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RESEARCH ARTICLE

Mechanisms of Social Movement Market Innovation: The Birth of the American Abortion Clinic

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ABSTRACT: How do social movements affect the development and diffusion of new organizational forms? This article theorizes and probes the plausibility of five mechanisms: 1) shaping state administrative regulation 2) entrepreneurship for the purpose of modeling 3) regulating market actors through competition and brokerage 4) developing and disseminating new technologies and 5) conducting scientific research on the efficacy and safety of new and existing technologies, products and services. It provides evidence for the role of these mechanisms in the creation and diffusion of non-hospital abortion clinics in New York City between April 1970, when the state of New York legalized early "on-request" abortions, and January 1973, when the U.S. Supreme Court legalized such abortions nationwide

KEYWORDS: Social Movements, Organizations, Health Policy, Abortion, Feminism

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1. Introduction

Over the past twenty years, social movement scholars have made strong progress in theorizing the determinants of social movement outcomes. But most research has focused on policy outcomes, and as a result, we know little about the key determinants of other types of outcomes: biographical, cultural, organizational or economic. In this paper, I examine an important *economic and organizational* outcome of social movements, the creation and diffusion of new market organizational forms. Empirically, I ask: how did abortion SMOs shape the invention and diffusion of a new organizational form of abortion provision, *the non-hospital outpatient abortion clinic* (hereafter "clinics"). Theoretically, I ask: How do social movements influence the creation and diffusion of new market organizational forms?

I theorize several mechanisms by which SMOs can influence the emergence and diffusion of new market organizational forms and probe their plausibility through historical analysis of the market for abortion provision in New York City between 1970 and 1973. In 1970, New York State legalized abortion on request (i.e., abortion without a statutorily-defined requirement of "medically necessity"). This made New York City the "abortion capital" of the United States, providing the majority of the nation's abortions, until the U.S. Supreme Court legalized early on-request abortions nationwide in 1973. New York City was one of the first places in which clinics became major sources of abortion provision. They eventually came to dominate the national market and currently provide more than 95 percent of all abortions in the United States. The creation and diffusion of clinics had important consequences. It dramatically increased the availability, quality and safety of abortions but it also created small, stigmatized, politically-weak providers that were especially vulnerable to legal restrictions, protest, and violence from the anti-abortion movement. It may also have made it easier for mainstream hospitals and physicians to avoid providing abortions, thus evading their professional responsibility to provide comprehensive reproductive care (Freedman 2010; Joffe 2009; Joffe, Weitz, and Stacey 2004; Augustine and Piazza 2021).

2. Theoretical Background

2.1 Market Innovation as a Social Movement Outcome

The majority of research on the outcomes of social movements examines policy outcomes and thus focuses on collective action that targets state actors—legislatures, administrative agencies and courts. But in recent years, scholars have increasingly attended to other types of movement outcomes—biographical, cultural, organizational and economic (Amenta, Caren, Chiarello and Su 2010; Bosi, Giugni and Uba 2016; Davis, McAdam, Scott and Zald 2005; Giugni, McAdam and Tilly 1999; Giugni and Grasso 2018), many of which occur in non-state domains such as science, medicine, cultural production or markets (Epstein 1996; Halfmann 2019; Moore 2008).

Because extant theories of social movement outcomes were largely built to explain policy outcomes, they apply only partially to other types of outcomes. For example, research shows that boycotts are an especially powerful tool for changing corporate behavior (King 2008) and that alliances with experts can increase the success of movements that target scientific or medical organizations (Epstein 1996; Moore 2008; Wolfson 2001).

Research on the *economic outcomes* of social movements has focused on the ability of movements to change corporate behavior, privately regulate market actors, and create and diffuse organizational forms (Giugni and Grasso 2018; King and Pearce 2010). Here, I focus on the emergence of a new organizational form, the non-hospital abortion clinic.

2.2 Mechanisms of Market Innovation: How Social Movements Shape Market Organizational Forms

In recent decades, social scientists have increasingly sought to identify not just causal effects but their mechanisms: the processes and steps that link causes to effects or, in other words, the "nuts and bolts, cogs and wheels" of causal relationships (Elster 1989; George and Bennett 2005; Hedstrom and Swedberg 1998; Mahoney and Thelen 2015). The goal of such research is to identify mechanisms that *may* be portable to a bounded set of other cases. As Campbell (2005) puts it, "although no social mechanism is likely to operate in every situation, some mechanisms may operate in several situations, so their specification enables us to generalize beyond atheoretical descriptions of a single case but without making indefensible claims about universal laws." Many social movement scholars have sought to identify mechanisms of movement

mobilization and outcomes (McAdam, Tarrow, and Tilly 2001; Campbell 2005; Andrews 2001; Jasper 2018; Kolb 2007; Meyer and Minkoff 2004).

Extant research suggests that social movements contribute to the creation of new organizational forms through a variety of mechanisms. They *develop new ideas and understandings* that delegitimate existing market niches and organizational forms and legitimate new ones (Hiatt, Sine, and Tolbert 2009; Greve, Pozner, and Rao 2006; Hoffman 1999; Rao, Morrill, and Zald 2000; Schneiberg 2002; Sine and David 2003; Sine and Lee 2009). For example, the temperance movement de-institutionalized brewing, creating opportunities for soft drink manufacturing (Hiatt et al. 2009). Movements also develop *frames* that may challenge the legitimacy of existing actors and suggest new products and organizational forms (Greve et al. 2006; Lounsbury, Ventresca, and Hirsch 2003; Schneiberg, King, and Smith 2008). Movement members act as *entrepreneurs,* directly providing new goods and services (Dioun 2017; Kurland and McCaffrey 2016; Lounsbury et al. 2003; McInerney 2014; Pacheco, York, and Hargrave 2014; Sine and Lee 2009; Weber, Heinze, and DeSoucey 2008). Movements *help non-movement market actors* by providing them with resources and frames or advocating for regulatory change (Ruef 2000; Schneiberg et al. 2008; Swaminathan and Wade 1999). Finally, movements bring *pressure* to bear on market actors through protests or boycotts (King 2008).

Here, I theorize additional mechanisms and elaborate those above. I suggest that social movements can influence market organizational forms by 1) influencing state administrative regulation 2) directly modeling the new form 3) regulating for-profit adopters of the form through competition and brokerage 4) developing and disseminating new technologies and 5) conducting scientific research.

