








Experiencing pregnancy at an advanced maternal age in a private hospital

Experienciando a gravidez em idade materna avançada em hospital privado

How to cite this article:

Chemim AK, Castro BC, Aldrighi JD, Wall ML, Carvalho AL, Medeiros BGN, et al. Experiencing pregnancy at an advanced maternal age in a private hospital. Rev Rene. 2022;23:e70958. DOI: <https://doi.org/10.15253/2175-6783.20222370958>

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Conflict of interest: the authors have declared that there is no conflict of interest.

EDITOR IN CHIEF: Ana Fatima Carvalho Fernandes
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ABSTRACT

Objective: to describe the experiences of pregnant women at advanced maternal age assisted in a private hospital. **Methods:** a qualitative study, carried out with 17 women, by means of semi-structured interviews via telephone. The data was submitted to Thematic Content Analysis. **Results:** the participants were between 35 and 40 years old. Two categories emerged: Experiencing pregnancy as a couple and family: the preparation of the couple for pregnancy and childbirth (Pregnancy after 35 years old as an element of potentiality; Change in the family routine for the baby's arrival) and Experiencing pregnancy and its changes: perceiving pregnancy as a healthy and calm experience (Change in emotional patterns related to the pregnancy process). **Conclusion:** experiencing pregnancy late in life was not a concern for women. Maturity and favorable socioeconomic conditions may have a protective influence on the course of healthy pregnancies in women attending the private health service.

Descriptors: Obstetric Nursing; Maternal Age; Pregnancy, High-Risk; Women's Health.

RESUMO

Objetivo: descrever as experiências de gestantes em idade materna avançada atendidas em hospital privado. **Métodos:** estudo qualitativo, realizado com 17 mulheres, por meio de entrevistas semiestruturadas via telefone. Os dados foram submetidos à Análise de Conteúdo Temática. **Resultados:** as participantes tinham idades entre 35 e 40 anos. Emergiram duas categorias: Experienciando a gestação como casal e família: o preparo do casal para a gestação e o parto (Gestação a partir dos 35 anos como elemento de potencialidade; Mudança na rotina da família para a chegada do bebê) e Vivenciando a gestação e suas alterações: percebendo a gestação como uma vivência saudável e tranquila (Alteração dos padrões emocionais relacionados ao processo gestacional). **Conclusão:** vivenciar a gestação tardiamente não foi uma preocupação para as mulheres. A maturidade e as condições socioeconômicas favoráveis podem ter influência protetiva para o transcorrer de gestações saudáveis em mulheres atendidas no serviço privado de saúde.

Descritores: Enfermagem Obstétrica; Idade Materna; Gravidez de Alto Risco; Saúde da Mulher.

Introduction

The postponement of childbearing beyond the age of 35 is a current phenomenon linked to the fertility transition experienced by the population in both developed⁽¹⁾ and developing countries⁽²⁾. Brazil has followed these changes and presents, in general, two profiles of women who delay pregnancy: first, women who are already mothers, with low income and education, but who, due to lack of reproductive planning, end up getting pregnant again, this time late⁽³⁾. Second, of women with more socioeconomic conditions, who consciously delay their first pregnancy for various reasons, mainly linked to educational and professional qualifications⁽⁴⁾. These last characteristics are commonly found in the international literature and represent a hegemonic profile of pregnancies in advanced age in developed countries^(1,5).

Pregnant women 35 years of age and older are traditionally considered at risk^(1,3,5), with a protocol for initiation of prenatal care by primary health care and referral to the specialized public network. However, women who have private health insurance are evaluated and seen in private practices and not necessarily referred to another service, but referred to maternity hospitals that have health insurance coverage for possible urgent and emergency care, as well as intensive care for her and her future baby. In this sense, private services receive a population of elderly women belonging to the second profile mentioned above, very similar to that found in the international literature^(4,6).

