Still Invisible?

LGBTQIA+ Women's Health and Service Needs in Northern Ireland

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Researcher



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Executive Summary

THIS REPORT IS A SECONDARY ANALYSIS of the 2026 OutConnections survey, "Being LGBTQIA+ in Northern Ireland", focused on the women who took part. It updates two earlier studies of lesbian and bisexual women's health in Northern Ireland, Marie Quiery's A Mighty Silence (2002) and Invisible Women (2007) and asks whether the pattern of invisibility those reports described is still present nearly twenty years later.

The analysis covers 279 women aged 18 and over, drawn from the 2026 OutConnections survey. The report combines closed-question survey data with the survey's own open-text responses, coded thematically and set against Quiery's original constructs where an objective comparison is possible.

Key Findings

- The concealment pattern Quiery described in 2002 and 2007 persists. Eighty-two percent of women hide or downplay some part of their identity, and 79% behave differently across different spaces. Concealment is driven mainly by safety.
- Mental health remains the area of greatest concern. Ninety percent of women report having experienced mental health difficulties. Fifty-nine percent have self-harmed. Thirty-four percent have attempted suicide, and at least 69% have experienced either an attempt or suicidal thoughts.
- Disability is the single strongest predictor of poor outcomes in this dataset, ahead of trans status, age or location. Disabled women are more than twice as likely to have attempted suicide and more than three times as likely to have experienced homelessness.
- Trans women report markedly worse outcomes than other women across almost every measure, from safety and online harassment to comfort expressing their identity and trust in local non-LGBTQIA+ organisations.

- Women outside Belfast are far less connected to the LGBTQIA+ community and far less likely to use planned services than women inside the city.
- The survey instrument has clear gaps against the 2002 and 2007 reports. It asks nothing about GP experience, cervical or breast screening, or parenting and fertility. These silences are as informative as the data itself.
- Eighteen percent of women have experienced homelessness, and 38% have faced family hostility linked to their sexual orientation or gender identity, a theme largely absent from the 2002 and 2007 reports.

Key Figures at a Glance

Measure	Figure
Women aged 18+ surveyed	279 (637 respondents overall)
Hide or downplay their identity	82%
Have experienced mental health difficulties	90%
Have self-harmed	59%
Have attempted suicide	34%
Have experienced homelessness	18%
Feel unsafe as an LGBTQIA+ person in NI	32% (62% of trans women)
Reported a recent hate incident to the PSNI	26%

Chapter 6 sets out recommendations by organisation and service type. In brief, the evidence points to five priorities: extending provision beyond Belfast, investing in mental health capacity with attention to trans and disabled women, building a welcoming and explicitly trans-inclusive community space, reducing the confidentiality and trust barriers that keep women away from sexual health services, and closing the data gaps that left GP experience, screening and parenting invisible in this survey.

Table of Contents

Executive Summary 2

Foreword 6

A Note on Terminology 7

1.0 Introduction 8

1.1 Background 8

1.2 Policy and Legislative Context Since 2007 8

1.3 Rationale for Secondary Analysis 10

1.4a Aims and Research Questions 11

1.4b Structure of This Report 11

1.5 Significance 12

2.0 Literature Review 13

2.1 Population-Level Evidence for Northern Ireland 13

2.2 Comparative Evidence 13

2.3 Disclosure to Health Services and Health Access Barriers 15

2.4 Mechanisms and Coping Strategies 15

2.5 Study Characteristics and Comparability 16

2.6 A Conceptual Framework 16

2.7 The Gap This Report Addresses 17

3.0 Methodology 18

3.1 Overview 18

3.2 Research Design 18

3.3a Data Source 19

3.3b Positionality and Reflexivity 19

3.4 Data Access, Ethics and Governance 20

3.5 Assessing the Suitability of the Data Against Quiery's Constructs 20

3.6 Quantitative Analysis 21

3.7 Qualitative Analysis 22

3.8 Integration of Quantitative and Qualitative Findings 22

3.9 A Worked Example of the Joint Display 23

3.10 Limitations 23

4.0 Findings 25

4.1 Social Health 25

4.2 Mental Health 30

4.3 Behaviours Impacting Wellbeing 32

4.4 Financial Wellbeing and Homelessness 34

4.5 Experience of Health Services and Other Services 36

4.6 Intersections 39

5.0 Discussion 44
5.1 *Does the Invisible Women Pattern Persist? Answering RQ1* 44
5.2 *What Else Do Northern Ireland's LGBTQIA+ Women Need? Answering RQ2* 48
5.3 *Reading This Dataset Against Its Predecessors* 50
5.4 *Policy Implications Beyond Health Services* 51
5.5 *A Common Thread: Minority Stress in a Northern Ireland Context* 51
5.6 *What the Survey Did Not Ask* 52
5.7 *Synthesis: Persistence, Novelty and Silence* 55
6.0 Recommendations for the Service Sector 56
6.1 *Summary of Recommendations* 56
6.2 *LGBTQIA+ Sector Partnership: HEReNI, The Rainbow Project, and Cara-Friend* 57
6.3 *Health and Social Care Services* 59
6.4 *Department of Justice and PSNI* 61
6.5 *Housing Executive and Housing Advice Services* 62
6.6 *Research and Data Infrastructure* 63
6.7 *Monitoring Progress* 64
7.0 Conclusion 65
References 66
Appendix A. Methodology Detail and Data Mapping 68
Appendix B. Full Quantitative Indicator Tables 76
Appendix C. Safeguarding Protocol 83
Appendix D. Full Qualitative Code Frequency Tables 84
Appendix E. Full List of Statistically Robust Subgroup Differences 91
Appendix F. Glossary of Terms Used in This Report 96
Abbreviations 97

List of Tables

Table 3.1 *A worked example of the joint display method, mental health findings* 23
Table 5.1 *Joint display, sexual health access* 46
Table 5.2 *Joint display, disability and trans status* 50
Table 5.3 *Themes the survey did not ask about* 52
Table 6.1 *Summary of recommendations by lead organisation and priority* 56
Appendix A.2 *Data mapping against Quiery's constructs* 72
Appendix A.5 *Theme coverage against the 2002/2007 reports* 75
Appendix B *Full quantitative indicator tables, by theme (185 indicators)* 76
Appendix D *Full qualitative code frequency tables, by theme (104 codes)* 84
Appendix E *Full list of statistically robust subgroup differences (98 findings)* 91

Foreword

THIS REPORT PRESENTS an independent secondary analysis of the OutConnections survey, "Being LGBTQIA+ in Northern Ireland", focused on the women who took part. It was commissioned to update the findings of Marie Quiery's A Mighty Silence (2002) and Invisible Women (2007), the two studies that first documented the health and social needs of lesbian and bisexual women in Northern Ireland.

As with any survey of this kind, what is presented here is what women chose to tell us, through their answers to closed questions and in their own words. It can show that a pattern is present. It cannot, on its own, explain why. Where the 2026 survey did not ask about a topic covered in 2002 or 2007, that gap is named.

We are grateful to the people who gave their time to complete this survey, including the many who wrote about difficult experiences in the open-text fields.

This report received institutional ethical approval prior to commencement, covering the secondary analysis of the OutConnections dataset. Access was granted by the Rainbow Project, Cara-Friend and HEReNI under a data-sharing agreement. All data supplied were pseudonymised before transfer.

Tolulope Agbede October 2026

A Note on Terminology

This report uses LGBTQIA+ throughout, reflecting the language HEReNI uses and the scope of the 2026 survey. Quiery's 2002 and 2007 reports used lesbian and bisexual, or LB, reflecting the predominant terminology of that earlier era.

Where this report discusses Quiery's original findings specifically, it uses her own terms, lesbian and bisexual women, to avoid misrepresenting the scope of her research. Where it discusses the OutConnections dataset, it follows that survey's broader scope.

"Women" in this report means everyone who identified as a woman on OutConnections' gender identity question, including trans women, consistent with how the survey itself was structured. Non-binary and gender-fluid respondents are reported separately, as a sensitivity comparison rather than merged into the women's figures, a decision explained in section 3.3a and left open for the reader to weigh.

"Plurisexual" is used in places to group bisexual, pansexual and queer women together, following Grant's (2025) terminology, where individual group sizes are too small to report separately. Where numbers allow, these groups are reported individually, following Grant's own recommendation discussed in Chapter 2.

1.0 Introduction

1.1 Background

IN 2002, MARIE QUIERY PUBLISHED A MIGHTY SILENCE, the first comprehensive study of the needs of lesbian and bisexual women in Northern Ireland (Quiery, 2002). Five years later, Invisible Women built on that work with evidence from the voluntary and counselling sector and focus groups with 39 lesbian and bisexual women (Quiery, 2007).

Invisible Women placed suicide and suicide attempts at the top of its agenda. Lesbian and bisexual women were "between two and three times more likely to attempt suicide than their heterosexual counterparts", with similar elevated rates of self-harm (Quiery, 2007). Over 40% of focus group participants said they would not feel comfortable disclosing their sexual orientation to their GP. Several described being denied care altogether. Four young women recalled being told they did not need a smear test. One went undiagnosed with polycystic ovary syndrome for five years as a result (Quiery, 2007). At the service level, Quiery found no dedicated health facilities for lesbian and bisexual women anywhere in Northern Ireland.

Invisible Women closed with a set of recommendations. It called on those responsible for the Northern Ireland suicide prevention strategy to investigate self-harm and suicidal ideation among lesbian and bisexual women specifically. It recommended a health strategy with targets addressing their needs directly (Quiery, 2007). For more than a decade, no further Northern Ireland-specific study followed, until this current research.

This report responds to that gap. It uses the findings of Being LGBTQIA+ in Northern Ireland, a survey delivered by OutConnections Belfast, a partnership between HEReNI, the Rainbow Project and Cara-Friend, funded through PEACEPLUS.

1.2 Policy and Legislative Context Since 2007

Much has changed in the policy and legal landscape since 2007. Same-sex marriage became legal in Northern Ireland in January 2020. Westminster legislated after the Assembly repeatedly failed to pass equivalent provisions, through the Northern Ireland (Executive Formation etc) Act 2019 and the Marriage and Civil Partnership (Northern

Ireland) Regulations 2020 (Northern Ireland (Executive Formation etc) Act 2019; Marriage and Civil Partnership (Northern Ireland) Regulations 2020). This followed the Republic of Ireland's own marriage equality referendum in 2015.

With regards equality legislation, Northern Ireland still relies on the Equality Act (Sexual Orientation) Regulations (Northern Ireland) 2006, the framework that shaped Invisible Women's findings. The Equality Act 2010, which consolidated equality law in England, Scotland and Wales, has never been adopted in Northern Ireland, despite a commitment to do so in the 2006 St Andrews Agreement. The Equality Commission for Northern Ireland has repeatedly described the region's framework as "lagging behind Great Britain, Ireland and other jurisdictions" (Equality Commission for Northern Ireland, 2026).

Hate crime law in Northern Ireland reflects a similar pattern of partial and uneven progress. Sexual orientation has been a listed aggravating factor in sentencing since the Criminal Justice (No. 2) (Northern Ireland) Order 2004, but the legal framework has not developed into dedicated hate crime offences. Unlike England and Wales, Northern Ireland has no standalone hate crime legislation. Judges may increase sentences for ordinary offences where a hatred motivation is established, but this falls short of the distinct aggravated offence model available elsewhere in the UK.

In 2019, the Northern Ireland Assembly commissioned Judge Desmond Marrinan to conduct an independent review of hate crime law. The Sentencing Bill, introduced to the Assembly in early 2026, draws on that review and includes sentencing aggravation provisions (Department of Justice, 2026). However, LGBTQIA+ advocates have raised concern that the Bill does not list transgender identity as a protected characteristic alongside sexual orientation. This places Northern Ireland behind both England and Wales and Scotland, where transgender identity is explicitly named in legislation.

The contrast with the Republic of Ireland is also noteworthy. The Criminal Justice (Hate Offences) Act 2024, which came into force on 31 December 2024, explicitly names sexual orientation as a protected characteristic (Department of Justice, Home Affairs and Migration, 2024). Trans people face disproportionate exposure to hate crime and consistently report lower confidence in criminal justice agencies. The absence of clear legislative recognition in Northern Ireland thus carries real consequences for this group.

Conversion practices follow the same pattern of slow progress despite broad cross-community support for reform. The Assembly passed a motion calling for a ban in April 2021, but a Private Members' Bill, the Conversion Practices (Criminalisation) Bill, was not introduced until June 2026 (Humanists UK, 2026). England and Wales remain at an earlier stage, with a similar bill in draft but not yet before Parliament (House of Commons Library, 2026).

Mental health policy offers the clearest institutional response to Quiery's recommendations. Protect Life 2, the region's Suicide Prevention Strategy, names LGBTQIA+ people, alongside people experiencing deprivation, trauma and the legacy of the conflict, as being at particular risk (Department of Health, 2019). The strategy has since been extended to 2027, with its most recent action plan published in October 2025 alongside the Mental Health Strategy 2021 to 2031 (Department of Health and Public Health Agency, 2025). This goes some way towards answering the concerns raised by Invisible Women. It does not, however, deliver the dedicated lesbian and bisexual women's health strategy that Quiery (2007) called for.

Gender identity services matter to trans and non-binary women within the wider population this report considers, and to HEReNI as an organisation. Northern Ireland's gender services have been under severe strain. The Brackenburn Clinic serves adults, while Knowing Our Identity serves those under-18s. As of August 2025, more than 1,000 adults and 45 children were on waiting lists, some for over seven years (The Brief NI, 2026). Prolonged waiting times have been documented as a significant source of psychological distress for trans and non-binary people, adding to existing mental health inequalities within this population (McNeil et al., 2012; Bachmann and Gooch, 2018).

Following the Cass Review into gender identity services for under-18s in England, the Department of Health commissioned an independent review of the Northern Ireland service from Dr Hilary Cass. Her report, published in early 2026, found practice in Northern Ireland broadly consistent with her recommendations for England. These included a move to a new Lifespan Gender Identity Service and continued use of puberty blockers under review (BBC News NI, 2026). Though some scholars have noted that the Cass Review has been received unevenly, with some clinicians and researchers raising concerns about its evidence base and potential policy implications for trans young people's access to care (Horton, 2024; Ashley, 2023).

1.3 Rationale for Secondary Analysis

The OutConnections survey was designed to measure LGBTQIA+ life in Northern Ireland broadly. While not built to replicate Quiery's instruments, it nonetheless incorporated closely related measures such as disclosure to health professionals, sexual health screening access and satisfaction, mental health, self-harm and suicide risk. It also included open-text questions that allowed respondents describe their experiences in their own words, much as Quiery used focus group evidence to illustrate the quantitative patterns in Invisible Women.

Secondary analysis is a well-established methodological approach in health and social research, particularly where large-scale primary data collection is resource-intensive or

logistically complex (Heaton, 2004; Smith, 2008). It offers a timely and efficient route to evidence while maximising the analytical value of existing datasets (Trzesniewski et al., 2011). A secondary analysis of the OutConnections dataset therefore provided a lower-cost route to relevant, large-scale evidence with direct applicability to the three organisations that commissioned the survey, at a scale that a fresh study could not easily replicate.

1.4a Aims and Research Questions

This report builds on A Mighty Silence and Invisible Women. The OutConnections dataset was collected independently of this report's research questions. Its focus is broader than the lesbian and bisexual women Quiery (2002, 2007) studied, covering issues specific to queer and gender diverse women that the earlier reports did not address, more recent service developments, and priorities defined by respondents themselves not by predetermined categories.

This report therefore engages with A Mighty Silence and Invisible Women on two levels. First, it updates and extends their findings, particularly on suicide risk and sexual health screening access. Second, by drawing on a dataset with a wider scope than lesbian and bisexual women alone, it identifies health needs the earlier research could not have covered.

Three research questions guide the analysis:

- RQ1. To what extent does the pattern of invisibility described by Quiery (2002, 2007) persist among LGBTQIA+ women in Northern Ireland today?
- RQ2. Beyond the specific issues raised by Quiery (2002, 2007), what other health needs and concerns do LGBTQIA+ women in Northern Ireland have?
- RQ3. What do the findings of this report mean for the provision of LGBTQIA+ women's health services in Belfast?

1.4b Structure of This Report

Chapter 2 reviews the literature on LGBTQIA+ women's health in Northern Ireland and comparable jurisdictions, building the comparative framework used throughout the rest of this report. Chapter 3 presents the methodology in full. It also explains what the OutConnections dataset can and cannot reveal. Chapter 4 present the findings, organised by theme: social health, mental health, behaviours affecting wellbeing, financial wellbeing and homelessness, experience of health services, and intersecting

identities. Chapter 5 discusses those findings against the literature reviewed in Chapter 2, answering RQ1 and RQ2 directly. Chapter 6 sets out recommendations for the service sector, answering RQ3. Chapter 7 closes with concluding comments.

Five appendices provide the full quantitative and qualitative evidence base behind every figure used in the main text.

1.5 Significance

This report combines an existing evidence baseline with new evidence from OutConnections, set against the wider UK and Irish literature reviewed in Chapter 2. Furthermore, it tests Quiery's specific claims about suicide risk and sexual health screening directly and builds on them with additional evidence the earlier studies could not capture.

The analysis is framed around a practical question: what does Belfast need to build and fund to meet these women's health needs. This framing lets the findings inform real service design decisions, instead of standing only as a historical update. It also treats OutConnections as a source of evidence in its own right, capable of showing where the original survey's design left gaps, which matters for whoever designs the next one.

2.0 Literature Review

2.1 Population-Level Evidence for Northern Ireland

The 2021 Census was the first census in England, Wales, and Northern Ireland to ask about sexual orientation or gender identity. Of the respondents, 2.1% identified as lesbian, gay, bisexual or other, the lowest rate of LGB+ identification of any UK or Irish jurisdiction. Among people over 65, only 0.3% identified as LGB+ (NISRA, 2023). This matters for a report focused on LGBTQIA+ women. It helps explain why Quiery's original reports, and this one, find so few older women in their samples.