Influencing state administrative regulation. As mentioned above, research on social movement outcomes has mainly focused on *policy* outcomes. It has also mainly focused on the *enactment* of policies rather than their implementation, which is unfortunate since movements may have more impact on policy implementation than on legislation (Andrews 2001). Of the research on policy implementation that exists, much of it has mainly focused on government implementers rather than market ones. But in the neoliberal, public-private American welfare state, many government policies are implemented, at least in part, through market mechanisms.

The literature on policy implementation suggests that movements can influence policy implementation by providing frames, models and resources to government implementers and by allying with experts and insiders (Andrews and Edwards 2004; Kellogg 2012; Chiarello 2013; Buchter 2020). But social movements can also shape government regulation of market actors by providing services themselves in order to demonstrate that such actors can provide high-quality, inexpensive, and plentiful services. They can publicize the strengths or weaknesses of alternative providers, whether private or public. They can also ward off undesirable government regulation by regulating market actors themselves to ensure that they produce socially-beneficial outcomes (Hacker 2002).

Entrepreneurial modeling. Existing research has shown that social movements often engage in entrepreneurship, developing products or services themselves, because desired ones do not exist or because existing ones are of poor quality, undersupplied or produced in unethical ways (Balsiger 2016; Giugni and Grasso 2018; Bosi and Zamponi 2015; Dioun 2017; Kurland and McCaffrey 2016; Lounsbury et al. 2003; McInerney 2014; Pacheco et al.; Sine and Lee 2009; Weber et al. 2008). While researchers have given considerable attention to SMO entrepreneurship, they have taken less notice of SMO entrepreneurship for the explicit purpose of creating models and demonstrations that can influence non-movement providers. Mimesis is, of course, an important part of the neo-institutional and diffusion literatures but these literatures focus mainly on the diffusion of existing models rather than on explicit attempts by social movements to create and disseminate new ones.

Movement actors often explicitly create products and services for the purpose of providing a model for other market actors, consumers, government officials and activists. They hope that the model will demonstrate the product or service's efficiency, efficacy, safety, quality and equity with the hope that other actors will adopt it or that government officials actors will aid its diffusion through favorable regulation. If the market contains bad actors who charge exorbitant prices or skimp on quality, the model can demonstrate

to consumers and regulators that this is not inherent to the product or to a particular organizational form. Movements can also reduce the stigma of a product or service by showing that it is consumed and provided by "normal" or high-status people, and that people are not punished, and may be rewarded, for the production or consumption of the product. The existence of such products or services can also remind consumers and producers of their moral or professional responsibilities to consume or produce similar ones.

Private regulation through brokerage and competition. Scholars have found that social movements, rather than the state, often regulate the behavior of market actors, for example, by certifying or labeling the products of firms that have positive social or environmental records (Bartley 2003, 2007). But SMOs can also regulate market actors by directly competing with them, or by brokering transactions between non-movement suppliers and their consumers. This can allow SMOs to demand that non-movement actors engage in particular practices related to morality, quality or price. When SMOs produce a good or service they can often undercut their competitors on price and quality because they don't need to generate a profit and are often subsidized (in money or labor) by activists and funders. They can offer higher-quality services by drawing on the commitment of personnel that support their cause. They can also broker market transactions in order to demand that non-movement producers lower prices, increase quality and equity and engage in desired practices. Non-movement producers are especially sensitive to competition and brokerage when SMOs have a monopoly on the supply of patients and when producers have a low-cost, high-volume business model that relies on a steady supply of consumers.

Developing and disseminating new technologies. Though technological change has long played a central role in the literature on organizational innovation (Sine and David 2003), few studies examine social movement effects on technological change, with the exception of the software (Mattoni 2013) and environmental sectors (Toke 2011; Smith 2005; Smith, Fressoli, Abrol, Arond, and Ely 2016; Hess 2007). New technologies can reduce start-up and production costs, allow higher volume production, and allow production in less-expensive locations—all of which may encourage new providers to enter the market. New technologies can also improve safety by reducing skill requirements and risks of error—making it easier to gain the approval of government regulators.

Social movements can contribute to technological change, including new ways of organizing production, in a variety of ways. They can import technologies from other countries, invent new ones, modify existing ones, or use existing technologies in new ways. They can diffuse new technologies by directly training non-movement suppliers, or by producing training materials and distributing them. They can hold conferences and create networks among providers. They can also manufacture and distribute new technologies and publicize the use of those technologies by high-status organizational and individual providers.

Conducting scientific research. While some scholars have examined the production of scientific knowledge by social movements (Epstein 1996), few have examined the implications of such research for the creation and diffusion of new market organizational forms. Scientific research can lead to the development of technologies that create new market opportunities. It can also provide evidence for the efficacy and safety of new technologies and organizational forms to consumers, elected officials, courts and regulators. Such evidence can also cast incumbent technologies and providers in an unfavorable light.

In what follows, I probe the plausibility of these mechanisms in the New York City abortion market of the early 1970s. I first outline my analytic strategy and data, describe the legal changes that de-institutionalized the existing system of abortion provision, and then show how abortion SMOs shaped the creation and diffusion of clinics. I end by reviewing the results and discussing their implications.

3. Analytic Strategy And Data

The paper offers a case study of abortion provision in New York City between 1970 and 1973. I engage in "theory-building process tracing," which uses empirical evidence to "build a midrange theory describing a causal mechanism that is generalizable outside of the individual case to a bounded context" (Beach and

Pedersen 2013: 160; George and Bennett 2005; Mahoney and Rueschmeyer 2003). The method involves investigating empirical material in instances for which two causal factors covary, in order to look for clues to a possible causal mechanism for that covariation, and then inferring the existence of that mechanism from those clues. The method combines induction and deduction. In addition to searching for clues in the empirical material, the analyst draws inspiration from existing theoretical and empirical work on phenomena, empirical contexts and causal relations that are analogous. The method is iterative because hunches "are investigated systematically, with the results of this search forming the background for further searches" (Beach and Pedersen 2013: 18). I present "strategic narratives" purposely structured to assess the degree to which hypothesized mechanisms are present in the case, but also to identify previously unrecognized ones (George and Bennett 2005; Mahoney and Rueschmeyer 2003; Timmermans and Tavory 2012).