A study conducted in 29 countries in Asia, Africa, Middle East and Latin America revealed that about 12.3% of pregnancies were in women over 35 years old⁽⁷⁾. In developed countries, this percentage is even higher: the United States registered 17%, while France, 21.3%⁽⁵⁾. In Brazil, birth rates for women aged 35 and older have also increased. In consultation with data from the Live Births Information System, in the period from 2010 to 2019, the increase in births from mothers aged 35 and over was 54%⁽⁸⁾. When consider-

ring that the average number of live births, in general, has been maintained, it is prudent to infer that there is a gradual and successive increase in the birth rate in this population of elderly women, as well as in the world scenario.

Because it has become a common reality, the production of knowledge about motherhood in advanced age is vast, especially when associated with the risks and complications of pregnancy. This bias has its relevance for the development of strategies and care protocols for these pregnant women. However, most of these studies have strong biomedical and epidemiological bases^(1,5), that do not allow a deeper analysis about the experiences, certainly diverse, of this population. In this sense, it is understood that knowing what pregnant women of advanced age experience during the pregnancy process is equally important to provide subsidies to health professionals in order to improve care and health promotion for them and their families. Thus, the guiding question is: What are the experiences of pregnant women of advanced age assisted in a private maternity hospital?

Thus, the objective of this study was to describe the experiences of pregnant women at advanced maternal age assisted in a private hospital.

Methods

Qualitative research that used the Thematic Content Analysis as a theoretical and methodological reference⁽⁹⁾. The research was developed in a private maternity hospital in Curitiba, in the period from August 2019 to July 2020, with pregnant women aged 35 years or older who were attending the birth preparation group for couples offered to users who performed prenatal care in that service. The group occurred on a monthly basis, was taught by obstetricians and was preceded by a presentation of the physical structure of the institution by the nurse to the new couples. Every month, new couples could be incorporated into the meetings, which had a predefined schedule with

themes that were repeated every four months. Issues related to birth preparation, postpartum, and breastfeeding were presented. The choice of this maternity hospital was due to the inter-institutional partnership signed for the development of research, stimulated by the total number of births in the place, which was 4,273, summed in 2019 and 2020.

The inclusion criteria were pregnant women in the age range previously indicated, who were undergoing follow-up in the maternity hospital in question, with gestational age starting at 28 weeks of gestation. The exclusion criterion was not being fluent in Portuguese due to the presence of immigrants in the local health services. It is noteworthy that there were no exclusions.

The women were intentionally selected through an invitation for participation by the first two authors, who were undergraduate nursing students at the time, and who were the interviewers in this study. The undergraduate students were trained by members of the Research Group and each conducted interviews separately with different participants. The interviewers came on the dates when the meetings of the group for pregnant women offered by the maternity hospital took place, at which time they presented the research and the objective of the study. Each group meeting had, on average, 20 couples, separated in two times of the day. Of this total, at least two women met the inclusion criteria.

The interviewers participated in eight face-to-face meetings, totaling 18 pregnant women eligible for the sample composition at this time. The 18 pregnant women were invited to participate and, of these, three refused because they did not have time for the interview, even though it was explained that another time could be scheduled. The women who accepted the invitation were invited to enter a reserved room so that the study could be detailed, as well as the schedule for the semi-structured interview via telephone.

It should be clarified that the inclusion of telephone interviews was the feasible way found to collect

data from this population, since initially there was less adherence when face-to-face interviews were requested, as well as the unavailability of structure in the maternity hospital for this purpose. There were three refusals before the telephone interview was adopted.

It is important to clarify that in March 2020, the world was ravaged by the pandemic causing the disease COVID-19, which suspended the face-to-face meetings of the couples group and made it impossible to maintain the previous recruitment. Thus, the service workers were willing to give a letter introducing the research to each pregnant woman who attended the prenatal consultation and, if the woman agreed to participate, she filled out a pre-form with contact data, which was collected weekly by one of the interviewers. Thus, two pregnant women accepted, adding to those 18 women already invited in person by the interviewers themselves, accounting for a total of 20 pregnant women. As mentioned, three women refused to participate in the research. It is noteworthy that ten interviews were conducted before the pandemic and seven after, totaling 17 women interviewed. All the pregnant women participating in this study read and signed the Free and Informed Consent Term.

