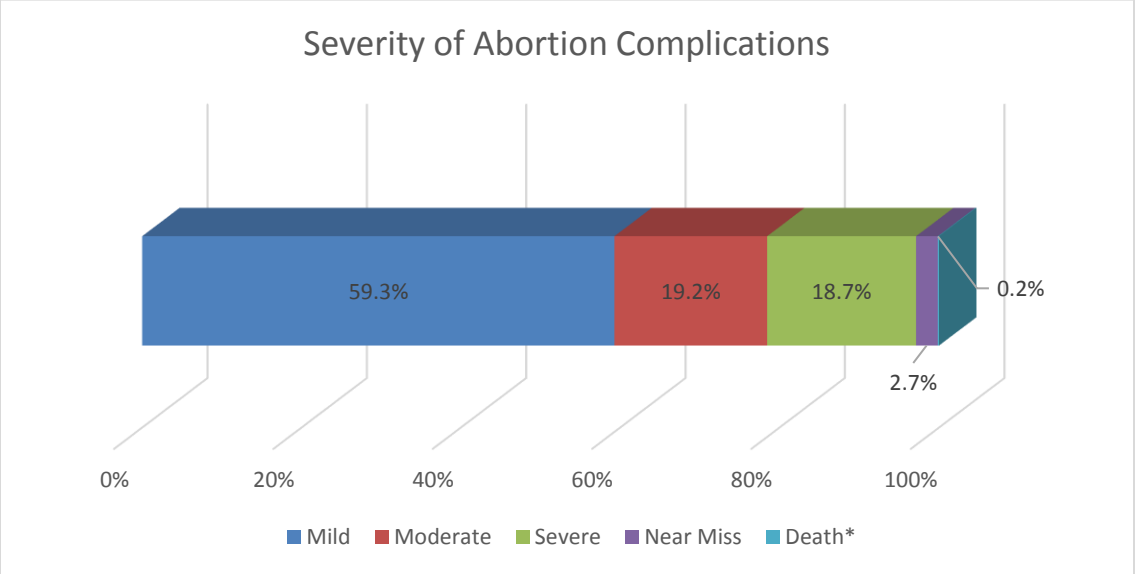
Supplemental Figure 1. Severity Classification, Zimbabwe 2016, Prospective Morbidity Study



* There were 2 additional deaths during the study period that were recorded in tracking forms at facilities but no data was collected on these women. There were also 12 reported near-misses in the tracking forms but no data was collected on these women as they were too sick to consent. The near-misses reported on the tracking forms are likely an overestimate as they are based only on provider reports, rather than a clinical assessment. Of those classified as near-miss by the provider in the sample, only 10% (n=9) were objectively classified as near-miss based on the clinical criteria. Therefore, due to over-reporting, it is likely the facility reported near-misses is actually just 1 case (10% of 12).

Supplemental Table 1. Distribution of eligible, sampled, and participating facilities, Zimbabwe 2016, Prospective Morbidity Survey

Facility type	Facility Level					Individual Level (unweighted)			
	# facilities that provide PAC	% sampled	# sampled facilities [a]	Response rate	# interviewed facilities	Total Number of Cases	Eligible respondents [b]	Response rate[c]	# interviewed women
Primary health center (public)	63	30%	18	100%	18	14	13	100%	13
District/general/mission hospital (public)	91	52%	47	100%	47	312	276	99%	274
Provincial hospital (public)	8	100%	8	100%	8	231	217	99.5%	216
Central hospital (public)	5	100%	5	100%	5	444	374	100%	374
Private hospitals	40	77%	27	96%	26	121	103	96%	99
NGO facility (for profit or not-for-profit)	38	68%	28	82%	23	61	35	74%	26
Total	**245**	**56%**	**133**	**95%**	**127**	**1183**	**1018**	**98%**	**1002**

a) Ten facilities were not eligible for the study as they did not have the capacity to provide post-abortion care. Facilities were added to the PMS after sampling to adjust for misclassification by province. In provinces in which facilities had been misclassified, we sampled 100% of facilities at the level where misclassification occurred.

b) Ineligible respondents include patients that interviewers missed in the facility, near-misses who were too sick to be interviewed, or maternal deaths. One respondent was ineligible as she had psuedocyesis (a pseudo-pregnancy), and therefore did not meet eligibility criteria of having an abortion complication.

