# The Double Dominion Over Women's Bodies as a barrier to exercising sexual and reproductive rights: a mixed-methods study in La Ladrillera, Mexico

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## Summary

**Background** Sexual and reproductive health and rights (SRHR) are essential to women's autonomy and well-being. Despite global recognition of SRHR as a cornerstone of public health and human rights, research and policy have often failed to account for the lived realities that impede access to SRHR for women on the urban periphery or in rural settings. This study aims to explore how deleteriously interacting social and structural factors shape access to SRHR.

**Methods** A convergent mixed-methods study was conducted in La Ladrillera, a brickmaking community in Baja California, Mexico. Quantitative surveys were administered to all adult women in the community using an adapted reproductive health toolkit, and descriptive statistical analyses were conducted. In-depth interviews were held with women, and a focus group with male community members. Qualitative data were analyzed using an inductive content analysis approach. A feminist and rights-based thematic analysis was employed to examine intersecting social, relational, and institutional determinants of SRHR.

**Findings** All adult women in the community (35) completed the survey, 18 participated in interviews, and six men took part in the focus group discussion. The women's average age was 43·1 years (range 18–84). Participants were asked about Indigenous affiliation; only one reported partial Huichol heritage, and no other racial or ethnic identities were reported. The data revealed that women's SRH experiences are constrained by patriarchal power in both private and public spheres. While quantitative data supported these findings, they were especially clear in the qualitative component, where many women described how intimate relationships frequently limit contraceptive decision-making and pressure young women into early partnerships. Simultaneously, healthcare providers often disregard informed consent and prioritize provider authority over women's preferences. These overlapping mechanisms of control reflect symbolic and structural violence, perpetuating reproductive inequities.

**Interpretation** Barriers to SRHR in underserved communities extend far beyond logistics or service availability; they are embedded in everyday practices of domination and neglect. Rights-based, context-informed interventions that actively engage women's voices, especially in clinic and community settings, are critical. Our findings underscore the need for innovative, feminist-informed approaches to SRHR that confront gendered power structures and center community-led solutions.

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### Research in context

**Evidence before this study**

We conducted a comprehensive search using the Harvard On-Line Library Information System, PubMed, and Google Scholar to identify studies on sexual and reproductive health and rights (SRHR), gender-based and structural violence, and barriers to care in underserved communities, particularly in Latin America. Articles published in both English and Spanish were reviewed, and the search spanned from September 2022 to May 2023. Additional relevant studies published through 2024 and 2025 were also considered during manuscript development. While existing literature acknowledges the role of social determinants and structural inequality in shaping SRH outcomes, we found limited research that centers women's lived experiences using ethnographic or mixed-methods approaches. There was a notable gap in studies examining how institutional and interpersonal forms of power operate simultaneously to restrict bodily autonomy in low-resource settings.

**Added value of this study**

This study offers an in-depth, mixed-methods analysis of how gendered power structures impact women's ability to exercise their SRHR in a marginalized community in northern Mexico. It introduces the concept of the "double dominion" to describe the intersecting control women face in both intimate relationships and health institutions. By combining quantitative data with feminist and rights-based qualitative analysis, the study highlights mechanisms of symbolic and structural violence that are often invisible in conventional health research. It also documents how women resist these constraints through community-based knowledge and everyday forms of agency.

**Implications of all the available evidence**

Findings from this study support a shift toward SRHR interventions that address not only access and availability, but also relational, institutional, and symbolic forms of violence. Health systems must move beyond technical fixes and adopt approaches that restore autonomy and dignity to women as central principles of care. Policies aiming to advance SRHR should incorporate gender-transformative strategies that engage community voices, particularly in marginalized or underserved settings. Future research should continue to apply rights-based and feminist frameworks to better understand and address the complex barriers shaping women's sexual and reproductive lives.

## Introduction

Sexual and reproductive health and rights (SRHR) are central to women's autonomy, well-being, and quality of life. However, in many settings, these rights remain severely constrained.[1] While the well-known socioeconomic, structural, and political factors are always relevant,[2,3] they alone cannot sufficiently explain the ongoing suffering and disadvantage experienced by women. Despite global recognition of SRHR as a cornerstone of public health and human rights, research and policy still fail to account for the lived realities and experiences of women, especially in settings and communities at the margins of societies.[4,5]

In Mexico, national sexual and reproductive health (SRH) indicators often obscure stark regional and local disparities.[6,7] In communities on the urban periphery or in rural areas, limited access to public services intersects with deeply rooted patriarchal norms. These intersecting factors contribute to elevated maternal mortality, limited contraceptive access, and unmet needs in sexual health.[8] Addressing these challenges requires innovative approaches[9] that go beyond logistical or biomedical solutions, approaches that directly confront the deeper gendered structures shaping access to care and the everyday exercise of SRHR.

To explore how intersecting social and structural conditions affect access to sexual and reproductive health services, we conducted a convergent mixed-methods study in La Ladrillera, a brickyard community on the outskirts of Mexicali, Baja California. This study aims to examine how gender, social, and structural factors shape women's access to SRHR. Using feminist and rights-based frameworks, including the Guttmacher-Lancet Commission framework, we examined how social, institutional, and relational dynamics shape women's experiences of reproductive health. Our approach emphasized listening to women directly and engaging with the social realities that standard indicators, such as skilled birth attendance or contraceptive prevalence, often overlook.