McKenna et al. (2025) used the same census data to provide the first population-level evidence on LGBTQIA+ mental health in Northern Ireland. Compared with heterosexual respondents, LGB+ respondents had more than three times higher odds of reporting a chronic mental health condition (adjusted odds ratio 3.25, 95% CI 3.15 to 3.35). This was higher than for any other minority group in the study, including ethnic minorities and Irish Travellers (McKenna et al., 2025). The findings give direct, current context to Invisible Women's earlier work.

2.2 Comparative Evidence

Evidence specific to Northern Ireland remains limited, particularly disclosure to family and health services, health screening and self-harm. Data from other comparable jurisdictions helps fill that gap. A meta-analysis of 12 UK population health surveys found higher rates of common mental disorder and lower wellbeing among lesbian, gay and bisexual adults than among heterosexual adults (Semlyen et al., 2016). The National Institute for Mental Health England reached a similar conclusion in its own systematic review, finding higher rates of depression, anxiety, substance misuse and self-harm among lesbian, gay and bisexual people (King et al., 2008). The LGBTIreland report, a national survey of 2,264 LGBTI people, found a similar pattern of higher self-harm and suicidal ideation, especially among young people, and disclosure to family and health services as a recurring source of stress (Higgins et al., 2016).

Australia offers the largest body of relevant LGBTQ survey research. A briefing paper drawing on the Private Lives 3 survey (Australia's largest national study on the health and wellbeing of LGBTQ adults), found that 75.6% of cisgender lesbian, bisexual and

queer women and 86.2% of trans lesbian, bisexual and queer women had experienced suicidal ideation at some point in their lives, against 13.3% of the general population (Grant, 2025). On sexual health, the Sexual Wellbeing of Lesbian, Bisexual and Queer Women and Transgender Women (SWASH survey) in Sydney found 58.3% of cisgender lesbian, bisexual and queer women had a cervical screen in the past two years, with cisgender lesbians considerably less likely to be screened than bisexual women (Grant, 2025). Consistent with Invisible Women, women with a regular GP who knew their sexual orientation were more likely to be up to date with screening. Trans women were more likely than cisgender women to be up to date with breast and bowel screening, a pattern worth noting for its contrast with the cervical screening finding (Grant, 2025).

The Australian evidence extends the literature in two ways. It confirms the elevated suicide risk documented by Quiery and others, and it offers detail on how care access works for the LGBTQIA+ population, not just whether disparities exist.

Australian research also points to needs the earlier Northern Ireland reports did not cover such as higher rates of intimate partner and family violence, higher alcohol and drug use, and under-screening for breast and bowel cancer as well as cervical cancer (Grant, 2025). More recent work on endometriosis and menopause care highlights further unmet need, including the effect of gender affirming care on wellbeing and unnecessary delays in diagnosis and treatment for lesbian, bisexual and queer women (Grant, 2025). Minority stress theory, the idea that chronic exposure to discrimination and stigma drives poorer health, remains the leading explanation for these disparities (Grant, 2025). Australian research also points to social connection and gender expression or affirmation as contributing factors, which may combine with minority stress to shape outcomes (Grant, 2025).

Grant (2025) recommends that future research separate bisexual, pansexual and queer women's experiences from those of lesbians, and address the specific and overlapping needs of trans women, disabled women, and rural and remote women. Both recommendations shape this report's own approach, described in Chapter 3. Like the Northern Ireland evidence, the Australian data draws on a convenience sample skewed toward highly educated, urban respondents already connected to LGBTQIA+ organisations, a limitation its author acknowledges (Grant, 2025).

2.3 Disclosure to Health Services and Health Access Barriers

Stonewall's Prescription for Change, at the time the largest survey of lesbian and bisexual women's health conducted in Europe with 6,000 respondents, found that 15% had never had a cervical screening, against 7% of women overall, because health professionals assumed women in same-sex relationships did not need one (Hunt and Fish, 2008). This is the precise mechanism Quiery's focus groups had described a year earlier in Northern Ireland. A decade on, Stonewall's LGBT in Britain Health report found that one in seven LGBT people avoided seeking healthcare for fear of discrimination, and one in eight had experienced discrimination from healthcare staff because of their identity (Bachmann and Gooch, 2018).

Public Health England's 2018 rapid evidence review reached conclusions close to Quiery's own. Despite growing recognition of LGBTQIA+ health disparities, lesbian and bisexual women, and women who have sex with women specifically, remain an area of particular unmet need, with far less attention than gay and bisexual men receive (Varney and Newton, 2018). A 2019 systematic review of 26 studies on sexual minority women's healthcare experiences found the same barriers encompassing heteronormative clinical assumptions, negative reactions to disclosure of sexual orientation, and clinicians with limited knowledge of sexual minority women's specific needs. The review also noted how little published evidence exists on bisexual and trans women's healthcare experiences specifically (Meads et al., 2019).

2.4 Mechanisms and Coping Strategies

Qualitative research helps explain how these barriers operate and how women respond to them. A US interview study with 39 LGBTQ respondents assigned female at birth found that reproductive healthcare experiences were largely negative, shaped by providers' narrow focus on fertility, limited clinical competence and discriminatory attitudes, all of which pushed respondents to avoid reproductive care altogether (Wingo, Ingraham and Roberts, 2018). A related study of 22 queer cisgender women and gender expansive respondents found that, despite frequent negative encounters, many developed effective coping strategies such as selective disclosure, actively seeking LGBTQIA+ friendly providers, and relying on peer networks for support (Carpenter, 2021).

These findings support the value of a mixed methods approach. Quantitative data show the scale of a problem. Qualitative data show the mechanism and the coping response. OutConnections offered this combination for Northern Ireland's LGBTQIA+ women, which this report uses throughout.

2.5 Study Characteristics and Comparability

The studies reviewed above vary considerably in scale, method and sampling. Semlyen et al. (2016) pooled 12 existing UK government surveys, giving it very large, combined samples but limited ability to probe mechanism. Higgins et al. (2016) surveyed 2,264 people across Ireland using a dedicated LGBTI instrument, closer in design intent to the OutConnections survey. Grant (2025) draws on Private Lives 3 and SWASH, both large-scale, purpose-built Australian surveys with samples in the thousands, run by established research centres with a long history of LGBTQIA+ health research. Hunt and Fish (2008) surveyed 6,000 women specifically, the largest lesbian and bisexual women's health survey conducted in Europe at the time. Meads et al. (2019) is a systematic review, not a primary study, synthesising 26 separate pieces of research.

This range matters for how the comparisons in the discussion should be read. Meta-analyses and systematic reviews, such as Semlyen et al. (2016) and Meads et al. (2019), describe a consistent direction of effect across many studies, which makes them a reliable benchmark for whether a pattern exists at all. Single surveys, including OutConnections itself, are better suited to describing the texture and mechanism of an issue within one specific population and period, but carry more sampling uncertainty about the exact size of an effect. Quiery's (2002, 2007) work sits closer to the second category as it is rich in qualitative and descriptive detail, albeit based on smaller numbers than the large UK, Irish or Australian surveys. Comparisons drawn in Chapter 5 are therefore treated as indicative of direction and scale, not as formal tests of whether Northern Ireland's figures differ significantly from any single comparator study.

2.6 A Conceptual Framework

Minority stress theory provides the dominant explanatory framework across this literature (Grant, 2025). The theory holds that sexual and gender minoritised people experience additional, chronic stress arising specifically from their minoritised status, on top of the general stressors everyone faces, and that this additional stress accounts for much of the documented health disparities. Three mechanisms recur across the studies reviewed here. These are: expectation of rejection or discrimination, which drives concealment; actual experience of discrimination and violence; and internalised stigma, where societal attitudes are absorbed into a person's own self-concept (Grant, 2025).

Survey data of the type OutConnections collected can show that concealment, discrimination and poor mental health co-occur. It cannot, on its own, establish the causal pathway between them with the confidence a longitudinal or experimental design would allow. The minority stress theory is used here as an interpretive lens for the

discussion in Chapter 5. Where the findings in Chapters 4 align with what minority stress theory would predict, this is noted. Where they do not, or where a simpler explanation fits better, that is noted too.

Kang (2026) extends this framework toward practice, arguing that health services organised around a single, binary moment of disclosure poorly serve a population for whom identity management is continuous and situational. This argument, developed in a women's health context, anticipates several of this report's own findings on concealment as an ongoing, context-dependent practice as opposed to a one-off event. This is discussed fully in Chapters 4 and 5.

2.7 The Gap This Report Addresses

Together, this review points to a consistent set of themes in LGBTQIA+ women's experience of health services and mental health, in Northern Ireland and beyond. The mechanisms of discrimination and the areas of health needing attention are broadly the same across the studies reviewed here. The 2021 Census with the McKenna et al. (2025) mental health record linkage study give Northern Ireland its first population-level mental health evidence, but previous Northern Ireland-specific work has never covered risk of suicide, sexual health and related needs in the same depth, and none of it has focused specifically on women.

This report responds directly to Quiery's call for further Northern Ireland-specific research. It uses OutConnections data to address these gaps and sets its findings against the wider UK and Irish context, with specific attention to LGBTQIA+ women's experience of health services.

3.0 Methodology

3.1 Overview

THIS IS A SECONDARY ANALYSIS of an existing dataset, the OutConnections survey Being LGBTQIA+ in Northern Ireland, undertaken to address the three research questions set out in section 1.4a. A secondary analysis reuses data collected for a different primary purpose, in this case a Community Needs Assessment facilitated by the Rainbow Project, Cara-Friend and HEReNI, rather than data collected specifically to test this report's questions (Heaton, 2004). This chapter sets out the research design, describes the dataset as verified against the raw export, explains how survey items were assessed against Quiery's original constructs, and details the quantitative and qualitative methods used. It closes with a statement of ethical considerations and the limitations of reusing data collected for another purpose.

3.2 Research Design

This report uses a convergent mixed methods design. Quantitative and qualitative strands of the OutConnections data are analysed separately and brought together at the point of interpretation (Creswell and Plano Clark, 2018). Two considerations drove this choice. RQ1 asks for comparison against Quiery's largely quantitative and descriptive baseline, which calls for statistical description of the survey data, given depth by open-text material that illustrates the pattern. RQ2 asks for open, inductive analysis of both strands, to surface needs Quiery's original constructs did not anticipate. Rather than treating quantitative and qualitative analysis as separate stages, this report brings them together through joint displays, described in section 3.8, so that convergence or divergence between what women reported in closed questions and what they said in their own words can be examined directly. RQ2 is treated as exploratory throughout. RQ3 draws on the integrated findings from RQ1 and RQ2 to inform the service design recommendations in Chapter 6.

3.3a Data Source

The OutConnections dataset comprises survey responses collected through Being LGBTQIA+ in Northern Ireland, delivered by the PEACEPLUS funded OutConnections Belfast partnership between the Rainbow Project, Cara-Friend and HEReNI.

Verification against the raw survey export for this analysis found 637 total respondents at the time of analysis. The export used a two-row header, common to this survey platform, in which the first row held each question and the second row held the answer option or an "open-ended response" marker. This second row had to be separated from the data before analysis. Once cleaned, women were identified by the survey's gender identity item (279 respondents aged 18 and over, after excluding 33 respondents younger than 18 across the full sample). A sensitivity sample of 361 adds non-binary and gender-fluid respondents aged 18 and over. These verified figures are used throughout this report.

The survey combines closed questions on demographics, health service disclosure, sexual health screening access and satisfaction, and mental health, self-harm and suicide risk, with open-text questions inviting respondents to describe their experiences in their own words.

Because the dataset was collected to inform the LGBTQIA+ sector's own service planning, not to test this report's specific research questions, its instrument was not designed as a replication of Quiery's (2002, 2007) survey and focus group tools. Section 3.5 sets out how this was handled.

3.3b Positionality and Reflexivity

This report was produced as an independent secondary analysis under the data-sharing agreement described in section 3.4. Reflexive thematic analysis, the method informing the qualitative approach in section 3.7, treats the analyst's own position as part of the analytic process (Braun and Clarke, 2019). Two aspects of that position are worth naming here. First, this analysis was conducted at a short distance from the original survey design and from the communities who completed it. This brings independence while keeping the analyst close to the context. Contextual knowledge about local services, or about recent events mentioned obliquely in open-text responses, was therefore unlikely to be missed. Second, the rule-based coding method described in section 3.7 was chosen to manage the volume of open-text data. It let a single analyst complete the coding rigorously within the scope of this report. That choice shapes what the qualitative findings in Chapters 4 can claim to show.

3.4 Data Access, Ethics and Governance

Access to the OutConnections dataset for this secondary analysis was granted by the Rainbow Project, Cara-Friend and HEReNI under a data-sharing agreement specifying the permitted scope of analysis, storage and retention arrangements, and reporting obligations. Participants in the original survey consented to their data being used for research and service planning purposes at the point of data collection, and this report's use of the data falls within that original consent.

Data supplied for this analysis were pseudonymised before transfer. Direct identifiers were removed, and free-text responses were reviewed to redact any detail that could identify an individual. This follows the data-sharing agreement and UK GDPR and Data Protection Act 2018 requirements. Because this report analyses existing data and did not recruit or contact participants, no new consent or additional participant burden was involved in its production.

Some open-text material addresses self-harm, suicide and experiences of violence or discrimination. The researcher followed a distress protocol when reviewing this material, ensuring that quotations used in this report were reviewed to avoid identifying detail or content that could function as a means or method reference for self-harm. Nine free-text responses disclosed current risk of suicide, self-harm or exploitation. These were flagged for safeguarding review, following the protocol set out in Appendix C, and are excluded from the quotations used throughout this report. This report received joint institutional ethical approval prior to commencement, covering the secondary analysis of the OutConnections dataset specifically.

3.5 Assessing the Suitability of the Data Against Quiery's Constructs

Before analysis, the OutConnections instrument was mapped item by item against the constructs central to Quiery's 2002 and 2007 reports. These included disclosure of sexual orientation or gender identity to health professionals, sexual health screening access and satisfaction, and mental health, self-harm and suicide risk. This established which OutConnections items could support a meaningful comparison, and which could not.

Where an OutConnections item closely paralleled a Quiery construct, for example a question on disclosure to health or support professionals, this report treats the item as broadly comparable, while noting differences in wording, response options and/or survey mode between the studies. Where no corresponding item existed, this report does not attempt a direct numerical comparison and instead uses the OutConnections

item to address RQ2. This mapping exercise is itself a finding. The OutConnections instrument reflects the priorities of the organisations that designed it, and gaps in the mapping show where LGBTQIA+ women's health needs may remain under-recorded even in a dataset collected specifically to represent this population (Taylor, Jantzen and Clow, 2013). The full mapping is set out in Appendix A.

Two gaps proved significant enough to shape the report's conclusions. OutConnections asks no dedicated question on GP experience, or disclosure of sexual orientation or gender identity to a GP specifically, and no dedicated question on cervical or breast screening. Quiery's most striking findings, the 40% who would not disclose their sexual orientation to a GP and the young women wrongly told they did not need a smear test, cannot be directly retested with this dataset. The closest available items, on openness with medical or support professionals in general and on use of sexual health services, are related but not equivalent constructs, and this report is open throughout about this difference.

3.6 Quantitative Analysis

Closed-question survey data were analysed descriptively, using frequencies and percentages for categorical items, disaggregated by the subgroup variables relevant to RQ2: age, sexual orientation, gender identity, disability, ethnicity and geography, where sample sizes permitted.

For subgroup comparisons, this report applies a stricter threshold than the five-respondent minimum. With 185 quantitative indicators, many comparisons were possible, so a difference was tested only where every outcome cell in every group had at least 10 respondents. Fisher's exact test was used for two-group comparisons and chi-square for three-group comparisons. A Benjamini-Hochberg false discovery rate correction was then applied across all comparisons. Only differences with a q-value below 0.05 are reported as findings. This approach lowers the risk of reporting chance differences in a dataset with a relatively small sample of women. The cost is a higher minimum group size than the five-respondent rule first proposed, which means some smaller subgroup comparisons could not be tested.

Where an OutConnections item was assessed as broadly comparable to a measure reported by Quiery (2002, 2007) or by the wider literature reviewed in Chapter 2, this report presents the current figure alongside the historical or comparative figure for descriptive contrast in Chapter 5. Because the OutConnections and comparator datasets differ in sampling method, instrument wording and historical period, these comparisons are presented as indicative, not as formal statistical tests of change over time.

3.7 Qualitative Analysis

Open-text survey responses were analysed using a two-stage coding approach informed by the deductive and inductive logic of reflexive thematic analysis (Braun and Clarke, 2006, 2019), though implemented differently from a fully manual, multi-coder reflexive analysis, for reasons set out below.

An initial set of codes was developed deductively from the constructs identified in the data-mapping exercise in section 3.5: heterosexism and homophobia, disclosure, health service access, mental health and self-harm, domestic abuse, intersecting identities, and the other themes drawn from Quiery's 2002 and 2007 reports. A further set of codes was developed inductively, without reference to Quiery's constructs, to let health needs and priorities not anticipated by the historical baseline emerge from the data on their own terms, addressing RQ2.

Given the volume of open-text data, coding was applied using a pattern-based method where each code was defined as a set of keywords and phrases, developed from an initial manual reading of a sample of responses, and then applied across the full dataset. Each code's matches were then checked against a further manually read sample to confirm precision, and code definitions were refined where this check found false positives or missed language. This is a documented departure from fully manual, line-by-line coding by multiple researchers, the method reflexive thematic analysis more typically describes. It was chosen to make coding of this volume of data feasible within the scope of this report, at the cost of the deeper interpretive judgement a manual, multi-coder process would bring to ambiguous or context-dependent responses. Readers should treat the frequency counts reported in Chapters 4 as indicative of the volume and pattern of themes raised. Illustrative quotations throughout this report were selected and reviewed individually to protect respondent anonymity, consistent with the rules in section 3.4.

3.8 Integration of Quantitative and Qualitative Findings

Quantitative and qualitative findings are integrated through joint displays (Fetters et al., 2013; Guetterman et al., 2015). A joint display is a table that places the survey statistics for a topic beside the qualitative themes and illustrative quotations on the same topic. This lets the reader see where the two strands agree (convergent), add to each other (complementary) or diverge. The discussion in Chapter 5 uses joint displays to answer RQ1, showing where qualitative accounts illustrate or adds context to a statistical pattern.

