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Childbirth Experiences among Moroccan Rural Women: A Qualitative Study

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ABSTRACT

Background & aim: Rural residency significantly impacts maternal health in Morocco, as women in rural areas face higher risks of pregnancy-related complications and reduced access to medical facilities. This qualitative study aimed to explore the childbirth experiences of rural Moroccan women to inform improvements in perinatal care and health equity.

Methods: In this descriptive qualitative study, we used purposive sampling. Twenty-five rural Moroccan women who gave birth between 2021 and 2022 in public hospital maternity wards in the Essaouira and Taza regions were interviewed. A semi-structured interview guide with open-ended questions was used to collect qualitative data on childbirth and hospital experiences. Data collection continued until data saturation was reached. Thematic analysis was conducted using MAXQDA 2020 to identify recurring themes.

Results: The analysis identified three overarching themes. The first theme, difficulties shaping birth experiences, included subthemes related to first birth challenges, hospital versus home delivery, and barriers to access. Also, a theme of social and institutional influences on birth experience emerged, which is characterized by minimizing hospital stays, family support, and disrespect by hospital staff. The third theme, obstetric violence, encompassed experiences of the Kristeller maneuver and non-consented episiotomy and/or vaginal examinations.

Conclusion: Findings underscore the need for systemic interventions, including improved access to maternal healthcare, better communication from care providers, and greater respect for patients' dignity and autonomy.

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Introduction

Significant progress has been made to improve health outcomes for Moroccan women and children. For example, the maternal mortality ratio decreased from 227 deaths per 100,000 live births in 2004 to 72.6 in 2018, reflecting substantial improvements in maternal healthcare services (1).

This progress is unequally spread between privileged and underprivileged places, literate and illiterate women, and rural and urban areas (2). In Morocco, the public hospital is most frequently used by women for childbirth

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(56.5%), with women from urban areas giving birth more frequently in health facilities (96% versus 73% in rural areas). The highest proportion of home deliveries is observed among women from rural areas (25.5%). In addition to geographical location, education level and parity are two other factors influencing the choice of delivery in a supervised environment (1).

Assessing the childbirth experience of rural and vulnerable women who use public facilities for childbirth can provide essential and cost-effective feedback for improving supervised facility-based childbirth services. The literature on women's experiences of childbirth in health facilities indicates that the care process, and interactions between women and caregivers are rooted in the women's cultural contexts (3).

In Morocco, especially in the countryside, giving birth is not only a medical event, but also a deeply social and cultural phenomenon. Women's hopes and choices about childbirth are shaped by their traditional beliefs and practices. For instance, women often listen to the advice of older female cousins or traditional birth attendants, especially when they are pregnant for the first time. Many drink herbal teas or certain oils before going into labor, avoid giving birth in hospitals unless they think there will be problems, and think that giving birth at home is better for their mental and spiritual health Women who prefer home birth often report fear of medical interventions such as cesarean sections or episiotomies and perceive hospital environments as impersonal or unwelcoming .These cultural factors affect how women go through labor and delivery and how they interact with the healthcare system (4–6).

Several studies examining the cultural and social perspectives of childbirth experiences reveal the need to improve the quality of childbirth and the involvement of healthcare personnel to improve mothers' experiences of childbirth (7-8).

Numerous studies exposed the insulting, disrespectful, and sometimes even careless treatment of women giving delivery in health facilities across the world (9–15). An in-depth analysis of women's emotions, ideas, and attitudes around delivery may be possible by looking at mothers' birth experiences through a qualitative study approach. Few qualitative studies in Morocco focused on exploring women's perspectives on their childbirth experiences (16). Quantitative indicators alone are insufficient to capture these issues; so incorporating women's voices is essential for developing contextually appropriate strategies. This qualitative study explored the birth experiences of rural Moroccan mothers to hear the voices of these women as a means to improve the standards of care during delivery, and help to formulate policies that lead to reproductive health equity for all Moroccan women.

Materials and Methods

This study was a descriptive qualitative research, which is a method that aims to provide a rich, straightforward description of an experience or event, rather than focusing on thick description, theory development, or interpretative meaning.

