Nevertheless, They Persisted: How Patterns of Opposition and Support Shaped the Survival of U.S. Abortion Clinics

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Abstract. Stigmatized organizations are generally assumed to face a variety of unique operational challenges. This paper examines the survival of stigmatized organizations in light of such challenges. Specifically, we investigate how patterns of opposition and support from multiple external stakeholders and audiences affect organizational survival within the context of abortion provision in the United States. We use a fuzzy-set qualitative comparative analysis (fsQCA) to examine the causal linkages between the above factors and the survival outcomes of the full identifiable industry of 983 abortion clinics that were in operation in the U.S. between 2011 and 2017. Our results reveal the existence of multiple paths to survival, based primarily on either the absence of overt opposition or the presence of factors like political support that enabled organizations to overcome other threats to survival. Our findings show how socio-political factors affect the survival of organizations in stigmatized industries.

Keywords: organizational stigma; abortion; survival; stakeholders; fsQCA

Stigmatized organizations routinely face negative evaluations from stakeholders, which often manifest into difficulties not experienced by their non-stigmatized counterparts (Devers, Dewett, Mishina, & Belsito, 2009; Hudson & Okhuysen, 2009). For example, stigma can reduce demand for an organization's products or services (McDonnell & King, 2013), bring about legal challenges to their operations (Hudson & Okhuysen, 2009), or result in suppliers or business partners withdrawing from exchange transactions due to concerns about stigma by association (Jensen, 2006; Pontikes, Negro, & Rao, 2010). Based on the myriad hurdles stigmatized organizations face, scholars have assumed that it is likely to be especially challenging for them to stay in business. At the same time, we know from experience that entire industries are often able to survive and persist *despite* being stigmatized; examples include adult entertainment businesses (Jensen, 2010; Voss, 2015; Wolfe & Blithe, 2015), tobacco companies (Galvin, Ventresca, & Hudson, 2004; Hsu & Grodal, 2021), and defense contractors (Durand & Vergne, 2015; Vergne, 2012). This raises the question of the conditions under which stigmatized organizations are able to survive.

The literature in this domain has frequently made the argument that many of the difficulties experienced by stigmatized organizations can be ascribed to *informal ostracism* from exchange partners, such as potential customers, suppliers, and landlords (Augustine & Piazza, 2022; Jensen, 2006), which makes the acquisition of resources more difficult. Informal ostracism, however, is not necessarily the only challenge that stigmatized organizations face. Rather, stigmatized organizations' fates are arguably also a function of the broader patterns of socio-political opposition and support that they engender among certain audiences and stakeholders. For example, stigmatized organizations often face targeted legislation aimed at outlawing the activities that they engage in (or curbing their diffusion). Along the same lines, when elected officeholders are hostile to stigmatized organizations and their activities, they can implement executive actions or appoint unfriendly regulators to try to drive them out of business or stymie their growth. Stigmatized organizations are also often a magnet for various forms of

oppositional activism (Ferns, Lambert, & Gunther, 2021; Fremeth, Holburn, & Piazza, 2022), which can further compound the challenges these organizations face. At the same time, many stigmatized organizations enjoy a core bloc of support, and the negative consequences of stigma can theoretically be mitigated by the backing of supportive audiences.

Overall, stigmatized organizations engender mixed patterns of opposition and support from specific stakeholders and broader audiences in their environment; however, we know relatively little about how stigmatized organizations fare in terms of survival and what role these dynamics play in shaping survival odds. Further complicating matters is the fact that these sociopolitical dynamics likely play out at the same time, and they are not necessarily additive, so that examining them in isolation via conventional methodologies—such as regression-based approaches—is unlikely to be helpful. Furthermore, it is important not only to examine these factors alongside one another, but also to be able to examine the same type of organization across different contexts to leverage variance in these factors. Therefore, in this paper we seek to examine the survival of organizations engaging in stigmatized practices in a comprehensive, open-ended fashion by asking: *how do patterns of opposition and support from certain external stakeholders and audiences affect organizational survival within a stigmatized industry?*

To address this question, we have identified a case of a stigmatized industry where there exists substantial local variation in the opposition that stigmatized organizations face and in the support they enjoy from external stakeholders and audiences. The empirical setting of our study is abortion clinics in the United States, which are perhaps the quintessential stigmatized organization (Augustine & Piazza, 2022; Hudson, 2008). The staunch opposition to their core business by anti-abortion activists, many politicians, and a sizeable fraction of the general public in the U.S. have made them controversial in the eyes of numerous audiences and stakeholders ever since elective abortion was legalized nationwide in 1973. We situate our study between 2011 and 2017—a particularly tumultuous time for these organizations, which faced myriad stigma-related challenges, especially at the U.S. state level

(Joffe, 2018). Headlines at the time emphasized rampant abortion clinic closure (Deprez, 2016; Winter, 2016). However, during this period abortion rights continued to enjoy a bloc of support from the public and elected officials alike, and the unique dataset that we have compiled reveals that most clinics survived during this challenging period—i.e., approximately three-quarters of the clinics that were open in 2011 were still in operation in 2017. Despite a substantial number of failures, when one looks at everything stacked against abortion clinics, the fact that so many survived during this period is both remarkable and surprising.

In the remainder of the paper, we first review the literature on organizational stigma, its consequences, and their effects on organizational survival to lay out the groundwork for our argument. We then examine communications from leading abortion rights organizations to understand the stakeholder and audience threats and sources of support that might have affected survival within this stigmatized industry. Taking these factors into account, we use fuzzy-set qualitative comparative analysis (fsQCA) to examine the causal linkages between the above factors and the survival outcomes of the full identifiable industry of 983 abortion clinics that were in operation at any point over our period of study. The results of the fsQCA analysis reveal the existence of multiple paths to survival, which we illustrate through examples from our data. In our discussion, we then elaborate on the implications of our findings for the scholarly understanding of the effects of socio-political factors on survival for stigmatized organizations and, by extension, for the broader literature in this area.

THEORETICAL BACKGROUND

Organizational stigma is defined as "a label that evokes a collective perception that the organization is deeply flawed or discredited" (Devers, Dewett, Mishina, & Belsito, 2009: 155). Such a perception can arise because of a one-time event, such as fraud (Jonsson, Greve, & Fujiwara-Greve, 2009; Paruchuri & Misangyi, 2015; Sutton & Callahan, 1987) or a scandal (Adut, 2008; Graffin, Bundy,

Porac, Wade, & Quinn, 2013)—in what Hudson (2008) refers to as *event stigma*. Alternatively, organizational stigma can be a byproduct of firm behavior, and specifically of activities that are characterized by broad social disapproval, such as the arms trade (Durand & Vergne, 2015; Vergne, 2012), pornography (Voss, 2015), nuclear power (Piazza & Perretti, 2015), and the case that we examine here of abortion (Reagan, 1997). These forms of stigma—referred to as either core (Hudson, 2008) or categorical (Piazza & Perretti, 2015; Vergne, 2012) in the literature—tend to be especially enduring, as they arise from sustained organizational engagement in practices that are themselves stigmatized. Organizations can therefore be stigmatized as a result of their engagement in practices that society devalues or views with distaste.[i]

While a few studies have investigated how organizations can use stigma to their advantage (Helms & Patterson, 2014), most research has concluded that, given stigma's nature as a negative social evaluation (Pollock, Lashley, Rindova, & Han, 2019), stigmatized organizations face unique challenges in their environment that non-stigmatized organizations typically do not face. The literature, however, has devoted relatively scant attention to investigating how various simultaneous challenges and supporting actions from multiple stakeholders and audiences affect organizational survival in the face of stigma. In particular, existing work has implicitly made the assumption that the consequences of stigma come about due to the opprobrium and informal ostracism associated with it (Durand & Vergne, 2015; Piazza & Perretti, 2015). A common theme in existing research is thus that societal disapproval is associated with social and economic sanctioning, resulting in informal ostracism, which makes everyday operations—and therefore long-term survival—challenging (Hudson & Okhuysen, 2009).