It then combines the findings from RQ1 and RQ2 to shape the service recommendations in Chapter 6, thus answering RQ3.

3.9 A Worked Example of the Joint Display

Table 3.1 shows a short, worked example of the joint display approach described in section 3.8, using the mental health findings reported in full in section 4.2. The full quantitative indicator set appear in Appendix B, and the full qualitative code frequency set in Appendix D. Chapter 5 applies this same approach across every major theme in the report.

Topic	Quantitative finding	Qualitative theme	Reading
Suicide risk	34% have attempted suicide; at least 69% have attempted or had suicidal thoughts	Concealment stress and family rejection recur as triggers in women's own accounts	Convergent. The scale shown in the closed data is echoed, not contradicted, by the mechanism described in the open text.
Self-harm and age	77% of women 18-24 have self-harmed, against 38% of women 45 and over	Younger women's open-text responses more often reference school, family and identity conflict than older women's	Convergent. Both strands point to youth as the highest-risk period.
Unmet need	20% of women who needed mental health support did not access it	Waiting times and unhelpful medication management recur in accounts of service contact	Complementary. The quantitative gap is given a mechanism by the qualitative data, which the closed question alone could not supply.

3.10 Limitations

- This is a secondary analysis of data collected for another purpose. The OutConnections instrument does not absolutely mirror Quiery's original tools, and two of Quiery's central measures have no direct equivalent in this dataset.
- The rule-based qualitative coding method, while validated against manually read samples, is not equivalent to full manual reflexive thematic analysis, and readers should weigh the qualitative frequency counts accordingly.

- An undocumented data-quality flag was present in the raw export for 26 of the 279 women. Its meaning could not be established from the data alone. Excluding these respondents changed no reported result by more than three percentage points, and results are reported both with and without them where relevant.
- The response option recording a negative answer to "ever had suicidal thoughts" was empty for every respondent in the export. This means no exact rate can be calculated for that item. Chapter 5 reports a minimum combined estimate instead.
- Two further items, isolation where living and the impact of mental health on housing, relationships or employment, were answered by roughly a third of women, disproportionately those who had already reported self-harm. Their percentages are reported but not generalised to the full sample.
- The sample, (much like the Australian convenience sample) is likely skewed toward women already connected to LGBTQIA+ organisations, which may understate the isolation of women with no such connection.

4.0 Findings

THIS CHAPTER PRESENTS THE SURVEY FINDINGS for LGBTQIA+ women. It covers six areas. These are social health, mental health, behaviours impacting wellbeing, financial wellbeing and homelessness, experience of health services and other services, and intersections.

4.1 Social Health

This section narrates what LGBTQIA+ women stated about disclosure, safety, discrimination, relationships and community.

Being Out

Women in the survey were most open with friends (86% always or usually open) and least open with strangers (32%). Between these, 69% are open with family, 58% with work colleagues and 55% with medical or support professionals. But a substantial minority are rarely or never open in each of these settings: 19% with family, 22% with colleagues, and 25% with medical or support professionals.

In the free-text responses, 82% of women say they hide or downplay some aspect of their identity, and 79% say they behave differently in different spaces. This was the single most common theme in the qualitative data. The most common reason women give for concealment is safety in public, not shame. They describe holding hands, walking at night and taking taxis as moments of risk.

> *"I keep my head down when walking around Belfast city centre – I don't want people to say anything to me or call me slurs etc."*
>
> *Lesbian woman, 25-44*

> *"It is always a juggling match of how much it is safe to reveal, particularly women perhaps."*
>
> *Woman, 45+*

Younger women conceal the most: 95% of 18-24s hide or downplay some aspect of identity, against 66% of women 45 and over. Bisexual and pansexual women are markedly less open than lesbian women with family (53% vs 80%), colleagues (43% vs 68%) and health or support professionals.

> *"Sometimes I feel like bi-erasure is a thing, even amongst the community. I feel like I don't quite belong anywhere and I'm sometimes anxious to be myself."*
>
> *Bisexual woman, 25-44*

Loneliness and Isolation

Forty-four percent of women feel disconnected or very disconnected from the LGBTQIA+ community in Belfast, and 71% want to feel more connected (only 3% actively do not; the remainder are content as they are). Isolation is far more pronounced outside Belfast. 27% of women outside Belfast feel connected to the community, against 57% of women inside Belfast.

> *"All the LGBTQI+ organisations seem to forget there are LGBTQI+ people living and working outside the Belfast and Derry cities. Rural NI is forgotten about. Not enough is done to have local activities and support groups."*
>
> *Woman, 45+*

The barriers women gave for not connecting more are: time constraints (36%), not knowing how to get involved (32%), the "scene" not being for them (31%) and distance (29%).

Discrimination and Negative Attitudes

General Exposure to Discriminatory and Negative Attitudes

Sixty-nine percent of women have been the victim of a crime or incident at some point, and 23% in the past 12 months; among those with a recent incident, 82% said it was related to their sexual orientation or gender identity. Forty-two percent have experienced online harassment, 70% of trans women and 59% of disabled women.

> *"I have faced harassment on social media from people specifically targeting my sexuality and calling me slurs. I have also faced transphobic harassment (despite not being transgender) from people assuming I'm trans due to my support for the community."*
>
> *Woman, 25-44*

Workplace Discrimination

Fourteen percent of women who answered report workplace bullying or prejudice related to their sexual orientation or gender identity. Looking ahead, 43% of women think that being open would harm their chances of finding work, and 25% think it would harm their career progression. Among trans women, these figures rise to 85% and 51% respectively. Women explain this expectation by pointing to social attitudes and conservatism in Northern Ireland, and to past experience. Trans women also anticipate hostility over bathrooms, pronouns and visibility.

> *"The background level of transphobia makes me deeply uncomfortable around strangers or potential employers."*
>
> *Trans woman, 45+*

> *"I have experienced homophobic comments and intolerance in every workplace where I was out, from both colleagues and managers. It was always very obvious that reporting it would be ineffective and that I would be perceived as overly sensitive if I tried to pursue the issue."*
>
> *Woman, 25-44*

Hate Crimes

Fifty women experienced a crime or incident in the past year that they linked to their sexual orientation or gender identity. Only 26% of them reported it to the PSNI. Women who described what happened next gave a consistent account. Little or no action was taken. Many felt they were not believed or taken seriously.

> *"The police laughed off domestic abuse and didn't take a report as 'women always take it back' so it wasn't worth their trouble."*
>
> *Woman, 45+*

Feeling Safe or Unsafe

Thirty-two percent of women said they feel unsafe or very unsafe as an LGBTQIA+ person in Northern Ireland. The experience differs markedly by group. Among trans women the figure is 62%, compared with 26% among non-trans women. This is one of the clearest and most consistent patterns in the data, and it shows where safety concerns are most concentrated.

Safety and discrimination indicator	Group A	Group B
Feels unsafe as LGBTQIA+ person in NI	Trans: 62%	Not trans: 26%
Ever experienced online harassment	Trans: 70%	Not trans: 36%
Ever experienced online harassment	Disabled: 59%	Not disabled: 31%
Expects that openness would harm finding work	Trans: 85%	Not trans: 34%
Victim of crime or incident, ever	Disabled: 82%	Not disabled: 60%

All five differences in the table above survived correction for multiple comparisons, described in section 3.6. Chapter 5 discusses the disability and trans status findings in full.

Domestic Abuse and Sexual Violence

Fifty-five percent of women report at least one of five harmful behaviours (physical, verbal/emotional, sexual, controlling, or financial) from a partner, and 49% from a family member; 74% report at least one from either source. Of the 204 women reporting any form of abuse, only 18% had reported it to police or another service.

Bisexual and pansexual women report sexual abuse or coercion from a partner considerably more often than lesbian or queer women (48% vs around 23%).

Quiery documented abuse mechanisms specific to LGB relationships in 2002 and 2007. These include threats to "out" a partner and using custody or family rejection as leverage. The survey did not ask about them directly although a small number of women did mention them unprompted in free text. However, closed questions cannot demonstrate their prevalence.

Marriage and Relationships Prior to Coming Out

A small number of women describe earlier relationships with men before they came out. Some mention marriage or children. They say this complicated both their coming-out and their sense of belonging. Some LGBTQIA+ spaces, they feel, can be perceived as unwelcoming to women with heterosexual history.

Support from Family, Friends and Others

Thirty-eight percent of women have experienced family hostility related to their sexual orientation or gender identity. In the free-text responses, this ranges from being disowned or made to leave home, through ongoing misgendering or "just a phase" dismissal, to being tolerated but not accepted.

> *"My older brother has stopped speaking to me since I came out as trans and won't allow his kids to see me or their cousin (my son)."*
>
> *Trans woman, 25-44*

Where family relationships are supportive, women describe this as central to their wellbeing; several responses describe a family relationship that improved substantially over time after an initially difficult reaction.

Parenting

The OutConnections survey did not set out to cover parenting, fertility, adoption or custody, so it had no dedicated question on these topics. Some women raised them unprompted in the free text. Eleven of 279 mentioned their own children, and 56 referred to children, parenting or fertility more broadly within family-related answers. These responses point to a topic worth exploring, though the numbers are too small to support firm conclusions. This marks an area where future research can build on the 2002 and 2007 reports, which treated parenting as a distinct theme, including barriers to donor insemination, custody fears and the legal position of the non-biological parent.

Role of the LGBTQIA+ Community

Women's views of the LGBTQIA+ community in Belfast are mixed. Most describe it positively or neutrally, but a recurring minority theme is that current social provision is centred on alcohol, nightlife and a "scene" that does not suit everyone, and that this can exclude older women, women from minority backgrounds, or women who simply do not drink.

> *"I just want to make friends without it having to take place against a background of sexualised entertainment. E.g. I want to go to Bingo without there being a stripper."*
>
> *Woman, 25-44*

A smaller number of women describe the community itself as a source of exclusion. Some feel "not gay enough". Some report biphobia within LGBTQIA+ spaces. Others worry that trans women are not consistently welcomed in women's spaces and groups.

> *"It feels aimed only for a particular sort of cis lesbian, with no support for trans lesbians."*
>
> *Trans woman, 45+*

Volunteering and Activism

A number of women describe volunteering or working for LGBTQIA+ organisations, several noting that this visibility itself increases their exposure to online harassment. Others describe activism and community involvement as protective for their own mental health and sense of belonging.

> *"I am an LGBTQIA+ activist, as is my wife, and we have both experienced a lot of online homophobia."*
>
> *Woman, 45+*

4.2 Mental Health

Mental health was the area Quiery placed at the centre of Invisible Women, and it remains the area of greatest concern in this dataset. Chapter 5 compares these figures directly with Quiery's 2007 findings and with the wider literature.

General Mental Health, Depression and Anxiety

Ninety percent of women report having experienced mental health difficulties, and 38% rate their mental health as poor or very poor over the past year. In the three months before the survey, 52% felt under constant strain more than usual, 46% felt unhappy, anxious or depressed more than usual, and 37% of women (102 of 279) reported at least four of six adverse wellbeing indicators together.

Disabled women show markedly worse mental health than other women across almost every indicator measured: 97% have experienced mental health difficulties (against 86%), and poor or very poor mental health is reported by 50% (against 31%).

90%
of women have experienced mental health difficulties

38%
rate their current mental health as poor or very poor

Self-Harm

Fifty-nine percent of women have self-harmed at some point. This is far higher among younger women (77% of 18-24s) than women 45 and over (38%), and higher among disabled women (75%) than non-disabled women (50%).

Mental health indicator	Group A	Group B / C
Mental health poor or very poor (12m)	Trans: 66%	Not trans: 32%
Mental health poor or very poor (12m)	Disabled: 50%	Not disabled: 31%
Ever self-harmed	Disabled: 74%	Not disabled: 50%
Ever self-harmed by age	18-24: 77%	25-44: 60%, 45+: 38%
Ever attempted suicide	Disabled: 55%	Not disabled: 22%
Needed support but did not access it	Disabled: 97% needed it	Not disabled: 85% needed it

Every difference in this table remained significant after correction for multiple comparisons, a statistical check that guards against chance findings. Disabled women show the largest and most consistent differences in mental health of any group tested.

Suicidal Thoughts and Behaviours

Thirty-four percent of women have attempted suicide. The exact figure on who has ever had suicidal thoughts cannot be calculated. Every respondent left the "no" option empty in the export. Combining attempts and reported thoughts gives a minimum. At least 69% of women (193 of 279) have experienced one or the other. The true figure is likely higher.

Trans women report attempting suicide more often than non-trans women (51% vs 31%), and disabled women considerably more (55% vs 22%).

> *"When I came out as gay to my family, I was self-harming and tried to kill myself. My mum reached out to the rainbow project. I also had some substance abuse and binge drinking, so I have been in counselling."*
>
> *Woman, 18-24*

Twenty percent of women who needed professional mental health support did not access it.

What Helps Mental Health?

Counselling, in-person or community support, and connection to other LGBTQIA+ people recur as protective factors in the free text. Several women describe a specific service as having played a critical role at a point of crisis, most often The Rainbow Project counselling. This should be read in context, as The Rainbow Project is the only organisation in the LGBTQIA+ sector that provides counselling. The frequency of these mentions therefore reflects both the value women place on the support and the limited number of services available to them.

4.3 Behaviours Impacting Wellbeing

Alcohol

Thirty-nine percent of women drink alcohol weekly or more, and 17% do not drink at all. Among those who drink, 49% report drinking six or more units in a single occasion at least sometimes. Disabled women are less likely to drink at all (26% vs 12%) but more likely to use recreational drugs weekly or more (17% vs 5%).

Drugs

Fifty-one percent of women report having used a non-medical drug at some point, most commonly cannabis (57%), anti-depressants outside prescription (43%), poppers (31%) and cocaine (24%). Among women who described their drug-use patterns in more detail, 44% reported having used more than one drug not required for medical reasons, and smaller numbers reported blackouts, withdrawal symptoms, or difficulty stopping.

Sex/Safe Sex

Twenty-six percent of women have used a sexual health service. Use varies sharply by orientation. It is 17% for lesbian women and 42% for bisexual and pansexual women. Thirty-nine percent of women have never had a sexual health check-up. This figure remarkably increases to 69% among those aged 18-24. Twenty-one percent of women thought they needed a sexual health appointment but avoided booking one. Among these women, the main reasons were:

- previous negative healthcare experiences (57%)
- fear of being judged (56%)
- confidentiality concerns (32%)

One in ten women do not know what PrEP is, rising to a quarter of women aged 18-24.

Sex Work

Six percent of all women reported having engaged in sex work at some point. When the figures are broken down by sexual orientation, the share is 2% of lesbian women, 8% of bisexual or pansexual women and 17% of queer women. These figures are descriptive and were not tested for significance, because the numbers in each group are small and fall below the minimum cell size set in the methods. They are best read as patterns that point to areas for further study, rather than as findings tested under the Benjamini-Hochberg correction. They do, however, fit a wider finding in this report: bisexual, pansexual and queer women face financial and safety pressures that stay hidden when lesbian and bisexual women are analysed as one group.

Online Activity

Online Gaming

A small number of women describe experiencing homophobic or transphobic harassment specifically within online gaming spaces, which they describe as a normalised part of that environment.

> *"Online gaming, it's kinda normalised in some of the games I play to insult people who are queer, that's just the online gaming scene in general."*
>
> *Trans woman, 18-24*

Social Media

Where women described online harassment in detail, the platforms named most often were Instagram, Facebook, X/Twitter, and dating apps; a smaller number describe threats, doxxing or being outed online, and abuse linked directly to LGBTQIA+ activism or visible support for the community.

4.4 Financial Wellbeing and Homelessness

Neither A Mighty Silence nor Invisible Women treated housing and homelessness as a distinct theme. This section reports a substantial body of evidence that it deserves to be one.

Financial Impacts

Financial precarity recurs across the housing and homelessness responses, most often tied to the cost of rent and heating. This was not a dedicated closed-question topic in the survey, so it can only be described qualitatively here.

> *"The cost of rent and heating continue to rise and I am getting close to crisis point, where I will no longer be able to afford those things. Once I reach that state, I will become homeless."*
>
> *Trans woman, 45+*

Homelessness

Eighteen percent of women have experienced homelessness at some point, and for 29% of those it was mainly related to their sexual orientation or gender identity. A further 32% have lived somewhere insecure or unsuitable without meeting the formal definition of homelessness, and 21% have left permanent accommodation because they felt unsafe there.

18%
of women have experienced homelessness

38%
have faced family hostility over their identity

Disabled women are much more likely to have been homeless. Thirty-two percent have been homeless, compared with 10% of non-disabled women. Women aged 45 and over are also more likely than younger women to have been without a safe, stable home at some point in their lives (54%). Trans women are more likely than non-trans women to say they struggled to find accommodation because of their sexual orientation or gender identity (18% compared with 3%).

Housing indicator	Group A	Group B / C
Ever homeless	Disabled: 32%	Not disabled: 10%
Ever homeless by age	18-24: 10%	25-44: 15% | 45+: 34%
Ever without a safe, stable home	Disabled: 49%	Not disabled: 27%
Left accommodation because felt unsafe	Disabled: 35%	Not disabled: 13%
Difficulty accessing accommodation (SO/GI)	Trans: 18%	Not trans: 3%

Disability and age together account for most of the statistically robust housing differences in this dataset. The age pattern, worsening housing security later in life rather than earlier, is discussed alongside the financial abuse finding in section 4.6.

Reasons given for insecure housing in the free text include family rejection and being made to leave home, domestic abuse, poor property conditions, unaffordable rent, and, in a smaller number of cases, harassment from neighbours.

> *"I was kicked out of my grandmother's home at 17 as my parents had moved to Scotland."*
> *Woman, 25-44*

> *"I lived in a house with no wallpaper or flooring in some of the rooms, a hole in the roof and no money to fix it. I wasn't able to leave because of my mental health."*
> *Woman, 25-44*

4.5 Experience of Health Services and Other Services

Heteronormative Assumptions and Heterocentric Services

The Quiery (2002, 2007) reports identified heterosexist assumptions in clinical questioning about contraception, sexual partners and relationships as a recurring barrier to care. The 2026 OutConnections survey did not ask about this directly, so the evidence here comes only from the free text, where three women described assumptions made by a health professional. These few mentions show that the theme is still present, but they cannot show how common it is. The same theme is well evidenced in the workplace and family sections of this report, where assumptions of heterosexuality are common. This presents an opportunity for future research to ask about it directly in a health setting.

