ANALYSIS OF THE ACCESSIBILITY AND AVAILABILITY OF HEALTHCARE SERVICES FOR TRANSGENDER PEOPLE IN THE REPUBLIC OF NORTH MACEDONIA

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Revised Analysis of the Health Needs of Trans People and the Availability of Health Services in the Republic of Macedonia Skopje, 2016

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Analysis

1. Introduction

This analysis pertains to the data collected from a research conducted by TransFormA - the Initiative for Promoting Transgender People's Rights in the Republic of North Macedonia. The research aims to overview the accessibility and availability of healthcare services that transgender people require, to determine and assess the existing medical gender affirming healthcare services and to what extent they are harmonized with the international standards for transgender people's health (WPATH Standards of Care).
For the purposes of the research, a semi-structured interview Questionnaire was prepared, which aims to consistently document transgender people's experiences with regard to healthcare in the last 5 years.

The research covers three major topics which include: experiences with medical gender affirmation (hereinafter referred to as MGA), experiences with other healthcare services, and transgender people's awareness regarding their rights as patients in relation to MGA and other healthcare services.

The data was analyzed based on the latest version of the standards for transgender people's health (WPATH 8), taking into account the gender identity-based discrimination and the social context in which transgender people live in the Republic of North Macedonia.

The analysis also includes texts written by healthcare professionals who have knowledge and experience in working with transgender people and who provide healthcare services in the fields of gynecology, endocrinology, urology and plastic surgery.

1.1. General guidelines according to WPATH 8 standards

1.1.1. Depathologization of transgenderism

People who have crossed the cultural boundaries of gender and sex have existed in cultures around the world ever since antiquity (Feinberg 1996). Contrary to the recent pathologization of gender diversity as a disease, some cultures traditionally celebrate and embrace diversity (e.g., Nanda 2014; Peletz 2009) WPATH 8 (2022).

It is disturbing that today transgender people around the world experience stigma, prejudice, harassment, abuse and violence, resulting in social, economic and legal marginalization, poor mental and physical health and death – "a process characterized as a descent from stigma to disease." (stigma-sickness slope; Winter, Diamond et all 2016). WPATH 8 (2022)

Globally, the medical science consensually no longer classifies transgenderism as a mental disorder. In the latest version of the Diagnostic and Statistical Manual DMS-5 from the American Psychiatric Association (APA 2013), the diagnosis gender dysphoria is to related to gender identity itself, but rather to any anxiety and discomfort that accompanies being transgender. This provides for a model of medical care that emphasizes the active participation of the patient in the decision-making processes regarding their own health with the support of a medical professional. WPATH 8 (2022)

1.1.2. Gender-affirming care

Unlike the approach that pathologizes transgenderism, the goal of gender-affirming care is to collaborate with transgender people in order to holistically address their social, psychological and medical needs, as well as their overall well-being, by means of affirming their gender identity with dignity. WPATH 8 (2022)

Gender-affirming care supports transgender people throughout their lives, that is, from the first signs of gender non-conformity in childhood, until old age, as well as people who are worried and/or uncertain about their gender identity, supporting them before and/or after the transition. WPATH 8 (2022)

As an integral part of the gender-affirming care, the healthcare necessary for transgender people entails a multidisciplinary approach, which includes endocrinology, surgery, voice and communication, primary healthcare, sexual and reproductive healthcare and psycho-social support, in order to provide quality MGA services, as well as to ensure preventive care and dealing with chronic diseases.

With regard to MGA, the WPATH 8 standards emphasize that the needs of transgender people are different and there is no one-size-fits-all approach to medical gender affirming, but rather it needs to be tailored to the individual needs of each transgender person.

1.1.3. Legal gender recognition

The WPATH 8 standards also emphasize the benefit of implementing inclusive policies, such as legal gender recognition which, among other things, enables transgender people to align the data in their personal documents without being obliged to undergo hormone therapy and/or surgical interventions as a prerequisite for this, and further states that "transgender people whose gender designation has been changed in their documents have better mental health (e.g., Bauer et all 2015; Scheim et all 2020).
A transgender rights-based approach can make a significant contribution to improving the health and well-being of transgender people." WPATH 8 (2022)

1.2. Social context

Being one of the more distinctly discriminated against marginalized groups, transgender people in the Republic of North Macedonia have been exposed to systemic discrimination for years, which prevents them from exercising their administrative and medical rights.

In the Republic of North Macedonia, there is no legal framework that recognizes gender identity. However, there is an improvement in the practice of the institutions after the ruling of the European Court of Human Rights in the case of "X against Macedonia", after which 7 transgender people have successfully completed the procedure for legal gender recognition based on self-determination so far, i.e. without submitting medical documentation.

Paradoxically, the condition set for the harmonization of personal documents, the Health Insurance Fund does not consider MGA as basic healthcare services, contrary to the recommendations in WPATH 8 which require the immediate implementation of the ICD-11 diagnostic criteria, in the RNM, transgenderism is still on the list of coded mental disorders F.64 under the term «trans-sexualism», and there are no clear protocols that would allow adequate health care and unhindered access to MGA services. The only thing in place is the Guidelines from 2013 on the practice of evidence-based medicine in the treatment of transsexualism, which orders the provision of healthcare services in an inappropriate manner. “Gender reassignment surgery” mentioned in the Guidelines is not regulated in any way in the Macedonian healthcare system, for which reason the surgical services that some transgender people need, instead of being part of the care for medical gender affirmation, they are managed and treatedas cosmetic surgeries or as medical care for cisgender patients.

In terms of the broader social context, it is troubling that in recent years the stigma surrounding transgender people has been amplified due to the increasingly aggressive anti-trans narratives in the world and in our country. According to the Research on Tolerance and Values of Citizens (2022), conducted by CIvica Mobilis, 81% of respondents declared that they do not want to have an LGBTI person as a neighbor. While according to the Equal Opportunity Barometer (2023) of MCIC, only 5% agree that school lessons and materials should include information regarding transgender diversity, and 79% do not accept a third gender definition in laws.

The MGA services are the main focus of the anti-transgender narratives, about which misinformation is spread in media reports and on social networks, characterizing MGA as “mutilation”, putting all the emphasis on the small percentage of cases of detransition, in order to stir moral panic. Such narratives inevitably spread stigma and apply pressure on medical staff. There is a danger that this will strengthen the already present prejudices among healthcare workers in RNM, who continuously show no interest in sensitizing themselves to work with transgender people and offering adequate MGA services.

1.3. Target group

A total of 15 people from 6 cities in Macedonia participated in the research.

The group consisted of transgender people with different gender identities – trans men, trans women, a non-binary person and an intersex person, who in the past 5 years have had experiences with MGA-related services.

These people have different needs in relation to MGA and are in different periods of their transition, both medical and social, which refers to a change of name, gender designation in personal documents, disclosing their gender identity to their loved ones and the environment and gender expression as well.

The respondents are from 17 to 40 years of age, whereas the minor responded to the questions in the presence of a parent.

Only 4 of the interviewed persons are employed, and the rest are unemployed, pupils, students, doing part-time work or sex work.

In terms of household monthly income, the group is composed of people who have different incomes which belong in the following categories: 2 respondents from 12,001 to 18,000 MKD, 3 respondents from 18,001 to 25,000 MKD, 3 respondents from 25,001 to 36,000 MKD, 4 respondents from 36,000 to 50,000 MKD, and 3 respondents with over 50,000 denars.