For the interviews, a semi-structured script and a form were used with socio-demographic data (maternal age; profession; marital status [married; separated; divorced or widowed; single]; education [illiterate; < 8 years; 8-12 years; > 12 years]; income [one to three minimum wages; three to five minimum wages; five to ten minimum wages; > ten minimum wages] and gestational status (parity [primiparous - no previous births; multipara - at least one previous birth]; gestational age; pre-pregnancy history; pregnancy complications; reproductive planning). The interviews lasted an average of 21 minutes and were all recorded by smart phone application and transcribed in full by the interviewers. The identification of the participants was expressed by the letter G (pregnant woman), followed by the numeral corresponding to the chronological order of the interviews, resulting in

the coding: G1, G2, G3... G17, which guarantees confidentiality and anonymity in the research process.

The data was organized and treated with the aid of the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ). The data processing was based on 435 text segments, of which 85.3% were used, resulting in five distinct classes when applying the Reinert Method or the Descending Hierarchical Classification⁽¹⁰⁾.

The research was approved by the Research Ethics Committee of the Clinics Hospital Complex of the Federal University of Paraná under Protocols No. 1,155,166/2015 and No. 3,182,968/2019 and Certificate of Submission for Ethical Appreciation No. 46154615.7.0000.0096, as well as authorized by the co-participating institution. The research was conducted according to the required ethical standards.

Results

Seventeen pregnant women participated in this study, with ages ranging from 35 to 40 years old, all of them were married, 16 had completed college, 13 were primiparous, 14 intended to have a vaginal delivery, only one of them did not plan her pregnancy, and all had incomes ranging from five to ten minimum wages at the time of collection.

The Descending Hierarchical Classification gave rise to five classes, which were categorized from the content analysis, resulting in the matrix category: Planning pregnancy in old age, which gave rise to two thematic categories, which, in turn, grouped subcategories, named: Experiencing pregnancy as a couple and family: The preparation of the couple for pregnancy and childbirth; Pregnancy from 35 years old as an element of potentiality and Change in the family routine for the arrival of the baby and Experiencing pregnancy and its changes: perceiving pregnancy as a healthy and peaceful experience and Change in emotional patterns related to the gestational process.

Experiencing pregnancy as a couple and family: the preparation of the couple for pregnancy and childbirth

The main theme of this subcategory is about the preparation and gestational planning on the part of the couple who decided to become pregnant. Some women waited until the end of their studies to start trying. Others had been trying for some time. Most of them had medical follow-up before and during the attempts: *We waited to become more financially stable and finish some study projects, then, when I finished my post-graduation, we decided to start trying to get pregnant, I went to the doctor to have tests done, to see if everything was okay, I stopped taking the contraceptive (G8). Then we took some time to recover our organism [after an abortion] and started trying again, it was a joint decision (G15). I talked to my doctor, I told him we wanted to get pregnant, he ordered exams to see if everything was in order (G17). We had been trying since I was 36 years old (G13). We had been trying for three years and, after a little treatment, we got pregnant (G4).*

At the same time that the couple understood the search for information as a tool to help in the planning and course of the pregnancy, they also saw it as a limitation that, in the case of older pregnant women, focuses on age and its relation to bad outcomes: *We are first-time parents, we go after, look for courses and try to find information, this is being very nice to help (G1). We were already well informed, with tranquility, we had already studied how the birth would be, in what we believe is right in humanized birth. It is important to get informed, go to educational activities and choose well the team that will accompany you in this process (G6). There is a lot of information, and sometimes we end up making a mistake because we get overwhelmed on the internet (G11). Sometimes, the risk is much more due to other factors than age, in this, the information is very limited to age (G13).*

Despite having planned and desired pregnancy, the women showed fear related to complications during pregnancy, delivery and life changes due to age: *We were afraid, we did not know exactly what it [cleft palate] was, I was afraid of being a syndrome (G11). When I found out, I was a little*

afraid, we know that the later [advanced age], there is more risk of something happening both to the baby and the mother (G17). Seeing as I was already a little older, I had a certain fear (G14). Fear of the new: I was until this moment without a child, so it makes me afraid (G5). Now, at the end, I feel that in a little while she will be here and there is that fear of not being able to handle it (G14). We are afraid of childbirth, afraid of not being able to (G12).

