



**AGE MATTERS: HOW MATERNAL AGE RELATES TO ANXIETY LEVELS IN
PREGNANT WOMEN FACING CHILDBIRTH**

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ABSTRACT

Pregnancy requires continuous psychological adaptation, and maternal age may shape how women perceive reproductive risk and childbirth. This study examined the association between maternal age and anxiety levels among pregnant women facing childbirth in the Membalong Community Health Center working area. An analytic cross-sectional study was conducted in July 2026 using total sampling of 90 pregnant women from all trimesters. Maternal age was categorized as non-risk (20-35 years) and risk age (<20 or >35 years). Anxiety was assessed using the 14-item Hamilton Anxiety Rating Scale (HARS/HAM-A); the Indonesian version has demonstrated construct-validity coefficients of 0.529-0.727 and acceptable internal consistency (Cronbach's alpha = 0.756). Data were summarized descriptively and analyzed with the Fisher-Freeman-Halton exact test. Most respondents were aged 20-35 years (77.8%) and had no anxiety (63.3%). Mild-to-severe anxiety occurred in 65.0% of women in the risk-age group compared with 28.6% in the non-risk group. Maternal age was significantly associated with anxiety level ($p = 0.014$). Maternal age can support early identification of psychological vulnerability, but anxiety screening should remain available to all pregnant women because symptoms were also present in the non-risk age group.

Keywords: anxiety; childbirth; maternal age; pregnancy

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INTRODUCTION

Pregnancy is a physiological process accompanied by biological, hormonal, emotional, social, and role-related changes that require adaptation from early gestation until childbirth. For some women, this transition is accompanied by worry about fetal development, uncertainty about labor, fear of complications, sleep disturbance, and concern about the ability to assume the maternal role. Psychological well-being is therefore an integral component of antenatal care rather than an issue separate from obstetric health (Aisyah & Prafitri, 2024; Yanti & Wirastri, 2022). Anxiety can occur throughout pregnancy, although its focus changes as pregnancy progresses. Early concerns may center on pregnancy viability and fetal development, while attention increasingly shifts toward pain, maternal and fetal safety, medical intervention, and the birth process as delivery approaches (Ana et al., 2025; Huang et al., 2025). In this study, anxiety in facing childbirth refers to the severity of general anxiety symptoms experienced within the context of pregnancy progressing toward childbirth. It is not treated as a psychiatric diagnosis, pregnancy-related anxiety, or fear of childbirth, because these related constructs are measured with different instruments.

Recent Indonesian studies indicate that maternal anxiety remains relevant in antenatal populations. Yanti and Hasrida (2024) reported substantial anxiety among third-trimester women and found a significant relationship between age and anxiety. Fransiska et al. (2024) similarly identified maternal age, knowledge, and husband support as factors associated with anxiety, while Wijayanti and Rizkiana (2025), using HARS, reported a significant difference in anxiety by maternal age. Anxiety is also shaped by psychosocial conditions. Titisari and Mawardika (2025), in an IJGHR study, found a significant relationship between husband support and maternal anxiety in facing

childbirth. These findings reinforce that maternal anxiety is multifactorial and that age should be interpreted together with individual and social context. Despite the growing number of Indonesian studies, several gaps remain relevant. Many reports focus on third-trimester women, a single obstetric subgroup, or multiple determinants analyzed simultaneously, so the specific age-anxiety pattern across a general antenatal population is less clear. In addition, studies use different anxiety constructs and instruments, which limits direct comparison of prevalence. A primary-care study that includes women from all trimesters and clearly defines HARS as a general anxiety severity measure can therefore contribute evidence that is both clinically practical and methodologically transparent.

Maternal age is particularly relevant because it reflects different biological and psychosocial circumstances. In Indonesian reproductive-health guidance, 20-35 years is generally considered a relatively safer reproductive period, whereas age below 20 years and above 35 years requires greater attention (Kementerian Kesehatan Republik Indonesia, 2021). Younger women may have less reproductive experience and emotional readiness, whereas women of advanced maternal age may be more aware of obstetric complications or fetal risks. These pathways can increase worry through different mechanisms; therefore, age should not be interpreted as a deterministic cause of anxiety.