2. Perception of the healthcare system

Perceiving the social stigma that surrounds them, as well as the daily experiences of discrimination and rejection in both social and personal life, transgender people lose their willingness and the opportunity to access health care.

In response to the questions related to the attitude towards the health system, all respondents stated that they believe transgender people are not accepted by the healthcare system, and 14 out of 15 answered that they often face different treatment, discomfort and condemnation by healthcare professionals.

For this reason, 11 out of 15 decide not to disclose their gender identity to healthcare

professionals, even when there is a need to disclose it, and 9 out of 15 avoid going to medical exams due to their feeling of shame, for fear of discrimination and to avoid unpleasant questions by the healthcare staff.

A transgender man explains why he avoids seeing a doctor even when it is a serious health problem in question:

> *"[...] for some things that are not related, for example a stomach problem, a heart problem, for whatever it may be, it's more difficult for me since I have to explain my situation from scratch, so that they know if they get confused, if they see the documents, and that's why I go to doctor. Even if it's a terrible health situation, I rarely go."*

It is interesting that despite the systemic discrimination, which is one of the reasons contributing to the inaccessibility to healthcare services, and that the experiences of the respondents suggest that all (15 out of 15) have faced discrimination when seeking healthcare services, in the response to the questionnaire, seven answered that they completely or partially disagree with the statement "The healthcare system does not accept and discriminate against trans/gender non-binary people", indicating that some transgender people do not recognize discrimination in their experiences.

(Table 1)

	The number of respondents that agree that they can access without discrimination	The number that have experienced discrimination and rights violations?
Accessibility to MGA-related services without discrimination	7	14 out of 15 (one person has not utilized MGA-related services yet)
Accessibility to other services without discrimination	6	14 out of 15

3. Availability and (in)accessibility of medical gender affirming services

Regarding the availability of MGA-related services, 10 out of 15 interviewees answered that healthcare institutions do have the capacity to offer the services.

As for the availability of MGA-related services according to individual's needs, 14 out of 15 stated that although most services are available, they are completely or partially inaccessible from a financial perspective.

Services related to MGA are not covered by the state Health Insurance Fund, which is why transgender people are obliged to pay for those services themselves, therefore they utilize these services in private healthcare facilities. Although 14 out of 15 of the interviewed persons have healthcare insurance, 14 out of 15 declared that in the past 5-year period, the MGA-related services that they can financially afford have been fully or partially utilized in the private healthcare sector.

One of the reasons that contributes to the inaccessibility to MGA-related services is the lack of formal regulations and clear protocols. In the RNM, contrary to the WPATH 8 standards, transgenderism is pathologized and is on the list of mental disorders in the Diseases Diagnoses Code according to the ICD-10 classification, the diagnosis being "Transsexualism» coded F64.0.

A transgender man explains that he had a hysterectomy because he had a life-threatening reproductive health condition, and the hysterectomy was performed as a procedure for cisgender women.

The same transgender man adds the following regarding the inaccessibility of genital surgeries:

> *"So, in terms of the financial aspect, given that genital surgeries are not financially covered by the health insurance, you cannot discriminate against me in terms of work, and ask me to pay 20,000 euros. You can't ignore me when I'm being kicked out of the house and expect me to work and save money to pay for a procedure because you, as a civil servant, have to provide these procedures for me."*

Hormone therapies are also procured privately. Testosterone therapy for transgender men is not listed on the Positive Medication Register, while transgender women, although they can obtain the therapy through the Health Insurance Fund, say that the hormone

therapy that is available in the RNM is a therapy that is not always suitable for their individual needs. They often look for ways to obtain gel hormone therapies which are available in other countries. Testosterone in the form of a gel is also unavailable; one trans man says that for this reason he is currently using a therapy prescribed abroad, where he obtains it from.

People who do not live in the capital city face even greater challenges in terms of obtaining the hormone therapy that is available in the RNM. A transgender man from an inner city says that he is forced to travel regularly to Skopje, subjecting himself to additional financial costs to obtain his prescribed testosterone, and other MGA-related services as well.

Respondents believe that the inaccessibility of MGA-related services, apart from the financial aspect and the lack of regulations, is largely due to the reluctance of doctors to be trained to be able to offer MGA-related services in an adequate manner. This, as shall be noted further on in the analysis, is confirmed through the experiences of the respondents with psychologists, psychiatrists, endocrinologists and gynecologists, who are not sensitized and are unwilling to sensitize themselves to work with transgender people, and the rhetoric used in conversations with patients as well as the way in which they approach them, mirror the widespread prejudices associated with transgender people and their need of MGA.

(Table 2)

Doctors consulted for MGA-related services in the last 5 years	Number of people who utilized or attempted to utilize services from healthcare professionals
Family doctor	12
Psychiatrist	13
Psychologist	11
Endocrinologist	10
Gynecologist	5
Urologist	/
Surgeon	7
Other	2

3.1. Violation of rights and incompetence of healthcare professionals

Regarding the violation of patients' rights and negative experiences related to MGA, all of the respondents who utilized MGA-related services in the past 5 years (14 out of 15) answered that they faced at least one of the situations listed in the questionnaire.

Most negative experiences or violations of patients' rights occurred in state healthcare institutions (13 out of 14), whereas some respondents reported negative experiences and violations of rights in private clinics as well (6 out of 14).
A transgender person talks about an experience with a gynecologist at a private clinic who attempted to dissuade them from medical transitioning:

> *"I think I mentioned that when I was at the gynecologist, yeah. He asked me if I was sure I wanted this to continue. If you start hormone therapy, you won't be able to have children, this and that. I don't know why he mentioned that a male sex organ will not grow – we all know that."*

Practices that are completely contrary to the WPATH 8 standards of affirmative care, accompanied by inappropriate mention of genitalia, a rhetoric that coincides with widespread prejudices about transgender people, are constantly repeated in the respondents' experiences:

> *"The first time at a psychiatrist I had some issues with my identity, problems that I experienced, the first time I had dysphoria, at the age of 16. I did not know what it was, how and what was happening to my body and to me. I did a little research on the Internet, so I wanted to talk to her. I tried a little, but she made fun of me and asked me what I would need a penis for and what I would do with it, so I didn't know how to answer. She told me that she knows a transgender woman from Turkey and it is obvious that she is transgender, but I am not and that 2% of people were transgender and it is not possible. I was a teenager and I still didn't know what I wanted. I was suppressing this and when I turned 19, it just had to come out and I couldn't suppress it any longer, I knew what it was, I knew what I wanted and I wanted to start a new identity and knew that all of this was normal, I knew how I felt."*

(Table 3)

	Public healthcare	Private healthcare	Number of respondents who answered YES
To be addressed in the wrong gender	9	5	10
To be addressed by your old name/the name you have changed	4	/	4
Incompetence of doctors for your questions/needs	7	1	7
Disclosing your transgender status without your consent to third parties or healthcare personnel who did not need to know	5	1	5
Avoiding to provide you the service (gave you a service begrudgingly)	5	2	6
Denial of service due to stigma and discrimination	2	1	2
You had to wait to be served last because of gender diversity (even though you weren't last)	1	/	1
Your gender identity was commented	8	2	9
They asked you unnecessary questions related to gender identity	6	/	6
They judged your gender identity	4	1	4
Dissuading/telling that you shouldn't be trans, that it's bad, etc.	6	1	6

Conversion therapy or other conversion practices (this may include psychotherapy, psychosocial counseling, electroshock therapy, use of drugs to make the patient cisgender)	2	/	2
Moving away, avoiding contact, such as greeting, touching the patient's possessions, etc.	1	/	1
Verbal violence (insulting, belittling))	3	/	3
Psychological violence (gossip, condemnation, threats, blackmail)	2	/	2
Physical violence (hitting the body with body parts or an object, not administering anesthesia or painkillers)	1	/	1
Sexual violence and sexual harassment (unwanted commenting and contacting, touching the body, sexual assault, rape)	2	1	3
Other violations of rights or bad experiences with healthcare (add)	2	1	2

3.1.1. Experiences with psychologists and psychiatrists

Experiences with psychologists and psychiatrists, who have a key role for a transgender person to be able to begin medical gender reassignment, indicate that they are not familiarized with the international standards for transgender people's health, and that not only do they have social prejudices related to transgender people, but also they do not refrain from expressing them to their patients.

