abortion care during the data collection period, the provider recorded information on the woman's demographic characteristics, her presenting clinical signs and symptoms and the clinical care she received. Ninety-eight percent of selected facilities participated in the survey.

**Health Facilities Survey.** The Health Facilities Survey was also fielded at each facility. After attending a weeklong training course on the study and its data collection tool, Ministry of Health zonal supervisors interviewed a key informant at each facility who was knowledgeable about provision of postabortion care at the facility. The informant, who was typically the facility's director or main provider of postabortion care, was asked to estimate the number of women treated for postabortion complications as inpatients and outpatients, both in the past month and in an average month. The two reference periods were used to take into account variation over time in the facility's caseload. The informant also provided information on a range of other topics, including the types of reproductive health services provided at the facility (such as manual vacuum aspiration) and details about postabortion family planning provision. Ninety-nine percent of sampled facilities participated in the study.

**Health Professionals Survey.** The investigators consulted with a range of experts in the field of reproductive health in Malawi to identify potential key informants for the Health Professionals Survey. This produced a list of 123 possible respondents—health professionals who had extensive knowledge of the conditions under which women obtain abortions in Malawi. Study investigators attempted to contact each prospective participant to assess his or her availability and interest in being interviewed; 56 were successfully interviewed. Most respondents were obstetrician-gynecologists (32%), medical officers (27%) or clinical officers (21%); on average, they had 16 years of experience in reproductive health. Sixty-one percent of participants were currently working in one of Malawi's two major cities (Lilongwe and Blantyre), although 52% had worked in a rural area for at least six months in the past five years. During the interviews, the experts provided three types of estimates: the percentage distribution of women who obtain abortions, according to the type of provider; the probability that women who have an abortion experience complications that require medical care, according to the type of provider; and the probability that women who experience complications obtain medical care at a health facility. Participants provided estimates for each of four subgroups (poor rural women, nonpoor rural women, poor urban women and nonpoor urban women) to capture expected social and demographic differences in women's access to abortion services and postabortion care.

**Additional data sources.** To cross-check whether postabortion cases were undercounted in the Prospective Morbidity and Health Facilities Surveys, as well as to assess the completeness of logbook records, Ministry of Health zonal supervisors collected logbook data from each facility on the number of procedures completed in the 30 days prior to and during data collection for the Prospective Morbidity Survey. This information was used to conduct a validity check of the number of women who obtained postabortion care. In addition, to estimate abortion incidence and to provide contextual information on reproductive health in Malawi, we used data from the following sources: the 2008 Malawi Housing and Population Census, the 2006 Multiple Indicator Cluster Survey, the 2004 and 2010 DHS, and the 2004–2005 Integrated Household Survey.

**Calculation of Abortion Incidence.**

In the AICM, the incidence of abortion is estimated by determining the number of women who received postabortion care at health facilities during a one-year period and then adjusting this figure to include women who had abortion complications but did not obtain care at a health facility and those who had an abortion but did not have complications (and thus did not need treatment). The number of women who received postabortion care is determined using annual postabortion care case loads from the Prospective Morbidity and Health Facilities Surveys. Because some women who receive postabortion care have had spontaneous abortions (miscarriages), the next step is to subtract the estimated number of women who had obtained treatment for complications of spontaneous abortions from the total number of women with abortion complications; the result is the number of women treated for complications of induced abortions. Next, a factor or multiplier is generated using information obtained from the Health Professionals Survey to account for the remaining women who had an induced abortion; the multiplier can be interpreted