Social Sciences and Development Review
Volume 17, No. 1, 2025

Polytechnic University of the Philippines

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DOI: https://doi.org/10.70922/9pee1v07

Article History:

Received: March 16, 2025
Revised: July 1, 2025
Accepted: July 25, 2025

How to Cite this paper:

Tena, M.R. (2025). Profile, Trends, and Determinants of Pregnancy Termination Among Filipino Women. *Social Sciences and Development Review*, 17(1), pp. 147-168.
https://doi.org/10.70922/9pee1v07

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ABSTRACT

Cultural and legal barriers force many Filipino women to undergo unsafe and secret abortions. This study examines the profile of women who terminated pregnancy among those who gave birth in the last five years according to selected independent variables, and the trends in pregnancy termination from 1992 to 2022 all National Demographic and Health Surveys. It also identified the determinants of pregnancy termination and estimated its likelihood. The analysis accounted for the complex survey design. Descriptive statistics, bivariate analysis, and multivariate logistic regression were employed. Results show that nearly 13% of women who gave birth in the last five years experienced pregnancy termination, and the distribution varies according to selected independent variables. Termination rates remained from 1997 to 2007 but declined in 2022. Logistic regression identified age as the strongest predictor, with odds rising sharply over time. Belonging to wealthier quintiles and having good self-rated health reduced the likelihood of termination, while education, marital status, religion, and residence showed no independent significance. Older, low-income, and poor health remain at higher risk, highlighting the need for targeted support. Expanding access to family planning, improving maternal healthcare, and addressing economic vulnerabilities can help reduce unintended pregnancies and unsafe abortions. Strengthening reproductive rights policies and ensuring access to safe abortion-related care and the legalization of abortion in the country are also crucial steps in promoting women's health and well-being.

Keywords: *abortion, determinants, ecological model, pregnancy termination, trends*

INTRODUCTION

Pregnancy termination includes induced abortion, miscarriage, and stillbirth. The 2022 Philippine National Demographic and Health Survey (NDHS) revealed that 13% of reproductive- aged women had unplanned pregnancies and unintended births, and 12% of

women had terminated pregnancy in the last three years preceding the survey (PSA & ICF, 2023). This is a public health concern, as some of them perform unsafe abortions despite several health repercussions. Globally, 60% of unplanned pregnancies lead to abortion, and 45% of these abortions are unsafe (World Health Organization [WHO], 2024). Despite the declining maternal mortality ratio in recent decades in the country (World Bank, n.d.), the lack of proper medical intervention for those who had terminated pregnancies could lead to potentially fatal complications (Center for Reproductive Rights [CRR], 2024).

Spanish colonization imposed Catholic doctrines that stigmatized reproductive autonomy and institutionalized patriarchy. This continued during the American period, and even in the postwar period (Austria, 2004). As a result, societal stigma surrounded both miscarriage and abortion, the latter of which was particularly condemned. The country's legal framework is heavily influenced by its Catholic and Christian traditions. The Catholic Church and other religious groups significantly shape public discourse and policies regarding reproductive rights and healthcare (Human Rights Watch [HRW], 2023). The Penal Code of the Philippines (1930) criminalizes abortion and imposes penalties on both women who undergo the procedure and the medical practitioners who perform it. Such legal restrictions and societal stigma compel many women to reframe their experiences as miscarriages or stillbirths, similarly experienced by women in other countries (Onukwuga et al., 2020). This environment restricts access to safe abortion services, contributing to maternal morbidity and mortality, which are significant public health concerns (Kassa et al., 2024; Onukwuga et al., 2020). Without proper medical care, women who undergo unsafe procedures may suffer from not only the physical aspect but also the mental aspect (WHO, 2024). If unsafe abortion continues, this will be detrimental to the objective 3.1 of the Sustainable Development Goal of cutting the maternal mortality ratio to fewer than 7 deaths per 10,000 live births by 2030, and the years to come (WHO, n.d).

In recent years, the incidence of unplanned pregnancies has declined, yet the number remains substantial (PSA & ICF, 2023). Despite government efforts to expand access to contraceptives, many women remain hesitant due to the influence of religious beliefs. Cultural and legal barriers further push women toward unsafe abortion methods (CRR, 2024), while those who experience stillbirths or miscarriages often face social stigma and judgment. Addressing these challenges necessitates a comprehensive understanding of pregnancy termination and a research-based approach to inform policymakers. By highlighting the urgency of considering the legalization of abortion in special cases and combating stigma, we can establish a society that better supports women who have experienced pregnancy termination.

The incidence of pregnancy termination varies widely in many countries and regions, commonly shaped by legal frameworks, healthcare access, and sociocultural factors. Ba et al. (2023) reported that, across 36 countries analyzed in their study, the pooled weighted prevalence of pregnancy termination was 13.3% (95% CI: 13.2%–13.4%), although significant regional differences were observed. The lowest prevalence was recorded in Namibia at 7.8% (95% CI: 7.2%–8.4%), while Pakistan had the highest at 33.4% (95% CI: 32.0%–34.7%). A more recent study by Mbona et al. (2025) reported a pregnancy termination prevalence of 14.3%, reflecting an increase compared to Ba et al.'s (2023) findings. This rise may be attributed to Mbona et al.'s use of the latest DHS data, capturing more recent trends and updates in the reproductive health behavior of women in Tanzania. In the case of younger women in six countries, the percentage of termination varies from one country to another, with the highest prevalence in Tanzania (6.3%) and lowest in Ethiopia (4%).