Pregnancy after the age of 35 as an element of potentiality

Some women did not find hindrances or difficulties in pregnancy because they were older. They attributed positive points to age, such as greater knowledge due to experience, maturity, as well as stability: *My husband and I already had, I think, a stronger couple relationship, more mature, so we had more conditions not only from the economic point of view, but also psychological, social, to deal with issues related to pregnancy (G6). People are opting to have children later in life to have a better life. I think this is positive, we are much more mature for everything, for life changes, for taking care of the child, we feel more secure (G8). We have more experience, I wouldn't be a mother at 20 (G12). Compared to other pregnant women... I think that, maybe, having a financial stability, a good support from my partner, we have facilities (G16). I think that, because of my age, I am more prepared, I have more knowledge about things, about what can happen (G17).*

Changes in the family routine for the baby's arrival

In this subcategory, the women demonstrated greater complicity of the couple, structuring of the house to receive the new baby and changes in the family routine: *I think the change in life was not to think only about us anymore, the support and more closeness between me and my husband, companionship (G1). Changes in life itself, for now, none, only in the house, that I made the room for the new baby (G3). We, as a family, are having a very pleasant moment of planning her life, how our life will be with her (G8). The simple fact that we are already increasing the family is a giant change in our space, in the logistics of our routine (G11).*

Experiencing pregnancy and its changes: perceiving pregnancy as a healthy and calm experience

The speeches in this subcategory reflected the experiences of women who, despite the expectation of a period of complications due to advanced age, experienced pregnancy as a healthy and uneventful period, evidenced by healthy eating habits, physical exercise, routine tests with favorable results and psychological support: *I always had a very good diet, always did physical activity and keep doing it, besides weight training, I also do Pilates twice a week (G15). I take care of my diet so as not to gain too much weight; I have been, since the beginning, doing physical activity, doing Pilates, water aerobics (G4). I had gestational diabetes, but with the diet it has already stabilized, I have a medical body that supports me, financial conditions to have a doula, go swimming, do Pilates (G13). My health is good, calm, I have no cholesterol, nothing, the exams are all good (G12).*

Although some of the women interviewed said they were healthy and calm, some changes expected in the gestational process were also pointed out, such as nausea, hypotension, discomfort due to edema and pain: *Everything was very calm until the first reactions of pregnancy, such as nausea, pressure drop (G6). At the beginning of the pregnancy, I was much more nauseous and now, at the end, I have more pain in the hip, sciatica, groin (G10). The chest also increased a lot, my hip and the swelling in the leg (G15).*

Changes in emotional patterns related to the gestational process

The women revealed mood swings, presenting conflicting and contrary feelings in a shorter period of time, being more fragile and sensitive, although also happy: *The emotional is complex, it varies a lot between each period of pregnancy; it is a mixture of mood, joy, sadness, concern, it seems like a roller coaster (G9). I am very irritated, my mood oscillates; at some moments, I am more sensitive, more tearful (G11). For being older, mood was also a difficulty because it changes a lot, you get very fragile for little things (G14). I had like an endless post-menstrual tension, very critical mood swings (G16).*

Emotional changes were not only restricted to the expression of feelings and mood swings, but also reflected the women's state of activity and anxiety, with repercussions on eating and body self-image: *At the beginning of pregnancy, I was very sleepy; then, the body stabilizes and, today, I am normal, the more active I get the better I get* (G6). *The fact of changing the body, this was also a little difficult, the weight gain, I was very anxious about the weight gain* (G14). *I made a very organized diet; as I don't like to eat much, I was worried that the baby would not gain weight and, at the same time, that the body would change a lot* (G14). *I gained weight, I think: "Will it go back to normal?"; because I have always been thin* (G5).