Qualitative interviews were performed from 2021-2022, on 25 Moroccan women living in two regions of the country. Thirteen women were from the rural communities of Essaouira is located on the western Atlantic coast of Morocco., and 12 were from rural communities of northeast Morocco (Taza) (Table 1).

Inclusion criteria were as follows: being a married woman who had given birth within the past two years, being of reproductive age (15–49), and residing in a rural community of the studied regions. Exclusion criteria included nulliparous women, single women, women who declined to participate, those unable to provide informed consent, and women not residing permanently in the selected rural communities. Participants formed culturally homogenous groups within each sitting, ensuring contextual relevance while capturing experiential variation.

To obtain a valid sample, we employed a combination of non-probability sampling techniques commonly used in qualitative research (17). Initially, participants were selected using convenience sampling and purposive (judgmental) sampling methods to ensure relevance to the study objectives (18-19). We obtained a homogeneous sample of married women of reproductive age who recently gave birth and lived in a rural area of the province studied. After a preliminary

analysis of the data, the sampling parameters were refined. After further analysis of purposive sampling, a sample of 25 participants who met the inclusion criteria was sought. The total sample size was determined by the ongoing analysis of participant narratives during the data collection phase, with recruitment ceasing once data saturation was reached.

The midwife researcher (CM), trained in qualitative methods, conducted semi-structured, open-ended interviews that lasted 60-90 minutes.

Demographic information was collected for each woman. Interview content addressed experiences, perceptions, attitudes, practices, and knowledge regarding childbirth. The focus was on health-related topics including childbirth experiences in the delivery room, family support, delivery practices, experiences related to previous and current deliveries, their postpartum period, fears related to delivery, and issues associated with accessing pregnancy health care.

Data collection was carried out using face-to-face interviews, guided by an interview guide. The interview guide included introductory, main, follow-up and closing questions, designed to explore participants' childbirth experiences in depth.

During the interviews, participants were invited to describe their childbirth experiences in detail, including their first birth and any subsequent deliveries, from the moment they left home until discharge from the hospital. They were asked to reflect on their physical and emotional experiences during labor, delivery, and the postpartum stay, as well as any difficulties encountered. The interviews also explored the type of information or support received prior to the first birth and whether it was perceived as sufficient. Participants were encouraged to discuss the factors influencing their decision to give birth at home or in a health facility, their feelings regarding this decision, and any fears or concerns related to childbirth. Additionally, questions addressed potential barriers to accessing maternity care, including transportation challenges and financial constraints, and how these factors affected their access to health services.

The interview guide was translated from French into local dialect of Arabic spoken in the studied regions, and the interviews were voice-recorded on a smartphone. Each one was recorded verbatim, followed by a second translation, first into French, then into English. Openness to new concepts and follow-up questions throughout the interview were characteristic of the data collecting process. Further questions were developed based on new themes during data collection, and the study's preliminary findings were discussed with women to boost validity. Data saturation was reached with 12 participants in each location.

Data on childbirth experiences were analyzed using thematic analysis, following Braun and Clarke's (2006) guidelines (20). These steps include: (1) familiarization with the data, (2) initial code generation, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. This structure enhances transparency and replicability and is a theoretically flexible method that organizes, describes, and interprets qualitative data (21). After a careful reading of the transcripts, initial codes were generated, and the data were examined with the research question in mind. After generating codes, these were grouped together keeping the common ideas between them, using MAXQDA 2020, into potential themes based on conceptual similarity, and these themes were then reviewed, refined, and clearly defined. Next, all relevant data for each theme were extracted and a system was developed to ensure that all relevant data were associated first with individual codes and then with themes. Themes were labeled when they were recognized. Once each theme was clearly defined, illustrative quotes from the transcripts were selected to support and exemplify the interpretation (21). Across the process, the researchers collaborated, exchanging ideas on the analysis and interpretation of their results.