## Methods

### Study design

A convergent mixed-methods study[10] was selected (Fig. 1) to describe and analyze key demographic characteristics of the population and women's experiences, needs, and concerns when accessing SRH care. The quantitative component, a cross-sectional descriptive survey, provided contextual information about the population and identified general patterns in SRH

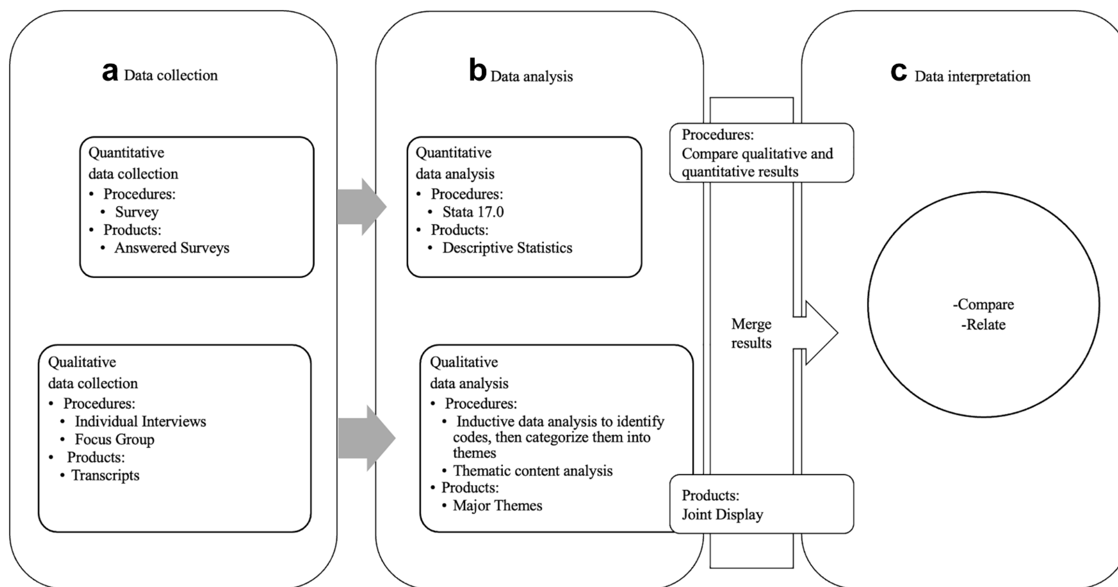


*Fig. 1:* **Convergent mixed-methods study design.** This figure illustrates the convergent mixed-methods design used in the study. Quantitative and qualitative data were collected concurrently from participants, followed by separate data analysis for each method. Results were then merged during the interpretation phase to integrate findings from both approaches, providing a comprehensive understanding of the barriers to exercising sexual and reproductive rights in La Ladrillera, Mexico. Panels **a** and **b** show the data collection and analysis steps, respectively, and panel **c** represents the merging of results and interpretation.

service use, access, and unmet needs. The qualitative component, an inductive study that included ethnographic observations, semi-structured interviews, and a focus group discussion (FGD), provided in-depth insights into the lived experiences underlying these patterns. By emphasizing qualitative approaches, we were able to explore how women interpret and navigate structural and interpersonal factors affecting their access to SRHR services. This mixed-methods approach enabled us to both quantify key trends and deepen our understanding of the complex, context-specific realities shaping women's reproductive health experiences.

## Setting and population

La Ladrillera is a brickyard community on the outskirts of Mexicali, Baja California, Mexico. Approximately thirty families reside in the area, primarily relying on artisanal brick production, often through informal, family-run kilns. Despite its physical proximity to the city, the community faces chronic neglect and limited access to basic services, including electricity, sewerage, and potable water. Road access is limited, and transportation is further challenged by extreme heat, which ranges between 45 and 50 °C during the summer. Most families do not own cars and rely on bicycles or walking for daily mobility, increasing their vulnerability and isolation. The nearest primary healthcare center is located 7.8 km from the community (about an hour by bike, if available), and the nearest OB-GYN facility is 19 km away. These distances, coupled with the harsh conditions, make access to healthcare far more difficult than the numbers alone suggest. Many of the individuals and families residing in La Ladrillera arrived from other regions of the country, with life stories marked by extreme poverty and violence. The settlement itself gradually relocates over time, following the sites of clay extraction used in brick production.

## Sampling and recruitment

The study was made possible through the lead researcher's long-term relationship with the La Ladrillera community, built over two decades of academic and community engagement. This long-standing relationship was built on a sustained commitment to ethical, respectful, and collaborative work with the community, and facilitated a level of trust that enabled a depth of access and participation that shaped the recruitment process and the openness with which participants shared their experiences.

Based on a census provided by a local leader, all women aged 18 and older living in the community were invited to participate in the quantitative survey. Participants were recruited based on their biological sex as female or male; all participants self-identified consistently with their recorded sex. Unlike most studies that focus primarily on reproductive-age women, we made a conscious effort to include women across a broader age range. Posters were placed throughout La Ladrillera

with study information, and a local phone number was provided for anonymous inquiries. The study team conducted home visits to ensure all households were informed, with particular care to respect the autonomy and privacy of women living in more isolated homes.

The community school teacher supported recruitment for the qualitative component. To ensure a diverse range of perspectives and experiences, we purposefully sampled for a range of ages, parity, and occupations. A purposive subsample of 18 women, half aged 18–40, and half over 40, participated in in-depth interviews. A FGD with six men aged 18 and older was also conducted; recruitment for men followed the same approach as for women, including posters placed throughout La Ladrillera and support from the community school teacher. Participants were selected to ensure diverse perspectives, including age and lived experience. Reasonable compensation was provided to participants. Data collection took place between June and August 2023.

