability Project (TAP), a Steering Committee of transgender, nonbinary, and cisgender queer persons from four partner organizations, was established and led the design, recruitment, implementation, and analysis of a community needs assessment. World café and human-centered design methods, guided two community conversations/listening sessions around four activities: the perfect provider, my dream job, safety planning, and a stakeholder reflection.

Results:
Sixty-three participants completed three activities and envisioned innovations for: 1) accessible and holistic gender-affirming healthcare, 2) autonomous, flexible, and community-focused jobs in the arts, non-profit/business, and care professions, and 3) safer social interactions and spaces. Ten stakeholders attended to listen and inform their organizational and clinical practices to empower Black and Latina transgender women.

Conclusion:
TAP prioritized accountability, connectedness, and centering the voices of Black and Latina transgender women as a starting point to intervene upon structural marginalization. Five insights emerged and have directed TAP's focus toward employment and collective care. Although further structural change remains a priority, TAP represents a mechanism for sharing power, improving communication and collaboration, and increasing transparency across relevant Chicago community-based organizations.

KEYWORDS: Community health research, Community health partnerships, Health disparities, Transgender, Structural Racism, Power Sharing

Introduction

Background

Black and Latina transgender women face enormous social and health disparities which are also associated with higher rates of HIV. Relative to cisgender populations, studies across the United States have found that Black and Latina transgender women experience disproportionately high levels of unemployment, unstable housing, food insecurity, interpersonal and community violence, incarceration, as well as high prevalence of HIV, depression, PTSD, anxiety, and substance misuse (1–10). A systematic review of social stress and mental health of transgender persons identified 77 studies from 1997-2017; depressive symptoms, suicidality, trauma exposure, substance misuse, anxiety, and general distress were consistently elevated compared to the general adult population (11). Unaddressed mental health problems increase Black and Latina transgender women's propensity to remain disadvantaged, amplify the risk for additional exposure to trauma and violence, and are associated with increased HIV sexual risk behaviors (4,12).

The Chicago Department of Public Health estimates that 10,500 (0.05%) transgender adults -- men, women, gender non-conforming, and nonbinary -- reside in the city, and yet transgender women make up 2% of the newly diagnosed HIV cases (13,14). Unlike the decreases in other HIV risk populations, HIV incidence has remained stable among Black and Latina transgender women in Chicago (15). Two cohort studies – one of HIV-negative and one of HIV-positive transgender women -- indicate high levels of social marginalization. A 2012-2014 cohort study (N = 180) of HIV-negative participants identified the following sample characteristics: mean age 23 years, 42% Black, 13% Latina, 71% unemployed, 23% uninsured, 47% ever engaged in sex work, 46% ever homeless, 29% ever incarcerated. Sixty-two percent of

participants met CDC guidelines for PrEP eligibility, but only 5% had ever taken PrEP medication (13). The HIV-positive cohort study had similar baseline characteristics and indicators of social marginalization with some notable differences. With a mean age 30 years, 94% Black, 5% Latina, 94% currently unemployed, 100% annual income < $6,000, and 77% had experienced homelessness as an adult, the HIV-positive cohort is older with nearly no White participants, higher unemployment, poverty, and homelessness (16). To address the ongoing systemic marginalization and harm (17), design and implementation of effective health interventions at the structural level require the leadership of Chicago's Black and Latina transgender women (16).

Objective

In 2019 three Chicago community-based organizations and one federally qualified health center (FQHC) established a Steering Committee to mobilize Black and Latina transgender communities, particularly on the West and South Sides of Chicago where access to care is limited and where many Black and Latinx Chicagoans reside. The purpose of the ongoing mobilization is to center the participation and needs of Black and Latina transgender women and expand their access to healthcare in the context of structural marginalization and racism. The near-term goal was to build and engage community around the establishment of service priorities. In this manuscript, we describe the findings from the initial mobilization and highlight the critical role that Black and Latina trans communities play in the development of relevant and effective strategies to mitigate structural marginalization and to expand access to quality care.