In line with the criteria proposed by Guba and Lincoln (23) for evaluating the scientific validity of qualitative research, namely credibility, transferability, dependability, and confirmability, several steps were taken to ensure the rigor of this study. To enhance credibility, a trusting relationship was

established with participants to encourage open and honest discussion on sensitive topics related to reproductive health. A diverse sampling strategy was adopted to reflect a wide range of experiences among women from various backgrounds. Regarding dependability, peer validation was used, with team discussions held to examine codes and emerging themes. Additionally, portions of the coded interviews were shared with some participants for member checking, allowing them to confirm the accuracy of the interpretations. Finally, to ensure confirmability, several interview transcripts and their analyses were shared with qualitative research experts who were not involved in the study. Their feedback was considered to minimize potential bias and support the objectivity of the analysis. These combined strategies contributed to the overall rigor and trustworthiness of the qualitative research process (22-23).

Results

As shown in Table 1, the sample consisted of twenty-five married women ranging in age from 19 to 44 years. All the women were unemployed. Fourteen of the participants lived with their in-laws. The age at which participants had their first child ranged from 17 to 30 years. The average number of living children was 2.88. Most pregnancies were unplanned. Most women planned to give birth in Morocco's public health system, which is typically comprised of midwife-led care. Data analyses revealed three themes, each comprising several subthemes (Table 2; Figure 1).

Table 1. Demographic characteristics of participants

Essaouira Province						
Number	**N° of live children**	**Age (years)**	**Age of first childbirth (years)**	**N° of people live in a household**	**Educational level**	**Occupation**
1	2	27	26	9	Illiterate	Housewife
2	2	23	17	4	Primary	Housewife
3	2	37	20	4	Middle School	Housewife
4	5	35	15	9	Primary	Housewife
5	2	21	18	4	Primary	Housewife
6	3	25	20	5	Primary	Housewife
7	3	29	19	11	Primary	Housewife
8	5	30	16	7	M'Sid	Housewife
9	1	31	29	6	Illiterate	Housewife
10	5	30	19	11	Illiterate	Housewife
11	5	37	19	7	Primary	Housewife
12	1	19	18	5	Primary	Housewife
13	3	30	26	5	Illiterate	Housewife
Taza Province						
14	2	27	19	4	Primary	Housewife
15	2	25	20	8	Middle School	Housewife
16	2	24	19	6	Primary	Housewife
17	4	25	17	6	Primary	Housewife
18	3	44	21	20	Illiterate	Housewife
19	3	32	22	8	Illiterate	Housewife
20	3	41	30	5	Primary	Housewife
21	4	29	19	12	Primary	Housewife
22	3	27	19	6	Illiterate	Housewife

Essaouira Province						
Number	**N° of live children**	**Age (years)**	**Age of first childbirth (years)**	**N° of people live in a household**	**Educational level**	**Occupation**
23	5	39	23	9	Illiterate	Housewife
24	2	32	28	8	Secondary High School	Housewife
25	3	24	17	5	Primary	Housewife

Table 2. Themes and subthemes extracted from the interviews

Sub Theme	Theme
Subtheme: First Birth Challenges Subtheme: Hospital versus Home Delivery Subtheme: Access Barriers	Theme 1: Difficulties Shaping Birth Experiences
Subtheme: Minimizing Hospital Stays Subtheme: Family support Subtheme: Disrespect from Hospital Staff	Theme 2: Social and Institutional Influences on Birth Experience
Subtheme: Kristeller maneuver Subtheme: Unconsented Episiotomy and vaginal examination	Theme 3: Obstetric violence

Theme 1: Difficulties Shaping Birth Experiences

Subtheme: First Birth Challenges: During the first delivery, most women struggled with the labor and delivery process due to a lack of knowledge about childbirth, which, in one case, was perceived by the participant as contributing to complications that resulted in a cesarean section.

«Because I had no prior experience with delivery, I struggled to breathe and push, which caused my daughter to have fetal distress and necessitated the doctor performing a cesarean section. » (Woman 23)

In contrast, the subsequent deliveries were often characterized as easier and less complicated due to the experience gained from the first childbirth.