LGBTQIA+ Identity and Clinical Judgement in Diagnosis

A small number of women describe being misdiagnosed or having a diagnosis delayed, in ways that, on their account, may relate to how they were perceived by clinicians rather than to their condition itself. These accounts are too few to generalise from but are consistent with the theme.

> *"5 yr history of weight loss, night sweats, feeling like dying to finally getting a scan that showed renal mass. Had one removed from my spine 2 years prior to that when the GP also decided that my 10 Yr history of back pain was me being a malingerer."*
> *Woman, 45+*

Holistic Service Provision

In their own accounts, women repeatedly link their mental health, housing, substance use and relationships. They do not describe these as separate issues. This supports the call in 2002 and 2007 for a more holistic approach to care.

GP Services

The survey did not ask directly about GP experience, satisfaction or disclosure of sexual orientation or gender identity to a GP. The 2002 and 2007 reports both treated GP experience as a central theme, so this is a strong area for future research to build on. The survey does show that GPs are the most common route into mental health support (see section 4.2). Women also mention GPs in free-text answers, with both positive and negative experiences described. These comments offer useful pointers, but a systematic, quantitative account of GP experience would need questions designed for the purpose.

Screening Appointments

As with GP services, the survey did not ask directly about cervical or breast screening. The 2002 and 2007 reports found that women were sometimes wrongly told screening was unnecessary, and this is an important theme to revisit in future work. A small number of free-text answers mention smear tests and screening, usually as accompanying detail within answers about cancer. These mentions show that screening is part of women's health experiences, though they cannot be used to test the earlier findings.

Sexual Health Clinics

Twenty-six percent of women have used a sexual health service in the past three years, and most of these users are satisfied. Access is the main area for improvement. Twenty-one percent of women did not book an appointment they believed they needed. The reasons they gave most often were past experiences of healthcare, worry about judgement and concerns about confidentiality (as presented in section 4.3).

Transgender People as Hospital Inpatients

The survey did not ask about inpatient experience, so this theme is not covered directly. Trans-specific healthcare experience is reported in the Gender Identity Services findings below.

HIV Stigma

The closed questions did not ask directly about HIV stigma. Related findings on PrEP awareness and use are reported in section 4.3.

Mental Health Services

Ninety percent of women with a mental health difficulty said they needed professional support. Of those who needed it, 21% did not access it. In free text, women describe waiting times, medication management and feeling poorly supported. These themes recur.

> *"I tried to access help twice. The first time I was put on medication that made me feel worse and when I spoke to my GP about it he doubled the dosage. It got so bad I wasn't able to eat so I stopped taking the medication."*
>
> *Woman, 25-44*

Drug and Alcohol Services

The survey did not include a dedicated question on experience of drug and alcohol services. Findings on substance use are reported in section 4.3.

Gender Identity Clinics

Thirty-five of the 47 trans women in the sample (74.5%) have sought care from Northern Ireland's regional gender identity services (GIC/KOI). Of these women, 18 were still on a waiting list at the time of the survey. Among those who gave a waiting time, about half had waited three years or more. Among those who described a change in their mental health while waiting, two-thirds said it had declined.

Of the 35 trans women who sought care, 29 answered the detailed follow-up questions. The waiting time and mental health findings rest on these responses, and each is based on a smaller group, because not every woman gave a waiting time or described a change in her mental health.

> *"Waiting times are horrific now and need addressed urgently."*
>
> *Trans woman, 45+*

> *"My psychotherapist at the Brackenburn is truly excellent, but has to commute from Scotland meaning I see her only a few times a year... The waiting list for hormone replacement therapy has also been unacceptably long."*
>
> *Trans woman, 25-44*

Gender identity services indicator	Figure
Trans women who sought GIC/KOI access	35 of 47 (74%)
All women who sought GIC/KOI access	37 of 279
Of those, still on a waiting list	18
Of those reporting a wait, waited 3 years or more	About half
Of those describing a mental health change while waiting, said it declined	About two-thirds

Fertility and Pregnancy Services

No dedicated question was asked. Fertility, conception and adoption are mentioned in only two free-text responses across the whole sample.

Fostering/Adoption

Not evidenced in this dataset.

Personal Care and Elderly Care Provision

Women aged 45 and over are markedly more likely to report a lack of a safe, stable home (54%) and past homelessness than younger women, consistent with the 2002/2007 concern about older lesbian and bisexual women's precarious position. No question was asked specifically about fear of disclosure in residential or elder care, which was a distinct 2002/2007 finding. This remains untested in 2026.

4.6 Intersections

The findings above describe LGBTQIA+ women in Northern Ireland as a group. Several sub-groups have markedly different outcomes, and most are considerably worse.

People of Faith

Religion and community background feature strongly when women describe conflict over their identity. Fifty-two women said they felt forced to choose between parts of their identity. More than half of them mentioned religion.

> *"My experience of being queer and growing up Catholic has always been in contention with each other."*
>
> *Woman, 25-44*

> *"As a queer Christian (progressive faith) it has felt in the past like this wasn't an option and I could only be one or the other, with devastating consequences for my identity. Now I am reconciling the two."*
>
> *Woman, 25-44*

Political and community background (Unionist/Nationalist, Troubles-era division) appears as a related but distinct layer of identity negotiation for some women, particularly around expressing political views alongside sexual orientation in the workplace or at home.

Disabled People

Disability is the single largest and most consistent axis of difference in this dataset. Disabled women (37% of the sample) report far worse outcomes than non-disabled women across nearly every measure:

- Ever attempted suicide: 55% vs 22%
- Ever homeless: 32% vs 10%
- Sexual abuse or coercion (any source): 55% vs 28%
- Online harassment: 59% vs 31%
- Ever self-harmed: 75% vs 50%
- Poor or very poor physical health: 49% vs 9%

Disabled women are more than twice as likely to have attempted suicide and more than three times as likely to have been homeless.

Among responses to the community hub design questions, disabled women were far more likely than other women to cite accessibility as a barrier to using community spaces (11% compared with 1%. They were also more likely to ask for a dedicated disability group within LGBTQIA+ women's organisations.

Trans Women

Trans women (47 of the 279 women in the sample) report substantially worse outcomes than non-trans women on nearly every measure in this report:

- Feels unsafe as an LGBTQIA+ person in NI: 62% vs 26%
- Poor or very poor mental health: 66% vs 32%
- Ever experienced online harassment: 70% vs 36%
- Expects openness would harm finding work: 85% vs 34%
- Comfortable expressing full self in Belfast: 40% vs 70%
- Positive impression of HEReNI: 30% vs 63%

Trans women have a lower positive impression of HEReNI than other women. Comments elsewhere in the dataset point to the same problem with women's spaces in general. These suggest that "women's services" need to show trans inclusion actively. They should not assume it is understood. Awareness of HEReNI is also lower among trans women, at 49% against 72%. This is despite HEReNI's clear remit as a women's organisation. Taken together, this points to an outreach gap as well as a perception gap.

Age

Age shows some of the widest and most consistent differences in the dataset. It cuts across almost every theme in this report.

Younger women are the least connected to services. Among women aged 18-24 who are currently in education, 58% report bullying or prejudice there, against 6% and 5% of older women in education. However, it should be noted here that women aged 45 and over are much less likely to be in education, so this question applied to only 20 of them. The difference may also reflect that school and college are where young people are most exposed to peers. Only 32% of women aged 18-24 know of HEReNI, against 76% and 84% of the other two older age groups measured in the survey. Awareness of the planned Belfast hub follows the same pattern: 14% of the youngest women, against 40% and 46% of older women groups.

Younger women also feel more pressure to conceal their identity, 95% hide or downplay it, against 66% of women aged 45 and over. Fifty-two percent name family expectations as a barrier to being open, against 20% of the oldest group.

Financial abuse from a partner shows the opposite pattern. It rises with age, from 7% of women aged 18-24 to 38% of women aged 45 and over. The survey does not ask about income. However, younger women are less likely to have their own income, savings or shared finances, so there is less for a partner to control. Older women are more likely to have longer relationships and shared money. This may explain the rise with age.

These findings describe two different age-related pictures. Younger women face strong pressure to conceal their identity and are cut off from the organisations meant to support them. Older women face other risks: greater housing precarity and financial abuse. Current LGBTQIA+ services do not appear designed around that abuse.

Rural/Urban Differences

Where people currently live produced some of the largest differences in the entire dataset. The comparison is between Belfast (BT1 to BT17 postcodes) and everywhere else.

- Feel connected to the Belfast LGBTQIA+ community: 57% in Belfast, 27% outside
- Would visit the planned Belfast hub: 77% in Belfast, 50% outside
- Name location or transport as a barrier to the hub: 10% in Belfast, 48% outside
- Know about the planned hub at all: 49% in Belfast, 23% outside

This is a Belfast and non-Belfast split based on postcode, as opposed to an urban and rural classification. A proper rural classification, for example using the NISRA settlement lookup is a recommended next step.

> *"I want to feel more connected within my own community, not have to travel to Belfast."*
>
> *Woman, 25-44*

Summary: Statistically Robust Differences by Group

The table below summarises the largest, statistically robust differences reported in this chapter, alongside the correction-adjusted significance level (q) described in section 3.6. The full set of 98 robust subgroup differences across all five comparison dimensions is reproduced in Appendix E.

Group	Indicator	Figures	q
Disability	Ever attempted suicide	Disabled: 55% | Not disabled: 22%	0.0000
Disability	Ever homeless	Disabled: 32% | Not disabled: 10%	0.0000
Trans status	Feels unsafe as LGBTQIA+ in NI	Trans: 62% | Not trans: 26%	0.0000
Trans status	Expects openness to harm finding work	Trans: 85% | Not trans: 34%	0.0000
Location	Feels connected to community	Belfast: 57% | Outside: 27%	0.0000
Location	Would visit the planned hub	Belfast: 77% | Outside: 50%	0.0000
Age	Education bullying (in education)	18-24: 58% | 45+: 5%	0.0000
Sexual orientation	Accessed a sexual health service	Lesbian: 17% | Bi / Pan: 42%	0.0048

Together, disability and trans status produce the widest gaps in absolute terms. Location produces the most consistent gap across every community-connection and service-awareness measure tested. Age cuts across nearly every theme in this report, in ways that point toward two distinct groups needing distinct responses rather than one continuous pattern. Chapter 6 reflects this ordering in how its recommendations are prioritised.

Experiences Relating to Perceptions of Social Class

Financial precarity recurs across the housing, substance use and service-access findings (see sections 4.3 to 4.5), but the survey did not ask directly about social class or income, so it cannot be analysed as a distinct dimension here.

5.0 Discussion

THIS CHAPTER SETS THE FINDINGS OF CHAPTER 4 against the literature reviewed in Chapter 2 and the historical baseline set out in Chapter 1. It discusses only what the survey could test. Sections 5.1 and 5.2 answer RQ1 and RQ2. Section 5.3 sets out the limits of comparing this dataset with earlier studies. Sections 5.4 and 5.5 draw out the policy implications and the minority stress frame. Section 5.6 lists what the survey did not ask, because those gaps limit how far the earlier reports can be retested. Section 5.7 draws the threads together and sets up the service design question addressed in Chapter 6.

5.1 Does the Invisible Women Pattern Persist? Answering RQ1

5.1.1 Disclosure and Concealment

Concealment is the clearest sign that the pattern Quiery described still holds. Eighty-two percent of women hide or downplay some part of their identity. A quarter rarely or never open up to medical or support professionals, as reported in section 4.1. Quiery described a population managing visibility as a constant, situational calculation, rather than a single decision made once. These figures describe the same calculation.

The 82% has no direct equivalent in Quiery's work, so the comparison is one of pattern, not of rates. Quiery's most specific disclosure finding concerned GPs. The survey could not retest it, as section 5.6 explains.

Carpenter (2021) documents the same calculation among queer cisgender women in the United States. Women use selective disclosure, chosen provider relationships and peer networks as coping strategies. The same strategies appear throughout the open-text data in section 4.1. Women choose when and to whom they come out, based on an assessment of safety rather than comfort.

5.1.2 Mental Health, Self-Harm and Suicide

Quiery's central claim was that lesbian and bisexual women were between two and three times more likely to attempt suicide than heterosexual women. Self-harm was similarly elevated (Quiery, 2007). OutConnections found that 34% of women had attempted

suicide and 59% had self-harmed. The dataset has no heterosexual comparison group, so Quiery's multiplier cannot be recalculated. Both figures are high in absolute terms. The direction of Quiery's finding, substantially elevated risk, is strongly supported.

This sits well within the wider literature. Semlyen et al. (2016) found higher rates of common mental disorder and lower wellbeing among lesbian, gay and bisexual adults across 12 UK surveys. King et al. (2008) found the same pattern for depression, anxiety, substance misuse and self-harm. McKenna et al. (2025) found LGB+ people almost three and a half times more likely to report a chronic mental health condition than heterosexual people. This was the highest elevated risk of any minority group studied, including ethnic minorities and Irish Travellers. In OutConnections, 90% of women report having experienced mental health difficulties. This is a lifetime, self-reported figure, not a diagnosed chronic condition, so it measures something different from the odds ratio reported by McKenna et al. (2025). Even so, both point in the same direction.

Grant's (2025) Australian evidence offers the closest comparator. Private Lives 3 found that 75.6% of cisgender lesbian, bisexual and queer women, and 86.2% of trans lesbian, bisexual and queer women, had experienced suicidal ideation at some point. The figure for the general population was 13.3%. The minimum combined estimate is that at least 69% of women have experienced either an attempt or suicidal thoughts. This sits below the Australian cisgender figure. It is a floor, not a true rate, and the true figure is very likely higher. Given that limitation, the two findings are broadly consistent.

Higgins et al. (2016) found self-harm and suicidal ideation especially elevated among young LGBTI people in Ireland. OutConnections found the same age pattern. Seventy-seven percent of women aged 18 to 24 had self-harmed, against 38% of women 45 and over. This is one of the more consistent findings across every study reviewed here. It argues for youth-focused intervention, a point taken up in Chapter 6.

5.1.3 Sexual Health Service Access

The survey can speak to sexual health access, but not to screening. Twenty-six percent of women had used a sexual health service in the past three years. Thirty-nine percent have never had a sexual health check-up of any kind. This rises to 69% of women aged 18 to 24. Twenty-one percent avoided an appointment they believed they needed.

These findings match the literature on access barriers. Bachmann and Gooch (2018) found that one in seven LGBT people avoided healthcare for fear of discrimination. One in eight had experienced discrimination from healthcare staff. The 21% found here is in the same range, though it covers a narrower service and a different question. The reasons women gave were previous negative healthcare experiences, fear of judgement and confidentiality concerns. They match the barriers Meads et al. (2019) identified in

their systematic review of 26 studies: heteronormative clinical assumptions, negative reactions to disclosure, and clinicians with limited knowledge of sexual minority women's needs. Varney and Newton's (2018) Public Health England review reached a near identical conclusion nearly a decade ago. Lesbian and bisexual women remained an area of particular unmet need relative to gay and bisexual men. Nothing in this report's findings suggests that has changed.

Table 5.1: Joint display, sexual health access

Quantitative (sections 4.3, 4.5)	Qualitative theme (sections 4.3, 4.5)	Comparator study
39% never had a sexual health check-up; 69% among women aged 18 to 24	Fear of judgement and past negative experience recur as reasons for avoidance	Bachmann and Gooch (2018)
21% avoided an appointment they believed they needed	Confidentiality named specifically, alongside distrust built from earlier contact with services	Meads et al. (2019)

5.1.4 Heterosexism and Institutional Response

Quiery's 2002 and 2007 reports found heterosexism embedded in institutions and services, alongside individual and workplace homophobia. OutConnections finds the same institutional pattern in a different form. Sixty-nine percent of women have been the victim of a crime or incident. Among those with a recent incident, 82% said it was related to their identity. Only 26% of these women reported it to the PSNI. Where women describe what happened after reporting, in both hate crime and domestic abuse contexts, the account is consistent. Little or no action was taken, and women did not feel believed.

Quiery could not have made this finding in the same way as Northern Ireland's current hate crime and Sentencing Bill reforms came two decades after her reports. The finding still shows the gap those reforms are meant to close. The low reporting rate also raises a question: will legislative change alone shift women's willingness to engage with the Police Service of Northern Ireland (PSNI)?

5.1.5 Domestic Abuse and Relationship Violence

Grant (2025) found higher rates of intimate partner and family violence among Australian lesbian, bisexual and queer women. OutConnections found a comparable pattern. Fifty-five percent of women report at least one of five harmful behaviours from a partner. Seventy-four percent report at least one from either a partner or a family member. Only 18% of those affected had reported it to police or another service. This strikingly low figure echoes the low hate crime reporting rate discussed above. Quiery's reports also described abuse mechanisms specific to same-sex relationships. The survey did not ask about them, so section 5.6 treats them as a gap.

5.1.6 Service Infrastructure: An Institutional Echo of the Pattern

Quiery's 2007 recommendations called for a dedicated lesbian and bisexual women's health strategy. They also called for further government-led research into self-harm and suicide risk in this population. As section 1.2 sets out, the policy response since then has been partial. Protect Life 2 names LGBT people as an at-risk group within a general suicide prevention strategy, but it does not offer a dedicated strategy for lesbian, bisexual and queer women (Department of Health, 2019; Department of Health and Public Health Agency, 2025).

The survey can show one clear example of the same pattern: access to gender identity services. Thirty-five of the 47 trans women in the sample (74%) have sought care from Northern Ireland's regional services, 18 were still on a waiting list at the time of the survey. Of those who gave a waiting time, about half had waited three years or more. Of those who described a change in their mental health while waiting, two-thirds said it declined. These numbers are small and should be read as a guide, not as precise estimates.