## Key procedures

### *Quantitative data collection*

The survey was administered between June and August 2023 in participants' homes or at the Community School, according to their preference, using a pen-and-paper format. The Reproductive Health Assessment Toolkit for Conflict-Affected Women[11] was used and adapted to the specific context of La Ladrillera and the objectives of this study. Although originally developed for conflict-affected populations, this tool was selected because it comprehensively addresses reproductive health in settings marked by systemic neglect, gender inequality, and limited access to services, conditions also present in La Ladrillera. In addition to sociodemographic information, the tool includes six key categories: motherhood, family planning, marriage and live-in partnerships, sexually transmitted infections, prevention, and access to SRH programs. The survey conducted by the principal investigator (PI) and supported by a female research assistant (RA) lasted 10–30 min. Missing data were documented.

### *Qualitative data collection*

All individual interviews were conducted in Spanish by the PI and lasted between 60 and 90 min. To ensure participant comfort and confidentiality, interviews took place in private, quiet settings, either at participants' homes or in a reserved room at the community school, based on their preference. Interviews were audio-recorded with prior informed consent. A semi-structured interview guide explored women's experiences, needs, and concerns related to accessing SRH care, as well as perceived barriers to services.

The FGD with men was conducted in Spanish by a male research assistant (RA), with support from a note-taker, and lasted approximately 90 min. It was held in a private room at the community school and audio-recorded with participants' informed consent. The FGD used a structured guide to explore male perspectives on gender roles, family responsibilities, support-seeking behaviors, and their influence on women's access to SRH services.

Ethnoghraphic observations were conducted during all field visits, with extended stays with the people, in-depth informal conversations, and accompaniment to health consultations. Triangulation between the different data collection methods (interviews, FGD, and ethnographic observations) and member checking were conducted to ensure the quality and validity of the findings. Member checking was conducted throughout the analysis period, with a final debrief in the community in December of 2023.

## Analysis

### *Quantitative data analysis*

Descriptive statistical analyses were conducted using STATA to summarize sociodemographic characteristics and key reproductive health indicators, including experiences related to motherhood, access to SRH services, and marital or cohabiting status. Categorical data were presented as counts and percentages, while continuous data were presented as mean (with Standard Deviation (SD) range). These data were also used to support the interpretation of qualitative findings in the integrated analysis.

### *Qualitative data analysis*

All interviews and the FGD were transcribed verbatim. An inductive content analysis approach was used to identify patterns and meanings grounded in participants' narratives. After an initial round of open coding, preliminary concepts were developed and refined into a codebook through iterative testing on a subset of transcripts. Coding was managed using Dedoose® software. Three members of the research team then analyzed the coded data to identify recurrent themes, paying attention to relationships between categories and the broader social structures influencing participants' experiences. Through constant comparison, iterative discussion, and analytic consensus, the initial descriptive themes were refined into analytic categories that reflected both individual experiences and structural dynamics related to bodily autonomy and SRH access. Ethnographic observations, including everyday interactions and field reflections, enriched this interpretive process by providing contextual depth to participants' narratives and supporting the translation of lived experiences into analytic insights.

### *Mixed methods data analysis*

Finally, quantitative and qualitative findings were integrated using a joint display technique.[12] This involved organizing thematic categories alongside supporting

qualitative excerpts and corresponding quantitative data. The integrated findings were then mapped onto the Guttmacher-Lancet Commission framework to illustrate how each theme reflected infringements of SRHR.[1]

### Ethics statement

The study protocol was reviewed and approved by the Harvard Faculty of Medicine IRB (IRB23-0172), and UABC local IRB. Written informed consent was obtained from all enrolled participants.

### Role of the funding source

The study funders had no role in study design, data collection, data analysis, interpretation, writing of the report, or the decision to submit.

## Results

### Quantitative results

*Study population*

Derived from a local census, all 35 women aged 18 and older from La Ladrillera participated in the survey. The average age was 43·1 years (range 18–84), with most women (74%) married or cohabiting. Participants were asked about Indigenous affiliation; only one reported partial Huichol heritage, and no other racial or ethnic identities were reported. Educational attainment was generally low, with over half not completing beyond primary school. Most participants (86%) identified as housewives, many also engaged in brickmaking. Over half of the families earned 5000 pesos (~267 USD) or less monthly, and 71% of women lacked health insurance (Table 1).

Reproductive histories revealed high pregnancy rates, with 29 women (83% of the total population) having had at least one pregnancy, and a mean of 5·3 pregnancies per woman. Notable adverse outcomes included a 44% cesarean section prevalence, 48% reporting miscarriage, and 71% experiencing pregnancy complications (Supplementary Table S1). These socioeconomic and reproductive factors contextualize the significant constraints on women's bodily autonomy and reproductive rights identified in the qualitative findings.