While insightful, we believe this account to be unnecessarily limiting in two main ways. First, the reprobation associated with stigma is often associated with overt and coordinated forms of opposition from what Hudson (2008: 259) referred to as "hostile audiences." For example, it is not

uncommon for stigmatized organizations to find themselves at the receiving end of sit-ins, protests, and boycotts from social movements (Vasi, Walker, Johnson, & Tan, 2015; Weber, Rao, & Thomas, 2009). Such opposition can threaten the very existence of stigmatized organizations in very tangible ways—threatening a firms' customers, resources, and operations, for example—going beyond mere ostracism. Along similar lines, stigmatized organizations often attract unwanted attention from key stakeholders, such as politicians, regulators, and other elected officials, who can deprive them of much-needed legitimacy, launch investigations into their operations, or make unfavorable political appointments to regulatory agencies (Fremeth et al., 2022). And in the same vein, the mere existence of stigmatized organizations can often trigger hostile legislative changes aimed at curbing the diffusion of behavior seen as deviant. For example, in the late 1990s the New York city enacted a number of legislative measures targeting adult entertainment businesses, as part of a broader initiative against pornography. The newly introduced requirement that X-rated merchandise could comprise no more than 40 percent of inventory meant that, to stay open, stores had to expand or shift a majority of their inventory to old comedies, Hollywood classics, and children's cartoons, likely at a significant cost.[ii] Further complicating matters, the above sociopolitical factors are likely not independent from one another; rather, within any given social milieu they are likely to be tightly coupled.

Furthermore, existing accounts of stigma have failed to consider how stigmatized organizations may be affected by the extent and prevalence of the support they enjoy. Just as the continued existence of stigmatized industries indicates sustained demand for certain goods and services, the persistence of stigmatized organizations over time is likely attributable to an enduring core, or bloc, of support for their products, activities, and their role in society. And this support is likely to buffer—at least to a degree—organizations that engage in stigmatized practices from the consequences of stigma discussed so far. When support for stigmatized organizations exists in certain segments of the population, or amongst certain stakeholders or audiences, organizations might be

more likely to endure and thrive even in the face of adversity. For example, support from elected officials in the legislative and executive branches of government may discourage opponents from taking aggressive action. And the existence of legislation safeguarding stigmatized organizations is likely to act as a barrier from stigma-associated hurdles. Once again, however, we know relatively little about how the forms of support articulated above may modulate the challenges associated with stigma, and if so under what conditions.

In the following, we seek to advance this line of inquiry by zeroing in on a crucial outcome for all organizations, stigmatized or otherwise: survival (e.g., Jourdan, 2018; Pajunen, 2006). While the prima facie importance of survival for organizations at large is obvious, survival is arguably of particular consequence when it comes to stigmatized organizations. Many of these organizations—such as marijuana dispensaries (Hsu, Kocak, & Kovács, 2018), brothels (Blithe & Wolfe, 2017), and abortion clinics (Augustine & Piazza, 2022)—are often the sole providers of sensitive goods and services, so that failure is inevitably associated with a reduction in the availability of such goods and services, if not their outright disappearance. We therefore continue by introducing our empirical setting—abortion clinics in the United States—with a view to understanding how central actors within the field make sense of the sociopolitical factors that may aid, or jeopardize, their survival.

EMPIRICAL SETTING

With the exception of a handful of U.S. states, elective abortion was illegal throughout the United States until 1973, when a landmark Supreme Court decision known as *Roe v. Wade* legalized abortion nationwide overnight. This came as a surprise to most Americans, even those who had been campaigning for legalization of the practice. In the wake of legalization, the organizational landscape shifted to allow for the provision of abortion procedures. Even though in most of the developed world abortions are provided by hospitals, in the U.S., hospital facilities were wary of being associated

with what was already a contentious practice, and often gave in to political pressure to avoid doing abortions in order to please funders, communities, or local government authorities (Augustine & Piazza, 2022). The above reasons, coupled with the desire by some pro-choice activists to separate the procedure from the (male-dominated) medical establishment, led to the creation of independent clinics. While independent clinics had some benefits, such as the fact that they could hire personnel who were more supportive of the right to have an abortion (Ginsburg, 1989; Joffe, 2009), the separation of specialist abortion clinics from generalist hospitals reinforced the stigma surrounding the practice and created visible organizational targets for disapproval that were isolated from the mainstream medical establishment (Augustine & Piazza, 2022; Press, 2006). As the contention surrounding abortion grew and the pressure from legislators and the general public increased, the procedure became marginalized in hospitals and medical schools, and clinics became virtually the only providers of abortion services in the nation (Bader & Baird-Windle, 2015). By the late 1980s, more than 90 percent of abortions in the U.S. were performed in standalone clinics, and this figure eventually rose to 95 percent by 2000 and held almost steady until 2011, when it was 94 percent.[iii] [iv] [v] Despite their dominance of the practice, clinics faced numerous obstacles to operating, and after withstanding intense stakeholder disapproval for years, many began to close, especially in the early 21st century (Deprez, 2016; Winter, 2016). Our study concludes in 2017, before *Dobbs v. Jackson Women's Health Organization*, the 2022 Supreme Court decision which overturned *Roe v. Wade* and which is certain to usher in widespread change in this industry.

FUZZY-SET QUALITATIVE COMPARATIVE ANALYSIS

For our analysis, we utilize fuzzy-set qualitative comparative analysis (henceforth fsQCA) to examine the survival of abortion clinics in the U.S. between 2011 and 2017 (Ragin, 2000). A relatively novel methodology within the landscape of organizational research methods, fsQCA builds on the idea that

real-world phenomena are best modeled not in terms of correlations, as in traditional regression analysis, but rather in terms of set-theoretic relations. While regression analysis is especially well suited to examine the impact of individual factors on an outcome variable of interest, it also makes some fairly restrictive assumptions—notably, that predictors should be independent of one another, with little or no multicollinearity. This can create an analytical blind spot in that it does not allow for the possibility that *configurations* of factors, rather than individual factors, may produce an outcome (Ragin, 2000), nor does it account for the fact that the same outcome may, on occasion, arise from very different causes, or combinations thereof—the idea of *equifinality* (Furnari et al., 2021). Regression also does not allow for asymmetric causality, i.e. the possibility that the configurations predicting "success" may differ from those leading to "failure" (Greckhamer, Furnari, Fiss, & Aguilera, 2018).

By contrast, in fsQCA the relationship between an outcome of interest and a set of input factors—or conditions—is examined through a set-theoretic approach encompassing all possible Boolean combinations of input factors across cases. In so doing, fsQCA seeks commonalities among cases that share the same outcome, with a view to understanding which conditions, or combinations of conditions, are sufficient to produce an outcome (that is, they are a subset of all possible combinations of conditions producing the outcome), and which are necessary (i.e., they must be present for an outcome to manifest). In the following, all fsQCA analyses were carried out by means of the *QCA* package in R (Duşa, 2019).

Sample and data

We compiled a unique primary dataset of abortion clinics operating between 2011 and 2017. Our choice of observation window is bounded by the fact that data collection took place in 2017 and one of our main data sources—the *Who Decides?* reports by NARAL—are only available online beginning with the 2011 issue. Our dataset is based on data from two main sources: 1) the watchdog website *AbortionDocs*;[vi] and 2) a national directory maintained and updated annually by the National

Abortion Federation (NAF).[vii] For completeness, and in order to reduce the amount of missing data, we triangulated the above sources with a similar dataset hand-collected by *Bloomberg News* (Deprez, 2016), as well as the website of Planned Parenthood, the largest network of abortion providers in the United States, and other available Internet directories and Web sites. We utilized the *Internet Archive* to triangulate data across these sources, and additionally to examine the defunct websites of closed clinics to pinpoint their closure date. This hand-collection and triangulation of primary data was done to obtain as comprehensive a picture as possible.

In total, we identified 983 abortion clinics that were in operation in the U.S. at any point over our period of study. We then assigned a coordinate pair to each clinic through geo-coding and we matched clinic data to state and county level information from other sources, including the U.S. Census Bureau, the Pew Religious Landscape Survey, annual reports by the abortion non-profit organization NARAL on abortion access and targeted regulations by state, data on crisis pregnancy centers (CPCs) from Swartzendruber & Lambert (2020), and election data from the Roper Center at Cornell University. Figure 1 is a graphical visualization of all of the clinics in our data superimposed on a map of the United States, with failed clinics in red and clinics that survived in blue.