South and Southeast Asia also exhibit notable variations in pregnancy termination prevalence. According to Ba et al. (2023), rates are highest in Pakistan (33.4%), followed by Afghanistan (19.5%), Bangladesh (19.2%), Nepal (20.1%), and Myanmar (9.4%). Afghanistan, Bangladesh, and Nepal reported similar prevalence levels, suggesting an ongoing need for comprehensive reproductive health services and family planning initiatives in their respective countries. In Nepal, Yogi et al. (2018) reported that 21.1% of women had terminated a pregnancy, which is slightly higher than Ba et al.'s (2023) report of 20.1%. The discrepancy may stem from differences in the data they used in their respective studies. Similar to the results in Zambia, the increase may be attributed to the changes in reproductive health behavior of women in Nepal. Meanwhile, in Sierra Leone, West Africa, only 9% of women terminated pregnancy (Sesay et al., 2023). These differences may also stem from the changes in the reporting of pregnancy termination incidences. In the Philippines, despite the stigma and negative connotation regarding abortion in the country, the 2022 NDHS reported that 12% of women had a terminated pregnancy.

Several factors have been identified as associated with pregnancy termination. Age strongly correlates with pregnancy termination, although high-risk groups vary geographically. In Tanzania, women aged 35–49 and 25–34 have over twice and nearly threefold higher odds, respectively (Mbona et al., 2025). Conversely, studies in Rwanda, Nigeria, Kenya, Burundi, Tanzania, and Ethiopia identify women aged 20–24 as the most likely to terminate a pregnancy (AORs: 1.69 in Ethiopia to 4.04 in Rwanda), followed by those aged 25–29, who have higher odds than women aged 15–19 (Kassa et al., 2024). Meanwhile, another study found that women aged 45-49 had the highest odds of pregnancy termination (Sesay et al., 2023). In contexts where abortion is perceived as unsafe, women aged ≥35 show reduced odds (Yogi et al., 2018).

Contraceptive use has been linked to lower odds of pregnancy termination. Mbona et al. (2025) reported that women who use contraceptives have a 16% lower probability of experiencing termination compared to those who do not use them. A machine learning study also identified contraceptive use as a predictor of pregnancy termination (Setegn & Dejene, 2024). Additionally, research indicates that women who express a desire for children within the next two years are significantly more inclined to terminate a pregnancy (Mbona et al., 2025). Self-rated health also correlates with pregnancy termination. Women who perceive their health as moderate have a higher likelihood of terminating a pregnancy compared to those who consider themselves in good health (Mbona et al., 2025).

Marital status is associated with pregnancy termination at the relational level. In two different studies, married women were more likely to terminate pregnancy compared to unmarried women (Mbona et al., 2025; Sesay et al., 2023). In the study of Kassa et al. (2024), pregnancy termination is less likely to happen to unmarried women compared to formerly married women in six out of six countries included in the study, while being married or being in cohabitation increases the odds of pregnancy termination by more than five times. The number of children a woman has is a significant factor influencing pregnancy termination. Women with one to five children have a 38% higher likelihood of terminating a pregnancy compared to those with no children. This likelihood increases to 58% among women with six or more children (Mbona et al., 2025). However, a contrasting finding from another study found that having six or more children decreases the likelihood of pregnancy termination by 60% (Sesay et al., 2025).

At the community level, place of residence is significantly associated with pregnancy termination, although which group has the higher likelihood varies by context. In Nepal, urban women are twice as likely to terminate a pregnancy compared to their rural counterparts (Yogi et al., 2018). In contrast, in Tanzania, rural women have significantly lower odds of pregnancy termination than those in urban areas (Mbona et al., 2025). Place of residence was one of the most crucial factors that predicted pregnancy termination in six African countries (Setegn & Dejene, 2024). The role of internet use in pregnancy termination has also been examined. Evidence suggests that women who use the internet have a 21% higher likelihood of terminating a pregnancy compared to non-users (Mbona et al., 2025).

At the societal level, education is a critical determinant of pregnancy termination, though findings vary across regions. Using machine learning, Setegn and Dejene (2014) were able to find women's educational attainment as a predictor of pregnancy termination. Studies in six sub-Saharan African countries link no formal education (or primary education only in Ethiopia) to higher rates of pregnancy termination versus higher educated women (Kassa et al., 2024). Conversely, in Tanzania, women with secondary education are more likely to terminate

pregnancies than those with no education (Mbona et al., 2025), while in Sierra Leone, women with primary education only had the highest likelihood of pregnancy termination (Sesay et al., 2023).

The wealth index of the woman is also crucial in determining pregnancy termination. Wealth index significantly predicted pregnancy termination in six African countries (Setegn & Dejene, 2024). Poorest women were less likely to terminate pregnancy compared to women in the richest quintile in Kenya and Burundi, while it was the richer women who were less likely to have pregnancy termination compared to the richest women (Kassa et al., 2024). Meanwhile, Tanzanian women in the middle and rich wealth quintiles have higher termination odds than poorer women (Mbona et al., 2024). In contrast, the poorest women have the highest odds of termination compared to poorer, middle, richer, and richest women in the case of Nepal (Yogi et al., 2023).

Employment status is a predictor of pregnancy termination (Setegn & Dejene, 2024). Employed women have a higher likelihood of pregnancy termination as compared to unemployed women (Sesay et al., 2023; Kassa et al., 2024). Religion influences pregnancy termination. In the context of Nepal, Buddhist women are two times more likely to terminate pregnancy compared to Muslim women and other religions (Yogi et al., 2018).