c) Of the 1018 eligible respondents, 16 respondents refused to be interviewed.

d) The sample was stratified by province and facility type so the total sampling proportion does not add up to a round proportion nationally. We sampled 100% of the central hospitals, provincial hospitals and not-for-profit NGO facilities, and 50% of district hospitals. For primary health centers we sampled 50% in Matabeleland South and Matabeleland North. In Manicaland there were more primary health centers with post-abortion care capacity (N=43), so only 20% of primary health centers were sampled in this province. There were two levels of private facilities (lower and higher levels), so we sampled 100% of high-level private facilities (operating with a similar capacity to provincial hospitals) and 50% of lower-level private facilities and for-profit NGO facilities (operating at a level similar to district hospitals). This table collapses categories of facilities to ensure that no individual facility could be identified.

Supplemental Table 2. Sociodemographic and reproductive characteristics of women seeking post-abortion care, Zimbabwe 2016, Prospective Morbidity Survey

	Total		Residence		
Characteristic	Weighted N	%	Urban (%)	Rural (%)	p-value
TOTAL	1302	100%	60%	40%	
Age					0.00
15-19	155	12%	8%	17%	
20-24	287	22%	23%	21%	
25-29	307	24%	24%	23%	
30-34	299	23%	25%	20%	
35+	249	19%	19%	20%	
Marital status[a]					0.01
In union	1027	80%	78%	83%	
Not in union	257	20%	22%	17%	
Educational level					0.00
No education	9	1%	0%	1%	
Any primary schooling	184	14%	7%	25%	
Any secondary schooling	927	71%	74%	68%	
University or more	177	14%	19%	6%	
Religion					0.00
Apostolic	431	33%	24%	48%	
Pentecostal	374	29%	35%	20%	
Protestant	194	15%	16%	13%	
Catholics/other Christian/Muslim/other	261	20%	23%	16%	
None	36	3%	2%	3%	
Work status					0.00
Unemployed, unpaid family worker/housewife, or student	816	63%	54%	77%	
Full-time, part-time, or self-employed worker	479	37%	46%	23%	
Relative wealth quintile (adjusted by urban/rural status)[b]					0.00
Poorest	183	14%	17%	10%	
Poor	182	14%	14%	13%	
Medium	184	14%	16%	11%	
Wealthy	271	21%	22%	19%	
Wealthiest	482	37%	31%	47%	
Number of living children					0.00
None	364	28%	27%	29%	
1-2	644	50%	55%	41%	
3-4	259	20%	16%	26%	
5+	29	2%	1%	3%	
Region					0.00
Matebeleland (Bulawayo, Mat North, Mat South, Midlands)	400	31%	33%	27%	
Mashonaland and Harare (Mash East, Mash West and Mash Central)	643	49%	52%	46%	
South Eastern region (Manicaland and Masvingo)	259	20%	15%	27%	
Intentions[c] **related to pregnancy that resulted in seeking care**					0.02
Wanted then	900	70%	68%	72%	
Wanted later	192	15%	14%	16%	
Did not want at all	188	15%	17%	12%	
Don't know	13	1%	1%	1%	
Estimated gestational age					0.00
First trimester	841	65%	69%	60%	
Second trimester[d]	446	35%	31%	40%	
Facility where post-abortion care was received					0.00
Primary health center	44	3%	2%	6%	

District/general/mission hospital	523	40%	24%	65%	
Provincial hospital	216	17%	17%	16%	
Central hospital	374	29%	42%	9%	
Private hospital	115	9%	12%	4%	
NGO facility (for profit or not-for-profit)	30	2%	3%	1%	

a) In union indicates currently married or living together; not in union indicates never married, with partner and not living together, or separated/divorced/widowed.

b) Wealth quintiles are relative to the national distribution of wealth in the country, as reported in the 2015 Zimbabwe DHS. The variable reported here is adjusted for differences in wealth between urban and rural individuals; that is, individuals in the "wealthiest" category who are urban are not equivalent to individuals in the "wealthiest" category who are rural.

c) At the time of becoming pregnant.

d) One respondent was at 28 weeks gestation, but is included in second trimester for analytical purposes.