| Women characteristics | N (%) or Mean (SD, range) |
|---|---|
| Age | |
| 18–39 | 18 (51%) |
| 40–84 | 17 (49%) |
| Mean age in years | 43·1 (17·9, 18–84) |
| Religion | |
| None | 5 (14%) |
| Catholic | 12 (34%) |
| Christianity (Protestantism) | 17 (49%) |
| Jehovah's Witnesses | 1 (3%) |
| Current marital status | |
| Single | 6 (17%) |
| Married | 13 (37%) |
| Cohabiting | 13 (37%) |
| Divorced | 1 (3%) |
| Widowed | 2 (6%) |
| Number of people living in home | 4 (2·02, 1–10) |
| Last grade completed at school | |
| Never attended | 5 (14%) |
| Elementary | 15 (43%) |
| Middle school | 12 (34%) |
| High school | 2 (6%) |
| University | 1 (3%) |
| Occupation | |
| Housewife | 30 (86%) |
| Brickmaker | 22 (63%) |
| Other | 9 (25%) |
| Average monthly income | |
| 5000 pesos or less[a] | 18 (56%) |
| 5001–7500 pesos | 6 (19%) |
| More than 7500 pesos | 8 (25%) |
| Health insurance | |
| IMSS[b] | 5 (14·3%) |
| Public health insurance (Seguro Popular, INSABI[c]) | 5 (14·3%) |
| None | 25 (71·4%) |

3 women did not know their monthly income. [a]18·72 pesos mexicanos = 1 USD. [b]IMSS: Instituto Mexicano del Seguro Social (Employer-based insurance). [c]INSABI: Instituto de Salud para el Bienestar.

***Table 1:* Descriptive characteristics of women 18 years old and older living in La Ladrillera, June–August 2023 (N = 35).**

### Qualitative results

*Study population*

We performed 18 interviews with female participants and one FGD with six male participants. Table 2 shows the detailed sociodemographic characteristics of female and male participants. Female participants (mean age 43, range 18–83) were mostly married (72%), housewives (100%), and half were also brickmakers. Male participants (mean age 48, range 40–54) were mostly married (83%) and brickmakers (83%).

*Thematic analysis*

Two main themes emerged, highlighting key factors that limit women's exercise of SRHR and representing analytic concepts developed by the first author during the inductive process. The first, *"The Private Dominion over Women's Bodies,"* explores the ongoing violence women experience in their private lives, impacting their ability to make autonomous decisions. The second, *"The Public Dominion over Women's Bodies,"* addresses how violence is perpetuated within the healthcare system, where invasive procedures are often performed without women's full consent or agency.

| Characteristics | Female participants (Individual interviews, N = 18) mean (Range) or N (%) | Male participants (FGD, N = 6) mean (Range) or N (%) |
|---|---|---|
| Age | 43 (18–83) | 48 (40–54) |
| Married or cohabiting | 13 (72%) | 5 (83%) |
| Number of children | 4 (1–12) | 4 (2–6) |
| Secondary education | 12 (66%) | 3 (50%) |
| Never attended school | 0 (0%) | 1 (17%) |
| Occupation | | |
| Housewives | 18 (100%) | 0 (0%) |
| Brickmakers | 9 (50%) | 5 (83%) |
| Garbage separation worker | 0 (0%) | 1 (17%) |

*Table 2:* **Descriptive characteristics of participants in the qualitative study.**

*Theme 1: The Private Dominion over Women's Bodies: implications for SRHR*

***Pressure and effects of early partnerships.*** Women described how cultural norms and family violence push adolescent girls into early, often age-disparate, relationships. One participant describes intrafamilial violence as a reason to get married when she was 17 years old:

> *My mother beat me a lot. My mom used to beat me a lot. And I met him ... and he told me that if I would go with him ... I was desperate, and I say ... I don't say anything to my mother now, but I used to tell her, "Mother, remember that for me there were daily, daily were your beatings and your bad words. I tell her I decided that ... that, to leave your house and ... and well yes ... if my mother had not hit me so much it would be maybe different [sobs].*
>
> *(Participant 18, Female).*

Participants with teenage children reflected on their own experiences of entering relationships when they were young and lacked proper information on contraception. They went on to question social norms and narrate how they are seeking better options for their daughters.

> *You know what, take care of your sons, your daughters, don't let them live what one lived ... I say how beautiful dating is, "Live it, enjoy it" ... So that they don't get involved with the first person who says, "Oh, I love you, I don't know what," and then they kick the girls.*
>
> *(Participant 11, Female).*

> *So I don't cover any of that up for my children. I don't get scared about sexuality, about talking to them about sex, about contraceptive methods, or all that. I don't get scared because it's better. It's better that adolescents and children of different ages are aware of this so that there are fewer minors who get pregnant.*
>
> *(Participant 13, Female).*

***The sexual act as an inherent obligation.*** For participants, living with a partner often creates the expectation that women must fulfill sexual obligations, ignoring their own needs. Many women experienced sexual encounters as traumatic, dealing with pain, bleeding, or even rape without addressing the underlying issues. The pressure to meet sexual expectations led to anxiety, especially when women feared that failure to comply with sexual obligations could result in violence or abandonment.

> *She says that when she had sex with her husband, it hurt and hurt her ... And she told me that every time and then, sometimes she even bled, and that always happened with her husband. I told her, 'You should go and check yourself' ... she never went. She always put up with having sex with pain, but she says she didn't enjoy it. For her, it was traumatic every time she was with her husband, and now they are separated. Now she is alone.*
>
> *(Participant 15, Female)*

***Social expectations on women's care-seeking behaviors.*** When SRH issues arise, many women first consult their partners for permission or advice, reinforcing a dynamic where the man holds the decision-making power. This leaves women without the autonomy to seek medical help or discuss SRH concerns openly.