Methods

The Trans Accountability Project: the Partnership

The Trans Accountability Project Steering Committee formed as a result of a community mobilization grant award to address the dearth of HIV prevention and treatment services on the South and West Sides of Chicago. The FQHC had proposed to form organizational partnerships with 3 key organizations on the South and West sides, selected based on their history of service to transgender women or their proximity to high HIV incidence in Chicago. One organization is a large, Latinx-serving affordable housing organization on Chicago's northwest side with a trans-inclusive homeless youth program, and the other two are smaller, grassroots, and Black-and-Queer-led or Black-and-Trans-led organizations. Although one now has non-profit status, in 2019 these fiscally sponsored organizations served primarily Black trans persons with a range of programs such as a food pantry, clothing closet, housing and employment services, affinity and support groups, and designated space for socializing and for voguing.

The Steering Committee named itself the Trans Accountability Project, or TAP. TAP's objective in year one was to design a community needs assessment, conduct outreach and recruitment, and host two mobilization events where community members and allied stakeholders could convene and collectively assess community needs. TAP met five times with 10 weeks to plan the two mobilization events. The Steering Committee consisted of seven Black, Latina/x, and White transgender and nonbinary persons, plus one cisgender, queer Latinx person from the four partner organizations. The Steering Committee was the primary mechanism driving the community mobilization events, including event planning, participant recruitment, assessment design, data collection, and analysis. Of note, TAP chose the term "Black and Latina transgender women" to refer broadly to the social position of TAP's priority communities; TAP members never assumed or specifically defined the term as an identity or expression knowing how varied individual identities and expressions are.

Approach

World café and participatory design methods were engaged to conduct the two community mobilization events (18,19). Depending on the stakeholder or audience, TAP referred to these events with different terminology: community conversations, design workshops, listening sessions, and town halls have all been used to describe the mobilization events. In this manuscript, we use community conversations - a term that centers the concerns of Black and Latina transgender women - and listening sessions which defines the function of the events for invited stakeholders. World café method, established in the 1990s, fosters relationship building, collective and experiential learning, community organizing, and community mobilization around specific goals (20,21). Typically, world cafes are structured around numerous small-group discussions on curated topics and questions, relevant to the specific goals. This modality circumvents "research fatigue" elicited by more top-down, individually-focused, extractive methods, instead promoting cooperative, practical ways of knowing, and connectedness among communities and stakeholders (22).

Given the World Café approach, TAP Steering Committee agreed upon three domains around which to curate activities and discussions: employment, healthcare, and safety planning. The funder's evaluation team encouraged TAP to include an activity explicitly focused on HIV risks and PrEP uptake, and after prototyping activities, the Steering Committee rejected this one based on "research fatigue" around HIV-specific topics and TAP's desire to explore collectively how these more upstream domains might relate to challenges like accessing PrEP.

Human-centered design principles were used to develop three activities as the basis of three small group discussions. Human-centered design promotes activities, curated around an initial ask – addressing structural racism and access to care -- that foster imagination and

creativity about possibilities for self and community activation (19). These activities were intentional in asking participants to imagine new possibilities for healthcare, employment, and safety rather than centering past, personal or negative experiences. TAP Steering Committee members and four human-centered design consultants from communities adjacent to or intersecting with Chicago Black and Latina trans communities prototyped and iterated three activities resulting in colorful worksheets with semi-structured prompts, modified for language, timing, and relationship to TAP's longer-term goal (see **Figure 1.** for an example). The final versions were translated into Spanish.

Figure 1. Activity 3 worksheet from Trans Accountability Project Community Conversation in 2019; "Who is in your pod?" prompts participants to consider their support systems for the interpersonal and community violence they face.

WHO IS IN YOUR POD?*

Responding to violence & making a safety plan

REFLECTIONS

In the past, when I have told others about violence I have experienced, they responded with: _____

When I don't tell others about violence I experienced, it's because: _____

IMAGINE YOUR POD: Fill in each pod as a way of planning for your response to violence.

If a sexual partner harmed me...

- People I would or might tell
- People I would want to tell, but probably wouldn't
- Organization(s) I might seek help from
- Organization(s) I would NOT seek help from

Organization(s) Organization(s) You

If a healthcare provider harmed me...