« The previous deliveries (first and second) were much more complicated than this one (third). As you know, the first one I was primiparous, it was the first time I saw how the delivery happened."» (Woman 19)

Subtheme: Hospital versus Home Delivery: Hospital delivery allows for complications to be prevented or rapidly addressed. Women expressed the desire for this type of delivery because of exposure to the trauma of maternal mortality within the family. The experience of maternal death within the family is a painful event where the woman takes precautions to avoid the same problem experienced by family members.

«I prefer to give birth in the hospital, at least in hospital they save us if something happens …, it's not like if I give birth at home what will they do for me? My sister-in-law died during the delivery on the road. When she was on the way to the hospital, she lived 7 kilometers away, she died on the way to the hospital because a donkey had transported her. One of my sisters-in-law died during the home delivery because of a uterine rupture.» (Woman 20)

Subtheme: Access Barriers: Transportation was described as a major barrier to accessing timely labor and delivery care. Women often worried about dying while traveling to the clinic with their babies, as well as lengthy wait times before entering hospitals. A participant identified barriers and difficulties in accessing health facilities, including the system of referrals from one level of care to another and the lengthy wait times to enter a hospital.

« Finding transportation is tough, which further complicates delivery. Once I arrived at the health center with the delivery bed in BniFrassen, she put me in condition and took a

venous line to administer the treatment in the serum. After one hour and a half, she finally told me that I could not give birth due to the labor stoppage…» (Woman 15)

Due to the high cost of transportation and the scarcity of automobiles in the neighborhood, women find it challenging to receive health services, which places a significant financial burden on low-income families.

« …When I got to the hospital, they sent me to Taza and transported me back by ambulance; indeed, it cost 250 dirhams to take me back to the hospital…I usually give birth at night, the second and third times we got a cab, it was as pricey as ambulance.» (Woman 17)

Theme 2: Social and Institutional Influences on Birth Experience

Subtheme: Minimizing Hospital Stays:

To avoid hospital stays before delivery, women wait until the very last minute to seek help. This allows them to stay home and care for other children or family members right up to the time of delivery. Once they have vaginal discharge, and their contractions are at their strongest, they go to the hospital.

«I gave birth at the hospital's entrance. However, the baby's head got stuck, so they had to enter me; they took the baby out, and I underwent an episiotomy. As a result, I delayed going to the hospital until or once I had lost the amniotic fluid… I try to get through the contractions in my house and not go to hospital until the baby is about to be delivered. » (Woman 24)

Women expressed relief at not having to stay in the institution for an extended period. After giving birth, some women were eager to leave the hospital as quickly as possible because they found the hospital atmosphere uncomfortable. Additionally, women reported that their children were upset at home due to missing their mothers.

«It's 12:30, and I had a birth at 2:00 in the evening; my husband requested me to go, but I can't leave without the doctor's permission. I'll try with the staff; I paid money to go out fast. » (Woman 3)

Subtheme: Family support

The presence of the family in the hospital and the abandonment of the woman by the medical staff were some of the aspects that influenced the woman's hospital stay, especially in the postpartum ward. Having a support person present throughout labor and delivery was an example of supportive care. In general, a mother cares for her daughter after the delivery. The presence of close family members in the hospital plays a crucial role in a woman's positive feeling about childbirth.

« I am grateful that my mother is with me at this time, and my husband helped me a lot by looking for a client of our relatives who works in the hospital to help us. Next, they called the gynecologist, who performed the ultrasound … when I went alone, they neglected me.» (Woman 25) «Being with family at the hospital is crucial; even if they do nothing, their presence is crucial and psychologically beneficial.» (Woman 15)

The women appreciated the advice of relatives with expertise in maternal health. «This time, my sister advised me to drink a glass of oil before going to the hospital to give birth. I drank directly from the bottle, and this method helped me a lot in the expulsion of the baby. My sister is a great multiparous … this time was the easiest, the delivery went easy by this method.» (Woman 19) .These accounts reflect participants' personal beliefs and experiences and do not imply clinical effectiveness or safety.

Subtheme: Disrespect from Hospital Staff:

Women felt abandoned when healthcare professionals neglected to check on them regularly, failed to react to their cries for assistance quickly, or sent them to another institution after an extended time of admission without providing much assistance.