Instead of an affirmative approach, transgender people encounter psychologists and psychiatrists who attempt to delay the initiation of MGA, dissuade them in terms of elaborating that they are not or should not be transgender, as well as experiences with verbal violence, conversion therapy and prescription of antidepressants for gender dysphoria are also mentioned.

> *”At a state clinic, a psychiatrist wanted to forcefully prescribe me antidepressants, and since I told him I don’t want to take medication, he asked me if I would take anti-depressants, to which I said “No” and then he replied that I would, after which I was forcibly prescribed anti-depressants in the report at the end.”*

3.1.2. Experiences with endocrinologists

The experiences with endocrinologists at state clinics are similar. Trans woman talks about her experience with an endocrinologist at a state clinic who delayed prescribing her hormone therapy and intimidated her by telling her that the hormone therapy would shorten her life expectancy:

> *“I went to her for the first time. First, there were 5-6 students who were studying and I was really uncomfortable, but I don’t know, I communicated all of that in the most normal way. The first time she didn’t tell me anything, she just gave me a referral to do to a microbiology test and told me to come back for a check-up in a week to see what the results were going to be. That was it, she gave me the referral and I left. I went to microbiology, a week passed, I went back to her with the results and although the blood count was quite good, except I don’t know, the sugar levels were at the upper limit, but within the limit that is allowed, it was not exceeded. She said I can’t give you hormones. Go on a special diet, I don’t know what you want to eat, if I don’t give you medicine now, and next time if your sugar is like this, I will take you to the diabetes ward. I was all confused; I said I didn’t come for diabetes. I don’t have a problem with sugar. But your fat levels are also high, to which I said well, fine, I’ll do something to correct that. Okay, come back in 6 months for a check-up and just so you know, wait, don’t go, just so you know we will shorten your life by 10 years and your kidneys will fail”*

3.1.3. Self-prescribed hormonal therapy

The endocrinologists' reluctance and refusal to prescribe hormone therapy leads transgender people to reach for hormones on their own and expose themselves to the risk of its inappropriate use.

A minor transgender person who has the rare privilege of being supported by a parent participated in the research.

The parent said that it was impossible to obtain hormone therapy for transgender minors. They said that despite a recommendation by a psychologist and a signature by the parents that they agree, the endocrinologists refused to prescribe it. There is no legal provision that prevents endocrinologists from prescribing hormone therapy to minors with parental consent, but because of the stigma attached to transgender people and the wrongful belief that being transgender is just a «phase,» endocrinologists refuse to prescribe it.

According to the WPATH 8 standards regarding the criteria an adolescent must meet to be able to utilize MGA-related services, there is no age limit for starting MGA (including puberty blockers, which are not available in our country); the only criterion that must be met is that the patient has entered Tanner stage 2 of their development.

As a prerequisite, it is required that the person meets the diagnostic criteria for gender dysphoria according to ICD-11, and countries that have not yet implemented the ICD-11 diagnostic criteria are recommended to implement them as soon as possible.

The adolescent's mental health that needs to be managed should not be a barrier to commencing MDA where indicated.

Parents/guardians should be involved in the MGA process, unless it is impossible to do so or their involvement is deemed detrimental to the adolescent.

The parent explains how endocrinologists are not competent to manage hormone therapy for transgender individuals:

> *"They don't even know if it is allowed to prescribe it to minors or not. I would say that there are also gaps in knowledge about gender identity. I mean, I could write a whole book about it... Endocrinologists also have no idea how to manage that therapy, the one for change, for hormone therapy."*

For this reason, the person decided, together with the parent, to take hormone therapy on their own. Aware of the risks, they try to reduce them by informing themselves from studies and informal sources, as well as doing all necessary medical tests at their own private expense.

Regarding taking hormones on their own, 3 people (including the minor) stated that they had taken hormones on their own at some point in their life. A trans woman explains that she was aware of the risk and that the estrogen injections she gave herself made her sick, but decided to take the risk due to the unavailability of hormone therapy appropriate for her individual needs prescribed by a medical professional.

3.1.4. Insults and blackmail

Apart from systemic and "subtle" discrimination, transgender people also face insults, blackmail and sharing information related to gender identity and health with third parties..

A transgender man says he frequently experiences inconveniences and rights violations when attempting to access MGA-related services:

> *"It would be considered sexual assault by a gynecologist without my consent, there was a lot of persuasion, manipulation, sharing my and other people's information, I was outed as trans. There was also a lot of verbal abuse."*

Such cases remain unreported, they say that, if they report, they do not believe that they will get any support whatsoever by the system.

3.2. MGA-related needs

In relation to the needs for MGA-related services, several transgender people stated that healthcare professionals need to be sensitized and educated; they reaffirm their need for a clinic specialized in MGA; several of them emphasize the need for psychological support during the entire transition process.

(Tabl 4)

MGA-related services	Number of people who utilized or attempted to utilize MGA services in the last 5 years	Number of people who indicated that they need the services listed
Psycho-social support	5	2
Hormone therapy	9	14
Chest surgery	6	11
Genital surgery	1	6
Face feminization/ masculinization	3	2
Voice and communication therapy	/	/
Other aesthetic procedures	2	4

4. Други здравствени услуги

With regard to other healthcare services, 6 respondents answered that the health services are accessible to them from a financial perspective and without discrimination. However, most of the respondents answered that they either avoid medical exams due to fear and shame of stigma (9 out of 15), or hide their gender identity due to fear of discrimination (11 out of 15) and have personally experienced violation of patients' rights (14 out of 15). This may be due to the fact that the majority of them focuses on accessibility from a financial perspective, as several stated – that services are accessible to them because of health insurance, or not recognizing discrimination in their lived experiences.

Negative experiences related to other healthcare services commonly include the following: people who have not changed their name and gender in personal identification documents are often exposed to unpleasant situations when healthcare personnel who are not only not sensitized to work with transgender people, but they also act as if they have no knowledge that they exist at all – for which reason, they are confused about the

it happens for them to suspect that the documents are someone else's, to ask for an explanation and not infrequently, without consent, to reveal the person's gender identity in front of other patients.