- People I would or might tell
- People I would want to tell, but probably wouldn't
- Organization(s) I might seek help from
- Organization(s) I would NOT seek help from

Organization(s) Organization(s) You

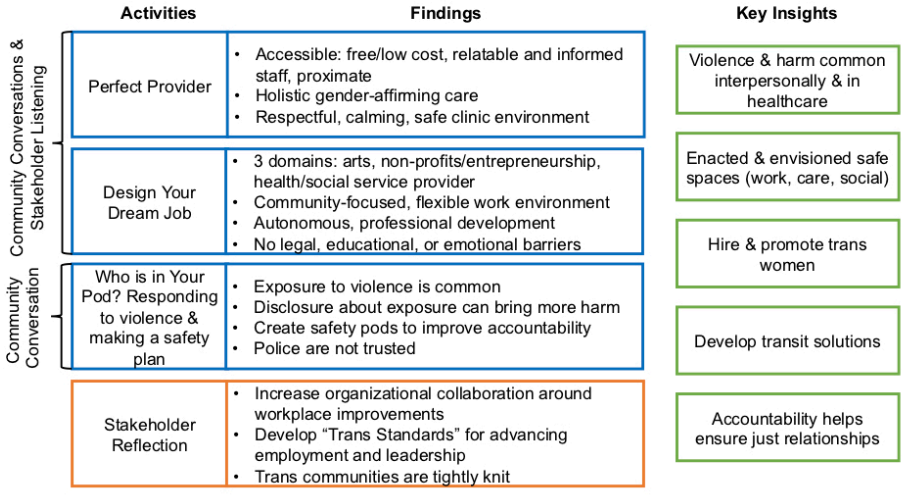
SUPERPOWERS

My top TWO values or habits that could promote safety for myself and others are: 1) _____ 2) _____

* Borrowed and adapted from the Bay Area Transformative Justice Collective.

Community Conversation and Facilitation Recruitment

Figure 3. Activities, findings, and key insights from the Trans Accountability Project community conversations (n = 63) and stakeholder listening sessions (n = 10). Hosted in Fall of 2019.



To encourage more open discussions, TAP wanted community members to facilitate the community conversations. As only two members of TAP Steering Committee were members of the priority communities, TAP recruited six additional community members, plus one White trans woman from the Steering Committee. Facilitators attended one unpaid, 3-hour facilitation training and were compensated $125 for each event they facilitated.

Community Conversations and Listening Sessions: Setting and Procedures

TAP chose locations and spaces accessible to community members on the South and West Sides of Chicago that were relatively friendly and familiar to community members. These sites were also accessible to public transportation and had free parking on-site or nearby.

As described in the Approach, the Steering Committee invited stakeholders to attend the community conversations as listeners (20,21). With accountability as a core value, TAP members wanted key, recognizable figures, such as known gender-affirming physicians, policymakers, advocates, and service provider leadership, to listen to and reflect on the experiences and knowledge shared among participants. During the third activity (see **Figure 1**), regarding safety planning, the stakeholders were asked to leave the main room and engage in a reflection activity and discussion together.

Prior to activities, a community-owned caterer provided a sit-down dinner to participants. Although the activities were the focus, the meal provided social and somatic nourishment. A facilitator hosted each table which held up to 5 participants, plus one stakeholder and one note taker. Each facilitator guided their table through the following activities:

Activity 1: Your Perfect Provider

Activity 2: Your Dream Job

Activity 3: Who is in your pod? Responding to violence & safety planning

The Steering Committee chose these topics for their central relationship to transgender health and autonomy. To accommodate language accessibility, one facilitator was available to conduct their table's sessions in Spanish. For each activity, TAP allocated 10 minutes to write and reflect and 20 minutes for discussion. Written and oral modes of data collection allowed participants to choose whether to participate in one or both modes. Both events concluded with a large-group discussion for 20 minutes.

Measures and Analysis

Materials were offered in both Spanish and English so that the event was accessible to Spanish speakers who were not fluent in English. Materials were translated into Spanish by bilingual members of TAP. These same members coded any worksheets that were written in Spanish while the notetaker translated the Spanish discussions into English for coding.