I chose New York City because it was the most important site of abortion provision before the U.S. Supreme Court legalized on-request abortion nationwide in 1973. In 1969 and 1970, six states established *de jure* or *de facto* abortion on request but only three of them, New York, California, and Washington, D.C. allowed abortions for non-residents.[1] Between 1970 and 1972, New York provided approximately 50% of the nation's abortions while California and Washington, D.C. provided 25 percent and 5 percent respectively (Petitti 1977; Guttmacher Institute 1980; Guttmacher Institute 2008). I also chose New York City because it was one of the first cities to develop non-hospital abortion clinics and because the SMO-affiliated clinic, the Center for Reproductive and Sexual Health (CRASH), was the most important national model of such clinics. Additionally, the headquarters of the three national abortion SMOs, the National Association for the Repeal of Abortion Law (NARAL), the Association for the Study of Abortion (ASA) and the Clergy Consultation Service (CCS) were all located there. This increased the significance of New York clinics as national models and increased data availability. New York and California were also much larger states than the others that legalized on-request abortions, and thus received much more national attention. And this was even more the case for New York because it's legalization occurred through legislation rather than through a series of ambiguous court decisions and broad interpretations of existing law as in Washington, D.C. and California. Finally, I examine New York *City* rather than New York State because the two had much different political dynamics and the vast majority of abortions occurred in the city.

The period begins with a "critical event," New York State's 1970 legalization of early *on-request abortions*. Critical events often lead to institutional change by raising questions about the value or appropriateness of existing institutional logics (Clemente, Durand, and Roulet 2017). As I show below, legal change in New York led to the deinstitutionalization of the existing field of abortion provision. This period is also a "critical juncture"— "a branching moment of relatively high uncertainty" in which "options open and then close off" (Katznelson 1997: 12). This "closing off" launched a "path-dependent" process in which many of the developments of the period established precedents and logics that continue to the present (Capoccia and Kelemen 2007). The period ends with another critical event, the U.S. Supreme Court's *national* legalization of early on-request abortion in January 1973.

I use primary documents and secondary historical monographs to reconstruct key events, chronologies, contexts and meanings, triangulating them to corroborate and contextualize them. Primary data include the records, reports, correspondence and newsletters of SMOs, as well as contemporaneous government documents, newspapers, magazines, professional journals, and legal briefs. Primary documents are drawn mainly from the archives of NARAL at Harvard University's Schlesinger Library of Women's History, as well as the papers of Dr. Alan Guttmacher (the President of Planned Parenthood and a founder of the ASA) at the Harvard University's Countway Medical Library. I also rely on the memoirs of three key figures in the development of abortion clinics: Howard Moody, the head of CCS, which referred women for abortions both before and after New York's legalization and founded the first SMO-affiliated abortion clinic, CRASH

[1] In addition to New York, California, and Washington, D.C., it appears that pre-*Roe* clinics were established only in Madison, Wisconsin (1971), Santa Fe, New Mexico (1971) and Seattle, Washington (1972).

(Carmen and Moody 1973); Lawrence Lader, the longtime Chairman of NARAL's Board, who was also involved with referral services and attempts to establish abortion clinics (Lader 1973); and Bernard Nathanson, a NARAL Board Member who was also involved in NARAL's attempts to establish abortion clinics and served as the first medical director of CRASH (Nathanson and Ostling 1977).

4. The Deinstitutionalization of Abortion Provision

Because the United States is a federal polity in which crime policy, including abortion policy, was reserved to the states, abortion laws varied by state. At the beginning of the 1950s, state laws allowed a licensed physician to provide an abortion for reasons of "medical necessity" if a pregnant woman's life or, in a few states, her physical health was threatened by childbirth. But as the decade passed, many doctors cautiously broadened those criteria to include physical health, mental health and fetal abnormality. Even under these expanded criteria, however, legal abortions were rare. Of the approximately one million legal and illegal abortions per year in the 1950s and 1960s, the vast majority were self-induced or performed by lay providers. Only about one percent were provided in hospitals, where "therapeutic abortion committees" decided if they were medically necessary. A small number were also provided in private physician's offices but the vast majority of physicians performed few or no abortions (Graber 1993; Reagan 1997).

In 1955, the birth control organization, Planned Parenthood, sponsored a national conference on abortion law that called for the broadening of medical necessity criteria to include physical and mental health and fetal abnormality. And beginning in 1962, abortion reform organizations, composed mainly of professionals, tried to change state laws along those lines. Over the next decade every state considered reforms and, beginning in 1967, thirteen states, mainly on the coasts or in the South, enacted them. These reforms were predictably disappointing since the vast majority of women sought abortions for reasons that went beyond statutory definitions of "medical necessity" (Burns 2005; Garrow 1994; Halfmann 2011; Luker 2009; Staggenborg 1991).

In response, activists, both from the earlier "reform" movement and the growing feminist movement, began to call for the *repeal* of abortion laws. But while most states considered "repeal" bills, only four enacted them (New York, Alaska, Hawaii and Washington State, all in 1970). These bills did not actually *repeal* abortion laws because they contained various restrictions such as hospital, physician and residency requirements but they were still a major breakthrough because they allowed early on-request abortion. In addition to these four legislative enactments, state and federal courts struck down abortion laws in 14 additional places between 1969 and 1972 (Washington, D.C., California, Georgia, Michigan, Pennsylvania, South Dakota, Texas, Wisconsin, Connecticut, Florida, Illinois, Kansas, New Jersey, and Vermont). Most of those decisions were appealed to higher courts, and in January 1973, the U.S. Supreme Court struck down abortion laws nationwide in the *Roe v. Wade* (1973) and *Doe v. Bolton* (1973) decisions (hereafter "*Roe"*). The Court ruled that states could not regulate abortion in the first trimester of pregnancy (except for physician requirements) but could do so later in the pregnancy to protect women's health and fetal life. These legislative and legal changes dramatically increased the number of legal abortions: from 18,000 in 1968 to 600,000 in 1972, to 1 million in 1975, and 1.5 million in 1980 (Lader 1973; Schoen 2015; Tietze 1970).

5. The Birth of the Clinic

New York was the most important site in the birth of the clinic. As mentioned above, New York provided approximately half of the nation's abortions between 1970 and 1972. The legalization of early on-request abortions dramatically increased the number of legal abortions. In New York City, there were only 850 in 1969, but 140,000 in the first year after reform, and 200,000 in the second (Pakter, Nelson, and Svigir 1975). After legalization, abortions might have been provided solely in hospitals or doctor's offices as they had been

before. Instead, SMOs and other actors created a new organizational form, the non-hospital abortion clinic. By early 1973, there were twenty-one clinics in New York City, four of which were non-profit. The clinics' share of abortions rose steadily: 16 percent in 1971, 31 percent in 1972, and 36 percent in 1973 (Pakter and Nelson 1971; Pakter et al. 1975). This share continued to rise after *Roe* both in New York State (62% in 1979 and 90% in 1990) and nationwide (74% in 1980 and 86% in 1988)(Henshaw and Van Vort 1992; New York (State), 1979-1990).