«The first birth was challenging and unpleasant; they didn't leave the family with me, they left me alone, and they showed no sign of caring. » (Woman 21)

Women's opinions about the place of delivery are influenced by their experiences giving birth at home. A bad prior experience in the hospital such as poor treatment and/or neglect provided by healthcare professionals, discouraged them from returning to health facilities for the future care.

« « When the human being is insulted and neglected by the health caregiver, this hurts the psychic health that pushes us not to access health structures.» (Woman 23)

Once I fell from the ladder and didn't go to the hospital, I stayed home. I told my husband I preferred to die at home then to go to the hospital. Even if I had pain ... at night nobody comes to help us. In the morning, because the student trainees are there, they knock on the door every minute...The trainees take care of people, but once they gain enough practical experience, they begin to adopt the same behavior as the regular healthcare staff. » (Woman 25) .The narrative highlights perceived disparities in the quality of interpersonal treatment between trainees and permanent healthcare staff. Participants seemed to associate trainees with increased attention and responsiveness, while experienced staff were considered less involved. The change observed in trainees' behavior over time may indicate the impact of institutional norms and professional socialization processes within the maternity environment. These findings highlight the important implications of respectful maternity care and the influence of organizational culture on provider-patient interactions.

Women felt ignored when clinicians did not check on them regularly or respond quickly to their needs for assistance. One woman with stomach bloating and a two-day delay in gas emission is given a suppository by a new mother.

« I'm in a lot of pain. I can't walk or lift. It's been 24 hours since the delivery, and I haven't done my gas. They advised me to drink a vervain broth …I hadn't eaten in three days, and the staff was no longer responding to my pain, so a Cesarean patient next to me offered me this suppository to relieve my intestinal gas.» (Woman 4)

The support provided by health personnel had a positive impact on the woman's psychology despite the physical suffering associated with the mode of delivery.

« A year later, I got pregnant again and gave birth, the midwife treat me kindly …When they treat us well at the hospital, I feel very happy. Of course, when healthcare providers treat us kindly, we feel joy and relief. However, when we are treated badly, it pushes us away from the healthcare system—we avoid going to health centers and do not want to consult with staff. » (Woman 1)

Theme 3: Obstetric violence

Subtheme: Kristeller maneuver:

The Kristeller maneuver, defined as the application of fundal pressure during the second stage of labor, was described by participants as a distressing intervention. Receiving this maternity procedure was a horrific and terrifying experience for the women. Reporting their personal experience, women indicated that the Kristeller maneuver caused them constant abdominal and uterine pain, and one woman reported breathing problems and chest pain since giving birth.

«They got on top of me and pushed my belly. They pushed me until they traumatized my uterus. I suffered a lot. I had unbearable uterine pain.» (Woman 4)

« During my first delivery, I suffered a lot, especially when the baby got stuck at the top of the uterus, he didn't want to come down, a midwife stood over me and pushed my belly, ….I suffered a long time because of that, I still feel tired, breathless and sometimes my heart hurts.» (Woman 8)

Subtheme: Unconsented Episiotomy and vaginal examination:

Participants reported exposure to forms of physical violence such as obstetric interventions, episiotomy (episiotomy repair) with insufficient analgesia, accompanied by frequent vaginal examinations. Episiotomy, according to the participants' perception, was a moment of brutality, painful and against humanity.

« She gave me an episiotomy, and then she sewed me up. I'm starting to cry. I've suffered a lot because of them.» (Woman 15)

«The midwife makes a big episiotomy. I suffered a lot, especially since the baby did not descend and a midwife started to press my uterine fundus. Although my baby is bigger this time than the first one, I didn't suffer enough like the first delivery.» (Woman 5)

«I gave birth quickly, but suffered a lot from the episiotomy...Because of the episiotomy, I am sick now. » (Woman 24)

Vaginal examination, which is used in obstetric assessments and is common in maternity institutions, was viewed as a disrespectful intervention. Excessive vaginal

touching was a form of physical violence declared by women before giving birth.