Human-centered design principles guided the analysis and synthesis of the data generated by the activity worksheets and the discussion notes. In human-centered design, data synthesis is a collective process of analysis where collaboration is key to building ideas and insights from the data (19). With some pre-coding and organizing of data done by two members, the Steering Committee used three 3-hour meetings to code and analyze worksheets. The discussion notes from each table were coded to validate worksheet coding and further develop themes identified. TAP worked in small groups and collectively to identify themes, patterns, and insights within and across activities. One TAP member synthesized these analyses and integrated event evaluations and the stakeholder reflections.

TAP did not collect personally identifiable health information from participants in the community conversations. As these events were specific to local contexts and challenges, the sample was not intended to be representative or generalizable to a broader transgender

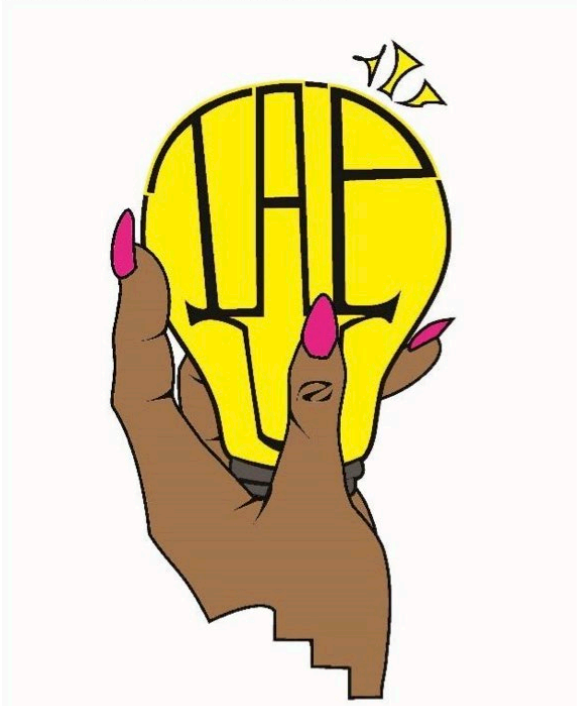
population. An institutional review board determined that the activity design and data collection processes were exempt as human subjects research.

Results

Community Sample Characteristics

There were 37 participants and 9 community facilitators at the first event; two participants chose to sit at the Spanish-speaking table. Twenty-six (26) participants, all English speakers, and 6 of the 9 community facilitators attended the second event for a total of 63 participants (N = 63). TAP thought it was important to capture the facilitators' responses to the activities as well as the participants'; TAP collected facilitator worksheets at the second event but not the first to avoid duplication. There were three stakeholders at the first event although one left before the stakeholder reflection. Nine stakeholders attended the second event, and 8 participated in the activity (N = 10). For a summary of participant and stakeholder activities, major findings, and key insights, see **Figure 3**.

Figure 2. The Trans Accountability Project logo designed by the Steering Committee in 2019.



Activity 1: Your Perfect Provider

Worksheets

Instead of imagining and communicating their vision of a perfect provider, more than half of respondents described their current or past provider as "perfect." Participants named the following desirable qualities whether the provider was actual or imagined: knowledgeable, caring, compassionate, gender-affirming, geographically proximate, and relatable. Participants expressed wanting a provider with similar racial, gender, ethnic, and age characteristics.

Respondents desire a clinic space that is accessible both financially, geographically (i.e., walkable or near public transit routes), and in terms of a range of appointment times throughout the day and week. Also desired are Black and Brown staff, who are LGBTQ-friendly or trans

themselves, and a clinic space that is a homey, comfortable, and safe atmosphere with plants, fresh scents, and natural light.

Respondents envisioned office visits that treat for holistic wellness, including mental health, gender-affirming needs, primary care, as well as sexual health and STI/HIV screening. Spiritual health and trauma-informed approaches were also named as desirable. In response to the prompt, "When we first met, [my perfect provider] said," participants commonly specified that their perfect provider begins by sharing their name and pronouns and asking for the patient's. In response to the prompt, "I know [my perfect provider] respects me and my privacy because…." respondents seemed to express a high level of confidence in privacy protections by citing HIPAA, rather than any new method or mode of protections. Participants expressed that clear communication and listening skills from providers were critical to their care and would enable them to recommend a provider.