While existing studies highlight socio-demographic and geographic determinants of pregnancy termination, critical gaps remain. Several determinants like age, number of children, and wealth show conflicting findings across regions, suggesting context-specific dynamics that have not been explored in restrictive, Catholic-majority settings like the Philippines. Moreover, most of the studies conducted examining pregnancy termination included all women or all younger women who has ever had terminated a pregnancy. These studies failed to capture the timing of pregnancy termination as they did not take into account when termination actually occurred. While the 2022 Philippine NDHS also did not capture when the pregnancy termination happened, this study only included those who gave birth in the last five years. Considering the cross-sectional nature of the data used in the previous studies, capturing the approximate time of the event is crucial. In addition, there is a gap in analyzing the trends of pregnancy termination in a 20-year period. These are the gaps to be addressed in this study.

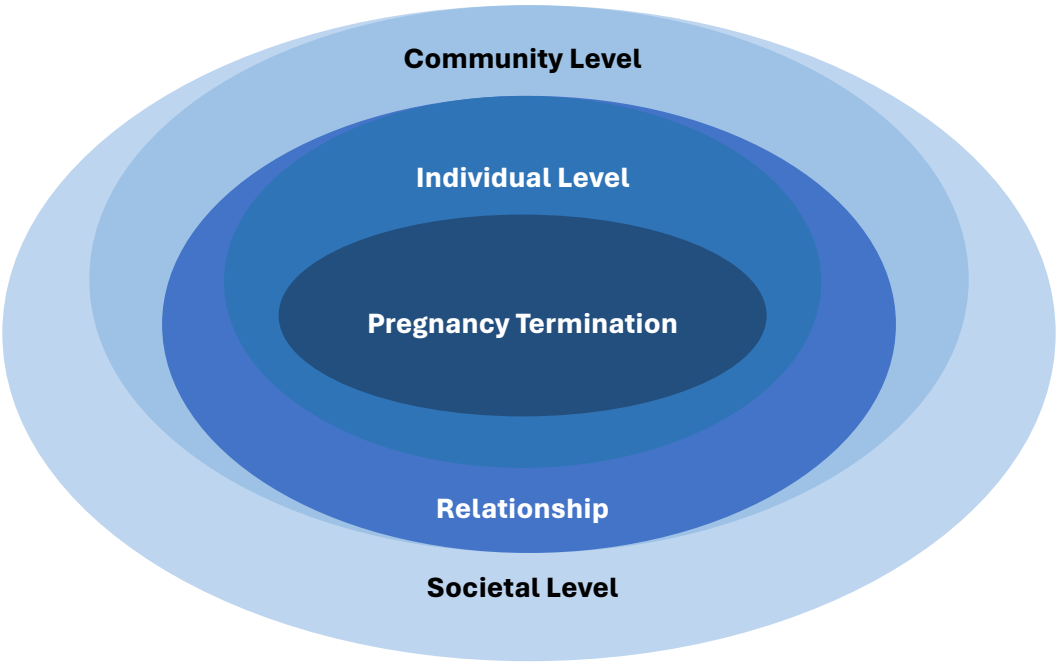
Conceptual Framework

Pregnancy termination is a complex reproductive health outcome and is likely shaped by dynamic interactions between individual agency, relational dynamics, community norms, and societal inequities. This conceptual framework adapts Heise's ecological model (Heise, 1998), originally designed to analyze violence against women, to systematically examine

how multi-level factors intersect to influence the likelihood of pregnancy termination. By categorizing predictors into individual, relationship, community, and societal levels, this model provides a holistic lens for understanding the interplay of factors across different layers in determining pregnancy termination among women who gave birth in the last five years in the Philippines. This framework acknowledges that decisions surrounding abortion or pregnancy termination are not simply individual decisions but are shaped by other forces. By applying the ecological model in this study, it allows for a more nuanced and deeper understanding of reproductive health decisions. Figure 1 presents the relationship of different factors in influencing an individual's action or an event. In this case, pregnancy termination.

Figure 1

Ecological Model of Factors Influencing Pregnancy Termination



At the individual level, age is presumed to influence pregnancy termination, as older women in some contexts face higher termination odds (Mbona et al., 2025), while younger women (e.g., 20–24 years) in other settings may terminate pregnancies due to social stigma or limited resources (Yogi et al., 2018; Kassa et al., 2024). Contraceptive use also plays a key role in influencing unintended pregnancies, with inconsistent or ineffective use raising the likelihood of termination. The desire for children is another important factor influencing pregnancy termination, as women who have achieved their fertility goals prioritize career or educational aspirations may seek termination to align with their life plans. Self-

rated health reflects perceived physical and mental capacity to carry a pregnancy to term, influencing decisions among women with chronic illnesses or inadequate support. These individual factors, however, do not operate in isolation but are constrained or amplified by other factors.

Relationships also influence reproductive decisions. Married or cohabiting women often face pressures tied to partner preferences. For instance, studies show married women have significantly higher termination odds than unmarried women (Mbona et al., 2025; Kassa et al., 2024). Conversely, unmarried women may terminate pregnancies to evade the stigma associated with non-marital fertility. Formerly married women may face heightened vulnerability. These relational pressures emphasize how interpersonal hierarchies affect individual agency. The number of children a woman already has may shape her perception of whether they should have more children or not. Thus, it may influence whether to continue or terminate a pregnancy.

At the community level, place of residence (urban vs. rural) is also presumed to influence pregnancy termination, as it stratifies healthcare access. Urban women often benefit from proximity to clinics and relatively better social services. Meanwhile, rural women may encounter logistical barriers and entrenched stigma, particularly in the more conservative rural areas of the Philippines. Additionally, internet use expands access to reproductive health information and other healthcare options. Thus, those who have internet access in the Philippines may have access to how to access them discreetly, making them potentially more inclined toward pregnancy termination than women who do not use the internet.