International evidence supports this contextual interpretation. Miskeen et al. (2026) reported that women aged 40-50 years had higher odds of pregnancy-related anxiety than women aged 18-28 years in Saudi Arabia, whereas Nembot et al. (2026) found younger maternal age associated with pregnancy-related anxiety among antenatal women in Cameroon. Huang et al. (2025) identified maternal age among factors related to fear of childbirth near delivery, while Zhu et al. (2026) documented a high burden of fear of childbirth in women aged 35 years or older. The direction of age-related psychological vulnerability is therefore not uniform across populations, instruments, or stages of pregnancy.

Instrument selection is important when comparing these studies. The Hamilton Anxiety Rating Scale, internationally known as HAM-A and commonly termed HARS in Indonesia, measures the severity of psychological and somatic anxiety symptoms (Hamilton, 1959). Ramdan (2019) reported acceptable psychometric evidence for the Indonesian version, although the validation population consisted of nurses rather than pregnant women. Importantly, HARS/HAM-A has also been applied in pregnancy. Nabwire et al. (2024) used HAM-A among antenatal women in Uganda, and Wijaya and Mawardika (2025) used HARS among pregnant women before emergency caesarean section. This supports its empirical use for describing general anxiety symptom severity in pregnant populations while preserving the distinction from pregnancy-specific anxiety or fear-of-childbirth instruments.

Evidence from primary-care settings remains important because anxiety is influenced by obstetric history, education, family support, access to information, and service context. Membalong Community Health Center serves a geographically dispersed area of Belitung, including villages with different access conditions, and local maternal-health information has traditionally emphasized physical and obstetric indicators (Dinas Kesehatan Kabupaten Belitung, 2024). A focused examination of maternal age and anxiety may therefore add a practical psychological dimension to routine antenatal assessment. This study aimed to determine the association between maternal age and anxiety levels in facing childbirth among pregnant women in the working area of Membalong Community Health Center.

METHOD

A quantitative analytic cross-sectional study was conducted in the working area of Membalong Community Health Center, Membalong Subdistrict, Belitung District, Indonesia, in July 2026. Maternal age and anxiety level were measured during the same data-collection period, so the

findings were interpreted as associations rather than causal relationships. The accessible population consisted of all 90 pregnant women registered and present in the community health center working area during the study period. Total sampling was used, and all 90 women were included. Data were collected through antenatal-care activities at the community health center, integrated health posts, auxiliary health centers, and home visits. Age information was obtained from the respondent identity form and could be confirmed using maternal health records, identity documents, medical records, or the maternal cohort register.

Maternal age was classified into non-risk age (20-35 years) and risk age (<20 years or >35 years) based on the reproductive-risk classification used in Indonesian maternal-health guidance (Kementerian Kesehatan Republik Indonesia, 2021). Anxiety was measured with the 14-item Hamilton Anxiety Rating Scale (HARS/HAM-A). Each symptom group was rated from 0 to 4, producing a total score of 0-56. The operational categories used consistently in this study were no anxiety (0-13), mild anxiety (14-20), moderate anxiety (21-27), severe anxiety (28-41), and very severe anxiety/panic (42-56). HARS was used to quantify general anxiety symptom severity and not to diagnose an anxiety disorder or measure fear of childbirth specifically (Hamilton, 1959; Ramdan, 2019). The Indonesian version demonstrated construct-validity coefficients of 0.529-0.727 and acceptable internal consistency (Cronbach's alpha = 0.756) (Ramdan, 2019). Because this psychometric testing was conducted among nurses rather than pregnant women, these findings were treated as supporting evidence for the Indonesian version rather than pregnancy-specific validation. Previous studies have also applied HARS/HAM-A in pregnant populations (Nabwire et al., 2024; Wijaya & Mawardika, 2025).

Researchers and trained enumerators explained the HARS symptom groups in understandable language and recorded one severity score for each group. Respondents received information about the study and provided written informed consent before participation. Ethical approval was granted by the Research Ethics Committee of Universitas Ngudi Waluyo (No. 519/KEP/EC/UNW/2026, June 30, 2026). Confidentiality and anonymity were maintained throughout data collection and analysis. Data were analyzed using IBM SPSS Statistics version 27. Frequencies and percentages described respondent characteristics, maternal age, and anxiety level. The association between the two categorical variables was initially evaluated through the contingency table. Because four of eight cells (50%) had expected counts below five and the minimum expected count was 1.33, the Pearson chi-square assumption was not met. The two-sided Fisher-Freeman-Halton exact test was therefore used for the 2 x 4 table, with statistical significance set at $p \leq 0.05$.