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Outcome, conditions, and measurement

In addition to the outcome of interest, which is clinic survival, it is necessary to select a number of conditions to include in the fsQCA analysis. In choosing conditions, we focused on what we judged to be the main factors—both oppositional and supportive—that may be predictive of the outcome, based on our setting as well as on existing literature. Identifying conditions often requires gaining a deep understanding of the setting of interest, which we did via two means. First, we spoke with five expert informants, including three abortion scholars (two sociologists and one historian), as well as one abortion activist and one individual who has held various leadership positions in the professional

federation for abortion providers. From these conversations, we were able to start to understand the sociopolitical factors of interest. These informants also helped us identify the primary organizations that were working to support abortion provision in the U.S. during our observation window, which included: 1) Planned Parenthood, which is one of the largest providers of abortion services in the U.S. and is also known for its political advocacy work; 2) the Guttmacher Institute, which was founded in 1968 as a pro-choice research institute; 3) the National Abortion Federation (NAF), which is the primary professional association for abortion providers; and 4) NARAL Pro-Choice America (NARAL), an abortion rights advocacy group that was founded in 1969. As we deepened our expertise of the setting, we saw that each of these organizations hosted a repository of public-facing documents on their websites, including press releases, reports, research articles, and op-ed pieces. So, the second way that we deepened our understanding of this context was to gather and read all the available documents from each of the organizations' websites from our period of study (2011-2017), which resulted in 403 documents totaling 1,735 pages of text.

Based on our in-depth reading of these communications, we identified several of the common threats and the sources of support from key audiences and stakeholders that shaped the environment that different abortion clinics were operating in during our period of study. The communications discussed three primary threats.[viii] The first was hostile (anti-abortion) legislation. The second was anti-choice officeholders occupying positions of political power—as is the case, for example, when a state has an anti-choice governor or an anti-choice majority in one or both chambers of the legislature. And the third was opposition from local anti-abortion activists—which manifested during our period of study through the establishment and operation of so-called crisis pregnancy centers (CPCs). Other factors were framed as facilitating the provision of abortion services and, by extension, the everyday operations of clinics, thereby potentially enabling their survival—the stigma attached to abortion provision notwithstanding. The two supporting factors we found in the communications were the

presence of supportive legislation, such as protections on service provision, and the presence of supportive elected officials in positions of power. Exemplar quotes for each of these threats and supporting factors are shown in Table 1.

----------Insert Table 1 about here----------

In the following, we also include three additional factors based on existing organizational stigma research. The first is the degree of local opposition towards the practice of abortion, as attitudes toward stigmatized practices have been used in prior research on stigmatized organizations (see, for example, Hudson and Okhuysen, 2009). The second is local support for the practice, given our earlier argument that even though a practice may be stigmatized at the societal level it can also find pockets of public support. Finally, in consideration of the fact that in most industries organizational survival is frequently a function of market demand, and that demand for abortion services has been steadily declining in the U.S. for decades, we include a condition accounting for the local demand for abortion services. We explain each of these, and their operationalization as conditions in our fsQCA analysis, in the following.

Outcome: clinic survival. Our outcome of interest is *clinic survival*, which we operationalize as a dummy whose value is 0 if the clinic failed during our observation period, and 1 if the clinic survived. Within our observation period, 221 clinics (or 23.1 percent) closed and 762 (76.9 percent) survived. Because we measured all conditions between 2011 and 2016, we look at survival between 2012 and 2017.[ix]

Threats

Anti-abortion legislation. Our analyses of communications from abortion rights organizations revealed that anti-abortion legislation at the U.S. state-level was seen as a substantial threat to clinic survival. For example, in 2016, a report by the Guttmacher Institute stated, "States have adopted 288 abortion restrictions just since the 2010 midterm elections swept abortion

opponents into power in state capitals across the country (Benson Gold & Nash, 2016)." The professional association NAF (National Abortion Federation, 2017) noted a similar trend, and connected these restrictions to clinic survival:

> Since 2011, we have seen an unprecedented number of medically-unnecessary, politically-motivated restrictions aimed at reducing women's access to abortion care being introduced and enacted in the states. This patchwork of medically-unnecessary state laws and burdensome regulations has created a situation where a woman's ability to access abortion care now largely depends on her zip code.

We therefore include state legislative restrictions in our further analyses. To construct this condition, we used the annual *Who Decides?* reports released by NARAL. We coded this measure as a count of anti-abortion legislative measures on the books in each state, which include such laws as criminal bans on abortion, waiting periods for women seeking abortions, insurance prohibition for obtaining abortions, and burdensome operational restrictions such as hallway widths and proximity to emergency services that have been formulated to target abortion providers.

Political opposition to abortion. The communications from abortion-rights organizations also indicated that they saw the presence of anti-choice politicians as affecting clinic survival. They wrote about how anti-choice politicians influenced the abortion provision landscape through their rhetoric, political appointees, budgets, and actions such as investigations into clinics' activities. For example, when the Kansas Attorney General launched an investigation into abortion clinic operations, Planned Parenthood (2014) responded by writing that this was "a fishing expedition to further his personal anti-abortion agenda," and said that he "spent years wasting taxpayer money pursuing his extremist ideological agenda."

To code this condition, we once again relied on the *Who Decides?* reports from NARAL, which include a detailed state-by-state breakdown of whether the legislature and the governor of each U.S. state are pro-, anti-, or mixed-choice. We assigned anti-choice governors a value of 1, and we assigned

each chamber of the legislature a value of 0.5 if anti-choice. Summing these scores, we obtain a resulting score ranging from 0 to 2.

Strength of anti-abortion activism. During our period of study, there was considerable attention paid by abortion rights organizations to crisis pregnancy centers (CPCs). CPCs are non-medical centers staffed primarily by anti-choice volunteers who attempt to counsel pregnant women out of pursuing an abortion. During our period of study there were an estimated 2,500–4,000 CPCs operating in the United States (Rosen, 2012). The communications from abortion-rights organizations note that CPCs were making particular gains in coordination, funding, and professionalization during our period of study, and they were portrayed as challenging clinics' abilities to survive. NARAL (2018b) reported how the anti-abortion movement was using CPCs alongside other tactics, writing:

> These fake health centers also serve as the physical infrastructure for the anti-choice movement's broader misinformation and intimidation campaigns and often partner with anti-choice protesters who harass women outside of clinics. Clinic protesters work to redirect women away from legitimate, full-service clinics and toward nearby fake health centers or to their own fake health center buses parked outside legitimate clinics. Protest groups and fake health centers often share personnel or funding sources, and protesters sometimes use allied centers as organizing or meeting space.

During our period of study, CPCs were seen as the physical manifestations of the anti-abortion movement within communities (Fallert, 2022). We build on this insight and treat the number of CPCs located near an abortion clinic as a measure of the local strength of anti-abortion activism. To identify CPCs, we followed a multi-step approach. First, we obtained the data on all crisis pregnancy centers operating within the United States collected by Swartzendruber & Lambert (2020).[x] We then used each CPC's name and address to cross-check the CPCs against *ReferenceUSA*, a directory service covering current and historical U.S. businesses. This enabled us to validate the existence of each facility reported by Swartzendruber & Lambert (2020) as well as determine the exact years during which each CPC was operational. Finally, because CPCs tend to cluster near abortion clinics, we operationalize

the strength of anti-abortion activism as the ratio between the number of CPCs within 50 miles of the clinic and the total number of abortion clinics (including the focal one) within the same radius.[xi]

Local public opposition to abortion. As previously discussed, public opposition to a practice has been recognized as a major predictor of the challenges experienced by the organizations that engage in such practices. Accordingly, we include a condition proxying the degree of local public opposition to abortion, which we operationalize as the fraction of the state population who thinks that abortion should be illegal in all or most cases. We construct this condition with data from the Religious Landscape Study by the Pew Research Center, carried out in 2007 and 2014, and the PRRI American Values Survey, conducted in 2014 and 2018; these three data points in time (2007, 2014, and 2018) were then linearly interpolated to construct values for missing years.[xii]

Supporting factors

Supporting legislation. The communications from abortion-rights organizations emphasized that in addition to threatening clinic survival, legislation was also put in place to support clinics. For example, some states had constitutional protection for the right to obtain an abortion, others enabled women to use state insurance programs such as Medicaid to cover the costs of an abortion, and some had laws in effect to protect clinics from overt harassment. As the Guttmacher Institute wrote, regarding our period of study: "Between 2001 and 2016, states have enacted 214 legislative measures aimed at expanding access to abortion, contraception, and related services and education (Nash & Benson Gold, 2017)." Another example of reference to pro-choice legislation is the following, which is from a press release from the National Abortion Federation (2013a):

> Today, California Governor Jerry Brown signed a bill into law that will allow appropriately trained nurse practitioners (NPs), physician assistants (PAs), and nurse midwives (CNMs) to provide first trimester aspiration abortion care […] We commend Governor Brown for taking this very important step toward increasing women's access to abortion care. We've known for years that appropriately trained NPs, CNMs, and PAs—collectively referred to as advanced practice clinicians (APCs)—have the skills and expertise to provide safe first trimester abortion care.