At the societal level, education is a key structural determinant. Higher educational attainment is associated with greater health literacy and economic independence to navigate healthcare systems. However, disparities exist, as women with secondary education in some contexts (e.g., Tanzania) report higher termination rates (Mbona et al., 2025). This positively reflects the heightened awareness of legal options to delay or stop childbearing. Wealth further stratifies access as those relatively wealthier women often bypass legal restrictions through private care, while poverty worsens reliance on unsafe methods. Employment also plays a role in pregnancy termination. Employed women may have better access to healthcare services and knowledge about abortion than unemployed women. Religion shapes the opinion of women about the death of a fetus. Thus, religion is also considered as a factor that may influence pregnancy termination. Collectively, these factors contribute to shaping the outcome of pregnancy.

By applying Heise's ecological model, this framework explains the complexity of factors shaping pregnancy termination, ranging from intimate partner dynamics to systemic inequities. It challenges reductionist narratives that attribute pregnancy termination solely to

individual irresponsibility, instead positioning the outcome as a manifestation of intersecting factors across multiple ecological layers.

METHODOLOGY

The data for trend analysis were drawn from every demographic and health survey conducted in the Philippines from 1993 to 2022. It covers pregnancy termination in all women included in the survey. In the analysis of the profile of and identifying the correlates of women who had a terminated pregnancy, the most recent 2022 Philippine National Demographic and Health Survey (NDHS) was utilized. The 2022 NDHS used a two-stage stratified sampling methodology based on the 2010 Census of Population and Housing, which was updated using the lists of households from the 2015 Census of Population (PSA & ICF, 2023). The data from the NHDS were weighted to account for probability selection differences and adjusted for non-response.

For this study, the sample was limited to women aged 15-49 who reported giving birth within the five years preceding the survey. Since the data do not capture the date of pregnancy termination in the Philippines, only the year of the most recent birth was considered. Having this in mind, those women who gave birth before 2018 were excluded.

The dependent variable was from the women's answer to the question of whether they had a terminated pregnancy or not. The variable of interest in this paper is the woman who has ever had a terminated pregnancy (1) compared to those who never had a terminated pregnancy (2) The time of pregnancy termination was not collected in this survey. Thus, it is impossible to examine the exact timing of pregnancy termination. However, since the focus of this study is the pregnancy termination of those who had given birth in the last five years, only the approximate timing was captured.

The selection of independent variables for this study was based on the conceptual framework used and the findings of studies reviewed to ensure the availability of the selected variables in the NDHS.

Age refers to the current age of the woman at the time of the survey, grouped into five-year intervals: *19-24, 25-29, 30-34, 35-39,* and *40-49* to capture variations across reproductive age groups, with 19-24 as the reference. Contraceptive refers to the type of contraceptive the woman is using. It is classified into *not using*, *traditional method*, and *modern method*. Desire for another child refers to the desire to have another child within 2 years or the next 2 years. It is categorized into *with desire* and *without desire*. Self-reported health serves as a measure of the woman's perceived health status. This is categorized into *good health* and *otherwise*.

Marital status refers to the current relationship status of the woman. It is categorized into *currently not married* (which includes never married, divorced, separated, and widowed women) and *married* (currently married). Meanwhile, the number of children refers to the woman's total number of living children. The number of children is grouped into *two or less* and *three or more* children to account for how the current number of children may affect pregnancy termination.

Place of residence is classified as either *rural* or *urban* based on the 2022 NDHS classification of living areas (PSA & ICF, 2023). Internet use refers to whether the respondent reported *using* or *not using* the internet in the past month. Education refers to the highest educational attainment of the respondents. It is categorized into three levels based on the highest educational attainment: *primary and below* (no education or primary education), *secondary* (some secondary or completed secondary education), and *tertiary or higher* (education beyond secondary level).

Meanwhile, wealth status follows the NDHS classification of wealth index quintiles. It is grouped into *very poor* (lowest quintile), *poor* (second quintile), *middle* (third quintile), *rich* (fourth quintile), and *very rich* (highest quintile). Employment was categorized into *employed* and *unemployed* (reference group). Religion is the woman's self-reported religious affiliation. It is classified into *Catholics* and *other religions*, which include Islam, Iglesia ni Cristo, and other religious groups. The rationale for these groupings is based on the predominance of Roman Catholicism in the Philippines.

Before performing the analysis, the data were organized by filtering out unselected cases, specifically omitting women who had never given birth and those who gave birth prior to 2018. Using Stata version 17, the SVYSET and SVY commands were employed to account for the complex sampling design employed in the NDHS. Since this includes all women who gave birth in the last five years, V005 was used as the weighting variable after dividing it by a million. It was then used as the probability weight, and used primary sampling unit (V021) as the PSU, and V022 as the sample strata for sampling errors. Descriptive statistics were used to present the profile of Filipino women who gave birth in the last five years according to selected independent variables. Bivariate analysis using a contingency table was also generated to examine the differences in pregnancy termination according to the selected independent variables. The chi-square test was used to measure the association of the independent variables and pregnancy termination. A p-value of less than .05 was considered to be associated with pregnancy termination.

Meanwhile, to present the prevalence of pregnancy termination from 1992 to 2022, the percentage of women who reported ever having terminated a pregnancy was obtained from every NDHS conducted. The trend analysis was descriptive and not weighted. In identifying

the determinants of pregnancy termination, binary logistic regression was used to generate crude odds ratio (COR) to capture the unadjusted associations between each category of independent variables and pregnancy termination. After this, multivariate logistic regression was performed. To facilitate the inclusion of more independent variables in multivariate analysis, all the independent variables at $p < .20$ in bivariate analysis were included in regression analysis. Multivariate logistic regression was utilized to identify the determinants of pregnancy termination in the adjusted model, after controlling for other covariates. Odds ratios in the adjusted model were reported as adjusted odds ratios (AORs). P-values <.05 were considered determinants of pregnancy termination.