RESULT

Respondent characteristics

Table 1.
Respondent Characteristics (n = 90)

Characteristic	Category	f	%
Education	Basic	52	57.8
	Secondary	31	34.4
	Higher	7	7.8
Occupation	Housewife	84	93.3
	Civil servant	4	4.4
	Honorary employee	2	2.2
Gravida	Primigravida	45	50.0
	Multigravida	41	45.6
	Grand multigravida	4	4.4
Gestational age	Trimester I	17	18.9
	Trimester II	33	36.7
	Trimester III	40	44.4
Pregnancy condition	Physiological	69	76.7
	Pathological	21	23.3

All 90 pregnant women in the accessible population were analyzed. As shown in Table 1, most respondents had basic education (57.8%), were housewives (93.3%), and had physiological pregnancies (76.7%). Half were primigravida, and the third trimester was the largest gestational-age group (44.4%).

Maternal age

Table 2 shows that 70 respondents (77.8%) were aged 20-35 years, while 20 respondents (22.2%) were in the reproductive-risk age category (<20 or >35 years).

Table 2.

Maternal Age Distribution (n = 90)

Variable	Category	f	%
Maternal age	Non-risk age (20-35 years)	70	77.8
	Risk age (<20 or >35 years)	20	22.2

Anxiety level

Table 3 shows that 57 respondents (63.3%) had no anxiety, while 16 (17.8%) had mild anxiety, 11 (12.2%) had moderate anxiety, and 6 (6.7%) had severe anxiety. Overall, 33 women (36.7%) experienced mild-to-severe anxiety, and no respondent was classified as very severe/panic.

Table 3.

Anxiety Level Distribution (n = 90)

Variable	Category	f	%
Anxiety level	No anxiety	57	63.3
	Mild	16	17.8
	Moderate	11	12.2
	Severe	6	6.7
	Very severe/panic	0	0.0

Association between maternal age and anxiety level

The anxiety distribution differed by maternal age (Table 4). In the non-risk group, 71.4% had no anxiety and 28.6% had mild-to-severe anxiety. In the risk-age group, only 35.0% had no anxiety, whereas 65.0% experienced mild-to-severe anxiety. The Fisher-Freeman-Halton exact test showed a statistically significant association between maternal age and anxiety level ($p = 0.014$).

Table 4.

Association Between Maternal Age and Anxiety Level (n = 90)

Maternal age	No anxiety n (%)	Mild n (%)	Moderate n (%)	Severe n (%)	Total n (%)	p-value
Non-risk age	50 (71.4)	9 (12.9)	7 (10.0)	4 (5.7)	70 (100.0)	0.014
Risk age	7 (35.0)	7 (35.0)	4 (20.0)	2 (10.0)	20 (100.0)	

Note. Two-sided Fisher-Freeman-Halton exact test. The very severe/panic category was excluded from the contingency table because its frequency was zero.

DISCUSSION

Respondent characteristics

The sample was heterogeneous in education, gravida, gestational age, and pregnancy condition. Basic education predominated (57.8%), half of the women were primigravida, 44.4% were in the third trimester, and 76.7% had physiological pregnancies. These characteristics provide context because anxiety during pregnancy does not arise from age alone. Knowledge, reproductive experience, gestational stage, clinical conditions, and family support can shape how a woman interprets uncertainty and prepares for childbirth (Amalia et al., 2025; Ana et al., 2025). Education and reproductive experience deserve particular attention when translating the findings into practice. A majority of respondents had basic education, which does not imply inability to understand health information but may require clearer language, repetition, visual explanation, and opportunities to ask questions. Half of the women were primigravida and therefore had no direct experience of labor. Uncertainty about pain, the sequence of delivery, possible referral, or newborn care can

become a source of anticipatory worry. These factors may partly explain why anxiety was still observed in women within the non-risk age range and why an age-only interpretation would be incomplete (Amalia et al., 2025; Ana et al., 2025).

Maternal age

Most respondents (77.8%) were aged 20-35 years, while 22.2% were younger than 20 years or older than 35 years. Thus, the study population was dominated by the non-risk reproductive-age category, although more than one-fifth remained in the age-risk group. This univariate distribution describes the composition of the sample and should not, by itself, be interpreted as evidence that age is related to anxiety; that relationship is addressed separately in the bivariate analysis.