Published figures show the same strain. More than 1,000 adults are waiting for gender identity services, some for more than seven years (The Brief NI, 2026). This is the pattern Quiery described in 2007: a real need, and a service response that has not kept pace. The experience of the Republic of Ireland offers a useful caution. Its first National LGBTI+ Inclusion Strategy was graded C+ by an independent review, because having a strategy does not by itself deliver change (LGBT Ireland, 2023). Northern Ireland has not yet reached the point of having a comparable dedicated strategy to under-deliver on.

5.2 What Else Do Northern Ireland's LGBTQIA+ Women Need? Answering RQ2

Several findings in this report have no clear precedent in Quiery's work. Some reflect genuinely new phenomena. Others reflect this survey's broader scope. It covers trans, bisexual, queer and disabled women in a way the 2002 and 2007 reports, which focused on lesbian and bisexual women only, did not.

5.2.1 Online Harassment

Forty-two percent of women have experienced online harassment. This rises to 70% of trans women. Neither Quiery's reports nor the wider literature review addresses this directly. Most of that evidence predates the social media environment in which this harassment now happens. This is best read as an emergent finding. Future Northern Ireland research should treat it as a standing item, not an afterthought.

5.2.2 Disability as the Dominant Axis of Disadvantage

Grant (2025) recommended that future research address the specific and overlapping needs of disabled lesbian, bisexual and queer women. This report's findings strongly support that recommendation. Disability, not trans status, age or location, is the single strongest predictor of poor outcomes across this dataset, as section 4.6 sets out. Disabled women are more than twice as likely to have attempted suicide (55% against 22%). They are more than three times as likely to have experienced homelessness (32% against 10%). This is one of the clearest and most policy-relevant findings in the report, it is not visible anywhere in the 2002 or 2007 literature.

5.2.3 Trans Women's Distinct Position

A Mighty Silence and Invisible Women focused on cisgender lesbian and bisexual women. OutConnections includes trans women. Their experience is markedly worse than other women's on almost every measure in this report. Sixty-two percent of trans women feel unsafe as an LGBTQIA+ person in Northern Ireland, against 26% of other women. This gap sits alongside the gender identity service waiting times discussed in section 5.1.6, and the broader Cass Review context set out in section 1.2. Northern Ireland's move toward a Lifespan Gender Identity Service is a direct policy response to part of this picture. This report's findings on safety, workplace fears and community trust

show that clinical waiting times are only one part of what trans women in Northern Ireland are telling researchers they need.

5.2.4 Bisexual and Pansexual Women's Distinct Patterns

Grant (2025) recommended separating bisexual, pansexual and queer women's experiences from lesbian women's in future research. Lesbian, bisexual and queer women should not be treated as a single group. This report's subgroup analysis, described in section 3.6, follows that recommendation, and the results justify it. Bisexual and pansexual women are markedly less open than lesbian women with family, colleagues and health professionals. They also report considerably higher rates of sexual abuse or coercion from a partner. Both patterns would have been invisible in an analysis that grouped all sexual minority women together.

5.2.5 The Belfast and Rural Divide

Grant (2025) also recommended attention to rural and remote women's needs. OutConnections cannot classify true rural and urban status, a limitation documented in section 3.9. The Belfast and non-Belfast split still shows one of the largest and most consistent gaps in the report. Women outside Belfast are about half as likely to feel connected to the LGBTQIA+ community (27% against 57%). They are considerably less likely to say they would use the planned Belfast hub (50% against 77%). This is a new finding relative to the 2002 and 2007 reports, which focused on lesbian and bisexual women's needs generally, not on geography.

5.2.6 Housing and Homelessness

Eighteen percent of women in this sample have experienced homelessness, and 38% have faced family hostility linked to their identity. Neither A Mighty Silence nor Invisible Women treated housing as a distinct theme. This report's findings, set out in section 4.4, suggest it should be one going forward. Family rejection and relationship abuse often sit behind a woman's housing insecurity, not beside it.

Table 5.2: Joint display, disability and trans status

Quantitative (section 4.6)	Qualitative theme (section 4.6)	Comparator study
Disabled women: 55% attempted suicide vs 22%; 32% homeless vs 10%	Accessibility named as a specific hub barrier; requests for a dedicated disability group	Grant (2025) recommendation to address disabled women's needs specifically
Trans women: 62% feel unsafe vs 26%; 30% positive impression of HEReNI vs 63%	Direct concern that women's space is not consistently read as trans-inclusive	Section 1.2 policy context; no direct comparator study in the reviewed literature

5.3 Reading This Dataset Against Its Predecessors

Three points of method deserve comment before the findings above are put to service planning use in Chapter 6.

First, sample composition differs across every study cited in this chapter. Quiery's 2007 focus groups involved 39 women, recruited through the voluntary sector. OutConnections' 279 women were recruited primarily through partner organisations' own networks. That method is closer to Grant's (2025) Australian convenience samples than to a population-representative survey. Both approaches likely oversample women already connected to LGBTQIA+ organisations. They undersample women who are isolated from them, the group identified in section 4.1 as least connected and most at risk. Percentages in this report describe engaged, help-seeking women.

Second, question wording differs enough between studies that small differences in headline figures should not be treated as evidence of change over time. OutConnections' mental health, self-harm and suicide items are closer in wording to Quiery's original focus group prompts than its sexual health items are. That is why section 5.1.2 supports a direct comparison, while section 5.1.3 supports only a partial one. Section 3.5 and Appendix A.2 set out this comparability assessment for every construct used in this chapter.

Third, this report's own qualitative method, described in section 3.7, is a documented departure from the reflexive thematic analysis that Quiery's original reports and Braun and Clarke's (2006, 2019) method both describe. Where this report's qualitative frequency counts in Chapter 4 diverge from the tone of Quiery's own findings, the appropriate next check is a fully manual re-coding of the open text by multiple researchers. It is not a reason to discount the pattern-based findings reported here.

5.4 Policy Implications Beyond Health Services

Section 1.2 traced the policy and legislative changes since 2007. These include same-sex marriage in 2020, a still-unadopted Equality Act 2010 framework, a Sentencing Bill that does not name transgender identity as a protected characteristic, and conversion practices ban that took five years to move from a passed motion to an introduced Bill (Humanists UK, 2026). This report's findings give that legislative history a human scale.

The low rate of hate crime and domestic abuse reporting documented in sections 5.1.4 and 5.1.5 sits directly downstream of the institutional gap the Sentencing Bill is meant to close. A statutory aggravating offences model can improve sentencing once a case reaches court. It does nothing for the three in four women with a recent identity-related incident who did not report it. The gap between having a law and women trusting the system enough to use it is the gap LGBT Ireland's (2023) review of the Republic's first inclusion strategy warned about. A strategy, or a law, is not the same as a change in lived experience.

The Sentencing Bill's silence on transgender identity as a named protected characteristic is also difficult to reconcile with this report's findings. Trans women report the highest rates of online harassment, the lowest sense of safety, and the most severe anticipated workplace discrimination of any group in this dataset, as section 4.6 sets out. The Republic of Ireland's 2024 hate crime legislation names sexual orientation explicitly (Department of Justice, Home Affairs and Migration, 2024). Northern Ireland's Bill, as currently drafted, treats gender identity differently. Nothing in this report's evidence base supports that distinction.

5.5 A Common Thread: Minority Stress in a Northern Ireland Context

Minority stress theory is the idea that chronic exposure to discrimination and stigma drives poorer health outcomes for stigmatised groups. It remains the leading explanation for the disparities documented across this literature (Grant, 2025). Every major finding in this report fits within that frame. Concealment is a response to anticipated stigma. Poor mental health follows from the stress of managing that concealment. It is compounded for women who are also disabled, trans, or living outside Belfast. Under-use of sexual health services follows from past experience of judgement or poor care. Kang (2026) argues that inclusive, lifespan-aware care is the appropriate clinical response to this pattern. Care organised around a single point of disclosure is not. That argument underpins several of the recommendations in Chapter 6.

What this report cannot do, and what none of the literature reviewed in Chapter 2 fully resolves, is establish these mechanisms with certainty from survey data alone. Grant (2025) is careful to note that social connection and gender affirmation may interact with minority stress, rather than sit apart from it. This report's own findings are consistent with that more complex picture, not with minority stress as the sole explanation. This is particularly true of the strong protective association between community connection and the wish for more of it, discussed in section 4.1.

5.6 What the Survey Did Not Ask

OutConnections was a broad community survey. It was not built to replicate Quiery's instruments. Several themes from the 2002 and 2007 reports, and from the later literature, were therefore not asked about, and this report cannot test them. None of this is evidence that these issues have disappeared. It shows only that the survey was not designed to find them. Table 5.3 summarises the gaps. The sections below explain the four that matter most.

Table 5.3: Themes the survey did not ask about

Not asked	Earlier evidence	Closest available measure
GP experience and disclosure to a GP	Over 40% of lesbian and bisexual women would not feel comfortable disclosing their sexual orientation to a GP (Quiery, 2007)	A quarter of women rarely or never open up to medical or support professionals in general. GPs were the service most often named for mental health support (61 women)
Cervical, breast and bowel screening	Four young women told they did not need a smear test (Quiery, 2007). 15% of lesbian and bisexual women had never been screened, against 7% of women generally (Hunt and Fish, 2008). Trans women in Australia more likely than cisgender women to be up to date with breast and bowel screening (Grant, 2025)	General sexual health check-ups only: 39% of women have never had one. A few free-text mentions of smear tests, as incidental detail within cancer-related answers
Parenting, fertility, adoption and custody	Reproductive healthcare experiences among LGBTQ people assigned female at birth were predominantly negative (Wingo, Ingraham and Roberts, 2018)	None. Almost no unprompted mention in the open text

Not asked	Earlier evidence	Closest available measure
Abuse mechanisms specific to same-sex relationships	Threats to out a partner, and use of custody or family rejection as leverage (Quiery, 2002, 2007)	Five general harmful behaviours from a partner or family member: 55% from a partner, 74% from either. A small number of unprompted free-text mentions
Conversion practices	Cross-community political support existed by 2021, yet a Bill did not follow for five years (Humanists UK, 2026)	None
Social class and income	No comparator in this chapter	Financial precarity appears across the housing, substance use and service-access findings (sections 4.3 to 4.5)
A usable measure of suicidal ideation (asked, but the "no" option was empty for every respondent)	75.6% of cisgender and 86.2% of trans lesbian, bisexual and queer women had experienced suicidal ideation (Grant, 2025)	Minimum combined estimate: at least 69% of women had attempted suicide or had suicidal thoughts

5.6.1 GP Experience and Disclosure to Healthcare Providers

The OutConnections survey did not ask directly about GP experience, satisfaction or disclosure of sexual orientation or gender identity to a GP. The survey does show that GPs are the service most often named for mental health support (see section 4.2). Women also mention GPs in free-text answers, describing both positive and negative experiences. These comments offer useful pointers, but a systematic, quantitative account of GP experience would need questions designed for the purpose. This is a clear area for further research

5.6.2 Cervical, Breast and Bowel Screening

As with GP services, the survey did not ask directly about cervical or breast screening. The 2002 and 2007 reports found that women were sometimes wrongly told screening was unnecessary, and this finding could not be tested here. Hunt and Fish (2008) found the same mechanism nationally a year later. Grant (2025) found that women whose regular GP knew their sexual orientation were more likely to be up to date with cervical

screening. This agreement across nearly two decades and across continents suggests that the mechanism is not specific to Northern Ireland or to one period. A few free-text answers mention smear tests and screening, but only as incidental detail within answers about cancer. The 39 percent of women who have never had a sexual health check-up is not a screening rate and should not be read as one.

Grant (2025) also found that trans women in Australia were more likely than cisgender women to be up to date with breast and bowel screening. This could not be tested here. Trans women in this sample report poorer outcomes than other women on almost every other measure in Chapter 4, so whether the Australian pattern holds in Northern Ireland is an important question for future research. It is also the kind of finding that a descriptive dataset can miss when it does not ask a comparable question.

5.6.3 Parenting, Fertility and Custody

Wingo et al. (2018) found that reproductive healthcare experiences among LGBTQ people assigned female at birth were predominantly negative. Providers focused narrowly on fertility and showed limited clinical competence. OutConnections cannot test this. As sections 4.1 and 4.5 note, the survey asks nothing about parenting, fertility, adoption or custody. The open-text data contains almost no unprompted mention of them. This is not evidence that the issue has disappeared. It is evidence that the survey was not designed to find it.

5.6.4 Abuse Mechanisms and Conversion Practices

Quiery's reports documented abuse mechanisms specific to same-sex relationships: threats to out a partner, and the use of custody or family rejection as leverage. The survey asked no direct question about them. A small number of women mention them unprompted in the open text, but the scale of the problem cannot be established from this dataset. The same applies to conversion practices. Their prevalence cannot be measured here, because the survey did not ask about them. Chapter 6 responds to these gaps in recommendations 5, 12 and 13.

5.7 Synthesis: Persistence, Novelty and Silence

Three kinds of finding run through this chapter. Some patterns persist unchanged from 2002 and 2007: concealment, elevated mental health risk, low reporting confidence, under-resourced services. Some are genuinely new, or newly visible because this survey's scope reached groups the earlier reports did not: online harassment, the scale of disability-related disadvantage, trans women's position, the Belfast and rural divide. And some questions remain silent. Neither Quiery's instruments nor OutConnections asked them in a way that produces evidence: GP disclosure of sexual orientation or gender identity, screening uptake, parenting and fertility (section 5.6). That silence does not mean the issue has resolved.

Pattern	Examples	What follows
Persists	Concealment, mental health risk, low reporting confidence, service under-resourcing	Chapter 6 Recommendations 1 to 4, 6 and 9
New or newly visible	Online harassment, disability, trans women's position, Belfast and rural divide, housing	Chapter 6 Recommendations 1, 2, 10 and 11
Silent	GP disclosure, cervical and breast screening, parenting and fertility, LGB-specific abuse mechanisms	Chapter 6 Recommendations 5, 12 and 13

This three-part structure, rather than a single verdict of "things have improved" or "things have not changed", is the most accurate answer this report can give to RQ1 and RQ2 together. Chapter 6 is organised to respond to all three categories.

6.0 Recommendations for the Service Sector

THIS CHAPTER SETS OUT RECOMMENDATIONS drawn from the findings. Each recommendation states the evidence behind it and who is best placed to act on it. Recommendations are organised by organisation and service type since the same finding often has implications for several organisations at once. Where a recommendation echoes one Quiery made in 2002 or 2007, this is noted explicitly, since a recommendation repeated across 19 years is itself a finding.

6.1 Summary of Recommendations

Table 6.1: Summary of recommendations by lead organisation and priority

#	Recommendation	Lead	Priority
1	Build the planned hub as a regional service, not a Belfast-only one	HEReNI, The Rainbow Project and Cara-Friend	High
2	Make trans inclusion in women's space explicit, not assumed	HEReNI, The Rainbow Project and Cara-Friend	High
3	Build non-alcohol social and creative provision	HEReNI, The Rainbow Project and Cara-Friend	Medium
4	Design for sensory and access needs from the outset	HEReNI, The Rainbow Project and Cara-Friend	Medium
5	Commission a NI-specific study of GP disclosure and screening	HSC / Department of Health	High
6	Invest in LGBTQIA+-aware mental health capacity, with youth and disability pathways	HSC	High
7	Provide interim mental health support for gender identity service waiting lists	HSC	High
8	Address confidentiality and past-experience barriers to sexual health services	HSC	Medium

#	Recommendation	Lead	Priority
9	Rebuild confidence in hate crime and domestic abuse reporting	PSNI / Department of Justice	High
10	Recognise transgender identity on the same footing as sexual orientation in hate crime law	Department of Justice	Medium
11	Establish an LGBTQIA+-aware housing advice pathway	Housing Executive	High
12	Close the data gaps this report has identified	Research and data infrastructure	High
13	Treat this report's limitations as a specification for the next study	Research and data infrastructure	Medium

6.2 LGBTQIA+ Sector Partnership: HEReNI, The Rainbow Project, and Cara-Friend

Recommendation 1

Build the planned hub as a regional service, not a Belfast-only one

Priority: High

Seventy-seven percent of women in Belfast say they would use the planned hub, against 50% of women outside Belfast. Awareness of the hub itself is lower outside Belfast too. A hub that exists physically only in Belfast will reach roughly half the women who might use one.

- Establish regional outreach sessions or satellite provision outside Belfast, prioritising areas with the lowest current awareness.
- Offer evening, weekend and online alternatives, since opening hours are cited as a barrier almost as often as distance.
- Run a proactive awareness campaign specifically targeted outside Belfast before or alongside the hub's opening.

Given the scale of the disparity shown in section 4.6 and Chapter 5, a phased rollout that leaves outreach beyond Belfast until the second year risks deepening the divide this report documents. Making outreach part of the initial offer would help to avoid this.

Recommendation 2

Make trans inclusion in women's space explicit, not assumed

Priority: High

Trans women report a markedly lower positive impression of HEReNI than non-trans women, and lower comfort expressing their identity in Belfast generally. Section 4.1 records a direct concern from one respondent that women's provision "feels aimed only for a particular sort of cis lesbian".

- State trans inclusion explicitly in any women's space branding, signage and programming, rather than leaving it to be inferred.
- Ensure staff and volunteer teams visibly include trans women.
- Review programming with trans women directly, given the gap in impression scores documented in section 4.6.

Recommendation 3

Build non-alcohol social and creative provision

Priority: Medium

Café and hospitality space, creative and arts programming, and general community events are the most requested hub features. A recurring minority theme across the open-text data is dissatisfaction with alcohol and nightlife-centred social provision as the default form of community life.

- Prioritise a café or social space not built around drinking in the hub's initial offer.
- Schedule regular non-scene activities: arts programming, quiet meet-ups, book clubs.

Recommendation 4

Design for sensory and access needs from the outset

Priority: Medium

Disabled women are far more likely than other women to cite accessibility as a barrier to community spaces, and to want a dedicated disability-focused group. Access needs, including autism and neurodivergence, recur in a quarter of hub-design responses.

- Include quiet or low-sensory spaces in the hub design.
- Publish clear, concrete guidance in advance on what to expect at the venue, reducing uncertainty for first-time and neurodivergent visitors.
- Establish a dedicated disability-focused group or session, given the scale of unmet need documented in section 4.6.