Facilitated Discussions

The discussions provided space to share visions of a perfect provider and an opportunity to provide contrasting examples from their personal experiences. Whether imagined or real, perfect providers were personable, nonjudgmental, well educated, and reflected participants' lived experiences or identities, like having immigrated or transitioned genders. Clinics were easily accessible, often located on the South Side or in participants' neighborhoods. Participants shared clinic names like "the Happy Place," "Harmonize," and "Trans Affinity" and desired non-clinical and calming environments that included a range of scents like sage, lavender, lemongrass, and honey. Low- to no-cost, wraparound care, including mental and sexual and reproductive health, was often the ideal.

Participants cited instances of "deadnaming" and misgendering in provider waiting rooms as common and as deterrents to seeking care. Discussions also highlighted how many providers' lack information about gender-affirming medical interventions, the possible physical and psychological effects, and how to get them covered. This lack can impact choices around gender expression, medical transition timing, and one's ability to "pass." Access to medical interventions can be critical for passing, it was noted, and passing often is necessary for access to job interviews and sustained employment.

Activity 2: Your Dream Job

Worksheets

Dream job titles tended to cluster in three domains: art/performance/fashion, non-profit or business leadership, and healthcare and social services. A common theme across these domains is that participants' dream jobs are community-oriented, and these jobs were often structured as self-employed or in some relatively autonomous fashion. The workday was described as flexible and with opportunities to work from home. Also mentioned frequently was engagement with community—whether solving problems together or strengthening community relationships-- as part of the workday.

The skills participants bring to their dream jobs included self-motivation, determination, passion, hustling, assertiveness, and resourcefulness. The barriers that they envisioned removing to get these jobs included: a lack of motivation, internalized doubt, traumas, inaccessible transportation, and a lack of formal education.

Facilitated Discussions

Dream job discussions reinforced the three dream job domains and elicited new themes. Many participants reinforced wanting to give back to their communities; some, for example,

want to provide mental healthcare and case management to homeless trans youth of color. The arts-related jobs were also oriented toward community whether dancing to heal trauma, hosting balls to build chosen families, or producing videos to assist with transition or provide entertainment. In the nonprofit domain, leadership positions with more decision-making power and autonomy along with prioritizing hiring more Black and Brown transgender women were discussed as critical to addressing community needs more effectively.

Participants noted the credential and degree requirements that so often make positions inaccessible to Black and Latina transgender women; removal of these requirements and more support and mentorship around professional development are needed to make dream jobs a reality. The high prevalence of white or cisgender people in leadership positions can make a workplace feel segregated and leads to overvaluing degrees and devaluing the rich, lived experiences that Black and Brown transgender women bring to jobs. Participants identified difficulties with navigating educational and professional development bureaucratic systems that feel hostile to them.

Navigating being trans in the workplace itself was also a recurring theme. For example, non-profits may favor hiring persons who have volunteered or interned there, but trans women of color may not have the means to volunteer or intern and, even if they did, often are not selected to do so. Many expressed that not passing – and discrimination -- is a barrier to securing and keeping a job and advancing along a career path. Similarly, legal hurdles, such as background checks, name and gender marker changes, and consistent sources of identification, were named barriers to gaining employment, while mental health issues, such as anxiety and post-traumatic stress, were discussed as barriers to maintaining employment.

Safe and accessible transportation was identified as key to accessing and retaining employment. Many dreamed of having chauffeurs, drivers, or their own car or jet. More practically, Uber was discussed as a source of transportation that might be safer than public transit although some also mentioned a desire to have homes and jobs proximate to a safe public transit route.

Activity 3: Who is in your pod? Responding to violence & safety planning

Worksheets

Approximately half of respondents reported positive, supportive reactions from confidantes when disclosing violence perpetrated against them, and the other half reported negative, shaming reactions. The majority, however, said they typically avoid these kinds of disclosures out of fear of being blamed, shamed, disbelieved, or fear of indifference/inaction.

Though they varied between the sexual violence and provider violence scenarios, pods largely consisted of individuals like best friends, family members of origin, chosen family members -- and mothers, in particular. In terms of safe organizations in pods, most of those affiliated with TAP were named while the police were consistently named as the most unsafe institution when wanting accountability and support for any violence experienced.