In terms of operationalizing this condition, we coded this measure as a count of pro-abortion-rights legislation on the books in the state in which the clinic is located, based on the annual *Who Decides?* reports released by NARAL.

Political support for abortion. Abortion rights organizations also highlighted how politicians could support abortion providers in ways that went beyond legislative changes, in similar ways that they often had restrictive effects. For example the National Abortion Federation (2014) discussed how the Virginia Board of Health decided to go against existing regulations which they described in the press release as "politically-motivated regulations targeting the state's abortion providers." The communications continued, by stating:

> These regulations—which require covered entryways, a certain number of parking spots, and specific types of water fountains—do nothing to make abortion safer… Throughout the debate and passage of these regulations in 2011, it was clear that they were aimed at closing clinics and decreasing women's access to abortion care. Anti-choice politicians repeatedly ignored scientific evidence and testimony from medical experts, health care providers, and even the Virginia Health Commissioner who later resigned over the passage of these unwarranted regulations. NAF and our members have been actively working to have these onerous regulations revised and we applaud the Board for taking this important step today.

The Virginia Board of Health is appointed by the state governor, so this is just one example of how political support can go beyond legislative support. To capture the political support of state leaders, we coded this condition in an analogous fashion to what is discussed above with coding for political opposition to abortion, except for the fact that here we assigned pro-choice governors a value of 1, and we assigned each chamber of the legislature a value of 0.5 if pro-choice to obtain an overall resulting score ranging once again from 0 to 2.

Local public support for the practice. We have made the argument that public support for stigmatized practices can potentially countervail many of the hurdles that stigmatized organizations face. Accordingly, we also include in our analysis a condition to account for this, which we code as the fraction of the state population who thinks that abortion should be legal in all or most cases, from

the same public opinion data sources that we used to operationalize the local public opposition to the practice.

Abortion demand. One of the key takeaways from studies of organizational mortality is that failure is often due to competition for scarce resources (Baum & Singh, 1994).[xiii] Because abortion clinics are a low-margin business, and because the demand for abortions in the United States has been on a steady trajectory of decline for decades, any analysis of clinic survival that did not account for abortion demand in some form would thus be necessarily incomplete, inasmuch as the survival odds of any individual clinic are likely to be at least somewhat dependent on local demand. However, in the United States accurate statistics on the number of abortions obtained by women within localities are difficult to come by (and furthermore would not capture unmet demand). Abortion surveillance statistics provided by the Center for Disease Control and Prevention (CDC) report information on maternal and gestational age, race, marital status, and procedure-specific variables. However, this information is provided at the state level only, and there exists substantial intra-state granularity depending on local socioeconomic patterns. We do know, however, how abortion patients break down by race and socio-economic status. According to the Guttmacher Institute, the number of yearly abortions for 1,000 women in 2014 was 27.1 among Black women, 18.1 for Hispanic women, and 10 for White women.[xiv] Additionally, women below the federal poverty line accounted for 49.3 percent of all U.S. abortions in 2014.[xv]

In light of the above, we proceeded to construct the abortion demand measure as follows. First, we leveraged the above figures to construct a per capita estimate of abortion demand based on a) ethnic/racial background; b) age group; c) poverty status. Then, for each county in our data, we obtained Census data to calculate the number of women within each of these categories. For what pertains to ethnicity, we explicitly counted White, Black, and Hispanic women as we only had information about the abortion rates of these ethnic groups—all other ethnic groups were bundled

under Other and treated as a residual category. Finally, we multiplied these counts by the per capita abortion demand figures calculated above, and then aggregated these to obtain an overall estimate of county-level abortion demand. The figures thus obtained refer to 2014 estimates and were applied to the entire observation window, in what we believe to be a reasonable approximation. Summary statistics for the above conditions pre-calibration, as well as a correlation table, are reported in Table 2.

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Calibration of conditions

After identifying the conditions, the next step required to conduct a fsQCA analysis is the conversion of both the outcome variable and the causal condition measures into set membership scores (Ragin, 2008) via the specification of three threshold values: full membership, full non-membership, and a crossover point between the two. Such thresholds are often generated through the combined application of extant theories and features of the sample in what has been described as a "half-conceptual, half empirical process" (Greckhamer, Furnari, Fiss, & Aguilera, 2018: 488). For the political support and political opposition conditions, we chose to set the crossover point at the midpoint of 1, the fully out threshold at 0.5 and the fully in threshold at 1.5 (since the non-calibrated variable ranges from 0 to 2). For what pertains to the legislation conditions, in consideration of the fact that most states have either more than one law supporting/opposing abortion or none at all, we set the crossover point for these at 1, the fully out threshold at 0.5 and the fully in threshold at 1.5. The strength of anti-abortion activism was calibrated in consideration of the fact that its effects are likely to manifest when there is at least one CPC in the proximity of the clinic. Accordingly, we once again set the crossover point at 1, the fully out threshold at 0.5 and the fully in threshold at 1.5.

As for the other conditions, we did not have strong priors that could guide calibration. Our sample size is fairly large (N=983) relative to other fsQCA studies, and as noted by Greckhamer,

Misangyi, & Fiss (2013: 63-64), "because large-N researchers lack intimate knowledge of each individual case, and moreover because extant theory will often prove to be ambiguous in guiding the specification of the anchors used in calibration […], researchers might have to rely on empirical knowledge such as central tendencies in the data." For the remaining conditions, therefore, we adopt the algorithmic approach to the selection of calibration thresholds, as suggested by Duşa (2019). In particular, we leveraged the *findTh* function included as part of the *QCA* package in R to calculate threshold values for each condition based on hierarchical clustering. The threshold values for each non-binary condition are reported in Table 3.

---------- Insert Table 3 about here ----------

Fuzzy-set QCA analyses

We conducted analyses of necessity and sufficiency to assess which combinations of our eight factors are associated with survival.[xvi] As previously discussed, the sufficiency of a set of conditions implies that such conditions are a subset of all possible combinations of conditions producing the outcome. By contrast, necessity indicates that *all* cases associated with the outcome have the same given combination of conditions. In line with previous research, we evaluated our results based on *consistency* and *coverage*. Consistency—which can take any value from 0 to 1—is defined as the extent to which cases that share combination of conditions are reliably associated with the key outcome of interest. A consistency score of 1 indicates that cases sharing a given combination of conditions always lead to the outcome of interest; conversely, a consistency score of 0 indicates that they never do. By contrast, coverage—which also varies from 0 to 1—indicates the explanatory power of a given solution set—i.e., what percentage of cases a given combination of factors represents. In fsQCA, in fact, "a given outcome may result from several different combinations of conditions", so that "these combinations are generally understood as alternate causal paths or 'recipes' for the outcome (Ragin, 2008: 54)." Not unlike how variance is partitioned amongst covariates in regression analysis, existing

fsQCA studies draw a distinction between the above—usually referred to as "raw" coverage and "unique" coverage, which models membership in the outcome set which is not covered by other solutions, pointing to the relative empirical weight of each path.

Following calibration, the next step in any fsQCA analysis consists of the creation of a "truth table"—a data matrix listing all logically possible configurations of the seven factors. In our case, this means carrying out our analysis on the Boolean property space comprising 2^8 potential configurations. Typically, the configurations reported in the truth table are then filtered based on whether they meet certain criteria. Following prior literature, we consolidated the truth table by setting a minimum number of cases required for a solution to be considered, as well as a minimum consistency level for each solution (Fiss, 2011; Misangyi & Acharya, 2014). Following Fiss (2011), we set the minimum number of cases per configuration to three and the minimum consistency level for sufficient conditions to 0.80 (0.90 for necessary conditions). Additionally, as recommended by Misangyi & Acharya (2014) and Vergne & Depeyre (2016), we also set a threshold value for "proportional reduction of inconsistency" (PRI) equal to 0.75 for a more stringent analytical approach. Doing so minimizes the impact of configurations that may be associated with both the outcome and its negation.