> *Because I was saying. Well, maybe he [my husband] knows more than me, right? Why ... Why does this happen to me ... this or that or that he would give me, that he would tell me something, that he would tell me something, I don't know, go to the doctor or something like that ...*
>
> *(Participant 17, Female).*

> *And here, well, C. [second daughter] was going to be born here because we didn't have transportation, and I told him, "Take me [to the hospital], ask someone", and he didn't want to, and I remember that I couldn't walk or anything, she was almost born here.*
>
> *(Participant 1, Female).*

***Contraception: a man's choice, a woman's duty.*** According to participants, contraceptive decisions are often made by men, with economic factors playing a significant role in shaping these choices. Women may face consequences when they seek contraception without their partner's

| Theme | Supporting quantitative data | Qualitative evidence | Infringed sexual rights | Infringed reproductive rights |
|---|---|---|---|---|
| 1. The private dominion over women's bodies | | | | |
| Pressure and effects of early partnerships | • The mean age for women to first get married or start living with a man is 17·8, with a range between 13 and 26 years old, while for their male partners is 25·9, with a range between 15 and 65 years.<br>• 8 women out of 30 (27%) informed violence as the main reason to get married or cohabitate. These include escaping their dad's rapes, forced marriage, mother trying to sell her, domestic violence, abuse at home, violent father, flee from home, and community violence against her mother. | • "It's that they are so young, and that by the time you are 15 you must have a husband, not even a husband, no, a partner and your first child. I mean … I got married at 17, at 18 I already was, but it was not a rule in my house. That was because I was ahead of time. But now that they put them here like that to the girls and to the boys too, that oh no, you are already going to be 15, you already have to have a girlfriend, you have to have a partner, you have to." (Participant 11, Female)<br>• I was 16 years old when my dad got me married to him and I didn't even know who he was. He went and asked my dad for permission because he wanted to marry me. (Participant 10, Female).<br>• And to escape from him [my dad], I got together with the girls' father [my partner] … but my dad clung to be with me, and he even wanted to kill me once.(Participant 15, Female). | • Choose their sexual partner<br>• Choose whether, when, and whom to marry<br>• Enter into marriage with free and full consent and with equality between spouses in and at the dissolution of marriage | • The right to mutually respectful and equitable gender relations |
| The sexual act as an inherent obligation | • 12 women out of 35 (34%) have had at least one unintended pregnancy. | • Because it went very bad for me with the father of my children … I did not feel love with this man. I felt nothing, nothing. I didn't feel with him when I gave myself to him when we got married, and I gave myself to him. I felt nothing. I didn't feel love with this man, I didn't feel. We had intercourse, whatever you want, but I didn't, I didn't feel, I didn't feel. Oh, love, or that I'm done or that I never felt anything. I never felt. Why would that be? (Participant 17, Female).<br>• They tell me: How did you have so many children? Well, how do they rape women and have children, they don't have them for their own pleasure, I told them, so I felt very sad and very bad (Participant 10, Female). | • Have their bodily integrity respected<br>• Decide whether to be sexually active or not<br>• Engage in consensual sexual relations<br>• Pursue a satisfying, safe, and pleasurable sexual life | • The right to mutually respectful and equitable gender relations |
| Social expectations on women's care-seeking behaviors | • 2 women out of 21 (10%) mentioned that the reason for not seeing someone when needed during pregnancy is that their husband would not permit it. | • I never had any prenatal care for any of my children. No, not until the day I was going to give birth. That day is when I would go. Because he [my husband] never took me. Never, ever. He never worried about how you were doing. Until I went to … I felt the symptoms, and that's when he took me … he had me, like isolated, like alone, because I had almost no contact with anyone. I used to say that hanging out with friends and all that was bad. That's why the best thing for us is to have almost no contact with anyone (Participant 18, Female). | • Seek, receive, and impart information related to sexuality | • The right to attain the highest standard of reproductive health<br>• The right to mutually respectful and equitable gender relations |
| Contraception: a man's choice, a woman's duty | • 6 women out of 35 (17%) mentioned that the main problem with using contraceptive methods was that their partner would not permit it.<br>• 12 of them (34%) have never used a contraceptive method. | • I also when I married my wife, I told her: "We are going to have ten children", and she said: "No, as you like, as you decide", because in a way, the man is the provider, right? (Participant 5, Male).<br>• I never used any of that [contraceptive methods]. It's just that the man [husband]would never allow me. No, he never let me use that. Well, with one's ignorance … no, I didn't even know what it was. (Participant 18, Female). | | • Decide freely and responsibly the number, spacing, and timing of their children<br>• The right to attain the highest standard of reproductive health<br>• The right to make decisions concerning reproduction free of discrimination, coercion, and violence<br>• The right to mutually respectful and equitable gender relations |