Facilitated Discussions

Participants elaborated on the difficulties with disclosing violent encounters whether sexual, physical, or emotional. Embarrassment, shame, guilt, trust, abandonment, fear, being seen as a victim, and not being taken seriously were some of the barriers that participants identified as keeping them from disclosing. Although worksheet responses indicated half of participants received positive reactions to disclosures, the discussions tended to focus on negative reactions to disclosures. Participants said that when they had disclosed encounters with

violence in the past that loved ones had been victim-blaming, patronizing, uncaring, and often normalized abuse. Participants shared stories of childhood victimization at the hands of authority figures, family, and/or caregivers as well as stories of witnessing abuse and violence. Both self-healing as well as non-healing were addressed, emphasizing how often these traumatic events go unaddressed and fester. Participants expressed that they may not want to seek help from persons who are not like them and do not share their experiences and perspectives.

Participants discussed their "superpowers," or resilient traits that enable them to survive. Traits like empathy, strength, courage, perseverance, and self-defense skills were named as was tearing down organizations, not trusting anybody, and keeping to self. One participant said her experiences with sexual violence as a child have helped her as a healthcare provider; she knows some of her patients have been exposed to violence, and she provides a safe space for disclosure and helps them get the resources they need.

Participants emphasized that pods may not always consist of persons closest to oneself; for example, if it was sexual violence by an intimate partner, she might not feel safe telling mutual friends for fear they will not believe her, and they will side with the perpetrator. While participants almost uniformly did not trust police to address sexual violence and would likely not report it to them, participants did not hesitate to say that they would "spill the T" and report a healthcare clinician to provider leadership.

Stakeholder Activity: Reflection

Worksheet and Discussion

During the third activity, stakeholders were asked to leave the tables and come together in a separate room to participate in a different activity. At the first event, two cisgender partners of participants were included in this stakeholder activity. Stakeholders completed and discussed

together a worksheet with four reflection questions regarding: 1) outstanding themes from the event, 2) changes in one's work based on takeaways, 3) one word to describe event, and 4) one new understanding regarding Black and Latina transgender women.

Consistent with the findings from the participant data, stakeholders identified themes such as a gap in Black and Latina Trans representation on their staffs, a lack of safe and welcoming spaces particularly ones on South and West Sides, a lack of trusting and affirming relationships particularly with providers and employers, a high prevalence of poverty and violence, and a strong desire to be creative and to mentor peers.

Changes in stakeholders' work included creating more job opportunities, inclusive workplaces, and trans visibility, including the creation of "trans standards" for workspaces. Stakeholders agreed more collaboration between organizations and more trainings for businesses and providers might improve access to safe and affirming jobs, healthcare, and public accommodations broadly. A similar change named around employment was to build on the dream job activity and encourage trans clients to do more visioning around dream jobs and identify pragmatic pathways toward them. Finally, providers discussed how they might spend more time listening to their trans patients and build stronger, more trusting and longer-term relationships. As for new understandings, stakeholders noted that the communities reflected in the events seemed more complicated, more tightly knit, and demonstrated a greater level of belonging than they had realized.

Collective Group Discussion

At the end of the evening, a collective discussion provided space for reflection, acknowledgment, and coming together. Overall, participants expressed how meaningful it was to see so many of their peers in the room, sharing space, and sitting together to imagine new

possibilities for themselves individually and collectively. The need for more safe and accessible spaces were elaborated upon; for example, one person remarked how women over age 30 are not prioritized for services and do not have as many accessible spaces to share, to find and train for jobs, and to find housing. Spaces are key to relationship- and intergenerational community-building as well as healing and accountability processes.

Safety planning and accountability were highlighted as issues that often go unaddressed in the transgender health domains of research, care, and services. Participants wanted to think more about how to support each other, how to hold peers and leaders accountable when needed, and how to hold organizations accountable. Elder participants (i.e., 35-70 years) acknowledged the progress that has been made over the last 30 years on the part of healthcare providers, while also highlighting that much of the progress was due to Black and Latina trans women "breaking the system." By the same token, daily survival – with limited to no access to housing, jobs, transportation, and mental healthcare -- whether in the past or present was highlighted as a source of resilience and as a major barrier to building community.