Findings and solutions

----------Insert Table 4 about here----------

Our analyses of necessity did not reveal any combinations of conditions necessary for the survival of clinics. In other words, no combination of conditions cleared the necessary 0.90 consistency threshold while also meeting the 0.75 PRI threshold. By contrast, our analysis of sufficiency for the survival of clinics produced a number of solutions, which are reported in Table 4. Here, once again following Fiss' (2011) notation, we use a filled circle to denote the presence of a condition (or a "high" degree thereof) and an empty circle to denote its absence (or a "low" degree

thereof). The absence of a circle denotes "don't care" in fsQCA terminology—that is, the condition is not relevant to a particular solution.

Looking at Table 4, solution 1 delineates a first path to organizational survival characterized by the absence of local public opposition to abortion. As support for abortion and opposition to abortion are two separate conditions, it is important to note that this does not necessarily translate to the existence of public support for the practice; the lack of public opposition alone appears to be sufficient for survival in most cases. This solution has high consistency and high raw coverage. An example from our data that fits solution 1 is a Planned Parenthood clinic in Anchorage, Alaska which was able to survive despite Alaska being a hostile environment for abortion provision in many other ways, including legislation targeted at abortion rights and an anti-abortion political environment.

Along similar lines, solution 2 outlines a path to survival which goes through the absence of political opposition—meaning that neither the legislature nor governor are anti-choice (despite not being necessarily pro-choice). This solution also has high consistency and high raw coverage. An example from our data is given by the clinics located in Chicago, Illinois, where the state politicians were generally mixed-choice but where most clinics nonetheless survived during our period of study. Taken together, these first two solutions suggest that clinics tend to thrive in the absence of staunch opposition to abortion rights either from the general public or from elected officials—under such conditions, "turning a blind eye" and the lack of overt public or political disapproval appears to be sufficient for survival, while active support does not play a role one way or the other.

By contrast, solution 3 indicates that the existence of supporting legislation on the books at the state level is a sufficient condition for survival. Among other things, this suggests that an animus towards abortion among the general public, hostility from elected officeholders, and even hostile legislation passed are immaterial for the purposes of survival under this solution. For example, clinics in the state of Indiana fit this solution: despite the fact that Indiana had a hostile political environment,

high public opposition to the practice, and a high number of crisis pregnancy centers located near abortion clinics, some clinics in Indiana managed to survive during this period. This solution indicates that those that did survive likely did so because, according to NARAL, Indiana's constitution provided greater protection for a woman's right to choose than the U.S. Constitution. This is despite the fact that Indiana's leadership also passed many pieces of legislation aimed at restricting abortion during this period, such as a forced ultrasound law. In many cases, states that rushed to pass hostile legislation targeting abortion clinics during our period of study also had several pro-choice provisions on the books which could not be repealed, often for constitutional reasons.

The following two solutions, 4 and 5, indicate paths to survival under conditions of low abortion demand. In particular, solution 4 indicates that clinics located in areas with low abortion demand can still survive provided that anti-abortion legislation and anti-abortion activism are absent. Under such circumstances, clinics likely operate with very limited slack but are able to push through because they do not need to comply with burdensome legislation or deal with CPCs siphoning off demand. Clinics that fit this solution include those located in Bangor, Maine and Jackson, Wyoming. Along similar lines, solution 5 outlines that the presence of local public support is also sufficient for survival under conditions of low demand for abortion services. What this means is that in some areas where there is potentially not enough demand to sustain a clinic, by virtue of public support for abortion clinics, they are nonetheless able to survive (by means of fundraising, volunteering, and donations, for example). This is interesting, because it shows that as stigmatized practices split society into those who are "for" and "against" the practice, if there is a local community that is supportive of the practice it can provide means of enabling it to continue even if there is not high demand for it. Exemplar clinics that fit this solution are those located in Ann Arbor, Michigan; Napa, California; Missoula, Montana; and Eugene, Oregon.

Finally, solutions 6-10 collectively underline the importance of political support for abortion in creating a viable path to survival for clinics that find themselves in dire straits. Solution 6, for example, indicates that survival can be achieved when political opposition to abortion rights and political support for abortion rights coexist, independently of other factors. The fact that the raw coverage score for this configuration is 0.04, however, indicates that it is relatively rare. This solution fits clinics in only one state during our period of study: New Jersey, which during our observation period had both an anti-choice governor (Chris Christie, a Republican) and a pro-choice legislature. Solution 7—indicating the sufficiency of political support and low abortion demand for survival—is similar to 5: here, too, it would appear that clinics that enjoy political support do well even when they struggle with low demand for their services. The locations of these clinics are also similar to those in solution 5, and they include locales such as Ithaca, New York and Spokane, Washington. Solution 8 indicates that in the presence of anti-abortion activism (measured by the ratio of crisis pregnancy centers per clinics in a 50-mile radius), the presence of political support is sufficient for clinic survival. What this suggests is that even if a clinic is facing staunch oppositional activism, if it has political support (meaning that the governor and legislature at the state level are supportive of abortion), then there is a path to survival. An example that fits solution 8 is Bakersfield, California, where there are four crisis pregnancy centers in the vicinity of one single clinic, but that clinic has enjoyed political support and nonetheless survived.

Solution 9 requires the presence of political support, the absence of supporting legislation, and the presence of opposing legislation as sufficient conditions for survival. This is an unusual combination of factors (the raw coverage score for this solution is also 0.04), which—we found—mainly applies to clinics in Colorado. Colorado has had both Republican and Democratic leadership in the modern era, and during our period of study it had a pro-choice governor and on balance pro-choice legislatures in power but still had anti-choice laws on the books, such as a state funding ban on

abortion care. Finally, solution 10 points to the joint absence of local public support and the presence of political support as sufficient conditions for survival. In this scenario, elected officials are more in support of stigmatized organizations and their activities than the general public in their locale. Again, however, this solution covers very few clinics (the raw coverage score is .01), which were all located in Minnesota. During our period of study, the citizens of Minnesota at large did not particularly lean pro-choice, but the state's elected representatives did. This is relatively unusual, and Minnesota is the only state that fits this profile, as elected officials usually reflect the same stance as their constituents.

Theoretical takeaways

Our case brings to light the fact that the survival of stigmatized organizations can come about from multiple paths. Stigmatized organizations can experience "death by a thousand cuts"—as previously mentioned, during our period of study, 23 percent of clinics in our sample failed. This notwithstanding, however, most clinics in our sample survived, and our configurations reveal that survival tends to be due to either the *absence of opposition* or the *presence of support*, which allowed clinics to survive despite facing considerable hurdles that stem from the stigma of abortion. Among the configurational recipes presented in Table 4, the absence of opposition is most evident in Solutions 1, 2, and 4. In these solutions, support is not necessary, but the organizations are able to survive based simply on not being the target of overt hostility. Solution 1, in particular, shows that when opposition to the practice among the general public at the local level is not intense, survival is likely. Along similar lines, Solution 2 indicates that the same is true for the lack of political opposition—i.e., when the executive and legislative branch at the state level are not controlled by anti-abortion politicians, in our case—which points to the importance of political actors as stigmatizers. Solution 4 highlights a similar mechanism in that the joint absence of anti-abortion legislation and anti-abortion activism—in the form of crisis pregnancy centers— is sufficient for survival despite low demand for abortion services. Taken together, these three solutions, which also have some of the highest raw coverage scores

amongst the configurations in our findings, the absence of staunch opposition to abortion from various audiences and stakeholders—be it from the general public, elected officials, or activists—is often sufficient for survival in this stigmatized industry.