(Table 3 continues on next page)

| Theme | Supporting quantitative data | Qualitative evidence | Infringed sexual rights | Infringed reproductive rights |
|---|---|---|---|---|
| (Continued from previous page) | | | | |
| 2. The public dominion over women's bodies | | | | |
| Procedures without knowledge or consent | • When asked the reasons for not getting a PAP smear as often as is indicated, 5 out of the 28 (18%) were afraid of the doctor or nurse and 1 (4%) mentioned being mistreaded previously. | • … they put it on me [the intrauterine device], and I hadn't even said yes or anything, and they put it in me, and when I was, like, going through the pain, they told me, "Oh, mija [address to women or girls], we placed it on you. Sign here." (Participant 16, Female).<br>• … It makes me angry because I say, "Oh, you have to wait until you are more" because you end up [after delivery] very weak, very weak … because when … they are telling me that, is when one is just like that … "sign here, to put it [IUD] on and I don't know what" … Something like that by force. Like they want me to do things by force, that's how I feel, and I think that many of them, not just me (Participant 16, Female).<br>• I think that they [health workers] also did it with a trick. I think because they wanted me to have surgery [tubal ligation], and I did not want to have surgery. And they told me, "Now yes, ma'am, are you going to have surgery … when I was already dying there …. That's how they sometimes do it … they almost forced me, didn't they? … That's how I felt because from the moment I entered they were trying to convince me, trying to convince me … they make you feel bad, don't they?. Then, when I was on the verge of … of death because I felt like I was dying, I signed. (Participant 15, Female). | • Achieve the highest attainable standard of sexual health, including access to sexual and reproductive health services<br>• Have their bodily integrity respected | • To have the information and means to decide freely and responsibly the number, spacing, and timing of their children.<br>• The right to attain the highest standard of reproductive health<br>• The right to make decisions concerning reproduction free of discrimination, coercion, and violence<br>• The right to privacy, confidentiality, respect, and informed consent |
| Refusals or requests not honored | • 6 women out of the 35 (17%) mentioned that their main concern about accessing SRH programs was being afraid of the doctor or nurse, while 3 of them (9%) mentioned not being treated well previously. | • Look, first, I had asked to have surgery [tubal ligation]. I said, "No, not me, not anymore," but they told me … A doctor … he talked to me, he said, "It's that you're too young," he said. "And when older, you're going to want another baby. You'd better take care of yourself," he said, "And once your baby is bigger, you can get pregnant again … I wanted to have surgery because I said, "No, no more, no more, another baby.". In the end, they told me that I had to think about it because when older, I could regret what I had done, having had the surgery. (Participant 9, Female). | | |

***Table 3:*** **Integration of qualitative themes on private and public bodily dominion, supporting quantitative data, and evidence of infringed SRHR.**

approval. Despite this, many women are pushing for shared responsibility and decision-making in contraception, advocating for more control over their own bodies.

*Because the man wanted to have more family … And I told him what I had done, and he scolded me very badly, very badly. And then … he even abandoned us also because of that, because I had surgery [tubal ligation]. And he left … [sigh] because a woman who had surgery says she is a, he said … 'useless.' He told me that … if I didn't want babies anymore then he never supported me, not even … let's say to wash a plate, a spoon, to change the baby's diaper … he never helped me and that's why I took what the doctors told me. And now … but look, I don't regret it, I don't regret having the operation … I was never happy with that man, I was never happy. (Participant 18, Female).*

One participant advocated for a shared approach to contraception, calling upon the government to bring campaigns to the community that explicitly engage men in targeted sexual health initiatives:

*… What I would like them [health campaigns] to talk about is that … a man who has surgery [vasectomy] would be much better … Yes, that they promote that. Many men think that they are no longer useful for sexual matters "Oh no, it will come off, I won't be able to have a*

*hard-on or something, "[whispering], and they don't decide to have surgery. There is this myth, "Oh no, not me". They think that it will take away their manhood. Aha, because it is always the woman who has the surgery [tubal ligation], because it is always the woman who uses these things [contraceptive methods].*

(Participant 1, Female)

### Theme 2: The Public Dominion over Women's Bodies

***Procedures without knowledge or consent.*** Women frequently experience medical procedures, such as IUD insertions, cesarean sections, and hysterectomies, performed without their consent or knowledge. These procedures are often carried out when women are vulnerable, such as when they are sedated or in pain, and they only learn about the interventions after they have taken place. Postpartum women, in particular, feel that consent should not be requested during these times, as healthcare providers exploit their vulnerability to obtain signatures for invasive procedures.

*I don't have a womb, but they never explained why. And I said, "But why? Yes, why are they going to take out my womb? Why did they take out my womb? I said. But they didn't give me a reason ... I found out later ... when I was giving birth, when they were taking the plebe[kid], the* chamaca *[girl] out, I was still in the hospital. I was in the hospital for almost a week, and they told me. They told me they were going to take out my womb. I didn't say anything anymore. They had me all sedated. I didn't say anything anymore. What else was I going to say?*

(Participant 7, Female).

***Refusals or requests not honored.*** In the public sphere, healthcare providers often disregard women's refusals or requests for specific interventions. Women may refuse certain exams, but these are carried out anyway, justified as part of routine care. Alternatively, women may be persuaded to change their minds about procedures, especially contraception choices, reinforcing the dominance of healthcare providers' decisions over women's autonomy.

*In one of those check-ups ... they opened her stitches, I think because the doctors arrived and they just said: "Come on," as if she was there, she told me, "They came to me as if they were just as if they were checking the cattle." Let's go", like this, "this one is fine," and that's it ... And it was shift change, and she would tell me that she would tell them that "I had just been checked," and they would say, "No, it's shift change, and I have to check you," and that they would check her.*

(Participant 16, Female).

As one of the participants described, she repeatedly visited her doctor requesting the removal of her IUD due to the discomfort it was causing, but her concerns were dismissed as "normal." Out of frustration and desperation, she attempted to remove it herself and ended up cutting the threads at home:

*I cut them [IUD threads]. I wanted to pull them out there, but I felt as if I was pulling out my whole womb, and I was afraid, but I wanted to pull them out, pull them out, because I felt uncomfortable, they itched me ... They scolded me ... and even at the last moment they removed it, I told her "I am not going to have any more children anyway. My husband has already had surgery so that I don't have any more" "Yes, ma'am, yes you do. They think that one is going to ... " I told her, "No, you better take it off because it itches all over," and that was when they took it off.*

(Participant 1, Female).