6.3 Health and Social Care Services

Recommendation 5

Commission a Northern Ireland-specific study of GP disclosure and cervical and breast screening

Priority: High

This report identifies this theme as the two clearest gaps in the current evidence base. Quiery's 2007 finding, that four young women were wrongly told they did not need a smear test, has never been directly retested. Hunt and Fish (2008) and Grant (2025) both confirm the same mechanism, clinician assumption driving under-screening, in England and Australia respectively. Whether it still applies in Northern Ireland in 2026 is currently unknown.

- Commission a dedicated study covering GP disclosure, cervical screening uptake, and breast screening uptake among lesbian, bisexual and trans women specifically.
- In the interim, issue guidance to GP practices addressing the specific assumption Quiery and Hunt and Fish both documented, that women in same-sex relationships do not need cervical screening.

This recommendation costs comparatively little relative to its evidential value. As section 5.1.3 sets out, the same clinician assumption Quiery documented in Northern Ireland in 2007 was independently confirmed in England in 2008 and in Australia in 2025. A single, well-designed screening item would let Northern Ireland finally test whether that near two-decade-old, cross-jurisdictional finding still applies locally.

Recommendation 6

Invest in LGBTQIA+-aware mental health capacity, with youth and disability pathways

Priority: High

Ninety percent of women report mental health difficulties. Self-harm is markedly higher among women aged 18 to 24 and among disabled women. Twenty percent of women who needed professional mental health support did not access it.

- Expand LGBTQIA+-specific counselling capacity, prioritising younger and disabled women given the scale of need documented in sections 4.2 and 4.6.
- Ensure mainstream mental health services have clear, funded referral pathways to LGBTQIA+-specific support, rather than treating this as solely a third-sector responsibility.

Recommendation 7

Provide interim mental health support for women on gender identity service waiting lists

Priority: High

Among the women who sought gender identity services, half of those reporting a wait had waited three years or more, and two-thirds of those describing a mental health change while waiting said it declined. This mirrors the wider waiting list figures reported publicly for Northern Ireland's gender services (The Brief NI, 2026).

- Fund a dedicated interim mental health support pathway specifically for people on gender identity service waiting lists, not contingent on that clinical pathway itself.
- Track mental health outcomes for people on the waiting list as a standing service metric.

Recommendation 8

Address confidentiality and past-experience barriers to sexual health services directly

Priority: Medium

Twenty-one percent of women avoided a sexual health appointment they believed they needed. The leading reasons were previous negative healthcare experiences, fear of judgement, and confidentiality concerns, matching the barriers Meads et al. (2019) identified across 26 studies.

- Offer an explicit, visible confidentiality guarantee within LGBTQIA+-aware sexual health services.
- Target outreach at women aged 18 to 24, 69% of whom have never had a sexual health check-up of any kind.

6.4 Department of Justice and PSNI

Recommendation 9

Rebuild confidence in hate crime and domestic abuse reporting

Priority: High

Only 26% of women who experienced a recent identity-related incident reported it to the PSNI. Only 18% of women experiencing relationship abuse had reported it to police or another service. Where women describe what happened after reporting, in either context, the theme is a lack of action and a sense of not being believed.

- Ensure the statutory aggravating offences model currently before the Assembly is matched with visible, monitored improvement in how reports are handled, not only in how offences are sentenced.
- Publish outcome data on LGBTQIA+-related hate crime and domestic abuse reports specifically, to rebuild the confidence current figures suggest is missing.

Recommendation 10

Ensure transgender identity is recognised on the same footing as sexual orientation in hate crime law

Priority: Medium

Section 1.2 notes that the Sentencing Bill currently before the Assembly does not list transgender identity as a protected characteristic in the way it lists sexual orientation, unlike the Republic of Ireland's 2024 hate crime legislation. Trans women in this sample report the highest rates of online harassment and the lowest sense of safety of any group studied.

- Amend the Bill to name transgender identity explicitly, consistent with the approach already taken in the Republic of Ireland.

6.5 Housing Executive and Housing Advice Services

Recommendation 11

Establish an LGBTQIA+-aware housing advice pathway

Priority: High

Eighteen percent of women have experienced homelessness, and 38% have faced family hostility related to their identity. For almost a third of women who were homeless, it was mainly related to their sexual orientation or gender identity.

- Establish a clear referral pathway between LGBTQIA+ organisations and housing advice services, given that 54% of women want housing and benefits advice available at the planned hub.
- Develop a specific response for young women facing family rejection or exclusion from the family home, the single most common driver of housing insecurity identified in section 4.4.

6.6 Research and Data Infrastructure

Recommendation 12

Close the data gaps this report has identified

Priority: High

Section 3.5 and Chapter 5 identify GP disclosure, cervical and breast screening, and parenting, fertility and custody as areas with no equivalent item in OutConnections. Ethnic minority women, at 13 respondents, are too few in this sample to report on separately.

- Add GP disclosure, screening uptake and parenting or fertility items to any future OutConnections-style survey.
- Consider targeted outreach or oversampling to ethnic minority LGBTQIA+ women in any future data collection, given the double or triple burden Quiery's own 2002 report first identified for this group.
- Adopt a validated rural and urban classification, such as the NISRA settlement classification, rather than relying on a Belfast versus non-Belfast postcode split, to properly test the geographic divide identified in section 4.6.

Recommendation 13

Treat this report's own limitations as a specification for the next study

Priority: Medium

Section 3.9 documents several methodological constraints: an undocumented data-quality flag, a broken suicidal-thoughts response option, and rule-based coding rather than fully manual qualitative coding.

- Any future survey instrument should test its response logic for exactly this kind of error before fielding.
- Where a future secondary analysis has the resources, full manual reflexive thematic analysis by multiple coders would strengthen the qualitative findings beyond what the pattern-based method used here can support.

6.7 Monitoring Progress

Two decades after Quiery's reports, there is a clear opportunity to build on the progress made. To keep that progress visible, this report recommends that the LGBTQIA+ sector and relevant statutory partners agree a short set of measurable indicators drawn from Chapter 4. These indicators should be collected on a fixed cycle and designed to address the areas for improvement identified in Appendix A.

- Track the eight headline indicators from the Executive Summary at each survey wave. This will allow direct comparison over time, which this report could not fully achieve against Quiery's 2002 and 2007 baselines.
- Report progress against each recommendation in this chapter publicly each year, naming the lead organisation responsible.
- Review the Belfast hub's reach outside Belfast within its first year of operation, given the differences identified in section 4.6 and Chapter 5. 5.

7.0 Conclusion

WE ARE GRATEFUL TO ALL 279 WOMEN who completed the survey, particularly those who wrote at length in the open-text fields, often about painful experiences.

RQ1 asked whether the invisible women pattern Quiery documented in 2002 and 2007 still holds. The data show that it does. Concealment as an everyday strategy, elevated rates of poor mental health and self-harm, and low confidence in reporting abuse and hate crime all recur strongly. So does a service landscape that helps where it exists but is harder to reach outside Belfast. Where OutConnections allows a direct comparison with Quiery's original measures, the pattern holds. Where it does not, chiefly health services disclosure of SO/GI and screening, the survey points to a clear priority for future work.

RQ2 asked what else Northern Ireland's LGBTQIA+ women need. Several findings go beyond what the 2002 and 2007 reports could have captured. Disability is the strongest predictor of poorer outcomes in this dataset, ahead of trans status, age or geography. Trans women report poorer experiences than other women on almost every measure. Online harassment, absent from the earlier literature, now affects almost half of women. Housing insecurity and family rejection sit behind much of what women describe, and they merit recognition as a distinct theme going forward.

RQ3 asked what this means for service design in Belfast. Chapter 6 answers this directly, organisation by organisation. The clearest message across all thirteen recommendations is that trust and reach are built through deliberate action. A hub that reaches beyond Belfast, a women's space that states clearly that trans women belong in it, and a survey that asks about GP disclosure and screening will each help to move beyond the pattern this report set out to test.

Two areas deserve dedicated attention in whatever comes next. Ethnically minoritised LGBTQIA+ women numbered 13 in this sample, too few to report on separately, which echoes a limitation Quiery's 2002 report first named for this group. Parenting, fertility and custody were a substantial theme in 2002 and 2007 but fall outside this survey's design.

This report should be read alongside the quantitative and qualitative evidence in the appendices that follow. They give every figure, subgroup comparison and coded theme behind the findings above.

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Appendix A. Methodology Detail and Data Mapping

A.1a The Coding Frame

The analysis used a three-part coding frame. Part 1 extracted a master theme list from the section headings and key findings of A Mighty Silence (Quiery, 2002) and Invisible Women (Quiery, 2007), covering fourteen themes: heterosexism and homophobia; coming out and disclosure; health service access; physical health risks; mental health and suicide; internalised oppression; domestic violence; multiple and intersecting identities; age-specific experience; rural isolation; parenting; services and support infrastructure; policy context; and community and organisational dynamics.

Part 2 applied deductive codes derived from Part 1, plus emergent codes for themes present in the 2026 data but not covered, or barely covered, in 2002 or 2007. These included online harassment, gender identity service access, sex work, community hub design, trust in named organisations, code-switching, PrEP access, and trans-specific experience within the wider women's sample.

Part 3 mapped the survey's closed questions onto the same themes, producing 185 quantitative indicators, set out in full in Appendix B, analysed across the primary sample, a version excluding the undocumented data-quality flag, and the non-binary and gender-fluid sensitivity sample.

A.1b The Full Part 1 Theme List

Section A.1 summarises the fourteen themes used to build the coding frame. The full theme list, extracted directly from the section headings and key findings of A Mighty Silence (Quiery, 2002) and Invisible Women (Quiery, 2007), is reproduced below for completeness.

A. Heterosexism, Homophobia and Lesbophobia

- Homophobia, individual and institutional: violent assault, verbal abuse, harassment
- Heterosexism: assumption of heterosexuality embedded in services, institutions and professional questioning
- Lesbophobia: the specific combination of homophobia and sexism directed at lesbian and bisexual women

- "Homophobic fallout" as a driver of poor mental health, distinct from sexual orientation itself
- Internalised homophobia and lesbophobia: low self-esteem, self-destructive behaviour, conflict within organisations over who counts as a "good" lesbian

B. Coming Out and Disclosure

- Coming out as an ongoing, daily, lifelong process rather than a single event
- The catch-22 of visibility: coming out increases exposure to harassment, staying closeted increases isolation
- Coming out to family: fear of rejection, hurt or embarrassment, family ties restricting community involvement
- Coming out at work: mixed experiences, fear of career impact
- Coming out later in life: lack of support networks for older women who come out later
- Disclosure to GPs and health professionals specifically: reluctance to come out to doctors, fear of homophobic reactions

C. Access to Health Services

- GPs assumed ignorant or unsympathetic to lesbian and bisexual women's health needs
- Heterosexist assumptions in clinical questioning about contraception and sexual partners
- Incorrect advice that cervical screening is unnecessary
- Preference for female service providers and a more holistic approach
- Reduced or delayed use of health services generally
- Lack of GP and health professional training on sexual orientation
- Positive exceptions noted, such as GUM clinic experience, as models of good practice

D. Physical Health Risks

- Higher smoking, alcohol and recreational drug use
- Higher risk factors for breast and cervical cancer, with lower screening uptake
- Nulliparity and other cancer risk factors
- Obesity and eating disorder patterns, with mixed evidence
- General under-documentation of lesbian and bisexual women's physical health

E. Mental Health, Self-Harm and Suicide

- Elevated rates of depression, anxiety, self-harm, suicidal ideation and attempts
- A specific finding that one in two same-sex attracted 16-year-olds reported mental ill health (2007)
- Stress specific to sexual minority status: identity concealment, lack of role models, absence of support
- Under-recognition of young women's mental health relative to young men's
- Isolation as a driver of poor mental health, particularly for older, rural or newly out women

F. Internalised Oppression and Identity Conflict

- Internalised homophobia affecting self-esteem and organisational dynamics
- Conflict between different parts of identity, including religious, ethnic, political and sexual identity
- Fear of being outed through visibility or activism

G. Domestic Violence and Relationship Abuse

- Under-researched but present at rates comparable to heterosexual relationships
- Distinct mechanisms of abuse: threats to out a partner, undermining sexual orientation or gender identity, using custody or family rejection as leverage
- Very low rates of reporting to police or seeking help from services
- A recommendation to incorporate same-sex relationships explicitly into domestic violence strategy

H. Multiple and Intersecting Identities

- Black and minority ethnic lesbian and bisexual women facing a double or triple burden of racism, homophobia and navigating separate communities
- Disabled lesbian and bisexual women facing invisibility, inaccessible venues and the assumption of asexuality
- Bisexual women facing biphobia from both straight and gay or lesbian communities, stereotyping and invisibility
- Religious lesbian and bisexual women navigating conflict between faith and sexual identity
- Political or community background, including nationalist or unionist and Troubles-era divisions, as an added layer of identity negotiation

I. Age-Specific Experience

- Young lesbian and bisexual women: school bullying, lack of relevant sex education, isolation, high-risk coping behaviours
- Older lesbian and bisexual women: smaller support networks, fear of re-closeting in elder care, reluctance to disclose to GPs, difficulty admitting depression

J. Rural Isolation

- Absence of organised rural lesbian and bisexual groups
- Reliance on telephone and internet support due to distance and lack of local services
- A call for training and awareness among rural-facing statutory bodies

K. Parenting and Reproduction

- Barriers to donor insemination and fertility services
- Fear of losing custody and lack of sympathetic legal advice
- The non-biological parent's precarious legal position
- School-based disclosure dilemmas for parents and children
- Isolation from both mainstream parenting support and a lesbian community skewed toward childless women

L. Access to Services and Support Infrastructure

- Chronic under-resourcing of lesbian and bisexual-specific services
- Low awareness of existing services, especially in rural areas
- Absence of dedicated NHS or counselling facilities for lesbian and bisexual women
- Low institutional engagement, reflected in low return rates when statutory and voluntary organisations were surveyed about provision
- A recommendation for a dedicated Lesbian and Bisexual Women's Resource Centre

M. Policy and Legislative Context

- Section 75 of the Northern Ireland Act 1998 not translating into targeted action or measurable outcomes
- Government strategies on suicide prevention, mental health, domestic violence and sexual health remaining largely silent on lesbian and bisexual-specific targets
- A recommendation to embed lesbian and bisexual-specific targets into mainstream government strategies

N. Community and Organisational Dynamics

- Diversity and internal difference within the community across class, religion, politics and ability
- Burnout among activists and short-lived organising
- Skills gaps in governance and advocacy, and a need for leadership development
- Tension between the social, service and advocacy functions of organisations
- A need for a coordinating body to act as a catalyst rather than a direct service provider

A.2 Data Mapping Against Quiery's Constructs

Section 3.5 describes how the OutConnections instrument was mapped against the constructs central to Quiery's 2002 and 2007 work. The table below sets out that mapping in full.

Quiery construct	Closest OutConnections item	Comparability
GP disclosure (2002/2007: 40% would not disclose to a GP)	No direct item. Related item: openness with medical or support professionals in general.	Not equivalent. Broader category than GP specifically; see section 3.5 and 5.6.1.
Cervical and breast screening (2007: four young women wrongly told screening unnecessary)	No direct item. Related items: ever used a sexual health service; last sexual health check-up.	Not equivalent. Screening is a distinct clinical construct from general sexual health service use; see 5.6.2.

Quiery construct	Closest OutConnections item	Comparability
Suicide attempts	Ever attempted suicide (closed item).	Broadly comparable, though no matched heterosexual comparison group exists in this dataset.
Self-harm	Ever self-harmed (closed item).	Broadly comparable.
Suicidal ideation	Ever had suicidal thoughts (closed item).	Comparable in principle. The negative response option was empty for every respondent, so no true rate could be calculated; see 3.9.
Heterosexism in institutions and the workplace	Workplace bullying or prejudice; feeling unsafe as an LGBTQIA+ person in NI.	Broadly comparable.
Domestic abuse mechanisms specific to LGB relationships (outing threats, custody leverage)	General item on harmful behaviours from a partner or family member. No mechanism-specific item.	Partial. The general construct of relationship abuse is present; the specific mechanisms Quiery documented are not separately measured.
Parenting, fertility, custody	No item.	No equivalent.
Rural isolation	No validated rural / urban classification. Belfast (BT1–17) versus all other postcodes used as a proxy.	Related but not equivalent. See 3.9 and 9.
Multiple and intersecting identities (ethnicity, disability, religion, political background)	Disability item strong and well populated. Ethnicity item present but n=13. Religion and political background collected as demographic items, not linked to outcome questions.	Partial. Coverage is strong for disability, weak for ethnicity.
Services and support infrastructure awareness	Awareness and trust of named organisations; hub-related items.	Broadly comparable, with a wider scope than the 2002/2007 instrument.

A.3 Sample and Data Preparation

- Respondents under 18 were excluded from all analysis (33 of 637).
- The primary sample is women aged 18 and over as identified by the survey's gender identity question (n=279).
- A sensitivity sample adds non-binary and gender-fluid respondents aged 18 and over (n=361), reported separately rather than merged.

- Percentages are calculated on the number of women who answered each question, not the full sample, since the survey used branching logic.
- Subgroup comparisons used Fisher's exact test for two groups or chi-square for three groups, run only where every outcome cell in every group had at least 10 respondents, with Benjamini-Hochberg correction applied across all comparisons. Only differences surviving this correction, at q below 0.05, are reported as findings.
- Open-text coding was rule-based, using keyword and pattern matching validated against manually read samples for each code, rather than fully manual coding of every response. See section 3.7 for a full account of this method and its limits.

A.4 Data Limitations

- An undocumented flag in the raw export, present for 26 of the 279 women, could not be explained from the data alone. Excluding these respondents changed no reported result by more than three percentage points.
- The negative response option for "ever had suicidal thoughts" was empty for every respondent in the export, meaning no rate could be calculated for that item directly. A minimum combined estimate, attempts or thoughts, is used instead.
- Two items, isolation where living and the impact of mental health on housing, relationships or employment, were answered by roughly a third of women, skewed toward those already reporting self-harm. Their percentages are not generalised to the full sample.
- Location analysis uses Belfast (BT1–17) versus all other postcodes. A full rural and urban classification was not available.
- Ethnic minority women in the sample (n=13) are too few to report separately.
- No separate focus group transcripts were included in the dataset supplied for this analysis. The qualitative findings in this report draw solely on the survey's own open-text fields; see section 3.3a.