There is also a set of solutions that indicate that the presence of active support can lead to survival. As is the case with many stigmatized industries, we find that abortion provision exemplifies what Ferns, Lambert, and Gunter (2021) refer to as a "moral dualism" which splits individuals into "pro" and "anti" camps, with people viewing it as necessary to take a stance either against or in support of abortion. And we indeed find that the presence of blocs of support in our case enables organizations operating in this stigmatized industry to survive against the odds. In particular, solutions 3, 5, and 6-10 all contain the presence of supporting factors. In solution 3, having supportive legislation on the books is sufficient for clinic survival. Remarkably, while we found that supportive legislation mattered we did not find that targeted anti-abortion legislation mattered as much for survival, which is surprising given previous accounts of the effect of targeted legislation (e.g., Hiatt, Sine, & Tolbert, 2009; Wade, Swaminathan, & Saxon, 1998). This finding is also surprising given the degree of attention that the abortion rights organizations have paid to the threat of hostile legislation, which was rampant during our period of study. Solution 5 also requires the presence of a supporting factor—public support for abortion. And according to this finding, public support is also an answer to how clinics can survive even in places where they have lower demand for their services. Finally, solutions 6-10 all depend on supportive politicians in office. Having both the state governor and legislature supporting abortion, in our case, enabled clinics to endure other challenges, including anti-abortion activism, anti-abortion legislation on the books, and low demand for abortion services.

DISCUSSION

With limited exceptions (e.g., Helms & Patterson, 2014) most studies of the effects of stigma on organizations have highlighted the considerable operational barriers that stigma creates, which can

range from decreased sales (Aranda, Conti, & Wezel, 2020) to negative customer reviews (Barlow, Verhaal, & Hoskins, 2018) as well as pressures on organizations to divest assets from certain activities (Durand & Vergne, 2015) or exit sectors altogether (Augustine & Piazza, 2022; Piazza & Perretti, 2015). Based on this body of work, extant research has generally assumed that stigmatized organizations are likely to experience worse outcomes across the board, and in particular, that they would struggle to survive as a result of the condemnation aimed at them. However, a recurring theme in the study of stigmatized organizations has arguably been the surprising persistence of these organizations, which is seemingly against the odds (Hudson & Okhuysen, 2009). Our study has been explicitly designed as a first step towards addressing this theoretical and empirical tension. In so doing, we have sought to be comprehensive in our approach by accounting for the various ways that external stakeholders and audiences shape the survival of stigmatized organizations. Overall, our work makes three primary contributions, which we discuss in the following.

First, to our knowledge, our study represents one of the first scholarly efforts to directly examine organizational survival in stigmatized contexts. Survival is an especially important outcome for organizations that deal with controversial goods, services, and practices—arguably even more so than performance. Because these organizations operate in a complex social, political, and regulatory environment that can be challenging to navigate in its own right, market competition is not necessarily the main threat that such organizations face. As we also mentioned above, these organizations are often the only ones to offer certain sensitive—and often contested—goods and services, and so survival in this case also ensures the continued availability of these goods and services, often to groups or individuals who are marginalized themselves, like abortion patients.

Second, our study is also the first to link the outcomes experienced by organizations in stigmatized industries not only to the intensity of stigma as it is manifested via various factors and its negative consequences—as Hudson & Okhuysen (2009) have done—but also to potential sources of

support for the practices that define these industries. Up to this point, the stigma literature has—understandably—focused on the negative effects of stigmatization, often without considering the supporters that enable stigmatized organizations to persist and endure (although see Helms & Patterson, 2014). We therefore shed light on how these sources of support can help otherwise stigmatized organizations chart a viable path to survival. These findings also help explain why organizations operating in stigmatized industries do not necessarily experience the negative effects of stigma to the same degree.

Third, by examining the above factors in concert with one another methodologically, we contribute a view of stigma that builds on a configurational approach to organizational analysis. While existing methods can effectively examine single antecedents of stigma-related outcomes, such as media attention, they are not as well-equipped to look at multiple, overlapping mechanisms playing out at the same time. We have been able to look holistically at multiple factors that could affect the survival of stigmatized organizations in large part by building on recent theoretical and methodological innovations in configurational thinking (Furnari et al., 2021; Misangyi et al., 2016). Consistent with this approach, our findings highlight that the configurations of factors predictive of organizational survival are causally complex and difficult to model through the "net effects thinking" (Ragin, 2008) that is typical of regression-based quantitative approaches. In a similar vein, while regression-based approaches are unifinal (Fiss, 2007), the different "recipes" for clinic survival we have identified point to the intrinsic equifinality of the process at hand.

In addition to the above contributions, we believe our work meaningfully advances a number of scholarly conversations that have been taking place within the organizational stigma literature. For example, as noted by Zhang, Wang, Toubiana, & Greenwood, (2021: 188), "cultural understandings of what is discreditable or taboo do not come from the individual, occupation, organization, or industry that is stigmatized; on the contrary, they come from particular sources that transcend levels."

Our own work builds on this intuition to highlight how the stigmatization of certain contentious practices—in our case, the provision of abortion services—stems from a range of socio-political factors and reverberates to affect individuals and organizations that engage in them (Augustine & Piazza, 2022), so that organizational stigma can, in some circumstances, emanate directly from disapproval targeting certain practices, such as—but not limited to—the provision of contentious goods and services. In so doing, stigma polarizes social actors within a field and divides them into opposing camps (Ferns et al., 2021); in turn, dynamics of opposition and support from the general public, elected officials, and activists affect the outcomes experienced by stigmatized organizations in complex ways.

Our work also aims to further our understanding of how stigma transcends levels via our recognition that not all organizations within a stigmatized industry experience stigma in the same way. We therefore also contribute to the literature at the intersection of stigma and categorization theory (e.g., Hsu & Grodal, 2020; Hsu, Kocak, & Kovács, 2018; Lashley & Pollock, 2020; Pedeliento, Andreini, & Dalli, 2019). This body of work has generally assumed that, because stigmatization is a collective labeling process that groups similar organizations together and in fact de-individuates them (Devers et al., 2009; Link & Phelan, 2001; Tracey & Phillips, 2016), individual organizations in stigmatized categories should experience similar outcomes if the extent of such membership in the category is held constant (Piazza & Perretti, 2015; Vergne, 2012). While this research has provided important insights, as it acknowledges that under conditions of stigma individual organizational identity is largely viewed through the connection to a negative categorical identity, it may also overlook the inherent diversity in the ways that stigma differs contextually, and therefore the ways that it can affect organizations in unequal measure, even within the same industry or category. As an example, one may consider recent scholarship by Hsu, Kocak, & Kovács (2018) who found that incumbent medical cannabis dispensaries reacted differently to the entry of recreational cannabis dispensaries

depending on the level of community support for recreational cannabis—meaning that within the same category, i.e., recreational cannabis operators, stigma was experienced differently on the ground. We contribute to this scholarship and encourage future work that not only focuses on the diversity of organizational *responses* to stigma, but also further examines diversity amongst organization-level *experiences* and *consequences* of stigma, even within the same stigmatized industry or category.

Finally, our study contributes to a budding line of research that conceptualizes stigma—and, by extension, its consequences—not as something that is experienced passively by those individuals or organizations that are subjected to it, but as something that is enacted agentically by an array of social actors who act as stigmatizers. For example, Ferns et al. (2021: 36) examined how climate activists worked to stigmatize the fossil fuel industry discursively, and in so doing, outlined how the "process of stigmatization is contingent on constructing a moral dualism in which two opposing sides are emphasized: good, moral stigmatizers and an evil target." We extend this promising new avenue for research by showing that in our setting the consequences of stigma, too, materialize through the work of specific social actors, such as politicians and social movement activists, and we encourage further work along these lines.

Boundary conditions and limitations

In terms of the limitations and boundary conditions of our case, we must first acknowledge that we do not examine stigma management strategies, and how these may have led to variations in the survival of certain clinics. While previous work has focused extensively on stigma management strategies (e.g., Carberry & King, 2012; Durand & Vergne, 2015; Hudson & Okhuysen, 2009; Tracey & Phillips, 2016), and we believe them to be centrally important to organizational outcomes including survival, we have decided to focus on a less well-understood component of survival, which is how socio-political patterns of opposition and support interact to open up—or close off—paths to organizational survival. However, we encourage future work to explore the connection between

varying contexts and stigma management strategies. For example, perhaps organizations working within a stigmatized industry in one context could benefit from cultivating relationships with local politicians who see value in their work while organizations working in another context may try to conceal their activities so as to be less visible to the general public. We would theorize that these strategies would be more or less valuable depending on the full socio-political environment organizations are operating in, including the views held by the general public, elected officials, and activists (if present).