Discussion

The limitations of the study include the fact that there were two interviewers, which may mean that different approaches, based on the individuality of each one, may have been applied, although a script of questions was used in order to resolve possible contrasts, as well as the training of both for the development of the interviews. The use of telephone interviews can also be pointed out as a weakness of the study. Despite facilitating access to the participants, this technique may have made it impossible to perceive the facial expressions of the interviewees. Nevertheless, it is understood that the findings presented here cannot be disqualified due to the data collection tool used, because the results demonstrate important experiences about the gestational period of a population little studied in Brazil, especially collected in times of social isolation because of the pandemic.

It is considered that the study may contribute to point out possibilities of action by the nurse in private systems through Nursing consultations, considering the particularities of each woman, assistance in reproductive planning, guidance on delivery and postpartum, in order to facilitate the healthy maintenance of a pregnancy at an advanced age, besides adding to the current knowledge, the perspectives of women assisted in the private health service. Moreover, it is understood that the study fosters the development of

new approaches by nurses in all health systems, especially in the Unified Health System, in which there are high rates of reproductive non-planning.

In this study, women demonstrated to employ joint efforts with their partners, embodied in decisions and attempts to get pregnant, accompanied by a professional or not, as well as searching for knowledge related to pregnancy and childbirth. In this sense, the literature points out that women over 35 years of age present a pattern of behavior that permeates the search for information, planning, and preparation for pregnancy and childbirth^(4,6).

The possibility of planning a pregnancy and being able to decide when, how and why to get pregnant in Brazil, a country with low rates of reproductive planning, can still be considered a privilege. For some decades, the Ministry of Health has been referring to reproductive planning in primary care as a strategy to improve women's reproductive conditions and, although national data show a decrease in birth and mortality rates, planning and desiring a pregnancy are faculties linked to levels of schooling and income, the symbols of social inequality in the country⁽²⁾. Thus, it is clear, in this study, why only one pregnancy was not planned in the population studied, because these are women who present a profile compatible with that presented in the international literature. This reveals high levels of education and income of women over 35 years old, as well as that they report greater marital stability and better levels of pregnancy planning^(4,5). This is in line with a national study of women in the same age group, but belonging to a lower social class and treated in a public health service⁽³⁾.

Allied to this, women with more socioeconomic conditions have the possibility of expanding the sources of information about their situation, seeking to complement the guidance given by health professionals during prenatal visits^(4,6,11). In this sense, there is the access to content and support networks on the internet, groups for pregnant and birthing women, and breastfeeding counseling. Of these, the internet, with health and social media pages, can both help, with use-

ful and correct information, and also disseminate false and fraudulent content⁽⁶⁾, that may, instead of solving doubts and helping in the search for knowledge, bring insecurities and fears, in this case, specifically focused on the relationship between age, complications and negative outcomes for pregnancy.

Fear is a common component when it comes to the unknown and can be present in any pregnancy. The changes in the body, behavior, life routine, and family dynamics are fears that can be recognized, welcomed, and mitigated by the nurse throughout the gestational process, passing through childbirth and puerperium. Likewise, groups that intend to provide the sharing of information with the supervision of a trained professional are valuable strategies for being channels of active listening, identification of insecurities, doubts and, at the same time, a safe informational resource^(3-4,12). It is noteworthy that some women in this sample had other support resources, such as a private birthing team and/or doulas, who are also professionals who support the problems identified.

Although age is taken as a bias of risk and complications related to pregnancy, it is also seen as a positive factor because many pregnant women in advanced age are more secure professionally and financially, as well as living consolidated relationships, besides feeling empowered about their own body and their rights^(5-6,13). Thus, there are reported potentialities that, due to age, are attributed to the higher level of knowledge due to maturity and stability. The literature contextualizes the maturity resulting from age as one of the greatest advantages of late motherhood, implying greater security and competence in caring for the baby^(4,6).