Clinics had some precursors, such as private physicians who provided large numbers of quasi-legal abortions before *Roe* and lay providers such as Chicago's feminist Jane Collective. But clinics were truly a new form of market organization. They offered a new product—abortions that were legal, on-request and delivered in specialized, outpatient, non-hospital clinics. The legalization of on-request abortion helped to increase the legitimacy of abortion and reduced some of the stigma, fear and uncertainty attached to it: Patients and providers were no longer engaged in clandestine criminal activity, mainstream hospitals and physicians were increasingly involved, and activists and policy-makers increasingly framed it in terms of rights of equality, privacy and bodily autonomy. The legalization of early abortion on request also made abortions safer because physicians and facilities were now licensed and regulated by the state and unskilled providers left the field when they were unable to compete with better ones. Provision "on request" also reduced the stigma and increased the legitimacy of abortion because it allowed women to make fertility choices on their own and for their own reasons rather than asking for permission (often on grounds of mental distress), from mostly male hospital therapeutic abortion committees. Finally, abortion's legality and its provision in specialized outpatient clinics made it considerably less expensive than earlier legal and illegal modes of provision (Goldstein 1984; Joffe 1995; Reagan 1997; Graber 1993).

6. The Role of Social Movements

The main SMO contributors to the creation and diffusion of the new organizational form were CCS, NARAL and approximately 150 small women's liberation groups spread throughout the country. CCS, founded in New York City in 1967, was a nationwide organization of prominent Protestant and Jewish clergy that provided referrals to physicians willing to provide abortions either on request (illegally) or for broad interpretations of mental health (quasi-legally). Once New York repealed its law in April 1970, CCS referred thousands of women to clinics there. It also collaborated with Hale Harvey, a physician in its referral network, and Barbara Pyle, a women's liberation activist who had studied abortion clinics in England, to establish CRASH (also known as Women's Services), which quickly became the largest and most prominent clinic in the nation. It opened on July 1, 1970 and by August was providing 100 abortions per day, mostly for out-of-state patients referred by CCS (Carmen and Moody 1973; Dirks and Relf 2017).

NARAL was the most prominent national abortion SMO. Its members and leaders were drawn from birth control, religious, liberal feminist, women's liberation, social service and state repeal organizations and its financial support came from foundations or rich individuals affiliated with the birth control movement (Staggenborg 1991). It tried to open an abortion clinic in Washington, D.C. in 1969 and New York City in 1970 but was unable to find willing physicians for the first effort and abandoned the second after one of its top leaders, Dr. Bernard Nathanson, became the medical director of CRASH. NARAL was also strongly involved with CRASH and with the pursuit of regulations favorable to clinics (Lader 1973; Nathanson and Ostling 1977).

The feminist movement of the time had two wings: approximately 150 small, local "women's liberation" groups and national, federated organizations, including the largest of these, the National Organization for Women (NOW). The two wings have been variously described as "radical" versus "liberal", "younger" versus "older", and "small group" versus "mass." Women's liberation activists were heavily involved in abortion referrals and in the establishment of abortion counseling in non-profit and for-profit clinics. Though many women's liberation groups established feminist health clinics during this time, those clinics mainly

provided abortion referrals. Only a few, and none of those in New York, provided abortions (though this would change to some degree after *Roe*)(Freeman 1973, Staggenborg 1991; Hole and Levine 1973).

National NOW played no role in the establishment of clinics and had only a modest role in the struggle for abortion rights itself prior to *Roe*. Two exceptions, however, were its leader, Betty Friedan, who sat on NARAL's board, and its New York City chapter, which was active in the New York repeal movement (Staggenborg 1991; Lader 1973).

The national Planned Parenthood organization, the country's largest and most prominent birth control organization, played only a minimal role in the initial development of clinics but its New York City chapter partnered with the city government to establish a referral service in 1970 and it opened an abortion clinic in 1971. In the 1980s, Planned Parenthood, significantly increased its nationwide abortion provision however, and is now the largest provider of abortions (Ziegler 2020; Langmyhr 1971).

The antiabortion movement was still in its infancy nationwide but New York's 1970 legalization prompted a massive mobilization in New York, led largely by the Catholic Church. In Spring of 1972, the movement pushed a repeal of the 1970 legalization through both houses of the state legislature, only to have it vetoed by Republican Governor Nelson Rockefeller (Lader 1973). For the most part, the antiabortion movement focused on this legislative campaign rather than on the politics of abortion provision.

Though 16 of the 21 abortion clinics in New York City were owned and operated by for-profit entrepreneurs (most of whom were physicians), abortion SMOs were the true creators of the form, shaping the emergence of clinics in a number of ways. They 1) pursued city and federal regulations that allowed clinics 2) acted as entrepreneurs, opening model clinics 3) regulated for-profit provision 4) developed and diffused technologies that made clinic abortions safer and less expensive and 5) conducted medical research that helped to legitimate clinics.

6.1 Administrative Regulation

As New York prepared to implement its new law on July 1, 1970, abortion SMOs worked to ensure that city and state regulations allowed abortions not only in hospitals but in non-hospital clinics and doctor's offices. Concern about the supply of abortions was an important impetus for the establishment of clinics. Because abortion reform occurred state-by-state, the first states to legalize on-request abortions (without residency requirements) experienced strong out-of-state demand. Some predicted that the number of legal abortions in New York City would rise from 850 in 1969 to as many as 500,000 per year (the actual number was approximately 200,000). Most observers agreed that hospitals did not have the capacity to meet such heavy demand and many activists argued that they did not have the will to do so (Lader 1973; Nathanson and Ostling 1977).

Abortion SMOs had several reasons to believe that hospitals and mainstream physicians would not provide enough abortions. They had provided few under pre-reform medical necessity laws and the American Medical Association had offered only lukewarm support for abortion reform, though many state chapters were more amenable. In Britain, which legalized abortion for "social" reasons in 1967 and Washington, D.C., where abortions became available on request after a federal court ruling in 1969, hospitals had proven reluctant (Halfmann 2011). According to NARAL, "Our experience in Washington, D.C. shows...[that] hospitals will not move on their own" (NARAL Executive Committee (EC), April 17, 1970).