Anxiety level

Although 63.3% of respondents had no anxiety, more than one-third experienced symptoms ranging from mild to severe. This proportion should not be dismissed simply because the largest category was "no anxiety." Even mild symptoms may affect sleep, concentration, emotional comfort, and perceived preparedness, while moderate or severe symptoms may warrant closer assessment. Titisari and Mawardika (2025) demonstrated that husband support is related to maternal anxiety in facing childbirth, emphasizing that anxiety is embedded within the woman's social environment. The present findings therefore support attention to psychological status as part of routine antenatal contact rather than only when severe distress becomes visible.

The anxiety distribution differs from studies restricted to particular obstetric contexts. Yanti and Hasrida (2024) reported a larger proportion of moderate anxiety among third-trimester women, while Wijaya and Mawardika (2025) found moderate anxiety to be dominant among women awaiting emergency caesarean section. Such differences are expected because proximity to delivery, emergency procedures, pregnancy complications, and instrument timing can intensify perceived threat. The Membalong sample included women from all trimesters and both physiological and pathological pregnancies, which likely produced a broader distribution of symptom severity.

The absence of very severe or panic-level anxiety should also be interpreted carefully. It indicates that no respondent crossed the operational HARS threshold used for that category at the time of measurement, but it does not mean that severe psychological needs were absent. Six women were already classified as having severe anxiety, and symptom levels can change as pregnancy progresses or as new clinical events occur. A cross-sectional score is therefore best viewed as a snapshot that can guide follow-up rather than a permanent classification of the woman's psychological condition.

The HARS interpretation also requires caution. Its 14 symptom groups include psychological and somatic manifestations. During pregnancy, fatigue, sleep disturbance, cardiovascular sensations, gastrointestinal discomfort, and respiratory symptoms may reflect anxiety, normal pregnancy changes, or both. HARS is therefore useful for severity screening but should not be treated as a diagnostic instrument. The distinction is especially important when comparing the present results with studies using pregnancy-related anxiety or fear-of-childbirth measures (Hamilton, 1959; Huang et al., 2025; Nembot et al., 2026).

Gestational stage and pregnancy condition further shape the meaning of the anxiety categories. Forty respondents were in the third trimester, when childbirth becomes more immediate, while 21 women had pathological pregnancies that may require additional monitoring. These characteristics were not tested as explanatory variables in the primary analysis, so they should not be used to attribute anxiety to a specific cause. They do, however, illustrate why the same age category can contain women with very different psychological experiences. A 25-year-old primigravida with a

pathological pregnancy may perceive childbirth very differently from a 25-year-old multigravida with an uncomplicated pregnancy.

Association between maternal age and anxiety level

The principal result was the significant association between maternal age category and anxiety level. Mild-to-severe anxiety occurred in 65.0% of women aged <20 or >35 years compared with 28.6% of women aged 20-35 years. This pattern supports maternal age as a useful marker of psychological vulnerability in this population, while the cross-sectional design does not establish that age itself caused anxiety. The finding is consistent with several Indonesian studies. Fransiska et al. (2024) identified a significant relationship between maternal age and anxiety, and Yanti and Hasrida (2024) reported a significant age-anxiety relationship among third-trimester pregnant women. Wijayanti and Rizkiana (2025) also found anxiety levels differed significantly according to maternal age using HARS. These studies were conducted in different service settings and often focused on the third trimester, yet they collectively suggest that age deserves attention in maternal psychological assessment.

The magnitude of the descriptive difference is clinically notable even though the analysis tested association rather than effect size. The proportion with any anxiety was more than twice as high in the risk-age group as in the 20-35-year group. At the same time, the distribution was not concentrated in only one severity category: among risk-age women, mild anxiety was most common, followed by moderate and severe anxiety. This graded pattern suggests that age-related vulnerability may manifest across a spectrum of symptoms rather than as an abrupt transition from no anxiety to severe distress.

The association may be explained through different pathways at the two ends of the reproductive-age spectrum. Women younger than 20 years may have limited reproductive experience, less autonomy in health decisions, or less confidence in interpreting physical and emotional changes. Women older than 35 years may have greater awareness of obstetric risk, previous complicated reproductive experiences, chronic health concerns, or heightened worry about fetal well-being. Grouping these ages into one risk category is clinically practical for reproductive-risk screening, but the underlying psychological mechanisms are not necessarily the same.

Combining women younger than 20 years and older than 35 years into one reproductive-risk category follows the operational framework used in the study, but it should not obscure heterogeneity within that category. The study was designed to compare risk versus non-risk reproductive age, not to estimate separate effects for adolescents and advanced-age mothers. For journal interpretation, the observed 65.0% anxiety proportion therefore belongs to the combined risk-age group. Future samples should be large enough to analyze the two age extremes separately, because targeted counseling for a teenager may differ substantially from counseling for a woman over 35 years.