> *"When I was at the family doctor's, I entered the office in which there was the nurse in the waiting room and many other people as well. I gave the health report card and she read my name and surname out loud and commented on my voice and why I had changed so much and I didn't want to talk about it, I avoided the topic. After that she gave the card to the doctor and told me to enter, he started asking who the person on the health report card is. I tried to explain to him what the matter was and he didn't understand me, so I told him it was me and he claimed there was no way it could be me. I told him it was me and I would give him an ID. He was like there's no way you're female, you're definitely male, I told him that's the point. Finally, he asked me what the matter was and it turned out that I had inflammation of the breast - the man was amazed. I had to undress for the examination and he couldn't believe how this could be. He commented that I was very masculine. I felt very humiliated and did not know how to react and what to do, felt lost in space and made sure that the situation does not escalate."*

(Table 5)

	Public healthcare	Private healthcare	Number of respondents who answered YES
To be addressed in the wrong gender	8	1	8
To be addressed by your old name/the name you have changed	7	1	7
Incompetence of doctors for your questions/needs	5	0	5
Disclosing your transgender status without your consent to third parties or health care personnel who did not need to know	4	/	4
Avoiding being provided with a service (service was provided, but begrudgingly)	4	1	4

Denial of service due to stigma and discrimination	1	/	1
Your gender identity was commented on	/	/	/
They asked you unnecessary questions related to gender identity	8	1	8
Ти поставувале непотребни прашања поврзани со родовиот идентитет	6	1	6
They judged your gender identity	4	/	4
Dissuading/telling that you shouldn't be trans, that it's bad, etc.	6	1	6
You were charged extra because you are trans	4	/	4
Conversion therapy or other conversion practices (may include psychotherapy, psychosocial counseling, electroshock therapy, use of drugs to make the patient cisgender)	3	/	3
Moving away, avoiding contact, such as greeting, touching the patient's objects, etc.	1	/	1
Verbal violence (insulting, belittling)	4	/	4
Psychological violence (gossip, condemnation, threats, blackmail)	1	/	1
Physical violence (hitting the body with body parts or an object, not administering anesthesia or not giving painkillers)	1	/	1
Sexual violence and sexual harassment (unwanted commenting and contacting, touching the body, sexual assault, rape)	1	/	1

Other violations of rights or bad experiences with healthcare (add)	1	/	1

4.1. Sexual and reproductive health services

Even the changed documents do not solve the issues regarding the non-sensitized staff, and the problem is especially pronounced when it comes to sexual and reproductive healthcare services.

A trans man whose documents have been changed says he is anxious about going for a gynecological examination because he is certain that due to the changed documents he will be referred to a urologist and exposed to the discomfort of explaining his gender identity.

Some of the respondents completely avoid utilizing services for sexual and reproductive health that are not related to MGA, and the rest utilize these services offered by non-governmental organizations that are familiar with and sensitized to work with transgender people.

A total of 11 respondents stated that they utilized sexual and reproductive health services, out of which 7 stated that they had access to them via civil society organizations, a few answered that they specifically utilized services offered by the HERA Youth Center "I Want to Know". Only 4 used sexual and reproductive health services offered by public and/or private healthcare institutions.

The sexual and reproductive health services respondents reported to have utilized in the last 5 years include: gynecological services, HIV and STI testing, as well as access to PrEP and a dermatovenerologist.

In terms of sexual and reproductive health services needs, one respondent stated the need for a urologist and two emphasized the need for healthcare professionals to be sensitized to work with transgender persons. The rest answered with "I don't know" (2) or that they do not need other services than those already offered (9).

4.2. Mental health services

A total of 9 out of 15 interviewed individuals reported to have used mental health services, out of which 5 answered that they accessed those services through civil society organizations, they specifically mentioned the psychological support provided by TransFormA and the Queer Center, 1 person used such services in the private healthcare sector, and 1 person in the public healthcare sector; the rest did not specify.

Regarding the needs for mental health services, most did not give a precise answer, two indicated that there is a need for sensitized psychologists to work with transgender people, two indicated the need for a greater number of available psychologists and psychiatrists through organizations, and one person answered that there is a need for availability of ADHD therapy.

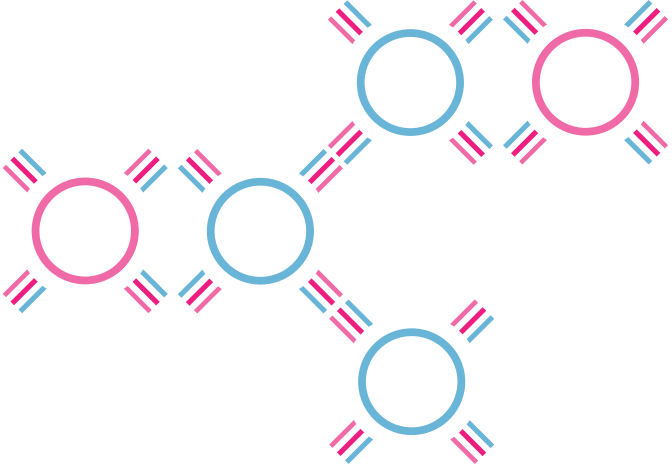
5. Awareness

In relation to the awareness of the rights related to MGA, more than a half of the interviewees answered that they are well informed.

A total of 10 out of 15 answered that they get information from personal contacts with activists from TransFormA, from the Queer Center, from other non-governmental organizations and from personal contacts with other transgender people who have more experience than them.

They emphasize the need for brochures, especially in virtual form, available on social networks and on the websites of organizations, as well as a translation of the WPATH 8 standards and news about legislative changes related to MGA. One person pointed out the importance of availability of these materials in Albanian and Romani languages.

Regarding awareness of their health rights as patients, 10 answered that they are not familiar at all or not enough, they point out the need for educational news on social networks, brochures and materials that would be understandable and accessible to the general population. Several of them mentioned seminars and workshops organized by NGOs and TransFormA.



THE CURRENT SITUATION REGARDING GENDER REASSIGNMENT SURGERIES AT THE CLINIC FOR PLASTIC AND RECONSTRUCTIVE SURGERY IN SKOPJE (2016 - 2023)

Research associate Dr. Igor Peev, MD, plastic surgery specialist

At the PHI University Clinic for Plastic and Reconstructive Surgery, in the last few years, approximately twenty gender reassignment surgeries have been performed, which is commendable. All of these operations were related to secondary gender characteristics, and we have also had one case of complete phenotypic transformation (excluding gender surgery), namely facial transformation (feminization in the case of a trans woman), body shaping with liposculpture, breast augmentation and buttock augmentation with implant and fat. Other surgeries were mainly related to breast surgery, i.e. placement of implants in trans women and breast removal in trans men. A noteworthy fact is that we have also had three foreign nationals, namely two from Canada (transgender couple) and one from Australia.

All surgeries were successful and satisfied the the patients' aesthetic criteria. We presented our results in this area this year at the meeting of the International Association of Plastic and Aesthetic Surgeons (ISAPS) in Athens, where we received words of praise. I believe that this success in the increase in number of patients is because these patients, the largest number of whom are socially networked, discuss in their circles, after which the patients receive a recommendation for the surgeon here, instead of traveling abroad (mostly to Serbia). Of course, the non-governmental organizations that are engaged in this subject matter, which protect the rights of transgender people, on the one hand, and who made a medical team of first choice when it comes to healthcare treatment, on the other hand, have a lot of credit for this. In that way, easier communication and integration of all parties in the process was made possible, with the aim to provide better healthcare for transgender people.

Regarding gender reassignment, based on the experience so far, I can say that almost none of the patients requested such a service and that most transgender people do not decide on it and are mostly interested in «top» surgery. Gender reassignment is technically a much more complex intervention and our public healthcare does not currently offer it as a service, nor is it willing to do so. Such interventions require more frequent operations to maintain an educational continuum and routine, which is of course impossible, because there is no interest. The small number of patients who decide on gender reassignment usually end up in private hospitals, where surgeons from Serbia operate, or the patients go directly to Serbia. The operations on the secondary gender characteristics that we perform are frequent operations for cis people as well, so their technical implementation for trans people is almost the same, with some peculiarities that are easily applicable.