Discussion

The three human-centered design activities and the world café framework yielded 5 cross-cutting insights (see **Figure 3.**) around which an intervention to address structural racism and marginalization vis-à-vis access to care might be developed and implemented (19). First, Black and Latina trans women reported a range of exposure to violence in healthcare, interpersonal and professional relationships, and with police. Second, and as a corrective, they envisioned safe and accessible spaces for services, care, employment, and for coming together. Third, part of making spaces safer, includes hiring and promoting Black and Latina trans women on staff and in leadership positions and making services more accessible to Spanish speakers and

undocumented persons. Fourth, creative and safe transit solutions are needed to mitigate harm and to access services, employment, and social support. Finally, accountability for self, peers, community, and organizations are required to repair the impacts of harms and to build more just relationships.

These community-engaged modes of data collection accomplished two feats not typical of transgender HIV prevention initiatives. First, the TAP Steering Committee itself and its use of human-centered design and the world café helped ensure that trans voices were centered in its establishment of priorities to address structural marginalization and racism in provider, employer, and institutional settings for greater health, safety, and autonomy. Seldom are transgender-focused HIV prevention grants awarded to transgender persons or transgender community partnerships, and the absence of transgender-led grants perpetuates relationships of extraction and inequity rather than empowerment and community building (23). Second, the events themselves enacted a vision – of a safe space for social support, nourishment, and community planning – that is more representative of the local communities' vision for health justice than a survey or focus group has ever identified and that demonstrated to stakeholders what is possible (24).

Traditional HIV prevention research brings a behavioral lens to individual-level "risk behaviors" and "risk factors," without centering the knowledge of Black and Latina transgender communities across the entire research continuum, engendering what is known as research fatigue (22), and without engaging structural analysis and critique. Our approach facilitated connectedness and community capacity building, helping to ensure that, in the presence of stakeholders, Black and Latina transgender community members collectively develop their own analyses of problems typically left to cis-led institutions to address or not.

Limitations

The legacies and presence of structural racism and marginalization in Chicago are vast, and community planning, mobilization, and research are not isolated from institutional or interpersonal power dynamics (24–30). Although diverse and inclusive, the TAP Steering Committee has been shaped through organizational, socioeconomic, and racial hierarchies. Hierarchies include: the federal and city grant requirements with limited funding for a broad-based collaboration, limited transgender health data collection, primacy of English language and fluency, and the relative wealth and power of two of the four organizations, which are cis-led, compared to the other two that are grassroots and Black-and-Queer-led or Black-and-Trans-led. These power dynamics also impact equity issues like involvement in the pre-award process, budgeting and governance, knowledge around administrative, financial, and grant requirements (30). With clear organizational power imbalances across the Steering Committee, post-grant award planning began with mistrust made explicit among members. Immediate and ongoing measures were taken to address mistrust. Accountability is a core value of TAP, and openly processing mistrust and enacting structural changes in the partnership, such as participatory budgeting, were integrated into TAP's processes. Ideally, this evolving partnership model where power and decision making are shared across organizations is an intervention on the structural marginalization facing trans communities. Finally, participants were not representative nor the results generalizable although the themes and priorities identified may be common to other U.S.-based Black and Latina transgender communities.

Conclusion

The TAP steering committee has chosen the domain of employment in which to develop a multipronged intervention. Without jobs, a community cannot thrive; moreover, U.S.

healthcare is largely employment-based. Jobs in leadership positions, jobs with healthcare benefits, and jobs that center trans voices will help strengthen and redistribute resources for transgender communities. With a limited budget and organizational capacities, TAP will continue to engage stakeholders and community members to build a stronger foundation on which individuals can advance their skills, education, training, and social networks. A key to understanding TAP's broader effectiveness may also reside in measures of structural change across organizations; put another way, the sustainability of TAP and the creation of more mechanisms like it will enable Black and Latina transgender communities to connect with each other and stakeholders across the city to guide more equitable distribution of resources. These nodes of collaboration and accountability can more directly address equity in employment, education, housing, healthcare, the arts, and community spaces but also expand organizational capacities for all.

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