

GENDER CONNECT
COUNTRY SAMyth vs Fact: Transgender and Gender
Diverse Sexual Health Information Sheet**Myth: People who take testosterone can't get pregnant.**

Fact: Most people taking testosterone can become pregnant.¹ If having sex with someone who produces sperm, contraception can reduce the risk of pregnancy. If you think you could be pregnant, see a GP you trust as soon as possible, as testosterone can impact a fetus. Consider reaching out to the following services for confidential support and information.

SHINE SA Sexual Healthline: 1300 883 793

Toll free (country callers): 1800 188 171

Pregnancy Advisory Centre: 8243 3999

Toll free (country callers): 1800 672 966

Myth: People who are on oestrogen can't get others pregnant.

Fact: People taking oestrogen may be able to cause pregnancy.² Factors like hormone levels and how long you have been on gender affirming hormones can impact sperm production. Using contraception is the best way to minimise risk of unintended pregnancy.

Myth: Menstruation always stops when people take testosterone.

Fact: A small (but considerable) percentage of people who take testosterone continue to have periods.³

If having a period triggers distress or dysphoria, a GP, endocrinologist, or sexual health physician can help. Options for managing periods include progestogen-only medications, such as progestogen-only pill (POP), IUDs, implants, and injections.

It's also important to know that if your period has stopped on testosterone, and you later experience spotting or bleeding, you should tell your GP or specialist. This may warrant further tests or scans.¹

Myth: Using testosterone will increase your libido, going on oestrogen will decrease your libido.

Fact: Gender affirming hormone replacement will impact individuals differently.

A recent Australian study⁴ found that:

- For trans men, 83.6% experienced increased interest in sex, while 1.4% had decreased interest, and 15% experienced no change.
- For trans women, 16.3% experienced increased interest, 40% had decreased interest, and 43.7% experienced no change.

- For AMAB (assigned male at birth) non-binary people, 16.5% experienced increased interest, 33.9% experienced decreased interest, and 49.6% experienced no change.
- For AFAB (assigned female at birth) non-binary people, 77% experienced increased interest, 0.5% experienced decreased interest, and 12.5% experienced no change.

Myth: If you've transitioned medically, you don't need to access cancer screenings (like cervical and prostate checks).

Fact: There is no evidence that gender affirming hormone therapy reduces the risk of cervical or prostate cancer.^{1,2}

After top surgery, some chest tissue remains, so there is still a need for screenings.¹ If you've had bottom surgery, the screenings you need can vary, so talk to your GP or specialist if you're unsure.

As a general rule, everyone should receive screenings for the body parts they have. If you feel uncomfortable or unsafe, consider asking for a referral to someone who has worked with other trans patients, and/or bringing a trusted support person with you to the appointment.

Myth: Sex work is common among transgender and gender diverse people in Australia, and transgender women are the most likely group to participate in sex work.

Fact: A recent Australian study⁴ found that participating in sex work is relatively common among trans and gender diverse people. Of all respondents, 21.8% had ever done sex work. However, trans women were least likely of respondents to have participated in sex work. Nonbinary participants assigned female at birth were the most likely demographic to have done sex work.

References

¹ www.transcare.ucsf.edu/article/information-testosterone-hormone-therapy

² www.transcare.ucsf.edu/article/information-estrogen-hormone-therapy

³ www.liebertpub.com/doi/full/10.1089/trgh.2017.0023

⁴ www.kirby.unsw.edu.au/report/2018-australian-trans-and-gender-diverse-sexual-health-survey-report-findings

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