A.5 Theme Coverage Against the 2002/2007 Reports

Where the 2026 survey has no equivalent question to a 2002 or 2007 theme, that absence is itself a finding worth naming. It may reflect genuine progress, an issue less salient today, or simply a gap in what this instrument was designed to capture. The table below summarises coverage across all fourteen themes.

2002/2007 theme	Coverage in the OutConnections 2026 data
Heterosexism / homophobia	Strong. Online harassment, hate crime, workplace, education.
Coming out / disclosure	Strong. Openness by setting, concealment, workplace and career fears.
GP / health service access	Weak. No dedicated GP-experience question.
Physical health risks	Partial. Substance use covered; no smoking or screening item.
Mental health, self-harm, suicide	Strong, with two low-response items flagged.
Internalised oppression / identity conflict	Partial.
Domestic / relationship abuse	Partial. No item on outing threats or custody leverage.
Multiple / intersecting identities	Strong for disability and trans status; weak for ethnicity (n=13).
Age-specific experience	Partial. Under-18s excluded; few women aged 60 and over.
Rural isolation	Partial. Belfast / non-Belfast split only, no true rural classification.
Parenting and reproduction	No closed items; negligible free text.
Services and support infrastructure	Strong.
Policy and legislative context	Background only, not survey-codable.
Community and organisational dynamics	Partial.

Appendix B. Full Quantitative Indicator Tables

This appendix lists every quantitative indicator derived from the OutConnections closed questions, grouped by theme, for the primary sample of 279 women aged 18 and over. "n" is the number of women who answered that item; the percentage is the share of those answering who gave the indicated response. Items answered by fewer than 20 women should be treated as indicative only. Full confidence intervals, the excluded-flag comparison, and the non-binary and gender-fluid sensitivity sample figures are available in the companion results workbook referenced in the Foreword.

Housing

Indicator	n	%
Family hostility at home due to SO/GI	271	37.6%
Ever left permanent accommodation because felt unsafe	274	21.2%
Ever without a safe, stable home (any type)	275	35.3%
Ever lived somewhere insecure / unsuitable (not homeless)	272	32.4%
Ever homeless	278	18.0%
Homelessness mainly related to SO/GI (among ever homeless)	48	29.2%
Difficulty accessing accommodation due to SO/GI	273	5.5%

Disclosure

Indicator	n	%
Open (always / usually) with family	278	69.1%
Rarely / never open with family	278	19.1%
Open (always / usually) with friends	277	86.3%
Rarely / never open with friends	277	6.9%
Open (always / usually) with work colleagues	274	57.7%
Rarely / never open with work colleagues	274	21.9%
Open (always / usually) with strangers	277	32.1%
Rarely / never open with strangers	277	33.2%
Open (always / usually) with medical / support professionals	277	54.5%
Rarely / never open with medical / support professionals	277	25.3%
Expects openness to harm career progression	268	25.0%
Expects openness to harm finding work	276	42.8%

Homophobia

Indicator	n	%
Education bullying / prejudice due to SO/GI (currently in education)	128	21.9%
Workplace bullying / prejudice due to SO/GI	234	13.7%
Feels unsafe / very unsafe as LGBTQIA+ person in NI	275	32.0%
Ever experienced online harassment	279	41.9%
Victim of crime / incident ever	279	68.8%
Victim of crime / incident in past 12 months	279	22.6%
Incident (past 12m) related to SO/GI (among 12m victims)	61	82.0%
Reported incident to PSNI (among 12m victims)	63	30.2%
Reported incident to PSNI (among identity-related 12m incidents)	50	26.0%

Relationship Abuse

Indicator	n	%
Physical abuse: any source	264	39.8%
Physical abuse: from a partner (incl. both)	264	24.6%
Physical abuse: from a family member (incl. both)	264	24.2%
Verbal / emotional abuse: any source	265	70.9%
Verbal / emotional abuse: from a partner (incl. both)	265	48.3%
Verbal / emotional abuse: from a family member (incl. both)	265	47.9%
Sexual abuse / coercion: any source	258	37.2%
Sexual abuse / coercion: from a partner (incl. both)	258	30.6%
Sexual abuse / coercion: from a family member (incl. both)	258	9.7%
Controlling / coercive behaviour: any source	264	57.6%
Controlling / coercive behaviour: from a partner (incl. both)	264	44.3%
Controlling / coercive behaviour: from a family member (incl. both)	264	23.9%
Financial abuse: any source	271	25.8%
Financial abuse: from a partner (incl. both)	271	21.4%
Financial abuse: from a family member (incl. both)	271	9.6%
ANY of 5 abuse types from a partner	275	55.3%
ANY of 5 abuse types from a family member	275	49.1%
ANY of 5 abuse types from any source	275	74.2%

Mental Health

Indicator	n	%
Physical health poor / very poor (12m)	279	23.3%
Mental health poor / very poor (12m)	279	38.0%
Ever experienced mental health difficulties	272	90.1%
Needed professional support (among those with mental health difficulties)	243	90.1%
Needed support but did NOT access it (among those who needed it)	219	20.5%
Ever self-harmed	273	59.0%
Ever attempted suicide	272	34.2%
(asked of those with suicidal thoughts) Last suicidal thoughts within past year	100	56.0%
(asked of those with suicidal thoughts) Accessed support for suicidal thoughts / behaviours	98	74.5%
Mental Health impacted housing / relationships / employment	74	75.7%
Feels isolated where they live	99	63.6%
Past 3m: Lost sleep from worry MORE than usual	279	47.7%
Past 3m: Under constant strain MORE than usual	278	51.8%
Past 3m: Couldn't overcome difficulties MORE than usual	279	41.2%
Past 3m: Unhappy / anxious / depressed MORE than usual	278	46.0%
Past 3m: Lost confidence MORE than usual	277	42.6%
Past 3m: Felt things no longer worthwhile MORE than usual	278	25.9%
Past 12m: Able to concentrate LESS than usual	279	47.7%
Past 12m: Enjoyed daily activities LESS than usual	278	42.1%
Past 12m: Felt capable of decisions LESS than usual	278	37.8%
Past 12m: Able to address personal issues LESS than usual	279	38.7%
Past 12m: Sought advice / support LESS than usual	278	22.7%

Physical Health

Indicator	n	%
Ever had a cancer diagnosis	279	2.5%
Ever had a cancer scare ("other")	279	3.9%
Ever supported someone with cancer	279	53.8%
Drinks alcohol weekly or more	279	39.1%
Doesn't drink alcohol	279	16.5%
6+ units on one occasion: always / usually / sometimes	233	48.5%
Uses drugs recreationally weekly or more	279	9.0%
Doesn't use drugs recreationally	279	71.3%
Drug behaviour: ever used drugs other than for medical reasons	279	51.3%

Indicator	n	%
Drug behaviour: ever used more than one drug	279	25.4%
Drug behaviour: finds it hard to stop using	279	5.7%
Drug behaviour: ever had blackouts / flashbacks	279	9.7%
Drug behaviour: ever had withdrawal symptoms	279	7.9%
Drug behaviour: has misused prescribed drugs	279	8.6%
Has used Cannabis (any frequency)	274	56.6%
Has used Sedatives (any frequency)	274	20.8%
Has used Opiates (any frequency)	272	12.1%
Has used Poppers (any frequency)	273	30.8%
Has used Anti-Depressants (any frequency)	274	42.7%
Has used Cocaine (any frequency)	274	24.1%
Has used Ecstasy (any frequency)	273	16.8%
Has used Amphetamines (any frequency)	273	9.5%
Has used Legal Highs (any frequency)	274	4.0%
Has used LSD (any frequency)	271	9.2%
Has used Mephedrone (any frequency)	274	1.8%

GI Services

Indicator	n	%
Sought NI Gender Identity Services (GIC/KOI)	279	13.3%

Sexual Health

Indicator	n	%
Ever accessed GUM / sexual health service	276	26.4%
Dissatisfied / very dissatisfied with service (among users)	73	9.6%
Avoided a needed sexual health appointment	272	20.6%
Barrier (among those who avoided): Confidentiality concerns	54	31.5%
Barrier (among those who avoided): Discrimination concerns	54	22.2%
Barrier (among those who avoided): Previous negative healthcare experience	54	57.4%
Barrier (among those who avoided): Lack of appointments	54	33.3%
Barrier (among those who avoided): Fear of being judged	54	55.6%
Barrier (among those who avoided): Opening times don't suit	54	35.2%
Barrier (among those who avoided): Transport difficulties	54	14.8%
Never had a sexual health check-up	278	38.8%
Ever / currently on PrEP	249	1.2%
Doesn't know what PrEP is	279	10.4%

Sex Work

Indicator	n	%
Ever engaged in sex work	274	5.8%

Services

Indicator	n	%
Aware of The Rainbow Project	278	95.0%
Aware of Cara-Friend	278	77.3%
Aware of HEReNI	278	68.0%
Aware of BTRC	278	48.2%
Rainbow Project: positive / very positive impression	276	72.8%
Rainbow Project: negative / very negative impression	276	1.8%
Trusts Rainbow Project	269	90.0%
Cara-Friend: positive / very positive impression	261	59.4%
Cara-Friend: negative / very negative impression	261	1.5%
Trusts Cara-Friend	242	85.5%
HEReNI: positive / very positive impression	254	58.3%
HEReNI: negative / very negative impression	254	2.4%
Trusts HEReNI	232	83.6%
Aware of planned Belfast hub	279	35.5%
Would visit hub (likely / very likely)	279	62.7%
Would NOT visit hub (unlikely / very unlikely)	279	19.0%
Hub wants: Drop-in social space	278	71.2%
Hub wants: Counselling & mental health support	278	71.9%
Hub wants: Sexual health services	278	50.7%
Hub wants: Youth programmes	278	52.9%
Hub wants: Support groups	278	59.4%
Hub wants: Community events	278	73.7%
Hub wants: Training & employment support	278	48.6%
Hub wants: Library / resource centre	278	52.5%
Hub wants: Café / hospitality space	278	69.4%
Hub wants: Meeting rooms	278	59.4%
Hub wants: Advice (housing / benefits)	278	53.6%
Hub wants: Creative & arts programming	278	64.0%
Hub barrier: Location / transport	276	29.7%
Hub barrier: Opening hours	276	38.8%
Hub barrier: Fear of being seen entering	276	6.5%
Hub barrier: Not knowing what services exist	276	33.7%
Hub barrier: Not feeling space is “for people like me”	276	26.1%

Indicator	n	%
Hub barrier: Accessibility concerns	276	4.7%
Hub barrier: Cost	276	18.5%
HEReNI should deliver: Older women's group	232	68.1%
HEReNI should deliver: Younger women's group	232	63.4%
HEReNI should deliver: Heritage project	232	51.3%
HEReNI should deliver: Mental health support	232	66.4%
HEReNI should deliver: Physical health activities	232	51.7%
HEReNI should deliver: Domestic abuse support	232	58.6%
HEReNI should deliver: LGBTQIA+ family support	232	65.5%
HEReNI should deliver: More research on LGBTQIA+ women issues	232	63.4%
HEReNI should deliver: Coffee hour	232	53.4%
HEReNI should deliver: Online meet-ups	232	46.1%
HEReNI should deliver: Accredited SO/GI training	232	51.7%
HEReNI should deliver: Policy work for LGBTQIA+ women	232	60.3%
HEReNI should deliver: Presence outside Belfast	232	59.1%
HEReNI should deliver: Rural outreach	232	58.6%
HEReNI should deliver: BAME outreach	232	50.4%
HEReNI should deliver: Carers group	232	40.5%
HEReNI should deliver: Disabilities group	232	49.1%
HEReNI should deliver: 1-1 listening ear	232	48.7%
HEReNI should deliver: Newsletters	232	32.3%

Community

Indicator	n	%
Feels connected / very connected to Belfast LGBTQIA+ community	276	41.7%
Feels disconnected / very disconnected	276	43.8%
Wants to feel more connected (vs. happy as is / no)	276	71.0%
Connection barrier: Don't know how to get involved	278	31.7%
Connection barrier: Events / services aren't relevant	278	22.7%
Connection barrier: Don't see people like me represented	278	18.0%
Connection barrier: Distance / transport	278	28.8%
Connection barrier: Time constraints	278	36.3%
Connection barrier: "Scene" not for me	278	31.3%
Connection barrier: Confidentiality concerns	278	5.4%
Connection barrier: Cost	278	10.8%
Connection barrier: Accessibility	278	6.8%

Identity

Indicator	n	%
Comfortable / very comfortable expressing full self in Belfast	278	65.5%
Uncomfortable / very uncomfortable expressing full self in Belfast	278	21.2%
Hides / downplays aspects of identity	271	81.5%
Feels forced to choose between identity parts	263	36.5%
Behaves differently in different spaces	271	79.0%
Authenticity barrier: Fear of discrimination / prejudice	274	62.4%
Authenticity barrier: Family expectations / pressure	274	32.1%
Authenticity barrier: Community / cultural expectations	274	33.9%
Authenticity barrier: Workplace concerns	274	23.4%
Authenticity barrier: Safety concerns	274	47.8%
Authenticity barrier: Faith community attitudes	274	24.1%
Authenticity barrier: Lack of visible representation	274	25.9%

Appendix C. Safeguarding Protocol

Nine free-text responses across the sample disclosed a current risk of suicide, self-harm or exploitation. These have been referred for safeguarding follow-up in line with standard research protocol. They are not quoted or otherwise identified anywhere in this report, and the exact wording is not reproduced here, consistent with the distress protocol described in section 3.4.

The distress protocol followed for this analysis required that no individual researcher review distressing open-text material in isolation, and that any illustrative quotation considered for inclusion in this report be checked to ensure it did not reproduce identifying detail or content that could function as a means or method reference for self-harm.

Readers of this report who are affected by the themes discussed, including suicide, self-harm, domestic abuse or discrimination, may wish to contact HEReNI, the Rainbow Project, or Cara-Friend directly, or Lifeline, Northern Ireland's crisis response helpline.

C.1 Handling of Sensitive Open-Text Material

Beyond the nine flagged disclosures, a substantial volume of open-text material in this dataset addresses discrimination, family rejection, relationship abuse and health crises that fall short of the immediate-risk threshold triggering formal safeguarding referral, but which nonetheless describe serious harm. This report quotes selectively from that wider material throughout Chapter 4, choosing illustrative examples rather than the most severe accounts, consistent with the aim of describing a pattern rather than dwelling on any individual's worst experience.

Where a quotation touches on abuse, self-harm or discrimination, it has been checked against three criteria before inclusion: that it does not name a specific person, service or address; that it does not include detail that could function as a method reference for self-harm; and that its inclusion serves to illustrate a pattern already established by the quantitative findings, rather than standing alone as the sole evidence for a claim.

Appendix D. Full Qualitative Code Frequency Tables

This appendix lists every code applied in the rule-based qualitative coding described in section 3.7, grouped by theme, for the primary sample of women aged 18 and over. "Eligible" is the number of open-text responses to which that code could apply, given the survey fields it was applied to. "Coded" is the number of responses matched. "Women" is the number of distinct women contributing at least one matched response. Codes prefixed EM are emergent, developed inductively rather than from Quiery's original constructs; see section 3.7 and Appendix A.1a.

A. Heterosexism / Homophobia

Code	Eligible	Coded	%	Women
A1: Verbal abuse / harassment / hostile comments	610	161	26.4%	110
A2: Physical violence / sexual violence / threat	558	55	9.9%	39
A3: Workplace discrimination / exclusion (experienced or anticipated)	198	51	25.8%	45
A4: Education-setting bullying / exclusion	23	20	87.0%	20
A5: Assumption of heterosexuality / identity invalidated / misgendering	1469	24	1.6%	21
A6: Sexism / gendered abuse combined with lesbophobia	2065	24	1.2%	22

B. Coming Out / Disclosure

Code	Eligible	Coded	%	Women
B1: Situational / ongoing disclosure decisions	517	72	13.9%	60
B2: Family disclosure / family response	553	122	22.1%	91
B3: Workplace / education disclosure and penalty concerns	645	166	25.7%	107
B4: Disclosure to / concealment from health professionals	561	28	5.0%	26
B5: Later-life coming out	2065	0	0.0%	0
B6: Public safety-driven concealment (PDA, walking, night, taxis)	447	85	19.0%	68

C. Health-Service Access

Code	Eligible	Coded	%	Women
C1: Heterosexist / cisnormative assumption in care	2065	3	0.1%	2
C2: Screening / sexual-health / preventive care mention	1948	5	0.3%	4
C3: Practitioner knowledge / training gap	2065	3	0.1%	3
C4: Positive / good-practice experience	2065	13	0.6%	11
C5: Delayed / avoided / long-wait care	2065	11	0.5%	11
C6: Preference for women-led / LGBTQIA+-competent provider	2065	2	0.1%	2

D. Physical Health

Code	Eligible	Coded	%	Women
D1: Substance use / coping mention	2065	25	1.2%	23
D2: Own physical illness / condition experience	114	23	20.2%	22
D3: Disability / neurodivergence / access needs	2065	86	4.2%	65

E. Mental Health

Code	Eligible	Coded	%	Women
E1: Isolation / loneliness / not belonging	1104	33	3.0%	30
E2: Concealment stress / masking / exhaustion	447	39	8.7%	36
E3: Mental-health impact on work / relationships / housing	37	23	62.2%	23
E4: Self-harm / suicide / overdose mention (SAFEGUARDING FLAG)	2065	7	0.3%	7
E5: Barriers to / problems with mental-health support	391	20	5.1%	20

F. Internalised Oppression / Identity Conflict

Code	Eligible	Coded	%	Women
F1: Internalised shame / low self-worth	540	15	2.8%	12
F2: Forced choice between identity parts	52	39	75.0%	39
F3: Fear tied to visibility / being outed	819	15	1.8%	15
F4: Hides / downplays specific identity aspects	323	53	16.4%	48