In terms of the financial implications for patients, these operations are completely privately covered, i.e. patients pay for them themselves. During the time when Minister Dr. Filipche held the office, a working group was formed within the Ministry of Health, with the aim of considering the idea of covering these operations by the Health Insurance

Fund for a certain number of patients per year, following the example of Serbia. After two or three meetings, for some obscure reasons, that working group has ceased to function and dissolved without reaching a conclusion. Meanwhile, in the current circumstances surrounding the public health insurance system, in the package of health services covered by the HIF, these operations are not covered, and the DRG system does not recognize these as valid procedures because it does not consider transsexual conditions and gender dysphoria as diagnoses. It is technically possible to "cheat" the system, but the doctor would be held legally liable and no doctor would do that. Therefore, these operations remain to be paid for privately by the patients. Finally, there is willingness shown by the last two medical directors to perform these operations here. Otherwise, the worse case scenario would be that they are not allowed at all.

The prices that patients pay for these interventions are the same which are determined by the Ministry of Health for the private interventions that we perform as an additional activity of the Clinic in the afternoon hours, i.e. after the regular working hours. The patient pays for the procedure we perform irrespective of whether it is considered as a transgender service or not. The list of operations and the price list as private procedures are publicly available on the official website of the Clinic (<www.plasticsurgery.com.mk>), as a Price List for additional activities. The prices have been the same since 2016, when the price list for additional activities was last revised, but their increase by 20% is in the process of consideration, for which the Minister's consent is impending.

The list of medical interventions offered by the Clinic is the same as in the previous report, and these are all procedures that include the transformation of the face and body, except for the change of biological sex. This includes: breast surgery (breast augmentation) with silicones or their removal, feminization and masculinization of the face with or without rhinoplasty (nose job), body sculpting with liposuction and lipofilling (liposculpture) and more. Of course, non-invasive procedures, such as fillers and neurotoxins are also included in the list. More specifically, the operations that could be performed at our Clinic and for which we are currently technically ready and equipped include the following:

Male to female medical interventions:

- Breast augmentation (silicone breast augmentation in one or two acts, with or without additional use of adipose tissue) - about MKD 100,000.00;

- Feminization rhinoplasty (correction of the nose with female fea tures) - about MKD 67,000.00;

- Augmentation (enlargement) of lips, cheekbones, etc. - approximately MKD 30,000.00;

- Brow & face lifting 24,000.00 – 12,000.00 denars;

- Body contouring;

- Liposuction and lipografting;

- Fillers, neurotoxins (Botox) and

- Other interventions.

Female to male medical interventions:

- Subcutaneous mastectomy (breast removal with nipple preservation)

- Masculinizing rhinoplasty

- Chin enhancement with lipofilling

- Body countouring

- Liposuction and lipografting

- Enlargement of muscle groups with lipofilling or implants.

Operations for which we are not trained and educated include:

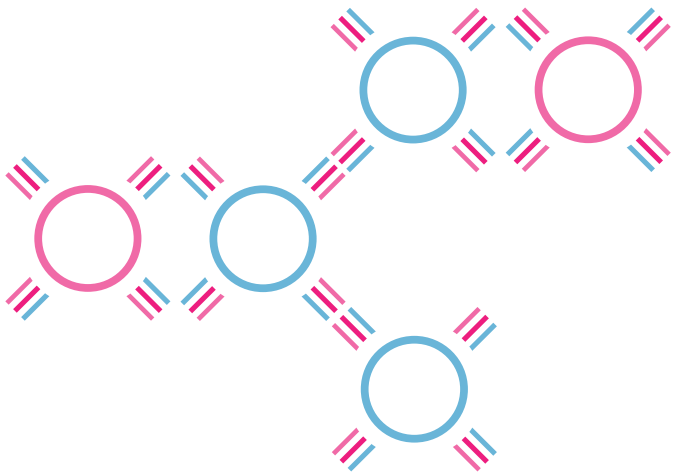
- male to female and female to male genital change operations;

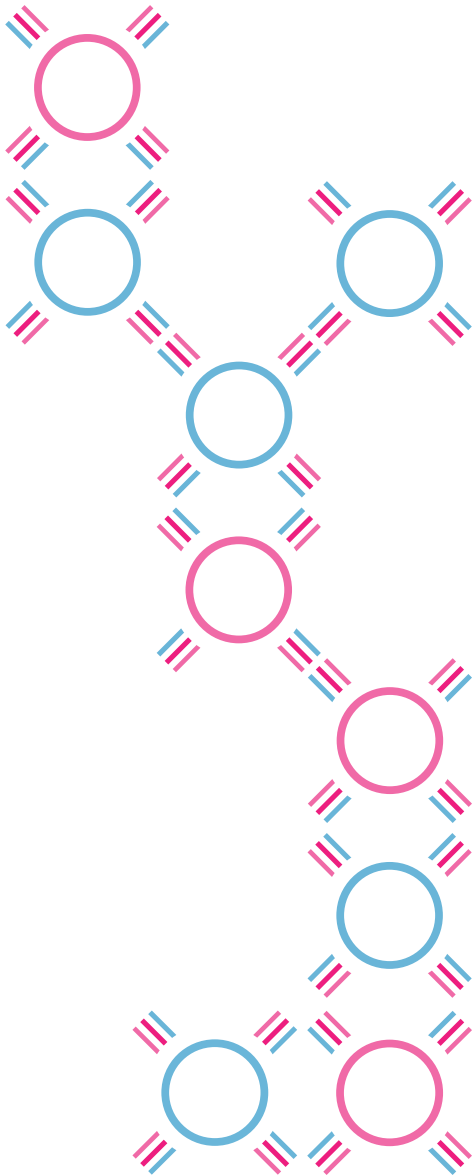
- reduction larygoplasty (reduction of the larynx);
- removal of ribs;

- reduction or augmentation mandibuloplasty (lower jaw reduction or enlargement);

- hip and queen ring resections and other procedures.

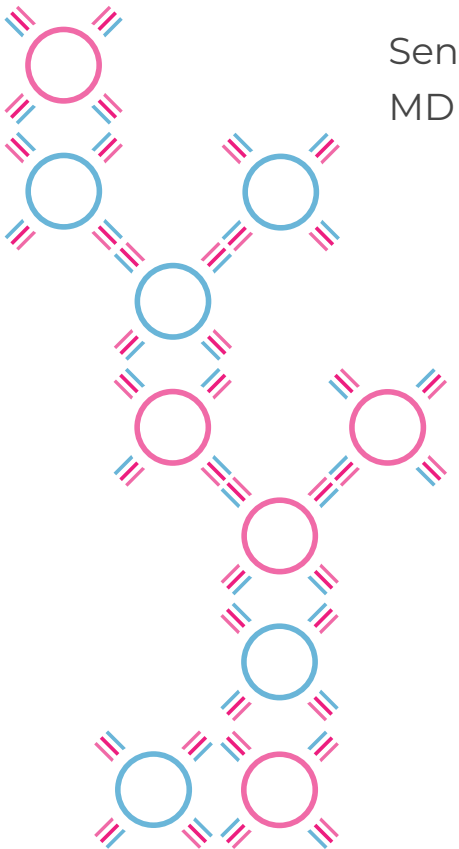
In conclusion, there is a growing interest in operations for transgender people in our country, with a constant increase year by year. They are performed by two or three surgeons at the Clinic who have the virtue, knowledge and patience for such an endeavor. It remains unclear whether everyone follows the WPATH (World Professional Association for Transgender Health) recommendations. Patients pay for the operations themselves at prices determined by the Ministry of Health, which are significantly lower compared to those in the region. The quality of the service is more than satisfactory. Plastic surgery should be the last step in the entire transformation process of a transgender person and be the icing on the cake of the body transformation that follows an adequate period of psychiatric-endocrinological preparations.