Additionally, there are likely other explanatory factors that may have helped explain survival in our case, but which we did not account for. For example, it is likely that supportive activism is often a significant factor shaping the survival of organizations in stigmatized industries, along with the public and political support factors that we did examine. Based on our knowledge of the case, supportive activism at the local level is not very common in the abortion movement – as most movement action has shifted from the grassroots to national organizations. However, one can imagine other stigmatized industries where supportive activism is likely relevant (see for example Helms & Patterson, 2014). Other factors that would have also been relevant to our case include media exposure for stigmatized practices, or the tone with which such practices are covered by the media. However, the aim of this paper is not to generalize to other settings the exact configurations that we find, but rather to show that organizations in a stigmatized industry do not experience stigma to the same extent and that in particular survival can be traced back to complex patterns of socio-political opposition and support from multiple audiences. Therefore, our approach encourages future scholarship to embrace these nuances in recognizing that the mechanisms by which stigma affects organizations are intertwined, and can work in a reinforcing manner that is difficult to disentangle into clean causal models. We have taken the first step in addressing this by adopting an analytical strategy that embraces configurational thinking, and we hope that future work will build on our efforts.

Finally, we would be remiss if we did not acknowledge that the landscape of abortion provision in the United States has changed substantially since we collected the data used in this paper. In particular, in June 2022 the U.S. Supreme Court overturned the landmark 1973 *Roe v. Wade* decision, thereby allowing individual states to ban abortion without exceptions. Previously, abortion had been legal in all U.S. states, and every state had at least one abortion clinic. At the time of writing, at least seventeen U.S. states have either banned abortion entirely—at times with narrow exceptions—or are expected to do so shortly. As a result, most—if not all—of the clinics in these states are expected to either close or relocate to states where abortion will remain legal (Ramkissoon & Glynn, 2022). This points to another potential limitation of our findings: while the environmental factors we have identified do operate in concert and in complex ways in shaping the survival of stigmatized organizations, some challenges—such as the sudden lack of federal support for abortion and the ensuing criminalization of the practice, in our case—can disrupt operations so severely that survival may be impossible. Additionally, we would infer that our findings are likely to have the greatest explanatory power in situations: a) where the sociopolitical landscape is slow to shift; and b) there exists a baseline level of tolerance of stigmatized organizations (i.e., their existence and activities are legal or at least tolerated). As recent developments show, if these conditions are not met stigmatized organizations can relocate, disappear, or even "go underground", de facto joining the informal economy (Webb, Tihanyi, Ireland, & Sirmon, 2009). This shift is already evident in the case of abortion provision: beyond relocating clinics, providers and activists are taking up strategies at the boundaries of the law, like forming underground referral networks and arranging for shipment of abortion-inducing medications from abroad (Gross, 2022).

CONCLUSION

By expanding the literature on organizational stigma through a focus on the socio-political factors that can contribute to the survival of stigmatized organizations, our research explores how organizations

engaged in the provision of controversial goods and services can endure and persist, often against the odds. In our approach we shift focus away from stigma management strategies to highlight how the views and actions of external audiences and stakeholders shape survival, and in particular, how stigmatized organizations may experience different outcomes based on patterns of local opposition and support for stigmatized practices. It is our hope that organizational scholars will build on these findings to further explore the remarkable persistence of organizations such as abortion clinics in the U.S. during our period of study, as well as the conditions under which other stigmatized organizations can survive and thrive—a topic which, we believe, is deserving of further scholarly attention.

NOTES

[i] Along similar lines, scholars (e.g., Durand & Vergne, 2015; Khessina, Reis, & Verhaal, 2020) have used the label *stigmatized industries* to refer to collections of organizations—typically firms—that are stigmatized as a function of their collective engagement in stigmatized activities, such as arms production or the sale of cannabis.

[ii] http://www.nytimes.com/2000/01/11/nyregion/giuliani-takes-on-the-sex-industry-again-with-stricter-rules.html

[iii] Henshaw, Stanley K. and Van Vort, Jennifer., "Abortion Services in the United States, 1987 and 1988," *Family Planning Perspectives,* Guttmacher Institute. Vol. 22, No. 3 (May - Jun., 1990), pp. 102-108+142

[iv] Henshaw, Stanley K. and Finer, Lawrence B., "The Accessibility of Abortion Services in the United States, 2001" *Perspectives on Sexual and Reproductive Health,* Guttmacher Institute. Vol. 35, No. 1 (Jan. - Feb., 2003), pp. 16-24

[v] Jerman J, Jones RK. Secondary measures of access to abortion services in the United States, 2011 and 2012: gestational age limits, cost, and harassment. *Womens Health Issues*. 2014;24(4):e419-e424. doi:10.1016/j.whi.2014.05.002

[vi] http://abortiondocs.org/

[vii] https://prochoice.org/

[viii] These three factors were the most frequently discussed in the communications and were the focus of communications from all four organizations in our sample. However, some communications also discussed the following factors: (1) federal legislative restrictions; (2) funding cuts; (3) stigma of providers; (4) the Republican political platform.

[ix] Unless specified otherwise, all of the conditions described below for which multiple years of data availability exist are averaged over our observation window or the life of the clinic, whichever is shorter.

[x] See: https://crisispregnancycentermap.com

[xi] We chose a 50-mile radius for CPCs because there is evidence that most U.S. women travel less than 50 miles to obtain an abortion. In particular, the only empirical study we are aware of on this topic indicates that "in 2014, 65% of abortion patients traveled less than 25 miles one-way, 17% traveled 25–49 miles, and 18% traveled more than 50 miles" (Fuentes & Jerman, 2019: 1623), indicating that over 80 percent of abortions occur within a 50-mile radius.

[xii] 2014 figures were averaged across surveys, since the relevant survey items were identical.

[xiii] We thank an anonymous reviewer for suggesting the inclusion of this condition.

[xiv] See: https://www.guttmacher.org/infographic/2017/abortion-rates-race-and-ethnicity

[xv] See https://www.guttmacher.org/sites/default/files/report_downloads/us-abortion-patients-table1.pdf for the full breakdown by age, ethnicity and poverty status.

[xvi] We also conducted analyses of necessity and sufficiency for mortality, but we did not find any configurations in doing so.

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Table 1: Data exemplars from abortion rights organizations' communications.

Anti-abortion legislation	"It is disturbing that the Texas Legislature is again choosing to ignore medical evidence in favor of playing politics with women's health…SB537 does nothing to ensure or improve patient safety. Instead it would impose 117 pages of unjustified and unnecessary requirements on facilities. Regulations like these are calculated to close clinics under the guise of legitimate regulation and would dramatically reduce access to safe, quality abortion care for women in Texas." – "Safe Abortion Care," *National Abortion Federation*, 2013 "This law is part of a coordinated national strategy by anti-abortion politicians, who've passed more than 330 restrictions on abortion at the state level since 2010." – "Federal District Court Temporarily Blocks Texas Measure Banning One of the Safest, Most Common Methods of Second Trimester Abortion," *Planned Parenthood,* 2017 "Earlier this summer, Kansas passed onerous and unnecessary abortion regulations, which dictated among other things the room temperature and exact sizes of everything from procedure rooms to janitorial closets at facilities that provide abortion care. The providers who testified have led a federal lawsuit, which has prevented these regulations from taking effect. At the hearing, the providers argued that the rules would harm women's health by curtailing abortion access and make it all but impossible for doctors to get licensed to provide abortion care." – "State News Round-Up," *National Abortion Federation*, 2011
Political opposition to abortion	"In the 2010 elections, anti-choice politicians seized control of many state legislatures, vowing to focus on the nation's economic challenges. Once elected, however, they abandoned their promises and instead launched a War on Women." – "Who Decides? The Status of Women's Reproductive Rights in the United States," *NARAL Pro-Choice America*, 2017 "The inquisition and threats made against Comprehensive Health of Planned Parenthood of Kansas and Mid-Missouri by former state Attorney General Phill Kline have been officially dismissed after a state review of the evidence… 'Former Attorney General Phill Kline launched a fishing expedition to further his personal anti-abortion agenda,' said Peter Brownlie, President and CEO of Planned Parenthood of Kansas and Mid-Missouri." – "Attorney General Ends Inquisition into Medical Records," *Planned Parenthood*, 2014 "This is an administration that has done everything possible to eliminate access to abortion in Ohio --- secretly writing laws, working to close health centers, and even appointing the head of Ohio Right to Life to the state medical board. We are seriously concerned that this report is not the result of meaningful investigation, but instead yet another attack on women's access to health care in the state of Ohio intended to end our ability to continue to provide safe, legal abortion… Through budget provisions and legislation, John Kasich has signed 17 anti-women's health measures." – "Planned Parenthood Statement in Response to Ohio Attorney General Inflammatory and Baseless Accusations," *Planned Parenthood*, 2015