When talking about the preparation for the baby's arrival, it was observed that planning for this stage was not centered only on the figure of the pregnant woman, but rather on the couple or the family. The father's involvement in pregnancy and in the first months of the child's birth has become increasingly common, showing that the experiences of the pregnancy period are less and less restricted to women.

This commitment of the father can be materialized through preparations for the day of delivery, such as arranging the "maternity suitcase", organizing the house and the "little room", but, more importantly, the paternal involvement can be characterized by the concerns, emotions and responsibilities shared between the couple regarding pregnancy, the preparation and contribution to the development of a positive environment for the exercise of parenthood and the welcoming of a child⁽¹⁴⁾.

Just as women in advanced age tend to show maturity, emotional preparedness, and priorities focused on quality of life, partners who become fathers in advanced age may also show a tendency to develop this behavior, contributing to the co-responsibility of parenting.

Pregnancy at late ages is related to higher rates of commitment to prenatal care and health, because more mature women, especially those with better socioeconomic conditions, are concerned about performing regular physical activities and taking care of their diet⁽¹⁵⁾, even by the need imposed, many times, by comorbidities, such as arterial hypertension and gestational diabetes, commonly present in women who are over 35 years old⁽⁷⁾.

In this study, we observe a group of women with a healthy lifestyle who consume specialized services that are not always present in the reality of care in the public health system, such as Pilates and hydro-gymnastics. In this sense, the study indicates the importance of the nurse playing an active role in promoting the practice of regular physical activity, before and during pregnancy, in order to provide relief from pregnancy-related pain, and reduce gestational weight gain⁽¹⁶⁾ and prevent depressive symptoms⁽¹⁷⁾.

The pregnancy experience is crossed by several psychological changes^(4,6). Mood swings and anxiety symptoms were well characterized in the reports: irritation, emotional fragility, and worry. The risk of pregnancy-related anxiety is potentially higher in primiparous women, as there is high self-questioning about preparedness for parenthood^(11,18). However, despite

being predominantly primiparous, these pregnant women showed more anxiety related to pregnancy than to motherhood itself, corroborating the perception of greater maturity and security for the experience of “being a mother” in older age^(4,6,11,13).

The anxiety more focused on pregnancy may be related to both the perception of pregnancy at advanced age as a risk and the feeling of loss of control over one’s own body. The risk associated with complications and the uncertainty of positive outcomes of pregnancy, both for the woman and the fetus, stresses both the woman and her family and the nurse, which can hinder the careful look beyond the biological needs of the woman⁽¹⁶⁾.

It is understood that this is a population that has a socially privileged position, with high education and income for Brazilian parameters. It is considered that mainly these two factors, together with the maturity that comes from age, are protective conditions, because they allow us to assume that women and their families have access to different strategies for health maintenance that can help them promote healthy experiences of pregnancy and parenthood.

It is important to emphasize that, although the Nursing team is constantly in contact with these pregnant women, the speeches highlighted the invisibility of these professionals in the direct care of women assisted in this private health service, considering that, in the supplementary sector, it is not a common practice to alternate prenatal consultations between nurses and physicians, as is done in the context of primary care. Thus, there is an urgent need for Nursing to claim and build its space in order to strengthen the health team, as well as to add knowledge and strategies for individualized or group care that meet the demands of these women.

Conclusion

Although age is an important factor when considered for risk stratification, the couple’s preparation for pregnancy and childbirth, the changes in the fami-

ly routine for the baby’s arrival, the calm and healthy experience, even with altered emotional patterns, anxiety and various fears, seemed to allow women to experience this moment in a less stressful way by attributing positive views related to age, mainly related to better purchasing power, maturity in marriage and professional life. Regarding the Nursing team, the need and importance of strengthening actions and the construction of the profession’s space in this scenario became evident.

Authors’ Contribution

Conception and design, data analysis and interpretation: Aldrighi JD, Wall ML.

Data analysis and interpretation: Chemim AK.

Analysis and interpretation of the data and writing of the article: Castro BC, Carvalho AL, Medeiros BGN.

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All authors approved the final version to be published.

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