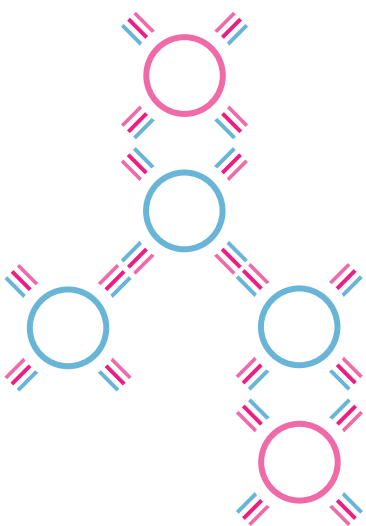




NEW PROCEDURES IN THE FIELD OF UROGENITAL RECONSTRUCTIVE SURGERY AT THE UROLOGY CLINIC IN SKOPJE, 2024

Senior research associate Dr. Ognen Ivanovski,
MD surgeon-urologist University Clinic of Urology





Genital reconstructive surgery is the final step in transgender transformation. While for many transgender people genital transformation surgery is not essential for the expression of their gender characteristics, for a large number of them it is a necessity in order to fully realize their gender identity. Genital transformation by surgery has proven to be effective in improving the feeling of well-being, comfort in one's body, improved cosmetic aspect, as well as adequate expression of sexual function in these persons.

As the last link in the gender transformation chain, the urogenital surgeon has to work closely with mental health experts and obtain written documentation that would confirm that it is indeed a transgender person in question and not a mental illness. Furthermore, the choice of the type of surgical procedures to be performed must be made between the transgender person and the surgeon in the form of a private agreement. The entire operative course must be explained and all possible post-operative complications must be stated and accepted by the transgender person. The cooperation with an expert endocrinologist who is involved in the patient's hormonal therapy is of no lesser value. This is important because it is necessary to achieve testosterone and/or estrogen suppression before the planned surgery.

Recommendations for informed consent

The recommendation remains to thoroughly discuss all procedures with the patient and to match their needs and requirements with the clinic's capabilities. In addition, the compliance of the requirements with the existing legal norms in the country is of no lesser value. Of course, there are also the technical capabilities and surgical skills of the surgeon himself that need to be taken into account.

In accordance with the above, the following recommendations must be considered:

1. Explanation of the various surgical techniques available at the institution (with recommendation of alternative options).
2. The benefits and drawbacks of each technique.
3. The limitation in certain procedures that do not achieve «ideal» results (the surgeon must provide images before and after the intervention, including unsuccessful outcomes).

4. Explanation of potential intraoperative and postoperative complications.

These points represent the basis for the informed consent that is required for any surgical procedure and is also an ethical and legal requirement prior its performance. It is important for the patient to have realistic expectations in order to achieve a satisfactory result aimed at alleviating gender dysphoria. All this should be explained in the language spoken and understood by the patient, and graphical representations should also be used. The patient is given enough time to carefully review the documents and consider.

Overview of surgical procedures that could be performed at the University Urology Clinic

The following procedures can be performed for the transition from male to female at the University Urology Clinic:

1. Penectomy and urethroplastica

2. Removal of the testicles (Oriectomy)

3. **It is a novelty that from September 2023 the Health Insurance Fund approved the implant of sphincters for urinary incontinence at the expense of the Fund. These sphincters are often used in transgender surgery in cases where there is post-operative incontinence.**

For the transition from female to male:

1. Phalloplasty using a skin graft (Ivanovski et all, EurUrol Supp 2016) (Ivanovski O., Eur Urol 2023)

2. Placement of testicular prostheses

3. Urethroplasty

4. Removal of buccal mucosa

5. Using the buccal mucosa as part of the urethral reconstruction (Ivanovski et all, EurUrol Supp 2015)

6. **The placement of penile prostheses is in the process of approval. The Fund requested more protocols and documents to be able to give its consent. Namely, before introducing these new services, it is necessary to submit an official protocol (signed by the Minister of Health) for the diagnosis and treatment of conditions (diagnoses) in which the implant of these prostheses is an option, as well as additional criteria in which patients will be fitted with these prostheses with a possible waiting list (the criteria and the list should be submitted to the Fund, they do not need to be signed by the minister, only by the expert collegium).**

A brief description of the types of penile prostheses

Erectile dysfunction is a condition in which the patient cannot achieve or maintain an erection. It is reported that almost 50% of the male population from the ages of 40 to 70 has this problem. Both psychogenic and organic impotence are treated from the beginning with conservative treatment. Medical treatment of erectile dysfunction involves the use of preparations from the group of phosphodiesterase 5 inhibitors with good success in 90% of patients.

If drug therapy is ineffective, according to the European Association of Urology Guide, a surgical solution to erectile dysfunction is approached by implanting a penile prosthesis. Implantation of a penile prosthesis enables a complete cure in 100% of patients resistant to medical therapy. Until now, PHI University Clinic for Urology has referred such patients abroad, where HIFRM is charged a multiple-fold.

Due to the above, the PHI University Clinic for Urology introduced two new surgical procedures, for which we requested new reference prices to be adopted, namely:

1. an inflatable penile prosthesis placement AMS 700
2. a semi-rigid penile prosthesis placement.

Based on the data presented above, we project an annual requirement for 10 penile prostheses (5 semi-rigid, 5 inflatable), while for the current year (2023) there is a need for 2 prostheses (one semi-rigid, one inflatable).

For each patient who needs a penile prosthesis, the expert collegium of the PHI Urology Clinic shall decide individually based on the following criteria:

1. Existence of proven organic impotence (cardiovascular status, long-term diabetes)

2. Duration of erectile dysfunction of at least one year

3. Resistance or unresponsiveness to drug therapy

4. Allergy to drug therapy

5. Previous attempt to use vacuum pumps or intracavernous injections

6. Hormonal evaluation to exclude the existence of hypogonadism or hyperprolactinemia

7. Comorbidities (their optimized management)

8. Active drug use as an exclusion factor

9. Previous surgical procedures

10. Existence of medical conditions that in themselves require the implantation of a penile prosthesis, which include:

- acute ischemic priapism lasting over 36 hours,
- history of ischemic type of priapism that lasts more than 24 hours resistant to therapy – severe forms of induration
- transgender surgeries

11. Psychological assessment, should the patient's condition require so.

The purpose of these procedures is a good-looking neophallus, normal urination, sustained sexual sensation and penetrative ability. Penile prostheses are inserted into the neophallus in order to obtain rigidity for penetration. Complications with these procedures are numerous and commonly include urethral strictures and fistulas. The most serious complication is necrosis of the neophallus. Due to these complications and their frequency, some patients do not opt for this procedure. Those who undergo surgery and experience serious complications rarely complain about the choice they made to undergo surgery.