Strength of anti-abortion activism	"Crisis pregnancy centers are organizations that provide counseling and other prenatal services from an antiabortion (prolife) perspective. According to a report prepared for Rep. Henry Waxman (D-CA) in 2006, they seek 'to persuade teenagers and women with unplanned pregnancies to choose motherhood or adoption.' Many of these centers—which are also known as pregnancy resource centers, pregnancy support centers and limited-service pregnancy centers—are affiliated with national antiabortion organizations and belong to evangelical Christian networks." – "The Public Health Risks of Crisis Pregnancy Centers," Guttmacher Institute, *Perspectives on Sexual and Reproductive Health*, September 2012, p 201-205, Vol 44, Issue 3. "The American anti-choice movement has built thousands of outposts across the country with the sole purpose of preventing women from accessing abortion (through lies and coercion,) and they're hiding in plain sight. They're called crisis pregnancy centers (CPCs), and behind the doors of what are designed to look like full-service health clinics, ideologically motivated staff members deceive and manipulate women with dangerous misinformation. They consider themselves the foot soldiers of the anti-choice movement." – "Crisis Pregnancy Centers Lie: The Insidious Threat to Reproductive Freedom," *NARAL Pro-Choice America*, 2015 "Another deceitful strategy favored by CPCs is co-locating either near comprehensive health clinics or in medical buildings that give the impression that medically accurate services are available. By locating near clinics that provide comprehensive information and services, CPCs purposefully try to confuse patients into mistakenly entering their deceitful clinics." - "Crisis Pregnancy Centers Lie: The Insidious Threat to Reproductive Freedom," *NARAL Pro-Choice America*, 2015
Supporting legislation	"Although state-level assaults on abortion access continued, 16 states took important steps in 2016 to expand access to other sexual and reproductive health services, adopting a total of 28 proactive measures... Between 2001 and 2016, states have enacted 214 legislative measures aimed at expanding access to abortion, contraception, and related services and education." – "Restrictions, But Also a Surge of Proactive Measures," *Guttmacher Institute*, 2017 "Today, California Governor Jerry Brown signed a bill into law that will allow appropriately trained nurse practitioners (NPs), physician assistants (PAs), and nurse midwives (CNMs) to provide first trimester aspiration abortion care….We commend Governor Brown for taking this very important step toward increasing women's access to abortion care. We've known for years that appropriately trained NPs, CNMs, and PAs—collectively referred to as advanced practice clinicians (APCs)—have the skills and expertise to provide safe first trimester abortion care." – "California Governor Signs Bill to Allow APCs to Provide Abortion Care" *National Abortion Federation,* 2013 "This groundbreaking law removes dangerous and medically unnecessary obstacles to abortion care so the state's underserved communities can finally access their right to essential reproductive health care…HB 40 lifts regulatory restrictions on abortion access, allowing Medicaid recipients and state employees to receive the care they need. The bill strikes down Illinois' so-called "trigger law," which previously allowed the criminalization of abortion should Roe v. Wade be overturned. It also lifts severe restrictions on abortion coverage for public employees

	and overturns medically unnecessary restrictions that prohibited abortion coverage except in cases of rape, incest, or when the life of the woman was threatened." - "NARAL Celebrates New Law Expanding Access to Abortion in Illinois," *NARAL Pro-Choice America*, 2017
Political support for abortion	"NARAL members applaud Governor Wolf for standing up to anti-choice GOP legislators and vetoing this dangerous legislation. Governor Wolf knows that families dealing with incredibly complex situations deserve compassion and understanding, not one-size-fits-all judgments from politicians…Governor Wolf's principled leadership stands in stark contrast to the misplaced priorities of anti-choice Republican leaders." - "NARAL Members Stand with Gov. Wolf As He Vetoes GOP Abortion Ban," *NARAL Pro-Choice America*, 2017 "Today, the Virginia Board of Health took an important step toward potentially revising politically-motivated regulations targeting the state's abortion providers. These regulations—which require covered entryways, a certain number of parking spots, and specific types of water fountains—do nothing to make abortion safer." - "Virginia Board of Health Will Reexamine Politically-Motivated Regulations Targeting Abortion Providers" - *National Abortion Federation,* 2014 "Yesterday, Virginia Attorney General Mark Herring reversed the legal advice of former Attorney General Ken Cuccinelli, and clarified that building and construction requirements apply to new construction and not existing abortion providers in the state." - "Virginia AG Clarifies Application of Architectural Regs" – *National Abortion Federation,* 2015

Table 2. Descriptive statistics and correlation table.

Statistic	N	Mean	St. Dev.	Min	Pctl(25)	Pctl(75)	Max
Clinic survival	983	0.755	0.430	0	1	1	1
Local public support for abortion	983	0.568	0.072	0.353	0.522	0.618	0.738
Local public opposition to abortion	983	0.393	0.071	0.225	0.351	0.440	0.600
Political support for abortion	983	0.894	0.815	0	0	1.7	2
Political opposition to abortion	983	0.787	0.877	0.000	0.000	2.000	2.000
Abortion demand	983	835.161	1,277.056	13.920	154.188	972.397	5,536.057
Supporting legislation	983	1.650	2.658	0	0	2	8
Anti-abortion legislation	983	1.661	2.442	0	0	3	12
Strength of anti-abortion activism	983	1.941	2.068	0.000	0.602	2.241	15.750

	1	2	3	4	5	6	7	8	9
1. Clinic survival	1	0.144	-0.197	0.117	-0.154	-0.016	0.205	0.003	-0.032
2. Local public support for abortion	0.144	1	-0.99	0.617	-0.691	0.004	0.152	-0.623	-0.524
3. Local public opposition to abortion	-0.197	-0.99	1	-0.643	0.699	-0.028	-0.195	0.61	0.529
4. Political support for abortion	0.117	0.617	-0.643	1	-0.876	0.293	0.657	-0.649	-0.435
5. Political opposition to abortion	-0.154	-0.691	0.699	-0.876	1	-0.199	-0.502	0.721	0.418
6. Abortion demand	-0.016	0.004	-0.028	0.293	-0.199	1	0.44	-0.144	-0.212
7. Supporting legislation	0.205	0.152	-0.195	0.657	-0.502	0.44	1	-0.369	-0.268
8. Anti-abortion legislation	0.003	-0.623	0.61	-0.649	0.721	-0.144	-0.369	1	0.454
9. Strength of anti-abortion activism	-0.032	-0.524	0.529	-0.435	0.418	-0.212	-0.268	0.454	1

Table 3. Calibration thresholds.

Condition	Fully out	Crossover point	Fully in
Local public support for abortion	0.438	0.523	0.62
Local public opposition to abortion	0.34	0.402	0.536
Political support for abortion	0.5	1	1.5
Political opposition to abortion	0.5	1	1.5
Abortion demand	154.18	382.85	972.39
Supporting legislation	0.5	1	1.5
Anti-abortion legislation	0.5	1	1.5
Strength of anti-abortion activism	0.5	1	1.5

Table 4: Configurations Sufficient for Abortion Clinic Survival

	Solution									
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Local public support for abortion					●					❍
Local public opposition to abortion	❍									
Political support for abortion						●	●	●	●	●
Political opposition to abortion		❍				●				
Abortion demand				❍	❍		❍			
Pro-abortion-rights legislation			●						❍	
Anti-abortion legislation				❍					●	
Strength of anti-abortion activism				❍				●		
Consistency	0.80	0.81	0.84	0.81	0.81	0.86	0.84	0.82	0.80	0.82
Raw Coverage	0.67	0.64	0.34	0.19	0.42	0.04	0.27	0.22	0.04	0.01
Unique Coverage	0.050	0.042	0.007	0.002	0.017	< 0.001	< 0.001	< 0.001	< 0.001	< 0.001
Overall Solution Consistency	**0.79**									
Overall Solution Coverage	**0.80**									

Figure 1. Visualization of the geographical distribution of U.S. abortion clinics between 2011 and 2017. Clinics marked in blue survived; clinics marked in red failed before the end of our observation window.