«I first hesitated to visit the hospital because I was worried, I would experience excruciating agony without dilation there. However, after I arrived, a midwife performed a vaginal examination, and another one came to do the same procedure on me. I also suffered several vaginal examinations.» (Woman 25)

Discussion

Maternal health is crucial to long-term development and is a major issue worldwide. The severity of this problem forces all governments to prioritize maternal well-being and survival (24). Women in the Eastern Mediterranean Region face many types of disrespect and abuse during childbirth. This occurs independently of the strength of the healthcare system or the country's GDP (25). Physical abuse (particularly overused routine treatments) and non-dignified care (rooted in patriarchal socio-cultural norms) are the most prevalent kinds of disrespect and abuse in childbirth in the Eastern Mediterranean region (22). Several studies explored women's delivery experiences, however most of this research was conducted in the industrialized world. In Morocco, research on women's delivery experiences and their perceived meaning is scarce.

This qualitative study investigated the delivery experiences of rural Moroccan women. The finding suggest that obstetrical interventions in the delivery room, the general treatment received at the hospital, and the presence or absence of family support played a fundamental role in shaping women's perceptions. These patterns may reflect structural constraints within public maternity services, including high patient load, limited staffing, and entrenched hierarchical models of care that reduce women's autonomy.

Additionally, and in line with previous research (23), distinguishing between the first and most recent childbirth experiences also appeared to influence how women evaluated their overall delivery journey. This may be explained by increased familiarity with the health system over time, as well as evolving expectations shaped by prior experiences.

Health professional support during delivery is an essential factor related to a positive birth experience. Supportive professional care appeared to mitigate the negative emotional impact of labor pain, regardless of its intensity. . Studies showed that fear of childbirth during pregnancy and postpartum correlate positively to fear but not to despair, during early active labor (24). In this study, fear of childbirth also includes difficulties in finding transportation to the hospital for labor and delivery. This highlights the influence of structural and social determinants, such as geographical distance and difficulties in accessing transportation in rural areas, on the overall experience of childbirth, beyond the context of clinical anxiety. In addition, women appeared to arrive at the maternity ward without being sufficiently prepared for childbirth, due in particular to a limited understanding of the stages of labor, pain management techniques, and hospital protocols. This may reflect gaps in prenatal education and maternal health knowledge in rural areas.

Limited health knowledge can increase anxiety, reduce women's confidence in their interactions with healthcare providers, and affect their ability to actively participate in decision-making during labor. From the providers' perspective, managing labor in such settings, particularly in crowded and resource-limited facilities, can generate additional stress and communication difficulties, which may contribute to misunderstandings or tensions between staff and patients. This dynamic suggests that strengthening prenatal consultations and childbirth education could improve cooperation, mutual trust, and the overall childbirth experience (29)(30). Our study showed that disrespect in a maternity ward influenced a woman's decision to give birth at home in their next delivery or not to have another child. Other research highlights that a bad birth experience was connected to delaying the birth of a subsequent child or requesting a Cesarean section without any medical indication (25-26). This suggests that negative childbirth experiences may have long-term reproductive consequences, influencing fertility intentions and trust in institutional care. Being mistreated might destabilize women, who

are frequently fragile during delivery. Limitations in personnel and physical resources, which lead to an unfavorable work environment, increase provider stress, and impairs patient care skills. When caregivers cannot handle this pressure, they may become hostile toward their patient population (9). These findings support existing evidence that provider burnout and systemic under-resourcing contribute to disrespectful maternity care, rather than solely individual attitudes.

Denying the woman, the option to select her birth position, extensive vaginal inspection, and external fundus pressure appear to be manifestations of obstetric violence in public health facilities. Obstetric violence is a type of human rights violation against women (27) and a process that persists despite warnings against these negative behaviors. Moreover, episiotomy and repeated vaginal examinations by several individuals, sometimes even if the woman is scheduled for a C-section, make the hospital birth experience a place of violence toward mothers. It also causes harmful mid-to long - term effects (6,8,10,25) . Within the framework of respectful maternity care, such practices may reflect power imbalances embedded in institutional culture, where women's preferences are subordinated to routine clinical protocols. Our findings suggest that to address negative perceptions of obstetric interventions, it is necessary to develop and implement clear policies and guidelines to define and regulate all types of obstetric care that may be considered abusive. In addition, care providers must improve their communication skills by explaining the reasons for proposed interventions and integrating women into the decision-making process. In this way, they can make decisions together with pregnant women and encourage them to express themselves and play an active role in managing their health. Strengthening accountability mechanisms and supervision systems may further help institutionalize respectful care practices.