Existing problems that are still relevant in 2024

The realistic obstacles to performing reconstructive genital procedures for transgender people in the Republic of Macedonia include:

1. Absence of codes for referral diagnoses
2. Lack of consent from officials in the Ministry of Health

With reference to the first point, the existing codes that are most appropriate as referral diagnoses are listed in the attachment. Most of them are marked F, which belongs to the domain of psychiatry and are not suitable for performing a surgical procedure:

FF52 SEXUAL DYSFUNCTION NOT CAUSED BY ORGANIC DISORDER OR DISEASE F52.0 LACK OR LOSS OF SEXUAL DRIVE F64.0 TRANSSEXUALISM F65 SEXUAL INCLINATION DISORDERS F65.6 MULTIPLE SEXUAL INCLINATION DISORDERS F66.1 EGODISTONIC SEXUAL ORIENTATION F52.1 SEXUAL ABOMINATION AND LACK OF SEXUAL SATISFACTION Q56 INDETERMINATE SEX AND PSEUDOHERMAPHRODITISM Q56.0 HERMAPHRODITISM, ELSEWHERE NON-CLASSIFIED Q56.2 FEMALE PSEUDOHERMAPHRODITISM, ELSEWHERE NON-CLASSIFIED Q56.1 MALE PSEUDOHERMAPHRODITISM, ELSEWHERE NON-CLASSIFIED Q56.3 PSEUDOHERMAPHRODITISM, NON-SPECIFIED
N48 OTHER DISEASES OF THE PENIS

This problem imposes a need for the introduction of more appropriate codes that would describe the real condition of the patient, which is necessary for performing corrective surgical procedures in a state institution in the Republic of Macedonia. The question is whether these procedures should be considered aesthetic or reconstructive. This is important because every aesthetic procedure is at the expense of the patient, on the grounds that it is not medically indicated and therefore not considered necessary. In most cases, there is no clear distinction between what is purely reconstructive and what is purely cosmetic. It is logical to consider that these interventions (for example, phalloplasty) are reconstructive and medically indicated, considering that in transgender people they lead to a radical and lasting effect in improving their quality of life, thus ending a long suffering of these persons.

The second point imposes a need for reaction and pressure on the medical authorities in order to approve the performance of this type of procedure. Currently, there are no obstacles by the director of the institution, should the Ministry approve these procedures.

Formation of a working group (Decision attached)

On 16th May 2019, the Minister of Health Venko Filipche formed a working group in order to make an assessment of the availability of health services to transgender people and to propose measures to improve their health. Unfortunately, with the onset of the COVID-19 crisis, this group ceased to hold meetings.

The need for certified surgeons to perform this type of surgery remains

Doctors who perform these procedures should have adequate training and be certified by relevant international or national associations. To achieve this, several months of training at a relevant transgender surgery center is required for all persons involved in the treatment process. The official control of surgical outcomes, as well as the publication of the achieved results, would be advantageous to both doctors and patients. There is a need to regularly attend workshops and seminars, in which various new surgical techniques are demonstrated and taught. This requires financial resources in the form of sponsorships.

Trainings conducted in the field of transgender surgery

A specialized masterclass in Turin, Italy, attended to observe the performance of transgender surgery, with special emphasis on the placement of penile prostheses in the neophallus and artificial sphincters. A new technique of phalloplasty with a skin flap from the lower abdomen was also presented (program attached).

Simultaneously, the conclusions and recommendations of the World Professional Association for Transgender Health were analyzed, which read as follows:

1. The main objective of any transgender surgery (transgender men) is to ensure a good aesthetic appearance of the neophallus, to provide urination in a standing position, as well as to ensure the possibility of penetrative intercourse.
2. Preservation of erogenousness and tactile sensitivity is an important component.
3. The procedure should be done in a minimum number of stages.
4. The ideal phalloplasty has not yet been demonstrated.

In June 2022, presence in the operating room and placement of a urinary sphincter together with Prof. Dr. Frank Van der Aa, at the University Hospital of Leuven, Belgium (certificate attached). On March 20, 2023, at the University Clinic for Urology, Prof. Dr. Frank Van der Aa, with whom three patients will be operated (implantation of artificial sphincter and penile prosthesis).

ANALYSIS OF THE AVAILABILITY OF MEDICAL SERVICES FOR TRANSGENDER PEOPLE, AS WELL AS PRACTICE REGARDING THEIR TREATMENT AT THE UNIVERSITY CLINIC FOR GYNECOLOGY AND OBSTETRICS IN SKOPJE

Ass. Dr. Iskra Krstevska, gynecology and obstetrics specialist

Ever since we have started actively working on improving healthcare services for transgender people, as well as many other projects in relation to marginalized communities, alongside promoting and improving sexual health and overall women's health in general at our clinic, it seems that once changes have begun to be implemented, the global pandemic of COVID-19 emerged and since then many activities have slowed down and some have even come to a halt.

In our university hospital, the experience with transgender people is still at a minimal level. The experience is still limited to standard protocol gynecological examinations for persons who have undergone all gender reassignment procedures abroad. The interest and treatment for conservative therapy in the sense of using hormone therapy is conducted by fellow endocrinologists, and information regarding patients who seek information or access to transgender operative treatments is reduced to a few cases, and since the period after the pandemic there was only one case, which is why we have to ask ourselves where these people sought help from a gynecologist.

During the period of the pandemic, the services in our hospital were completely diverted to the care of COVID-19 patients as the only facility in the country that had a maternity ward and treatment of pregnant women and women giving birth with COVID-19. All of the hospital's activities were diverted to emergency and malignant diseases, and many other services were suspended, such as reproductive, benign gynecological pathology, urogynecology, endocrinology and adolescent gynecology. Services for regular polyclinic activities were reduced to a minimum. This period lasted from the beginning to the end of the pandemic, and it seems that the reorganization and the pandemic itself caused many activities to proceed at a slower pace and return to the level from before.

In this period, an operation was performed on a transgender person, or rather castration surgery. Terminology, indication for surgery, and administrative use of personal data were not related to the transgender status. The patient was operated on due to emergency, i.e. due to extensive, frequent and profuse gynecological bleeding, which was the result of inadequate hormonal treatment that caused these conditions.

As a regular practice within the Clinic, treatment and health services are mostly given to intersex people, by the specialists at the Department of Child and Adolescent Gynecology and Endocrinology, as well as the Department of Operative Gynecology. This experience relates to the diagnosis and treatment of intersex patients. The operative procedures that have been performed and are being performed are for intersex patients, pseudohermaphroditism, or testicular feminization, or the so-called Androgen Insensitivity Syndrome (AIS). Of those operative procedures, laparoscopic or open-access gonadectomy is the most common, followed by vaginoplasty.

Another type of patients who have a lot in common with the treatment of transgender people and are diagnosed and treated are patients with congenital developmental

anomalies of the urogenital system. All of these can be subject to certain operative procedures, the likes of which include: hymenoplasty, labiaplasty, vaginoplasty, neo vagina, gonadectomy, septum excision and reconstruction of the genital part where the septum was located, etc.

Other gynecological surgical procedures that are performed at the Clinic due to a specific pathology with a pre-set medical indication, and are listed as surgical procedures for changing gender from female to male include: hysterectomy (open access, laparoscopy and vaginal access), salpingo-oophorectomy (open access, laparoscopy, vaginal access), labiaplasty, vaginoplasty, neovagina and hymenoplasty. The experience in performing these procedures is part of the daily practice of gynecologists who are engaged in operative gynecology and the number of interventions is substantial, precisely due to the fact that patients from all over the country come to our Clinic. The operation to make a new vagina in the last few years is almost never performed, due to the fact that children's urologists and surgeons are the ones who perform it, and what was performed at our Clinic was with skin grafts and models with which the new vagina was made.