## Discussion

Findings from this study indicate that the barriers women face in exercising their sexual and reproductive health and rights (SRHR) in La Ladrillera are not isolated or circumstantial, nor merely the result of geographic or service-related limitations. Rather, they reflect systemic patterns of gendered control operating across both private and public domains. Central to this is what we conceptualize as a *"double dominion"* over women's bodies, a dual mechanism of coercion and symbolic violence enacted within intimate relationships and healthcare institutions (Fig. 2). This continuum of control shifts between relational dynamics and institutional practices,[13] reflecting a normalized system of bodily regulation sustained by tacit social and medical acceptance.

The double dominion reflects what Bourdieu conceptualizes as *symbolic violence*: domination that becomes internalized and misrecognized as 'natural' through the very structures that reproduce it.[14] In La Ladrillera, such violence is rarely named or challenged, but instead embedded in routinized practices like non-consensual medical procedures and gendered relationship norms. These are not simply harmful behaviors but institutionalized practices that legitimize inequality and constrain women's autonomy in sexuality, reproduction, and health.[15]

Our findings underscore the importance of using an SRHR framework, rather than focusing solely on SRH outcomes. Women's experiences reflect not just health disparities but violations of fundamental rights: coerced marital unions, lack of contraceptive autonomy, and non-consensual medical interventions (Table 3). These align with key SRHR dimensions outlined by the Guttmacher–Lancet Commission, which promotes a

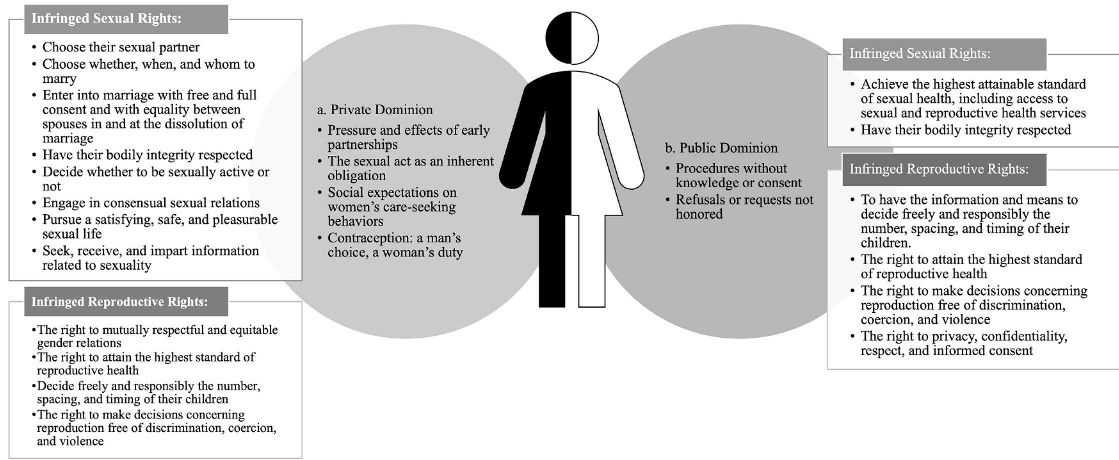


***Fig. 2:* The Double Dominion Over Women's Bodies.** Conceptual diagram illustrating the dual domain of control over women's bodies in La Ladrillera, Mexico. The central silhouette represents women, with 'Private Dominion' and 'Public Dominion' depicting the key spheres of influence that constrain sexual and reproductive health and rights (SRHR). Findings are based on qualitative interviews, focus groups, ethnography, and survey data.

comprehensive, rights-based understanding rooted in international agreements and public health standards.[1] Our data show that structural and interpersonal forms of control consistently undermine women's bodily autonomy, confirming that these are systemic patterns, not isolated incidents. This reinforces calls from recent systematic reviews for more rigorous application of rights-based approaches in SRHR, especially in LMICs, where such frameworks remain under-theorized and under-implemented.[16,17]

Importantly, this study responds directly to a core Guttmacher–Lancet Commission priority to "address evidence gaps and prioritize sexual and reproductive health and rights research needed for policy and programme decision making",[1] by generating primary, context-specific data on underserved populations. While rights-based frameworks have been examined in the context of systematic reviews, to our knowledge, this is one of the first studies to apply such an approach to primary data on SRHR in an LMIC setting. This contribution helps address a critical gap in the literature and demonstrates the framework's analytical value and relevance for context-specific policy and practice.

At the heart of this contribution are the lived experiences of participants, whose accounts illuminate how systemic gender inequalities shape women's everyday realities. Participants' accounts reveal a deeply rooted patriarchal hierarchy that limits women's ability to make decisions about their bodies. This structure reinforces gender-based inequalities through both interpersonal relationships and institutional systems.[18] The effect of patriarchal structures, internalized as ideologies that not only justify and perpetuate domestic violence through control and abuse but also undermine women's ability to fully exercise their SRHR, has been documented in other regions of Mexico and in Indian communities around the world.[4,19,20] In La Ladrillera, these dynamics extend beyond the home and are reproduced in healthcare, illustrating how gendered power relations are normalized across multiple levels of society.