Many hospitals were indeed reluctant. Physician attitudes were the most important determinant of their policies and practices (Miller 1979). Some physicians felt that "abortion on demand" (as they pejoratively called it) lessened their discretion and reduced them to "mere technicians." Others feared they would be stigmatized by community members or other physicians (*New York Times* (*NYT*), June 28, 1970; Hall 1971; Joffe et al. 2004). Many projected their negative views of pre-reform "back-alley butchers" onto legal providers (Goldstein 1984; Joffe 1995; Schoen 2015). Hospitals also wanted to avoid community disapproval or being seen as "abortion mills" and took steps to limit abortions. They set quotas, prohibited outpatient abortions, or established requirements for residency or parental consent that reduced patient eligibility and drove up costs

and delays. Some hospitals also had difficulty finding willing physicians or nurses. Another factor was that the market-based American health system treated health care as a private consumer good rather than a right. This, along with the legalization of abortion *on request,* helped physicians to construct it as an "elective" procedure, which was self-chosen rather than medically diagnosed, and thus not part of their professional responsibility or normal ob-gyn services (*NYT,* October 25, 1970; Schoen 2015). Some activists, such as the ASA's Dr. Robert Hall worried that the emergence of clinics might reinforce this view: "I want to see the hospitals forced to perform abortions. If we let them off the hook by setting up clinics, they'll never accept their responsibilities" (Garrow 1994: 456).

In addition to concerns about hospital resistance, some activists argued that clinics offered higher-quality abortions than hospitals. They were safer because they used the latest techniques, cheaper because they provided large numbers of abortions, and more compassionate and dignified because their personnel supported abortion rights and provided counseling. As one ob-gyn put it, "hospitals are no place for abortions, at least not for the simple, early ones. The entire hospital setup—with its involved bureaucracy, administrative delays, high overhead, and brusque efficiency—only serves to make abortions more costly, more complicated, and more traumatic for the patient" (*NYT,* Oct 20, 1970).

Given their expectations of strong demand and limited hospital capacity or interest, New York state and city regulators pondered whether to impose a residency requirement and whether to allow clinic and office abortions. State regulators opposed residency requirements and approved of clinic abortions but city regulators were more restrictive, initially proposing a residency requirement and a ban on clinic and office abortions. NARAL and CCS fought back, arguing that such restrictions were unnecessary and would create shortages and increase costs (*NYT*, June 28, 1970, May 13, 1970). NARAL's Nathanson contended that "a qualified person can safely perform an abortion anywhere" (*NYT,* June 28, 1970). In its newsletter, NARAL worried that the regulations might "set a pattern for the rest of the country" and attacked the medical profession, proclaiming that it opposed "all attempts by the medical hierarchy to undermine the intent of the law" (*NARAL News,* Summer 1970).

The ASA's Hall disagreed. He argued that the city's regulations were necessary to prevent a disastrous implementation of the New York law that would discredit the repeal movement nationally.

> There isn't one doctor in the state of New York who has ever done an abortion under…three conditions—out-patient, local anesthesia, and suction. To do 50,000 with these strange new techniques will be trouble enough in a hospital. But let the floodgates open, let in 500,000, and you will have independent clinics to accommodate them. Then you will have deaths, profiteering, gruesome stories on the front pages of the newspapers. Next January, the Legislature will meet again and say, "See what a mess they've made of the abortion law," and rescind it. The other 49 states, looking at the New York experience, will see us screwing it up and will stay away from abortion repeal. I'm even naïve enough to believe that Supreme Court Justices read the newspapers, and they'll wonder why they should legalize abortion repeal for the whole country if this is the way we behave in New York (*NYT,* June 28, 1970).

NARAL, CCS and other groups testified at hearings on the proposed regulations and organized protests. NARAL organized a symposium on abortion provision where it trained providers, discussed the City's proposed regulations with them and lobbied elected officials about the importance of office abortions (NARAL EC, June 25, 1970, July 1, 1970; February 5, 1971). For its part, CCS collected data showing long waiting lists and delays in hospitals. And Dr. Christopher Tietze of the Population Council presented evidence about the positive safety record at CRASH. In October 1970, the City abandoned the proposed residency requirement and allowed abortions in clinics if they had an operating room suitable for abdominal surgery, appropriately staffed x-ray, blood bank and laboratory facilities, and a backup agreement with a nearby hospital (*NYT*, June 28, 1970, October 25, 1970; Lader 1973; Pakter and Nelson 1971).

The new regulations did prohibit office abortions, however. Before reform, such offices had been the site of many quasi-legal abortions and, as a result, many physicians and regulators viewed them as deviant, unethical and unsafe (though this was not necessarily true). Regulators argued that doctors' offices did not have appropriate facilities to deal with complications and argued that such offices, because they were so

numerous, would be difficult to monitor—as the pre-reform period had shown (Neubardt and Tovell 1972). Thus, clinics offered a compromise for regulators between reluctant and "over-taxed" hospitals and "dangerous" and "unethical" physicians in private offices.

6.2 Entrepreneurial Modeling

In addition to fighting for favorable administrative regulations, SMOs engaged in entrepreneurship in order to create models of abortion provision for non-movement market actors. The CCS and the proposed NARAL clinics were meant to serve the enormous demand for abortions in New York City but also to legitimate clinics by convincing patients, other abortion activists, legislatures, courts and regulators that clinics were an appropriate, even superior, location for abortion services. Activists hoped to show that the clinics were safe, that they increased equity, and that they offered higher quality and more sensitive care than hospitals. They also hoped that for-profit providers would adopt their patient-centered and low-cost model of care and, where possible, they forced them to do so through competition and private regulation.