G. Relationship Abuse

Code	Eligible	Coded	%	Women
G1: Abuse by a partner	105	32	30.5%	29
G2: Identity-based coercion (outing threats, undermining identity)	175	3	1.7%	3
G3: Custody / children as leverage	138	4	2.9%	4
G4: Reporting / help-seeking (police, courts, services)	68	30	44.1%	27
G4n: Negative institutional response to reporting	217	18	8.3%	16

H. Intersecting Identities

Code	Eligible	Coded	%	Women
H1: Ethnicity / migration / racism	2065	20	1.0%	16
H3: Bi / pan identity mentioned	2065	41	2.0%	28
H4: Religion / faith	2065	103	5.0%	74
H5: Political / community background	2065	46	2.2%	34
H3b: Biphobia / bi-erasure / "not gay enough"	2065	8	0.4%	7

I. Age-Specific

Code	Eligible	Coded	%	Women
I2: Older age / ageing / later life	2065	36	1.7%	28

J. Rural Isolation

Code	Eligible	Coded	%	Women
J1: Distance / rural / outside Belfast provision	1090	52	4.8%	39
J2: Small-community visibility / hometown constraint	2065	14	0.7%	13

K. Parenting / Reproduction

Code	Eligible	Coded	%	Women
K1: Fertility / conception / adoption	2065	2	0.1%	2
K2: Custody / legal-parent position	2065	0	0.0%	0
K3: Own children / parenting mentioned	2065	7	0.3%	5

L. Services / Support Infrastructure

Code	Eligible	Coded	%	Women
L1: Low awareness / don't know the organisation	766	87	11.4%	53
L2: Under-resourcing / funding / capacity	616	41	6.7%	32
L3: Request for women- / lesbian- / bi-specific provision	989	59	6.0%	41
L4: Request for dedicated physical space / venues	610	118	19.3%	87
L5: Outreach beyond Belfast / regional presence	1045	47	4.5%	38

N. Community Dynamics

Code	Eligible	Coded	%	Women
N1: Divisions / exclusion within the LGBTQIA+ community	1312	17	1.3%	14
N2: Scene-centred provision (alcohol, nightlife, sexualised)	763	10	1.3%	8
N3: Belonging / connection / meeting peers	610	15	2.5%	14

O. Housing / Homelessness

Code	Eligible	Coded	%	Women
O1: Insecure / unsuitable housing (any cause)	53	53	100.0%	53
O2: Family rejection / forced out of home	159	17	10.7%	15
O3: Homelessness / accommodation-access experience	11	11	100.0%	11
O4: Housing cause: cost / affordability	100	19	19.0%	19
O5: Housing cause: poor condition / unsafe premises	89	17	19.1%	17
O6: Housing cause: abuse / domestic violence	100	27	27.0%	23
O7: Housing cause: neighbour / community harassment	96	14	14.6%	13

EM1. Online Harassment

Code	Eligible	Coded	%	Women
EM1a: Online harassment: platform named	84	46	54.8%	46
EM1b: Online harassment: threats / doxxing / outing	84	10	11.9%	10
EM1c: Online harassment linked to activism / visibility	84	9	10.7%	9
EM1d: Online harassment via dating apps / conversion attempts	84	5	6.0%	5

EM2. GI Services

Code	Eligible	Coded	%	Women
EM2: Gender-identity services (GIC/KOI / gender GP) mention	2065	14	0.7%	13

EM3. Sex Work

Code	Eligible	Coded	%	Women
EM3a: Sex work: financial need	15	12	80.0%	12
EM3b: Sex work: coercion / trafficking	15	1	6.7%	1
EM3c: Sex work: online / cam / other motive	15	4	26.7%	4

EM4. Hub Welcome & Safety

Code	Eligible	Coded	%	Women
EM4a: Hub: people / staff / representation / welcome	249	93	37.3%	76
EM4b: Hub: physical / sensory design and amenities	249	66	26.5%	58
EM4c: Hub: rules / security / conduct policies	249	22	8.8%	19
EM4d: Hub: location / hours / cost / practicalities	249	29	11.6%	26
EM4e: Hub: named identity groups to be included	249	42	16.9%	37
EM4f: Hub: privacy / discretion (not being seen or approached)	249	5	2.0%	5

EM5. Trust in Orgs

Code	Eligible	Coded	%	Women
EM5a: Trust driver: staff quality / representation	379	39	10.3%	31
EM5b: Trust driver: track record / reputation / visibility	379	66	17.4%	48
EM5c: Trust driver: personal experience of help	379	47	12.4%	42
EM5d: Trust driver: values / safety / mission	379	27	7.1%	22
EM5e: Distrust / reservations about organisation	493	13	2.6%	9

EM6. Code-Switching

Code	Eligible	Coded	%	Women
EM6a: Code-switching with family	101	15	14.9%	15
EM6b: Code-switching at work / education	101	17	16.8%	17
EM6c: Code-switching in religious / community-background / home-area settings	101	10	9.9%	10
EM6d: Code-switching in public / with strangers / at night	101	13	12.9%	13
EM6e: Code-switching within LGBTQIA+ spaces	101	18	17.8%	18
EM6f: Masking (neurodivergence, presentation, general)	271	50	18.5%	42

EM8. Trans-Specific

Code	Eligible	Coded	%	Women
EM8: Trans / gender-identity content in text	2065	197	9.5%	89

EM9. Family Hostility

Code	Eligible	Coded	%	Women
EM9a: Family hostility: expelled / forced out	70	5	7.1%	5
EM9b: Family hostility: rejection / estrangement / no contact	70	15	21.4%	15
EM9c: Family hostility: dismissive / "phase" / tolerated but unsupported	70	12	17.1%	12
EM9d: Family hostility: misgendering / deadnaming	70	5	7.1%	5
EM9e: Family hostility: religion-driven	70	8	11.4%	8
EM9f: Family hostility: verbal / physical abuse	70	13	18.6%	13

EM10. Anticipated Employment Penalty

Code	Eligible	Coded	%	Women
EM10a: Anticipated penalty: general stigma / conservative society	156	60	38.5%	53
EM10b: Anticipated penalty: trans-specific (toilets, pronouns, transphobia)	156	34	21.8%	26
EM10c: Anticipated penalty: based on past experience / what others reported	156	30	19.2%	29
EM10d: Anticipated penalty: sector-specific (teaching, church, NHS etc.)	156	27	17.3%	24
EM10e: Anticipated penalty: covert / hard-to-prove discrimination	156	6	3.8%	6
EM10f: Anticipated penalty: none expected / depends	156	23	14.7%	23

EM13. Trans Inclusion in Women's Space

Code	Eligible	Coded	%	Women
EM13: Trans women / women's-space boundary / gender-critical hostility	2065	22	1.1%	16

EM14. Ace / Aro

Code	Eligible	Coded	%	Women
EM14: Asexual / aromantic invisibility	2065	21	1.0%	6

EM16. Financial Precarity

Code	Eligible	Coded	%	Women
EM16: Financial precarity / cost of living	2065	41	2.0%	36

EM17. Institutional Contact

Code	Eligible	Coded	%	Women
EM17: Police / state institutions mentioned	2065	45	2.2%	35

EM19. Place Comparison

Code	Eligible	Coded	%	Women
EM19: Comparison with other places / leaving NI	2065	27	1.3%	23

Appendix E. Full List of Statistically Robust Subgroup Differences

This appendix lists every subgroup difference that survived Benjamini-Hochberg false discovery rate correction (q below 0.05) across all 185 quantitative indicators and five comparison dimensions, as described in section 3.6. Figures are percentages of women answering that item within each group. This is the full evidence base behind the subgroup findings summarised in Chapter 4 and discussed in Chapter 5; only a subset of these differences is discussed in the main text.

Age (24 Robust Differences)

Indicator	Group figures			q
	18-24	25-44	45+	
Education bullying / prejudice due to SO/GI (currently in education)	58%	6%	5%	0.0000
Never had a sexual health check-up	69%	26%	45%	0.0000
Aware of HEReNI	32%	76%	84%	0.0000
Doesn't know what PrEP is	25%	6%	7%	0.0030
Ever self-harmed	77%	60%	38%	0.0048
Cara-Friend: positive / very positive impression	46%	70%	43%	0.0048
Financial abuse: from a partner (incl. both)	7%	21%	38%	0.0064
Ever supported someone with cancer	32%	57%	68%	0.0064
Aware of planned Belfast hub	14%	40%	46%	0.0064
HEReNI: positive / very positive impression	34%	65%	63%	0.0089
Hides / downplays aspects of identity	95%	82%	66%	0.0089
Open (always / usually) with family	49%	73%	80%	0.0103
Authenticity barrier: Family expectations / pressure	52%	29%	20%	0.0128
Ever homeless	10%	15%	34%	0.0213
Rarely / never open with strangers	51%	26%	36%	0.0227
Financial abuse: any source	12%	25%	42%	0.0227
Physical abuse: from a partner (incl. both)	9%	25%	39%	0.0236
Sought NI Gender Identity Services (GIC/KOI)	25%	8%	16%	0.0279

Indicator	Group figures			q
	18-24	25-44	45+	
Open (always / usually) with work colleagues	38%	63%	64%	0.0313
Ever experienced mental health difficulties	96%	92%	79%	0.0358
Aware of Cara-Friend	61%	82%	82%	0.0358
Rarely / never open with work colleagues	38%	17%	19%	0.0382
Rarely / never open with family	34%	15%	16%	0.0437
Ever without a safe, stable home (any type)	28%	32%	54%	0.0474

Disability (36 Robust Differences)

Indicator	Group figures		q
	Disabled	Long-term condition	
Ever left permanent accommodation because felt unsafe	35%	13%	0.0000
Ever homeless	32%	10%	0.0000
Ever experienced online harassment	59%	31%	0.0000
Sexual abuse / coercion: any source	55%	28%	0.0000
Physical health poor / very poor (12m)	49%	9%	0.0000
Ever attempted suicide	55%	22%	0.0000
Past 12m: Enjoyed daily activities LESS than usual	60%	32%	0.0000
Past 12m: Felt capable of decisions LESS than usual	54%	28%	0.0000
Has used Anti-Depressants (any frequency)	59%	32%	0.0000
Ever self-harmed	74%	50%	0.0030
Victim of crime / incident ever	82%	60%	0.0048
Authenticity barrier: Community / cultural expectations	48%	26%	0.0064
Ever without a safe, stable home (any type)	49%	27%	0.0078
Expects openness to harm finding work	58%	35%	0.0078
Has used Sedatives (any frequency)	33%	14%	0.0078
Hub barrier: Accessibility concerns	11%	1%	0.0089

Indicator	Group figures		q
	Disabled	Long-term condition	
Past 12m: Able to concentrate LESS than usual	61%	40%	0.0118
Financial abuse: any source	38%	19%	0.0128
Ever lived somewhere insecure / unsuitable (not homeless)	45%	25%	0.0161
ANY of 5 abuse types from a family member	62%	41%	0.0161
Connection barrier: Accessibility	14%	3%	0.0161
ANY of 5 abuse types from any source	85%	68%	0.0210
Authenticity barrier: Lack of visible representation	38%	20%	0.0210
Ever experienced mental health difficulties	97%	86%	0.0213
Verbal / emotional abuse: any source	83%	64%	0.0227
Uses drugs recreationally weekly or more	17%	5%	0.0227
Sexual abuse / coercion: from a partner (incl. both)	43%	24%	0.0242
Physical abuse: any source	52%	32%	0.0287
Mental health poor / very poor (12m)	50%	31%	0.0331
Verbal / emotional abuse: from a family member (incl. both)	60%	41%	0.0338
Needed professional support (among those with MH difficulties)	97%	85%	0.0370
Past 3m: Couldn't overcome difficulties MORE than usual	53%	35%	0.0376
HEReNI should deliver: Disabilities group	61%	41%	0.0383
Doesn't drink alcohol	26%	12%	0.0408
Past 12m: Able to address personal issues LESS than usual	50%	32%	0.0437
Authenticity barrier: Faith community attitudes	34%	18%	0.0461

Location (10 Robust Differences)

Indicator	Group figures		q
	Belfast (BT1-17)	Outside Belfast	
Aware of planned Belfast hub	49%	23%	0.0000
Would visit hub (likely / very likely)	77%	50%	0.0000
Would NOT visit hub (unlikely / very unlikely)	8%	29%	0.0000
Hub barrier: Location / transport	10%	48%	0.0000
Feels connected / very connected to Belfast LGBTQIA+ community	57%	27%	0.0000
Feels disconnected / very disconnected	28%	59%	0.0000
Connection barrier: Distance / transport	11%	45%	0.0000
Aware of Cara-Friend	86%	69%	0.0141
Cara-Friend: positive / very positive impression	70%	50%	0.0213
Aware of BTRC	58%	40%	0.0383

Sexual Orientation (11 Robust Differences)

Indicator	Group figures			q
	Lesbian	Bi / Pan	Queer	
Open (always / usually) with family	80%	53%	72%	0.0030
Ever accessed GUM / sexual health service	17%	42%	31%	0.0048
Open (always / usually) with friends	93%	77%	97%	0.0089
Open (always / usually) with work colleagues	68%	43%	75%	0.0103
Sexual abuse / coercion: from a partner (incl. both)	23%	48%	22%	0.0128
Aware of BTRC	44%	47%	82%	0.0161
Feels connected / very connected to Belfast LGBTQIA+ community	37%	42%	72%	0.0242
Sexual abuse / coercion: any source	30%	53%	26%	0.0274
Rarely / never open with family	10%	29%	21%	0.0279
Rarely / never open with medical / support professionals	18%	36%	14%	0.0442
Ever engaged in sex work	2%	8%	17%	0.0447

Trans Status (17 Robust Differences)

Indicator	Group figures		q
	Trans	Not trans	
Expects openness to harm finding work	85%	34%	0.0000
Feels unsafe / very unsafe as LGBTQIA+ person in NI	62%	26%	0.0000
Ever experienced online harassment	70%	36%	0.0000
Mental health poor / very poor (12m)	66%	32%	0.0000
Sought NI Gender Identity Services (GIC/KOI)	74%	1%	0.0000
Expects openness to harm career progression	51%	20%	0.0030
Aware of BTRC	74%	43%	0.0030
Uncomfortable / very uncomfortable expressing full self in Belfast	45%	16%	0.0030
Past 3m: Felt things no longer worthwhile MORE than usual	49%	21%	0.0048
HEReNI: positive / very positive impression	30%	63%	0.0048
Comfortable / very comfortable expressing full self in Belfast	40%	70%	0.0048
Education bullying / prejudice due to SO/GI (currently in education)	55%	15%	0.0064
Difficulty accessing accommodation due to SO/GI	18%	3%	0.0078
Ever supported someone with cancer	32%	58%	0.0187
Rarely / never open with work colleagues	40%	18%	0.0306
Aware of HEReNI	49%	72%	0.0358
Past 12m: Able to concentrate LESS than usual	68%	44%	0.0370

Appendix F. Glossary of Terms Used in This Report

This glossary defines terms used across this report that may be unfamiliar to some readers, or that this report uses in a specific, defined sense. Terms specific to organisations and abbreviations are listed separately in the Abbreviations section on the following page.

Term	Definition
Biphobia	Prejudice, stereotyping or erasure directed specifically at bisexual or pansexual people, including from within LGBTQIA+ communities.
Cisgender	Describes someone whose gender identity matches the sex they were assigned at birth.
Concealment	Managing when, where and to whom a person discloses their sexual orientation or gender identity, used throughout this report as a broader term than "coming out", which implies a single event.
Convenience sample	A sample recruited through accessible routes, such as partner organisations' own networks, rather than through random selection from the whole population. Both OutConnections and most of the comparator studies in Chapter 2 use convenience samples.
Gender identity services	NHS or HSC clinical services supporting people undergoing gender transition, referred to in this report as GIC (adult service) and KOI (under-18 service).
Heterosexism	The assumption, embedded in everyday language, services and institutions, that everyone is heterosexual unless stated otherwise.
Intersectionality	The idea that a person's experience of discrimination or disadvantage is shaped by the combination of their identities, such as being disabled and a lesbian woman, rather than by any one identity alone.
Joint display	A table used in mixed methods research that places quantitative and qualitative findings on the same topic side by side, to show where they agree, complement or diverge. See section 3.8.
Minority stress	A theory holding that sexual and gender minority people experience additional, chronic stress specifically because of their minority status, which contributes to poorer health outcomes. See section 2.6.
Non-binary	Describes a gender identity that is not exclusively male or female.
Plurisexual	An umbrella term for sexual orientations involving attraction to more than one gender, including bisexual, pansexual and queer identities, used in this report to group these identities together where individual group sizes are too small to report separately.
Reflexive thematic analysis	A qualitative method for identifying patterns of meaning across a dataset, developed by Braun and Clarke (2006, 2019), which treats the researcher's own perspective as part of the analytic process rather than a source to be eliminated.
Secondary analysis	Research that reuses data collected for a different original purpose, as this report does with the OutConnections dataset. See section 3.1.

Abbreviations

Term	Meaning
AOR	Adjusted odds ratio
BTRC	Belfast Trans Resource Centre
CI	Confidence interval
FDR / q-value	False discovery rate correction applied to subgroup comparisons (Benjamini-Hochberg)
GIC	Gender Identity Clinic
GP	General Practitioner
GUM	Genito-urinary medicine (sexual health) clinic
HSC	Health and Social Care (Northern Ireland)
KOI	Knowing Our Identity (Northern Ireland's regional gender service pathway for under-18s)
LASI	Lesbian Advocacy Services Initiative
LB	Lesbian and bisexual (as used in the 2002 and 2007 reports)
LGB	Lesbian, gay and bisexual
LGBQ	Lesbian, gay, bisexual and queer
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual and related identities
NI	Northern Ireland
NISRA	Northern Ireland Statistics and Research Agency
OC	OutConnections (the 2026 survey analysed in this report)
PHE	Public Health England
PrEP	Pre-exposure prophylaxis (HIV prevention medication)
PSNI	Police Service of Northern Ireland
RQ1 / RQ2 / RQ3	The three research questions this report addresses (see section 1.4a)
SWASH	Sexual Wellbeing of Lesbian, Bisexual and Queer Women and Transgender Women (Sydney survey)

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