multiplier applied to women of all ages.

In estimating state-specific rates, we made two modifications to the protocol used in the 2006 study (which provided estimates for the four major areas but not for individual states). The first concerns the multiplier used for the North area. Although the earlier study used a single multiplier for all states in this area, we have used two multipliers. This is because the multiplier that we estimated using information from Health Professionals Survey participants in the North (all of whom lived in the state of Baja California) was much lower (4.9) than would be expected on the basis of its development level; for example, its multiplier is smaller than that for the Central area (6.7), which is markedly less developed than the North. The multiplier of 4.9 appears plausible for the northern states (such as Baja California) that border the United States, because Health Professionals Survey respondents likely based their estimates on abortions performed in Mexico, and did not take into account the safe procedures some women likely obtained in the United States. Thus, the abortions reported to be performed in these border states would likely be higher risk procedures, which means that the proportion of women needing treatment for complications would have been relatively high, and the multiplier relatively low. However, this multiplier is implausibly low for the rest of the northern states, from which travel to the United States for abortion is rare. In these states, which have a well-developed health care infrastructure and good economic conditions, access to low-risk (albeit clandestine) abortion is likely to be widespread, and we therefore expect the multiplier to be higher than the overall estimate for the North area. As a result, we assumed that the multiplier for the Central area applies to the states in the North that do not border the United States.

The second modification concerns the estimates of the abortion rate for Mexico City and neighboring Mexico State (part of which is within the Mexico City metropolitan area). Because women who live in the sections of Mexico State that border Mexico City sometimes obtain care in Mexico City hospitals, the 2006 study included women in these areas in the base population of Mexico City in calculations of the abortion rate. However, the bias caused by this adjustment became evident when abortion rates were calculated for Mexico State using this approach, as the resulting estimates were implausibly high. Because it does not appear possible to accurately separate out the number of hospitalized postabortion patients and the size of the base population for Mexico City from those for Mexico State, we concluded that the only acceptable solution was to merge for these two areas all input measures used to calculate the abortion rate (i.e., multipliers and numbers of abortion complications, births and women).†

**Regions and Level of Development**

In countries undergoing a fertility transition, such as Mexico, the desire for smaller families and for precise control of the timing of births is greater in more developed regions than in less developed ones. However, at the societal level, these desires tend to precede the widespread adoption of contraception, and for a time the prevalence of effective contraceptive use may fall short of the levels necessary to allow women to achieve their reproductive preferences. As a result, the incidence of unintended pregnancy—and thus of abortion—may be greater in more developed regions than in those that are less developed. We hypothesize that this is the case in Mexico.

Thus, we calculated regional estimates of abortion incidence by development level. We classified states into six regions using an official index of states’ level of development, the index included indicators of household amei