RESULTS AND DISCUSSION

Profile of Women Who Gave Birth in the Last Five Years

Table 1 shows the frequency (unweighted) and percent distribution (unweighted and weighted) of women who gave birth in the last five years prior to the survey. Pregnancy termination in the Philippines is nearly 13%, which is comparable to the global average of 13.3% (Ba et al., 2023), yet it remains significantly lower than in several South and Southeast Asian countries, such as Pakistan (33.4%), Nepal (20.1%), and Bangladesh (19.2%) (Ba et al., 2023). In contrast, the prevalence in the Philippines is higher than in Namibia (7.8%) and Myanmar (9.4%) (Ba et al., 2023), as well as in Sierra Leone, where Sesay et al. (2023) reported a termination rate of 9%.

Despite strong legal restrictions and persistent stigma surrounding abortion in the Philippines, the pregnancy termination rate remains similar to other countries where termination is more accessible. This suggests that unintended pregnancies and secret abortion methods may still be prevalent. In contrast, countries with more liberal abortion laws, such as Nepal, where abortion has been legal since 2002 and yet termination rates remain high (Yogi et al., 2018; Ba et al., 2023). This figure may be inherently good or bad, but it is concerning in terms of the issue about the safety of those who perform pregnancy termination. Data say less about the permissiveness in the Philippines but more about the urgency of expanding comprehensive reproductive health services.

Table 1

Profile of Women Who Gave Birth in the Last Five Years: Philippine NDHS, 2022

Independent Variables	f (unweighted)	% (unweighted)	% (weighted)
Pregnancy Termination			
No	5,385	87.04	87.36
Yes	802	12.96	12.64

Independent Variables	f (unweighted)	% (unweighted)	% (weighted)
Age			
19-24	1,306	21.11	20.82
25-29	1,610	26.02	26.50
30-34	1,455	23.52	24.10
35-39	1,070	17.29	17.11
40-49	746	12.06	11.47
Contraceptive Use			
Not using	2,299	37.16	34.57
Traditional Method	937	15.14	16.36
Modern Method	2,951	47.70	49.07
Desire for Children			
With Desire	2,111	34.13	34.56
No Desire	4,076	65.88	65.44
Self-Rated Health			
Otherwise	1,896	30.64	27.85
Good	4,291	69.36	72.15
Marital Status			
Currently not Married	2,814	45.48	50.59
Married	3,373	54.52	49.41
Number of Children			
2 or Less	3,358	54.28	56.72
3 or More	2,829	45.72	43.28
Place of Residence			
Rural	3,881	62.73	48.05
Urban	2,306	37.27	51.95
Internet Use			
Not Using	1,826	29.51	23.58
Using	4,361	70.49	76.42

Independent Variables	f (unweighted)	% (unweighted)	% (weighted)
Education			
Primary and Below	956	15.45	12.88
Secondary	3,024	48.88	50.62
Tertiary or Higher	2,207	35.67	36.50
Wealth			
Poorest	2,089	33.77	24.74
Poorer	1,426	23.05	21.35
Middle	1,068	17.27	20.58
Richer	823	13.30	16.92
Richest	781	12.62	16.42
Employment			
Unemployed	3,247	52.48	51.26
Employed	2,940	47.52	48.74
Religion			
Other Religions	2,075	33.54	25.53
Catholics	4,112	66.46	74.47
Total	**6,187**	**100**	**100**

Women aged 25-29 years accounted for the highest percent of recent births (26.50%), and nearly half (49.07%) use modern contraception. The majority (65.44%) do not want additional children, nearly three-fourths (72.15%) perceive their health as good, and around half of births occurred within marriage (50.59%). Moreover, more than half (56.72%) have two or fewer children, and slightly a higher proportion live in urban areas (51.95%) compared to rural areas (48.05%).

The vast majority (76.42%) have internet access. In terms of education, 12.88% have a primary education or below, half (50.62%) have at least a secondary education, and more than a third (36.50%) have a tertiary education or higher. Forty-six point zero nine percent (46.09%) belong to the poorest and poorer quintile, while 33.34% belong to the rich and richest categories. Employment status has a near-equal distribution, with 51.26% unemployed and 48.74% employed. With regard to religion, 74.47% identify as Catholic, while 25.53% belong to other religions, reflecting the dominant Catholic affiliation in the country. Women vary across diverse backgrounds. Overall, they are not confined to a specific factor but distributed across various age groups, education levels, residence, religion, and other socioeconomic and demographic backgrounds.

Variation in Pregnancy Termination According to Selected Independent Variables

Table 2 shows significant variations in pregnancy termination across individual, relational, community, and societal factors. Age had the strongest association ($p < 0.001$), with termination rates rising from 7.89% (95% CI: 6.06–10.21) among women aged 19–24 to 21.49% (95% CI: 17.58–26.01) among those aged 40–49. However, contraceptive use ($p = 0.413$) and fertility preference ($p = .120$) were not significant factors. Termination rates were similar among non-users (11.77%, 95% CI: 10.15–17.57), traditional method users (13.99%, 95% CI: 11.03–14.57), and modern method users (12.80%, 95% CI: 11.23–14.54). Likewise, women who did not desire more children (13.35%, 95% CI: 11.87–14.98) had non-significant slightly higher termination rates than those who did (11.29%, 95% CI: 9.43–13.46). Self-rated health was a significant factor in pregnancy termination ($p = .008$), with higher termination rates among those who perceive their health as otherwise (15.13% vs. 11.67%).