As the CCS planned its New York clinic, it hoped to "establish the feasibility of providing medical services to women with problem pregnancies at a minimum cost without refusing service to anyone because she lacks funds" (Dirks and Relf 2017, loc. 3143). And as NARAL planned its Washington, D.C. clinic, its leaders claimed that it would demonstrate that non-hospital abortions could be provided safely and would show the benefits of abortion liberalization for the poor. They said they hoped to provide a prototype for similar clinics once other states repealed their abortion laws and predicted that such a model would influence courts and legislatures (Lader to NARAL EC, "Washington, D.C. Free Clinic," January 13, 1970; NARAL EC; December 12, 1969; January 20, 1970; February 24, 1970, April 3, 1970; *Washington Post*, February 25, 1970; March 11, 1970; March 13, 1970; May 24, 1970). Similarly, NARAL's proposed New York City clinic "would be an essential demonstration that abortions can be done safely and efficiently in an out-patient clinic, and that abortions will be available to the poor" (NARAL EC, April 17, 1970). When Planned Parenthood established a clinic in 1971, it was meant to be a "prototype" for clinics nationwide that would "stimulate the conversion of so-called abortion clinics" into multi-service contraceptive clinics (*NYT*, April 1, 1971).

A model clinic would also help activists to defend clinics if New York's implementation proved to be a disaster. NARAL's Nathanson predicted that "a tremendous number of abortions will be performed in doctors' offices under poor conditions, and a large number of deaths will occur. The result will be that the state will want to clamp down by restricting abortions to hospitals, unless there is some model for the out-patient clinic" (NARAL EC, April 17, 1970).

Activists also hoped the clinics would convince physicians to provide abortions. Though NARAL had difficulty recruiting physicians for its Washington, D.C. clinic, Executive Director Lawrence Lader, predicted that they would change their minds once the clinic opened, "I think that Washington doctors will gain courage and join us. Our job, I believe, is to convince the medical profession that this is a pioneering effort and that participating doctors will be the heroes of the movement" (Lader to NARAL EC, "Washington, D.C. Free Clinic," January 13, 1970).

The new clinics also modeled a particular type of abortion care—patient-centered and feminist. CRASH took pride in its employment of abortion counselors. Such counseling had originated in pre-reform referral services, but was carried over to the CRASH clinic. Counselors were mainly young women affiliated with the women's liberation movement, many of whom had had abortions themselves. They stayed with patients from the beginning of their visit until the end, and sometimes assisted with the procedure. They provided information and emotional support, monitored physicians, and provided them with feedback about the sensitivity of their care (Goldsmith, Potts, Green and Miller 1970; Joffe 1986, 2012; Dirks and Relf 2017).

6.3 Private Regulation

Abortion SMOs also worked to ensure that for-profit clinics adopted the new model of abortion provision faithfully and in line with their priorities. A key aspect of this effort was the establishment of abortion referral services, which not only increased abortion access but monitored and regulated the price and quality of abortion services. Beginning in 1966, various organizations had begun referring women for foreign or (quasi-legal) domestic abortions (Hole and Levine 1973; Staggenborg 1991). CCS always referred to physicians, while some services, and especially women's liberation ones, referred to both physician and lay providers. But after the legalization of on-request abortion in Washington, D.C. and California in 1969, and in New York in 1970, referral services began to refer almost all of their patients to those three places for legal physician-provided abortions (Lader 1973; Carmen and Moody 1973).

New York City residents also obtained abortions through referral services such as the Women's Abortion Project (a women's liberation group) and a joint operation established by the New York City Planned Parenthood and the city government. CCS and New York City Planned Parenthood also launched a hospital referral service, Clergy and Lay Advocates for Hospital Abortion Performance, which helped clients to schedule hospital abortions and kept track of complaints (Dirks and Relf 2017). For-profit referral services also entered the field. Unlike the non-profits, they either charged fees to patients or received kickbacks from providers—sometimes both. They were criticized for price gouging, deceptive advertising, and fee-splitting and sometimes impersonated non-profit clinics or stole their clients at airports and bus stations. Abortion SMOs convinced the New York legislature to ban them in June 1971 (*NYT*, April 11, 1971; Harting and Hunter 1971).

Most activists, especially those in NARAL and CCS, supported for-profit clinics because they increased the supply of abortions beyond the capacity of hospitals and non-profit clinics and because some clinics were owned by social entrepreneurs with ties to the abortion movement. At the same time, activists sought to ensure that for-profit clinics provided safe, sensitive and inexpensive care that did not discredit clinics or the reform movement itself.

The activists regulated providers through competition and brokerage. First, they dissuaded for-profit clinics from charging high prices by competing with them directly. Non-profit clinics could offer low prices and sliding scales because they didn't need to turn a profit, were sometimes subsidized by donations, and could sometimes rely on *pro bono* work by physicians. They also utilized brokerage. They controlled the supply of patients (eventually almost exclusively) and this allowed them to demand lower prices and better-quality care. They sent undercover volunteers to inspect offices and ask questions about doctors' methods (Carmen and Moody 1973). They also monitored quality through follow-up patient questionnaires and sometimes forced providers to change their practices by threatening to cut off referrals. Many referral services required clinics to provide counseling and it eventually became available in most for-profit clinics (Carmen and Moody 1973; Joffe 1986, 2012; Dirks and Relf 2017). Clinic owners felt the pressure. As one put it, "Sure I couldn't really stand most of them, especially the feminists. But I understood them, saw what they wanted…They wanted us to do it their way…. Fine" (Goldstein 1984: 221).

The referral services not only monitored quality but put pressure on providers to lower prices by giving patients price information in advance of their procedures, setting maximum prices and demanding that the clinics provide a free abortion for every ten paid ones. Patients were quite price sensitive because most paid out-of-pocket and many were low-income (Pakter 1971).

The for-profit clinics were especially sensitive to private regulation because their high-volume business model required a large and reliable stream of patients. According to Goldstein (1984: 524):

> Mass production required a large number of patients to justify the facilities, personnel and low costs….The [clinic] entrepreneur had to ensure a steady flow of clients. They were usually provided by organizations which knew of, or sought out patients. These organizations' motives ranged from altruism to profit. Whatever their motives, the entrepreneurs were dependent upon them.

One for-profit provider acknowledged that the referral services "definitely drove prices down. There was tremendous competition" (*Wall Street Journal*, June 1, 1971). When the New York repeal first took effect, early hospital abortions had ranged from $400 to $600, but after a year, for-profit hospitals charged around $250, municipal and non-profit hospitals charged around $150, and non-profit and for-profit clinics charged between $50 and $200 (Pakter 1971).