All these procedures are included in the standard health services covered by the Health Insurance Fund of the Republic of North Macedonia and are charged according to the DRG system with numerical codes, but based on the diagnosis according to the ICD. This has been discussed in previous reports. They also have a price list for private financial coverage, but usually these are patients who do not have health insurance or are foreign nationals, and of course in relation to their diagnosis and medical indication. With the current price lists for the individual interventions described above, there are no changes in terms of prices, the minimum amount that the patient would pay is around MKD 30,000 to the maximum which is slightly less than MKD 50,000. The minimum amount would apply to vaginal reconstruction interventions and the higher amount would apply to castration surgery, i.e. hysterectomy with adnexectomy.

Surgical interventions as well as polyclinic health services should be offered to transgender people. Their performance are in compliance with the standards of care and ethical standards of the World Professional Association for Transgender Health that protects transgender people's rights. The way in which these interventions would be performed are identical to other patients who would be operated on for a gynecological pathology or indication, in terms of the technical performance. The current practice and experience of gynecological surgeons allows performing these interventions in transgender people, but they should be performed as a team together with other profiles of surgeons - the plastic surgeon and the urologist, who are to proceed with the creation of a new gender, which means there would be a difference in the time frame and extent of the planned operative treatment. The castration surgery that would be performed by gynecologists does not require additional or special improvements, that is, it requires the standard regular improvement of the already accepted operative techniques. From the previous practice

of the Clinic for Gynecology and Obstetrics, further improvement is needed pertaining to the specific techniques that encompass reconstructive surgery.

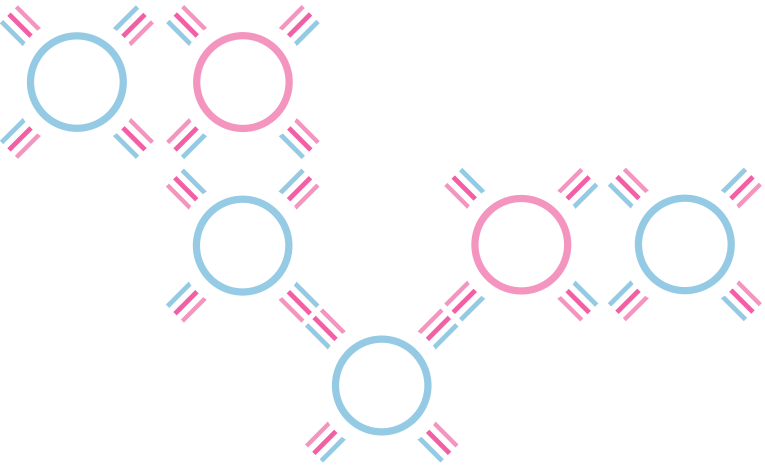
Although in Internet searches regarding the classification of people with transgender operations are coded as Z87.89, Z87.887, Z97.890, in the ICD classification item available in North Macedonia, through the ICD codes in My Appointment, they do not exist. The package of health services of the Health Insurance Fund of the Republic of Macedonia does not currently cover this type of surgery for people with transgender dysphoria. From a technical point of view, the procedures that will be carried out for people for gender change can and should be combined with the code according to the ICD classification that defines people with gender dysphoria, but this is a decision under the authority of the Health Fund and the Ministry of Health.

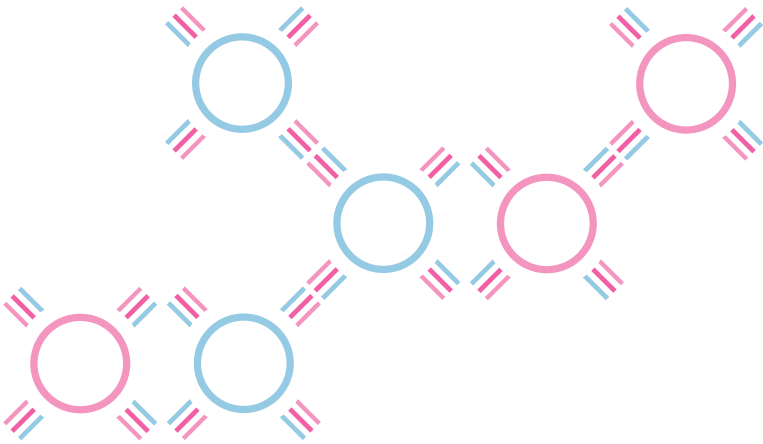
Due to the overall complexity of the problems in these patients and procedures, the planning and execution of operative procedures for sex change should be performed by a professionally trained and established team together with a plastic surgeon, a urologist and a general surgeon, with prior specific preparation of the patient by a psychiatrist and an endocrinologist. The only obstacle in performing these operations for the surgeon would be the ethical reason. It is necessary to appoint at least two specialists from all medical specialties who will be involved in this process. Each of the specialists will have theoretical, practical and logistical training according to the standards of care outlined by WPATH in centers where they already have regular practice regarding this matter. The surgeons who are to perform the operative treatments need to be practically involved in the performance, as well as in the center where they are to receive additional training. The surgical team should be managed appropriately by each institution from which they comes, but the mentoring and supervision of the performance of the operations should be observed by the leading surgeon from the center where the training was held, especially at first until a certain number of interventions have been performed.

The operative treatment is of course the definitive treatment of the transgender persons, but prior to this, the legislation adopted by the state institutions responsible for this subject matter is of crucial importance. This refers to the complete definition, coding, collection and listingn in the ICD and DRG through the HIF and the Ministry of Health, and then aligned with the heads of the institutions where these procedures would be carried out. It is necessary to define a work protocol, form teams and further train the staff (not only surgeons, but also ward nurses and OR nurses) who would deal with this issue, in relation to conservative treatment, preoperative preparation, the operative procedure itself, post-operative care, treatment of complications and the overall further care, as well as regular examinations of these patients.

One of the most successful and progressive decisions was the establishment of a National Commission at the Ministry of Health for Transgender Individuals, in which a gynecol-

ogist-obstetrician specialist from our Clinic actively participated and was supposed to participate in the creation of the program for a safe transition in transgender individuals with reference to rights, services and the care of primary, secondary and tertiary health and the legislation, but once the working meetings commenced, the pandemic emerged and their work was suspended, and we have no information on what the current status of the Commission is, because three ministers have changed in the meantime and not one member of the Commission was summoned for a meeting.





Conclusion

The analysis has shown that transgender people in the RNM face systemic challenges that hinder access to adequate health care.

In relation to the WPATH 8 standards, the RNM healthcare system does not even meet the minimum requirements for adequate care for MGA, in which the first step is the implementation of the ICD-diagnostic criteria that depathologize transgenderism.

The analysis identifies the following barriers in terms of accessibility to health services required by transgender people: lack of clear healthcare protocols for MGA-related services, lack of codes that would allow MGA services to become an integral part of the Health Insurance Fund system, lack of specialized and sensitized staff for MGA-related services, there are prejudices among healthcare professionals, there is a lack of adequate support for the mental health of transgender people and sensitized staff that would provide services related to transgender people's specific needs related to reproductive and sexual health.

In order to overcome these challenges, comprehensive changes are necessary, which include: introduction of inclusive policies such as legal recognition of gender, implementing ICD-11 diagnostic criteria, defining healthcare services in accordance with WPATH 8 standards, introducing appropriate codes that would be included in the ICD and DRG system of the Health Insurance Fund, provision of a wider range of modern hormone therapies aligned with the individual needs of transgender persons, trainings for sensitization and specialization of the medical staff related to MGA services, as well as emphasizing the transgender people's health needs within the broader healthcare system.

TransFormA

Коалиција
МАРГИНИ

TGEU

Skopje, January 2024