International evidence reinforces the absence of a simple linear age effect. Miskeen et al. (2026) found increased odds of pregnancy-related anxiety in Saudi women aged 40-50 years, whereas Nembot et al. (2026) found younger maternal age associated with pregnancy-related anxiety in Cameroon. These apparently different directions are not contradictory if age is understood as a context-sensitive marker rather than a uniform biological gradient. Social expectations, parity, obstetric history, economic security, family structure, health literacy, and access to care may alter how age translates into perceived threat.

A biologically plausible pathway may involve heightened perception of reproductive risk. At younger ages, incomplete physical maturity and concerns about readiness for pregnancy may coexist with social dependence or limited experience. At advanced maternal age, increased clinical

surveillance and discussion of complications can be reassuring when communicated well but may also heighten awareness of possible adverse outcomes. Psychological appraisal is therefore likely to mediate how biological risk is experienced. The same clinical information can reduce anxiety in a woman who feels informed and supported but amplify it in a woman who perceives little control or receives risk information without adequate explanation.

Evidence on fear of childbirth provides additional context without being directly equivalent to HARS anxiety. Huang et al. (2025) identified maternal age among factors related to fear of childbirth and also found general anxiety positively correlated with fear of childbirth near delivery. Zhu et al. (2026) reported a high prevalence of fear of childbirth among women of advanced maternal age and highlighted the role of spousal support. These studies support the broader clinical relevance of age and psychological well-being, but their outcomes should not be interpreted as direct validation of the HARS categories used in Membalong.

The current cross-tabulation also shows why age cannot be used as a deterministic label. Twenty of 70 women aged 20-35 years (28.6%) still had mild-to-severe anxiety. A relatively safer reproductive age does not eliminate uncertainty related to a first pregnancy, approaching labor, pathological pregnancy, limited health information, or insufficient support. Half of the total sample were primigravida and 44.4% were in the third trimester, both of which may contribute to anticipatory concerns even among women in the non-risk age group (Ana et al., 2025; Sari, 2022).

The two Mawardika-related studies are especially useful for interpreting the present findings because they address complementary aspects of maternal anxiety. Wijaya and Mawardika (2025) demonstrated that HARS can be operationally applied to pregnant women in a clinical obstetric context, while Titisari and Mawardika (2025) showed that husband support is strongly related to anxiety in facing childbirth. Together with the current age finding, these studies illustrate a broader model in which maternal anxiety reflects both individual characteristics and relational resources. This is more clinically realistic than viewing maternal age as an isolated determinant.

Conversely, seven of 20 women in the risk-age group (35.0%) had no anxiety. This finding is equally important because it shows that reproductive-risk age does not inevitably produce psychological distress. Previous childbirth experience, effective coping, supportive partners or families, reassuring clinical information, and a sense of control may buffer worry. Titisari and Mawardika (2025) found a strong relationship between husband support and anxiety in facing childbirth, while other Indonesian studies also identify knowledge and support as relevant factors (Amalia et al., 2025; Fransiska et al., 2024). Age should therefore trigger attentive assessment, not assumptions about a woman's emotional state.

The non-significant finding reported by Mufidah et al. (2024) among high-risk third-trimester women further supports this interpretation. Differences in sample selection, anxiety instruments, obstetric risk profile, and sample size can alter the observed relationship. Studies that restrict participants to high-risk pregnancies may also reduce contrast between age categories because all participants already share important clinical stressors. Variation across studies is therefore informative: maternal age appears relevant, but its association with anxiety is modified by context.

The comparison with pregnancy-related anxiety and fear-of-childbirth research is useful primarily for understanding context, not for pooling prevalence. PRAQ-R2, CAQ, GAD-7, and HARS emphasize different symptom domains and time frames. Consequently, a higher percentage in one study does not mean that its population was necessarily more psychologically distressed than the Membalong population. The value of the international literature lies in showing that maternal age repeatedly appears within a broader network of psychological and obstetric factors. Maintaining this construct distinction reduces overinterpretation and makes the present finding more credible.

Clinical Interpretation and Study Limitations

For primary care, the most defensible implication is a two-level approach. Women younger than 20 years or older than 35 years can receive proactive discussion about emotional readiness, perceived risk, childbirth concerns, and available support because the proportion with anxiety was higher in this group. At the same time, routine psychological inquiry should remain available to all pregnant women because nearly three in ten women aged 20-35 years also experienced anxiety. This prevents age-based screening from missing women whose distress arises from other maternal, social, or clinical factors.