Table 2

Percentage Distribution Pregnancy Termination Among Filipino Women
Who Gave Birth in the Last Five Years: NDHS, 2022

Factors	% (weighted)	Confidence Interval	P values
Age			***.000***
19-24	07.89	06.06, 10.21	
25-29	10.33	08.33, 12.76	
30-34	12.99	10.42, 16.08	
35-39	15.55	12.82, 18.72	
40-49	21.49	17.58, 26.01	
Contraceptive Use			
Not using	11.77	10.15, 17.57	.413
Traditional Method	13.99	11.03, 17.57	
Modern Method	12.80	11.23, 14.54	
Desire for Children			***.120***
With Desire	11.29	09.43, 13.46	
No Desire	13.35	11.87, 14.98	
Self-Rated Health			***.008***
Otherwise	15.13	12.96, 17.58	
Good	11.67	10.33, 13.17	

Factors	% (weighted)	Confidence Interval	P values
Marital Status			***.249***
Currently not Married	11.92	10.25, 13.83	
Married	13.37	11.78, 15.13	
Number of Children			***.000***
2 or Less	10.03	08.66, 11.60	
3 or More	16.05	14.18, 18.11	
Place of Residence			***.532***
Rural	13.05	11.59, 14.67	
Urban	12.25	10.44, 14.33	
Internet Use			***.069***
Not Using	14.66	12.33, 17.34	
Using	12.01	10.63, 13.55	
Education			***.077***
Primary and Below	15.44	12.16, 19.41	
Secondary	13.11	11.37, 15.08	
Tertiary or Higher	10.98	09.16, 13.12	
Wealth			***.031***
Poorest	16.29	14.14, 18.69	
Poorer	11.86	09.74, 14.37	
Middle	11.26	08.53, 14.73	
Richer	11.96	08.93, 15.85	
Richest	10.56	08.06, 13.72	
Employment			***.050***
Unemployed	11.57	10.08, 13.25	
Employed	13.76	12.13, 15.57	
Religion			***.295***
Other Religions	13.65	11.60, 15.99	
Catholics	12.29	10.91, 13.83	

Among relationship variables, marital status was not a significant determinant of pregnancy termination (p = .249), with similar rates among married women (13.37%, 95% CI: 11.78–15.13) and those who were not currently married (11.92%, 95% CI: 10.25–13.83). However, the number of children a woman had showed a strong association with termination (p < 0.001), as women with three or more children had a significantly higher termination rate (16.05%, 95% CI: 14.18–18.11) compared to those with two or fewer (10.03%, 95% CI: 8.66–11.60). The place of residence is not significantly associated with pregnancy termination (p = .532). Termination rates were slightly higher among rural women (13.05%, 95% CI: 11.59–14.67) compared to urban women (12.25%, 95% CI: 10.44–14.33), but the difference is minimal. Internet use is also not significantly associated (p = .069), with non-users having a slightly higher termination rate (14.66%, 95% CI: 12.33–17.34) compared to internet users (12.01%, 95% CI: 10.63–13.55).

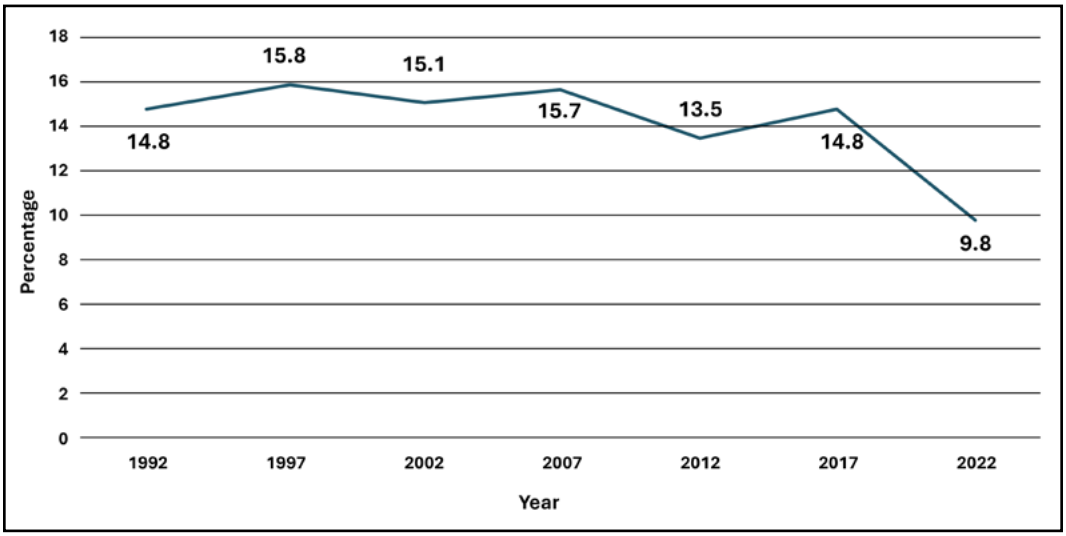
At the societal level, the education level is not a statistically significant determinant of pregnancy termination (p = .077), though a decreasing trend is observed with higher education. Women with primary education or below had the highest termination rate (15.44%, 95% CI: 12.16–19.41), followed by those with secondary education (13.11%, 95% CI: 11.37–15.08). Women with tertiary education or higher had the lowest termination rate (10.98%, 95% CI: 9.16–13.12). Meanwhile, a significant association between wealth status and pregnancy termination was observed (p = .031), with termination rates decreasing as wealth increases. The highest rate was observed among the poorest women (16.29%, 95% CI: 14.14–18.69), while the lowest was among the richest (10.56%, 95% CI: 8.06–13.72). Women in the middle wealth quintiles had similar termination rates, ranging from 11.26% (95% CI: 8.53–14.73) to 11.96% (95% CI: 8.93–15.85). When it comes to employment, no statistical relationship was found (p = .050). Women who were employed had a slightly higher termination rate (13.76%, 95% CI: 12.13–15.57) than those who were unemployed (11.57%, 95% CI: 10.08–13.25). Similarly, religion was not a significant factor (p = .295), with termination rates slightly higher among women of other religions (13.65%, 95% CI: 11.60–15.99) compared to Catholics (12.29%, 95% CI: 10.91–13.83).