The presence of family members in a hospital ward was an essential source of security and help. It helped the woman feel appreciated and recognized. It promoted her health during delivery and in the postpartum period and had a significant impact on delivery experiences (28). The presence of the family at the time of delivery is an emotional support for women (29). Like Morocco, governmental hospitals frequently forbid a woman's spouse or other family members being present during childbirth. These findings suggest that restrictive institutional policies regarding companionship during childbirth may unintentionally undermine women's emotional well-being. Allowing a chosen birth companion could represent a low-cost, culturally sensitive intervention to enhance maternal satisfaction and perceived safety during delivery. This study contributes to enriching the limited body of research on the childbirth experiences of vulnerable women in rural areas in Moroccan public health facilities, which is a major insight. However, several limitations must be acknowledged. Recruitment was limited to 25 women and did not take into account the perspectives of healthcare professionals or single mothers. Access to single mothers remains particularly difficult, as pregnancy before marriage is a sensitive issue socially and legally, which may limit data collection in hospitals for this group. In addition, data were collected at a single point in time during the postpartum hospital stay, a period that can be physically and emotionally stressful for women, which may influence their memories and reflections. Follow-up data on long-term postnatal outcomes were not obtained.

Despite these limitations, the results highlight the importance of the hospital environment, including the quality of care, interpersonal interactions, and emotional support, in women's experiences of childbirth. Participants emphasized the need for a respectful and supportive atmosphere during labor and the postnatal period. These findings underscore the relevance of strengthening respectful maternal care practices and promoting patient-centered communication among healthcare providers. They also suggest the need for policies that protect women's rights during childbirth and strengthen accountability within healthcare facilities. Further research is needed to explore interventions aimed at improving childbirth and postpartum experiences in similar settings.

Conclusion

The present study provided Moroccan married, rural women's perspectives of their childbirth experiences. Due to their negative birth experiences and those of relatives, the lack of resources, and their isolated, rural location, women developed behaviors that might put their health and that of their fetus at risk. These include: the delay of access to health services until the signs of childbirth appear, cultural beliefs such as taking oily products to facilitate the expulsion of babies, and the refusal to complete the number of hours of hospitalization after childbirth. Our results highlight the need for interventions at the individual and system levels to improve the prenatal, labor/delivery and postpartum experiences of women residing in these rural communities. Providers need to be made aware of the perceptions of the women and receive training to best address and care for these women with respect and dignity. More systemic adjustments, such as embedding access to prenatal care within villages, organizing transportation opportunities to clinics, and providing education to prenatal women about the labor and delivery experiences within hospitals would help address the concerns of the women. Our findings revealed that the relationship between the woman and her healthcare provider was crucial to enhancing her satisfaction. It is becoming accepted that the objectives of childbirth go beyond preventing injury, and that women's experiences during labor influence the health outcomes of both mother and child.

Declarations

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Conflicts of interest

The authors declared no conflicts of interest.

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki. Informed written consent was obtained from all participants prior to data collection. Participants were informed about the purpose of the study, the research procedures, and their right to refuse participation or withdraw at any time without consequences. Data were collected anonymously, and strict confidentiality was maintained throughout the study.

Code of Ethics

Ethical approval for this study was obtained from the Faculty of Medicine and Pharmacy of Rabat, Morocco (Reference No. 45/21). All participants provided informed consent prior to participation.

Use of Artificial Intelligence (AI)

We have not used any AI tools or technologies to prepare this manuscript.

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Authors' contribution

CM, LA, and JT contributed to study design, data analysis and drafting the manuscript. CM interviewed the women and wrote the original draft of the manuscript. JT was a major contributor in re-writing the manuscript. SY contributed in analysis and revising the manuscript. All authors read and approved the final manuscript

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