The findings from this study highlight a fundamental issue. Women are systematically excluded from decision-making in healthcare even though they are the primary subjects of that care.[21,22] This disempowerment, rooted in gendered hierarchies, undermines trust and bodily autonomy.[23,24] Prior research has consistently shown that when women are actively involved in healthcare decisions, outcomes improve and the quality and dignity of care are enhanced.[25] Yet in practice, particularly in maternal health, provider authority continues to override women's preferences, and informed choice remains unevenly implemented.[26] Meaningful improvements in women's health will remain out of reach unless governments and health systems commit to a fundamental shift, one that centers women's autonomy and restores decision-making power to them.[27,28] Anything less leaves the structural roots of gendered health inequities untouched.

Women in this study were not passive recipients of care but active narrators of their disempowerment. Despite these structural constraints, they are not only navigating existing power structures in La Ladrillera but actively working to reshape them. Participants called for comprehensive SRH education campaigns that include, rather than exclude, men, and are raising their children with more equitable values. These everyday acts of resistance reflect a broader shift toward gender-

transformative approaches that challenge harmful social norms and reduce practices such as gender-based violence and child marriage. Evidence shows that community-based interventions engaging diverse stakeholders and fostering critical reflection on gender, power, and SRHR can produce meaningful shifts in attitudes and outcomes.[29] Policy and practical interventions are critical in amplifying this grassroots resistance. Governments should invest in SRH education programs that include both men and women, challenge gender norms, and focus on the transformative power of shared responsibility. Health systems must be restructured to ensure that women's voices are not only heard but prioritized in decision-making. This includes training healthcare providers on the importance of informed choice and implementing patient-centered care protocols that emphasize dignity, autonomy, and mutual respect. These grassroots efforts, along with attention to the priorities voiced by women at the community level are themselves steps toward person-centered care and align closely with its core principles: dignity, trust, communication, and cultural relevance, all of which are especially critical for improving service access and quality in marginalized populations.[30] Taken together, these actions reveal how women, within the limited spaces available to them, are redefining autonomy not only as individual agency but as a collective, relational process rooted in community-driven change. This shift in perspective is proof that we can imagine and work toward a different future, one where SRHR are accessible to every woman, regardless of her condition.

## Limitations

This study was conducted in a single community, La Ladrillera, which may limit generalizability. However, the findings reflect broader structural dynamics, such as gender inequality, institutional neglect, and normalized violence, that are not unique to this setting. Although La Ladrillera is geographically near to an urban center, its social exclusion and patriarchal norms create conditions comparable to those in other underserved communities. Rather than identifying issues tied to geography alone, this study reveals patterns and dynamics that may be found elsewhere when examined through similarly rigorous and theory-driven approaches. The qualitative component allowed us to explore these underlying structures in depth, offering insights that extend beyond the local context. Additionally, the community's close-knit nature may have influenced participant responses, potentially introducing social desirability bias, especially in men's participation. To minimize this, a male research assistant (RA) led the FGD, helping create a more comfortable environment for male participants.

## Conclusion

To make SRHR a reality, gender-based violence must be addressed as a layered and interwoven system of control. The "Double Dominion" women experience, across intimate, social, and institutional relationships, is not made up of separate private and public forces, but rather a deeply connected dynamic that reinforces domination at every level. This pattern reflects a society that continues to regulate women's bodies to maintain gender hierarchies and reproductive control.

Transforming these entrenched dynamics requires more than technical interventions, it demands that we shift how we listen to, understand, and engage with women's lived experiences. The women in this study are not only affected by these power structures but actively resist them. Through everyday acts, teaching their children new values, advocating for shared responsibility in contraception, they reimagine gender relations and carve out space for change. Researchers, practitioners, and policymakers must recognize these acts of resistance and engage with them to foster lasting change.

Their resistance is not incidental; it is a vital resource. Any effort to advance SRHR must recognize and support the agency already present in these communities. By supporting women's leadership in shaping interventions and policies, and by integrating gender-transformative approaches into SRHR programs, we can build stronger, more effective solutions. This partnership with women in their ongoing work toward justice, health systems, researchers, and policymakers can move beyond reinforcing harmful norms and instead contribute to building a future where SRHR are not a privilege, but a guarantee, for every woman, regardless of her circumstances.

### Contributors

C.L.B.Z. conceptualized the study, led methodology, investigation, data curation, formal analysis, and validation, and contributed to writing the original draft and reviewing the manuscript. H.G. contributed to the conceptualization, methodology, supervision, mentoring, formal analysis, validation, and writing of the original draft and review. C.A.G.P. was involved in methodology, investigation, data curation, transcription, and writing the original draft. M.F.B.Z. contributed to methodology, investigation, data curation, transcription, formal analysis, and writing the original draft. J.M. and N.K. contributed to study design, supervision, data analysis, and writing the review. M.K. was involved in conceptualization, methodology, supervision, mentoring, formal analysis, validation, and writing both the original draft and the review. All authors had full access to the data, contributed to the interpretation of the findings, and approved the final manuscript. C.L.B.Z., H.G., and M.K. directly accessed and verified the underlying data.

### Data sharing statement

The data generated and analyzed during this study are not publicly available due to privacy concerns. However, some deidentified data may be made available upon reasonable request to the corresponding author.

### Declaration of interests

The authors declare that they have no competing interests.

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**Appendix A. Supplementary data**
Supplementary data related to this article can be found at https://doi.org/10.1016/j.lana.2026.101493.

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