Trends of Pregnancy Termination

Figure 2 shows the trends in pregnancy termination in the Philippines over a 20-year period. The prevalence of women who terminated pregnancy differs. The percentage of women who had terminated a pregnancy from 1992 to 1997 does not have a significant difference. There was a small increase recorded in the percentage of women who terminated their pregnancy from 14.8% to 15.8%. This accounted for about a 1-point increase only (6.22% approximately). This suggests that while there was an increase, it is considerably small. Meanwhile, between 1997 to 2002, a slight decline happened, decreasing from 15.8% to 15.1%. However, a slight increase happened in 2007 by 15.7.

Figure 2

Trends of Pregnancy Termination in the Philippines: NDHS, 1992-2022



The period from 1997 to 2007 shows relative stability with minor fluctuations, indicating that while the percentage of pregnancy termination varied slightly, they remained within a narrow range, between 15.1% and 15.8%. But there was a decline that began in 2012, when the rate dropped to 13.5. This downward trend continued gradually, concluding at a rate of 9.8 in 2022. The decrease from 2012 to 2022 represents a decline of 3.7 points (approximately 27.4%), indicating a substantial reduction in pregnancy termination rates over this period.

Over the entire 20-year period, the data reflect a general decrease in pregnancy termination rates, particularly pronounced in the latter half of the analyzed timeframe. The highest recorded rate was 15.8 in 1997, while the lowest was 9.8 in 2022, marking a total decrease of 6.0 points (approximately 38%). Trends in pregnancy termination in the Philippines reveal periods of stability, slight fluctuations, and a notable decline in recent years. From 1992 to 2007, termination rates remained within a narrow range of 14.8% to 15.8%, indicating relative stability. However, a significant decline began in 2012, with the rate dropping from 13.5% to 9.8% in 2022, a 38% reduction over two decades. This downward trend may reflect improvements in contraceptive access, shifting reproductive behaviors, or policy interventions. However, the restrictive legal environment and abortion stigma likely contribute to underreporting and reliance on unsafe methods (CRR, 2024). While reductions in termination may suggest better family planning efforts, they also raise concerns about access to safe abortion in restrictive settings (HRW, 2023).

Results of Logistic Regression

The logistic regression analysis reveals significant individual, relational, and societal determinants of pregnancy termination among reproductive-aged women who gave birth in the last five years in the Philippines, presented in Table 3. At the individual level, age emerged as the strongest determinant. Compared to women aged 19–24, the adjusted odds of pregnancy termination increased progressively with age: nearly two times higher for those aged 30–34 (AOR = 1.77; 95% CI: 1.20–2.61, $p < 0.01$), more than two times for 35–39-year-olds (AOR = 2.20; CI: 1.47–3.30, $p < 0.001$), and more than three times for women aged 40–49 (AOR = 3.26; CI: 2.11–5.04, $p < 0.001$). Notably, the 25–29 age group showed no significant association in both models (COR = 1.35, ns and AOR = 1.37, ns).

Table 3

Logistic Regression Analysis Determining the Odds of Pregnancy Termination Among Reproductive-Aged Women: NDHS, 2022

Factors	COR	AOR	CI
Age			
19-24	-----	-----	-----
25-29	1.35ns	1.37ns	0.92, 2.05
30-34	1.74**	1.77**	1.20, 2.61
35-39	2.15***	2.20***	1.47, 3.30
40-49	3.20***	3.26***	2.11, 5.04
Contraceptive Use			
Not using	-----	-----	-----
Traditional Method	1.22ns	-----	-----
Modern Method	1.10ns	-----	-----
Desire for Children			
With Desire	-----	-----	-----
No Desire	1.21ns	0.82ns	0.62, 1.07
Self-Rated Health			
Otherwise	-----	-----	-----
Good	0.74**	0.78*	0.62, 0.97

Factors	COR	AOR	CI
Marital Status			
Currently not Married	-----	-----	-----
Married	1.14ns	-----	-----
Number of Children			
2 or Less	-----	-----	-----
3 or More	1.71***	1.21ns	0.93, 1.58
Place of Residence			
Rural	-----	-----	-----
Urban	0.93ns	-----	-----
Internet Use			
Not Using	-----	-----	-----
Using	0.79ns	1.07ns	0.87, 1.57
Education			
Primary and Below	-----	-----	-----
Secondary	0.83ns	1.11ns	0.79, 1.56
Tertiary or Higher	0.67***	0.92ns	0.60, 1.43
Wealth			
Poorest	-----	-----	-----
Poorer	0.69*	0.67**	0.50, 0.89
Middle	0.65*	0.65*	0.45, 0.94
Richer	0.70*	0.71ns	0.47, 1.08
Richest	0.61**	0.58*	0.39, 0.88
Employment			
Unemployed	-----	-----	-----
Employed	1.21ns	0.06ns	0.39, 0.88
Religion			
Other Religions	-----	-----	-----
Catholics	0.89ns	-----	-----

*p < .05 **p <.01 *** p < .001 ns = not significant

Self-rated health reduced pregnancy termination odds, as women who reported to having good health had 22% lower adjusted odds (AOR = 0.78; CI: 0.62–0.97, $p < 0.05$) in the adjusted model. Desire for additional children did not emerge as a significant factor in the binary logistic regression analysis and remained nonsignificant even after adjusting for other variables. Specifically, not wanting more children (AOR = 0.78, ns) was not associated with pregnancy termination. Similarly, contraceptive use, whether traditional (COR = 1.22, ns) or modern (COR = 1.10, ns), did not show a significant crude effect on pregnancy termination, with p-values exceeding .20. Given its lack of statistical significance, contraceptive use was excluded from the adjusted model.