6.4 Technological Development

Movement actors also contributed to the development and diffusion of technologies for performing outpatient abortions and for organizing systems of abortion provision. In the late 1960s, the most common abortion method in the United States was dilation and curettage (D&C), in which the provider dilated the patient's cervix and removed the contents of her uterus with a curette, a metal instrument with a scoop or loop at the end. That method required skill to avoid infection or perforation of the uterus but a better method had been in use since the 1950s in Asia, the Soviet Union, and Eastern Europe. In "vacuum aspiration" (or suction abortion), the provider vacuumed out the contents of the uterus with a metal tube (canulla). A second, and equally important, innovation was a flexible, disposable plastic canulla invented by Harvey Karman, a lay abortion provider and activist. The invention in Yugoslavia of a new method for administering a paracervical block (a type of local anesthesia) further increased the feasibility of clinic abortions. These innovations made abortions safer, technically easier, quicker, less expensive and more comfortable (Joffe 1995; Schoen 2015; Tunc 2008).

Movement activists not only invented some of the new technologies but worked to spread them. In 1967, C. Lalor Burdick, a contraceptive manufacturer and abortion movement funder, traveled to Europe to learn about the suction device and commissioned an instructional film by Dr. Dorothea Kerslake, a British physician and abortion activist. It was distributed by California's Society for Humane Abortion (SHA) and shown at symposia sponsored by groups such as the ASA, NARAL, SHA and Planned Parenthood (Harting and Hunter 1971; *SHA Newsletter*, Winter 1970-71). Burdick also funded an appearance by Yugoslavian abortion specialist, Dr. Franc Novak, at an important ASA conference in 1968. Around 1969, physician-activists from UCSF Medical School worked with Berkeley Bioengineering to manufacture a vacuum aspiration machine and promoted the Karman canulla (Margolis and Overstreet 1970). The Berkeley machine was also lauded by Planned Parenthood's Guttmacher, ASA's Hall and NARAL's Nathanson, who adopted it for use at the CRASH Clinic (Joffe 1995; Tunc 2008).

The new methods spread quickly: when the New York law took effect, D&C's were the most prevalent technique, but within a year, suction was used in 93 percent of first-trimester abortions (Schoen 2015). This had enormous consequences for the diffusion of clinics. Before, only hospitals could afford to establish them but the new technologies reduced start-up costs considerably (Tunc 2008). Technical innovations also meant that providers needed less technical skill and that complications were much rarer, increasing patients' and policymakers' confidence in clinic abortions.

In addition to these technical innovations, SMO clinics helped to developed the high-volume model of abortion provision that offered economies of scale and kept abortion prices low. For-profit entrepreneurs, under pressure from referral agencies and non-profit competitors embraced the model. "You did maybe 15 to 18 an hour, especially on Saturdays—that was the day. It was an assembly line. You couldn't slow down or take a break" (Goldstein 1984: 523).

6.5 Scientific Research

As the activists formed model clinics and spread abortion technologies, they tried to establish the legitimacy of clinics by demonstrating their quality and safety. They provided evidence for those claims by conducting medical research. Many movement-affiliated clinics kept detailed records of complications in order to document the safety of their practices, and potentially use them to persuade legislatures and courts. Howard

Moody, the leader of CCS, told Hale Harvey, the first medical director of CRASH, that he should not expand the clinic if doing so interfered with such research. In this effort, the abortion movement benefitted from the presence of activists with the necessary medical and scientific knowledge to produce this research. In 1970, Christopher Tietze, an abortion activist and chief statistician at the Population Council, initiated a prospective study of abortion complications, the Joint Program for the Study of Abortion (JPSA). In 1971, he convinced the U.S. Centers for Disease Control to take it over (Carmen and Moody 1973). Its results, published in October 1971 and June 1972, showed that clinics had lower complication rates than hospitals and that suction abortions were much safer than D&Cs (Tietze and Lewit 1971, 1972). The study included data from six clinics but 70 percent of its abortions were performed at CRASH, probably the best clinic in the country, and as a result, it probably over-stated the safety of clinics. Though the study warned that generalizations should be made "with the greatest caution" it's not clear how much caution was actually exercised (Tietze and Lewit 1972: 116). In the same year, Bernard Nathanson of NARAL and CRASH described the procedures and positive safety record of CRASH in the *New England Journal of Medicine* (Dirks and Relf 2017; Nathanson 1972).

The research conducted at CRASH was used both to fight New York City's proposed ban on clinic abortions and to argue for the safety of clinic abortions to the U.S. Supreme Court. *Doe's* attorneys, as well as the *amicus* briefs of Planned Parenthood and the American College of Obstetricians and Gynecologists, argued that the hospital requirement in Georgia's abortion law was "irrational" because "clinics are fully capable, by virtue of the New York experience…to afford effective and safe abortion services."

Justice Harry Blackmun, the author of the *Roe* and *Doe* decisions, had strong personal and professional connections to the medical profession and, as a result, deferred strongly to medical opinion in his abortion decisions (Halfmann 2011). The fact that the abortion movement could provide medical research on the safety of abortion that was conducted by prominent physicians and biostatisticians and published in the nation's most prestigious medical journal may have helped to persuade Blackmun that abortions could be provided outside hospitals. His *Doe* decision stated that the Court was persuaded by the statistics as it struck down Georgia's hospital requirement (*Doe v. Bolton* 1973: 195; "Oral argument," *Doe v. Bolton* 1973: 15; "Brief for Appellants," *Doe v. Bolton* 1973: 13, 37, 39-40; "Brief of Amici for the American College of Obstetricians et al.", *Doe v. Bolton* 1973: 5, 85; "Brief of Amicus for Planned Parenthood Federation of America", *Roe v. Wade* 1973: 9, 16-18).

7. Alternative Mechanisms

Here, I argued that SMOs shaped the invention and diffusion of abortion clinics by pursuing favorable administrative regulation, modeling the new organizational form, regulating non-movement market actors through competition and brokerage, developing and diffusing new technologies, and conducting scientific research.