The findings can be integrated into antenatal encounters without creating a separate complex program. Health workers can ask brief questions about persistent worry, sleep, tension, fear of labor, previous negative obstetric experiences, and perceived family support, followed by HARS or another appropriate screening tool when indicated. Communication should be non-judgmental and adapted to educational level. For younger women, clear information and involvement of trusted family members may strengthen readiness; for women of advanced maternal age, balanced risk communication is important so that clinical vigilance does not unintentionally amplify fear. Women with moderate or severe symptoms should receive further assessment and appropriate referral or follow-up.

A practical workflow can remain brief. At routine antenatal contact, age can be noted as one vulnerability marker, followed by a short inquiry about persistent worry, sleep, perceived childbirth readiness, previous negative reproductive experiences, and available support. Women who report meaningful symptoms can then receive a structured anxiety assessment and counseling. This stepped approach preserves efficiency in primary care while reducing the risk of focusing resources only on extreme-age pregnancies. It is also compatible with community-based services because the first psychological inquiry can occur during health-center visits, integrated health-post activities, auxiliary-center contacts, or home visits.

Repeated assessment is preferable to a one-time label because anxiety may change with gestational progression, new test results, referral decisions, or changes in family circumstances. A woman without anxiety in the second trimester may become distressed as delivery approaches, while a woman who initially reports anxiety may improve after education, partner involvement, or resolution of a clinical concern. Primary care is well positioned for this longitudinal observation because antenatal contacts recur across pregnancy. The present cross-sectional result can therefore inform who may need closer attention, but continuity of care determines whether changing psychological needs are recognized.

The geographically dispersed service area gives this implication additional importance. Psychological assessment cannot depend only on referral-center encounters because pregnant women may receive routine care through different community points. A simple, consistent screening message across community health-center staff, village midwives, integrated health posts, and home visits can help maintain continuity. Standardizing when and how anxiety is asked about may be more useful than creating a separate program, particularly when staff already collect maternal risk information during antenatal care. In this model, age functions as one prompt for deeper assessment while the final clinical response remains based on the woman's symptoms and circumstances.

Several limitations should be considered. First, the cross-sectional design measures age and anxiety at one period and cannot establish temporal or causal relationships. Second, the primary analysis was bivariate, so potential confounding by gravida, gestational age, education, pregnancy condition, social support, or previous obstetric experience was not controlled statistically. Third, women younger than 20 years and older than 35 years were combined into one risk category even though

the psychosocial pathways may differ. Fourth, the inclusion of all trimesters increases real-world coverage but also introduces variation in the focus of anxiety across pregnancy stages. Fifth, HARS includes somatic symptoms that can overlap with normal pregnancy experiences, and the Indonesian psychometric evidence cited from Ramdan (2019) was obtained in nurses rather than pregnant women. Finally, the study was conducted in one community health center working area, limiting broader generalization.

The study also has a specific scientific contribution. Rather than estimating anxiety only near delivery, it captures a real-world antenatal population across the three trimesters and explicitly distinguishes general HARS anxiety from pregnancy-related anxiety and fear of childbirth. This distinction improves interpretive precision when local findings are compared with international literature. The results do not suggest a universal age threshold for psychological distress; instead, they demonstrate that reproductive-risk age is associated with a different distribution of anxiety severity in this particular primary-care population.

Despite these limitations, the study contributes local evidence from a geographically dispersed primary-care population and uses an established anxiety severity scale. The significant age-anxiety association, together with anxiety found in both age categories, supports a balanced interpretation: maternal age is useful for risk awareness, but psychological care should remain individualized. Future studies should separate younger and advanced maternal age groups, stratify or adjust for trimester and obstetric characteristics, include psychosocial variables, and use multivariable analysis. Pregnancy-specific anxiety or fear-of-childbirth measures may also be used alongside HARS to clarify which dimensions of distress are most relevant to antenatal care.

CONCLUSION

Maternal age was significantly associated with anxiety level among pregnant women in the Membalong Community Health Center working area. Anxiety was more frequent among women younger than 20 years or older than 35 years, but clinically relevant symptoms were also present among women aged 20-35 years. Maternal age can therefore be used as an initial indicator for closer psychological assessment rather than as a stand-alone predictor.

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