At the relationship level, the number of children initially showed a significant crude association with pregnancy termination, with women having three or more children being more likely to terminate a pregnancy (COR = 1.71, $p < 0.001$). However, this association became nonsignificant after adjusting for other factors (AOR = 1.21, ns), suggesting that the relationship was likely confounded by additional variables. Meanwhile, marital status, specifically being married, was not significantly associated with pregnancy termination in the crude analysis (COR = 1.14, ns). Given its p-value exceeding .20, it was not included in the adjusted model, indicating that marital status does not play a determining role in pregnancy termination decisions.

At the community level, place of residence was not a determining factor. Women living in urban areas had a slightly lower crude odds ratio (COR = 0.93, ns) compared to those in rural areas, but the association was not statistically significant and was therefore not included in the adjusted model. Internet use was not a significant factor in determining pregnancy termination. Women who recently used the internet had a lower crude odds ratio (COR = 0.79, ns) compared to non-users or those who did not use the internet recently. This association remained non-significant after adjustment (AOR = 1.07, ns; 95% CI: 0.87–1.57), suggesting no meaningful impact on pregnancy termination.

Educational attainment showed contrasting crude and adjusted effects. While tertiary education initially appeared significant (COR = 0.67, $p < 0.001$), this association disappeared after adjustment (AOR = 0.92, ns). Having secondary education has a nonsignificant effect in the unadjusted and adjusted models (COR = 0.83 vs. AOR = 1.11, ns). Wealth status demonstrated a strong inverse effect. Compared to the poorest women, adjusted odds were significantly 33% lower among poorer (AOR = 0.67; CI: 0.50–0.89, $p < 0.01$), 35% lower among middle-income (AOR = 0.65; CI: 0.45–0.94, $p < 0.05$), and 38% lower among the richest quintiles (AOR = 0.58; CI: 0.39–0.88, $p < 0.05$), though the richer category lost significance after adjustment (AOR = 0.71, ns). Employment status did not exhibit a significant association with pregnancy termination. While employed women had a slightly higher crude odds ratio (COR = 1.21, ns) compared to unemployed women, the association remained nonsignificant after adjustment (AOR = 0.06, ns; 95% CI: 0.39–0.88), indicating no meaningful effect. Similarly, religious affiliation was not a significant factor. Catholics had a

slightly lower crude odds ratio (COR = 0.89, ns) compared to women of other religions, but this association was not statistically significant.

This study highlights key individual, relational, and societal factors influencing pregnancy termination in the Philippines, with some findings aligning with, and diverging from, existing literature. At the individual level, age was the strongest predictor, with odds of termination increasing significantly after 30. This supports studies from Tanzania and other African nations where pregnancy termination is more prevalent among older women (Mbona et al., 2025; Kassa et al., 2024). However, unlike findings from Rwanda and Nigeria (Kassa et al., 2024), younger women in the Philippines did not exhibit a higher likelihood of pregnancy termination. Self-rated health also emerged as a factor, with healthier women less likely to terminate pregnancies, which is different compared to Tanzania (Mbona et al., 2025). Conversely, contraceptive use and fertility preference were not significant, challenging prior findings that linked them to pregnancy termination (Mbona et al., 2025; Setegn & Dejene, 2024).

At the relational level, the initial association between a higher number of children and pregnancy termination disappeared after adjustment, differing from studies in which more children increased termination odds (Mbona et al., 2025). Similarly, marital status was not a significant factor, diverging from research in other countries where married women had higher termination odds (Mbona et al., 2025; Sesay et al., 2023).

At the community level, urban residence and internet use did not significantly influence pregnancy termination, contrasting with studies in Nepal and Tanzania (Yogi et al., 2018; Mbona et al., 2025). This may suggest more uniform healthcare access among rural and urban residents, and internet users or non-users in the Philippines.

At the societal level, wealth status emerged as a key determinant, with poorer women exhibiting higher odds of pregnancy termination. This contrasts with the findings from Tanzania and Nepal, where wealthier women had higher termination rates (Mbona et al., 2024; Yogi et al., 2023). Education and employment status were not significant predictors, diverging from studies in other countries (Kassa et al., 2024; Sesay et al., 2023).

This study provides a comprehensive analysis of pregnancy termination among reproductive-aged women in the Philippines, revealing significant trends, demographic profiles, and key determinants. While the overall termination rate (13%) aligns with global averages, it remains lower than in several South and Southeast Asian countries despite the Philippines' restrictive legal environment. Trends indicate a gradual decline in termination rates, possibly due to improved contraceptive access and shifting reproductive behaviors, though underreporting and reliance on unsafe methods remain concerns. Age emerged as the strongest determinant, with termination likelihood increasing significantly after 30. Economic vulnerability also played a crucial role, as poorer women faced higher termination odds. In contrast, other factors were not significant predictors, differing from findings in other countries.

To improve reproductive health outcomes, the Philippines must enhance family planning programs, expand access to contraception, and address socio-economic barriers through targeted support. Strengthening maternal healthcare, particularly for older and low-income women, is crucial. Public awareness campaigns and counseling services can help reduce stigma and support informed decision-making. Additionally, reviewing the existing legal framework in the country and considering the legalization of abortion in specific circumstances may ensure access to safe medical care and reduce the risk associated with unsafe abortion. Further research on pregnancy termination or abortion barriers will aid in developing evidence-based policies that promote reproductive rights, reduce unintended pregnancies, and improve maternal health.

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