It is notoriously difficult to establish the effects of social movements on policy or economic outcomes because they typically have many determinants (Bosi et al. 2016; Amenta et al. 2010). When an SMO directly provides goods or services, it is obviously an economic outcome of the movement but it is harder to demonstrate that an SMO affected other market actors. Perhaps non-hospital abortion clinics would have developed and diffused just as quickly and widely without SMO action because for-profit entrepreneurs would have naturally seized the new business opportunities provided by the New York legalization. This seems unlikely for a few reasons. First, clinics were only possible because New York City abandoned its proposed ban on them and it was SMOs rather than for-profit entrepreneurs that lobbied and protested against the ban. The fact that the City changed its position so abruptly, radically and immediately after SMO action suggests that SMOs played at least some role in the City's decision-making. Second, City officials considered, but decided against, a residency requirement, again after protest and lobbying by abortion SMOs. The absence of such a requirement was crucial for the development of clinics. In the first year after

New York's law went into effect, hospitals performed approximately 100,000 of the 140,000 abortions in the City but only 50,000 went to residents. In other words, a residency requirement would have reduced abortion demand by almost two thirds, making it possible for hospitals to accommodate all of it. This might have reduced pressure on regulators to allow clinics that could address shortages and reduced the need and incentives for abortion SMOs and for-profit providers to establish clinics (Harris, O'Hare, Pakter and Nelson 1973). Moreover, a wholly in-state patient population might have reduced business opportunities for for-profit providers because nonresidents, who had little knowledge of New York providers and lacked scheduling flexibility, were easier to exploit.

SMOs also played an important role in developing and importing new technologies, particularly suction abortion and local anesthesia, that made abortions possible outside of hospitals as well as diffusing those technologies through SMO-sponsored conferences, symposia and training materials. Without such technologies, clinics would have been impossible.

Abortion SMOs also shaped prices and quality. Prices fell after SMOs competed with and regulated hospitals and for-profit providers and diffused technologies that made low-cost abortions possible. And providers admitted that they felt SMO pressure. SMOs and activists also pushed for patient-centered care and especially abortion counseling (Joffe 1986). Such counseling was first initiated by SMO-affiliated clinics but eventually spread to almost all clinics. There too, physicians acknowledged that abortion activists influenced how they provided care. "It was a learning time. We were learning from them. It was more confrontational and less collegial than I would have liked. But we were learning about how women needed to prepare for abortions…and how abortions should be done…(quoted in Joffe 1986: 135).

8. Discussion

Research has found that a key economic outcome of social movements is to contribute to the emergence and diffusion of new market organizational forms. But what are the mechanisms through which they do so? Existing research points to the development of new ideas, understandings and frames, entrepreneurship, aid to non-movement entrepreneurs, and protest and boycotts against non-movement providers (Hiatt et al. 2009; Greve et al. 2006; Rao et al. 2000; Schneiberg 2002; Sine and David 2003; Sine and Lee 2009; Lounsbury et al. 2003; Schneiberg et al. 2008; Dioun 2017; Kurland and McCaffrey 2016; McInerney 2014; Weber et al. 2008; Ruef 2000; Swaminathan and Wade 1999; King 2008).

Here, I theorized five mechanisms that add to and extend those above: shaping administrative regulations, creating and modeling the new form, regulating non-movement providers through competition and brokerage, developing and diffusing new technologies, and conducting scientific research.

I showed the plausibility of these mechanisms through analysis of the market for abortion services in New York City during the early 1970s. I showed that abortion activists lobbied and protested against New York City's proposed residency requirement and its ban on clinic abortions. They also collected data showing that hospitals were not adequately serving abortion patients. The City eventually abandoned these proposals and it seems likely that movement actions played a role since the City reversed its position abruptly and drastically and because no other actor advocated for the change. I also showed that abortion SMOs established their own abortion clinics and viewed these as models or demonstration projects that could help legitimate clinics in the eyes of patients, government officials and other providers. Through the clinics they also sought to model particular practices that they hoped would be embraced by the broader sector, in particular, low and sliding-scale pricing and the provision of feminist, patient-centered care and counseling. They worked to ensure the faithful replication of their model through private regulation of for-profit clinics by competing with other providers and by controlling patient referrals. Both put pressure on non-movement providers to offer lower prices, sensitive and safe care, and abortion counseling. Those practices diffused widely, prices came down and for-profit providers acknowledged that SMO action played a role. Activists also developed and imported new technologies that made outpatient abortions, and thus clinics, feasible. They sought to diffuse these

technologies through direct and mediated training and by demonstrating the technologies. The new techniques were used by both non-profit and for-profit providers. Finally, activists conducted scientific research on the safety of clinic abortions and then presented it to city regulators and the Supreme Court. The Supreme Court acknowledged that movement-initiated research on clinic safety had affected its thinking on hospital requirements.

There are several possibilities for further research. One is to test the importance of these mechanisms in other cases and across cases. Another is to identify their scope conditions. Private regulation through competition and brokerage may be more prominent in markets where prices are exploitive (e.g., check cashing and payday loans), where consumers lack the knowledge for evaluating quality or safety (e.g., healthcare), or where existing suppliers are under-regulated or have a reputation for dishonesty (e.g., solar panels). Movements may also have greater impact on the emergence of new organizational forms in situations where demand outstrips supply. Shortages may encourage regulators to allow new organizational forms and encourage consumers to try them. Excess demand may also make incumbents less resistant to newcomers because there are plenty of customers to go around. Finally, the inability of incumbents to satisfy demand may discredit them.

Direct competition and brokerage as forms of private regulation deserve greater attention, as do other mechanisms of private regulation such as identifying best practices, forming trade associations, and setting standards of care (Hern 1978; Schoen 2015). Market implementation of public policies also deserves greater study, in part because of its normative implications. When implementation is handled by SMOs or market actors rather than by government or professional ones, it may reduce democratic and professional accountability (Thomann, Hupe, and Sager 2018). For example, private implementation of abortion policy allowed government and professional actors to distance themselves from the abortion issue and avoid accountability for implementation failures. Finally, while research on the emergence of new market organizational forms has paid extensive attention to technological change, it has given less attention to movement-directed development and diffusion of new technologies and movement-initiated scientific evaluation of those technologies. Further research on both is warranted.

Additional study of the rise and diffusion of abortion clinics would also be useful. This study focuses on abortion provision in a single city right before the Roe decision. This limited focus is an improvement over most studies of the rise of abortion clinics, which do not attend to important differences across states, between large and small communities, and over time, but it is only a start.

The prominence of clinics is a distinguishing feature of American abortion policy. Some argue that access to abortion would be much weaker had clinics not gained such a large share of the market for abortion services since government and hospitals were unwilling to implement *Roe* (Rosenberg 1995). Others argue that clinics have served to discourage hospital provision, contributed to the stigmatization of abortion through its location in facilities outside mainstream medicine, and provided a visible and vulnerable locus for antiabortion attacks (Freedman 2010; Joffe 2009; Joffe et al. 2004. For both those who wish to encourage abortion provision in more mainstream medical settings and those who seek to encourage lay provision, understanding how clinics emerged and spread is crucial.

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