

The First Publication on Contraception in a US Medical Journal, 1928: Hannah Mayer Stone's Case for Contraceptive Care Before the Pill

Robin E. Jensen, PhD

Today, as access to women's reproductive health care in the United States has proven less than ensured, it behooves scholars of public health to explore how US medical contraceptive care was successfully established and perpetuated initially in the early to mid-twentieth century. This article highlights the work of Hannah Mayer Stone, MD, in building and advocating such care. From the moment she accepted the position of medical director for the first contraceptive clinic in the country in 1925 until her untimely death in 1941, Stone campaigned relentlessly for women's access to the best contraceptive regimes available, all the while navigating extensive legal, social, and scientific challenges. In 1928, she published the first scientific report on contraception in a US medical journal, thereby legitimating the provision of contraception as a medical endeavor and providing empirical grounds for clinical contraceptive work in the years that followed. Her scientific publications and professional correspondence provide insight into the processes through which medical contraceptive care became increasingly available in US history and offer guidance for a contemporary era when reproductive health care hangs in the balance. (*Am J Public Health*. 2023;113(4):390–396. <https://doi.org/10.2105/AJPH.2022.307215>)

The story of US women gaining access to safe and effective contraception is one that often focuses on major technological advancements, such as the development of the birth control pill.¹ Yet, long before the pill went on the market in the 1960s, a network of medical contraceptive care prescribing largely female-controlled contraceptive devices and products had already been established.² Hannah Mayer Stone, MD, (Figure 1) played a central role in building the empirical foundation for that care in the 1920s and '30s. Today, in an era when access to effective contraception is more imperative than it has been in the last 50 years, it behooves scholars of public

health to identify the processes through which contraceptive care was made increasingly available in US history, particularly as those processes unfolded alongside the accumulation of medical knowledge about developing birth control technologies.

In 1928, Stone authored the first report on contraception ever published in a US medical journal, in the *Medical Journal and Record*.³ Just three years before, she had agreed to become medical director of the country's first legal contraceptive clinic, the Clinical Research Bureau of the American Birth Control League (later renamed the Birth Control Clinical Research Bureau), directed by Margaret Sanger and

located in downtown New York City. At that point, there were scarce scientific data concerning the safety or efficacy of available contraceptives.

It was only in 1918 that—in the state of New York—physicians alone were granted the right to discuss or prescribe contraceptives at all,⁴ but this right was of limited value without associated medical information concerning which methods worked and under what circumstances. To address this problem, Stone coupled her in-depth consultations at the clinic with meticulous record-keeping about patients' experiences with specific contraceptive regimes. Overall, she collaborated with patients to collect almost 100 000



FIGURE 1— Hannah Mayer Stone, MD

Note. This photo was taken between 1930 and 1940.

Source. Property of the Harvard Medical Library collection, Center for the History of Medicine in the Francis A. Countway Library of Medicine. Printed with permission.

contraceptive case histories before her untimely death in 1941.⁵ Her 1928 publication was based on the earliest of these histories and reveals that Stone's patients themselves—in undergoing examination and study enrollment—played a vital role in shaping subsequent medical practice.

Drawing from a selection of Stone's scientific publications and archived professional correspondence, this article explores how Stone managed to practice medicine and perform foundational research despite a hostile legal and social climate. By translating her patients' individualized case histories into published medical data and fostering a professional network of data sharing and collaboration, Stone made it increasingly possible for health care providers, herself included, to offer the kind of

empirically based care that best fit individuals' specific circumstances and facilitated desired outcomes. Given the parallels between Stone's provision of individualized birth control in the 1920s and recent calls concerning the need for such care among underserved and marginalized patients in particular in 2022,⁶ I argue that Stone's research and interprofessional advocacy offer contemporary providers guidance for navigating the contested landscape of current US reproductive health care and social justice.

CHALLENGES TO EARLY CONTRACEPTIVE CARE

Extensive challenges stood in the way of efforts to establish safe and effective contraceptive care in the early twentieth

century. Beginning in 1873, Comstock laws went into effect that categorized all contraceptive information and products as obscene and therefore as illegal to possess or send through the US mail.⁷ When birth control advocate Margaret Sanger first tried to establish a contraceptive clinic in 1916 that was modeled on clinics in the Netherlands, her clinic was raided by police and shut down under the Comstock laws.

In 1918, the New York State Court of Appeals made a provision for licensed physicians specifically to prescribe contraception to married couples for the prevention or cure of disease, which the judge interpreted broadly to include any change in the body that could disturb health.⁸ In accordance with this ruling, Sanger re-established her contraceptive clinic in 1923 with a licensed physician at the helm. Sanger first hired Dorothy Bocker, MD, to serve as medical director, but she dismissed Bocker two years later for failure to keep adequate records and hired Stone as her replacement. At the time, Stone was a practicing physician at New York City's Lying-In Hospital who was trained in pharmacology and shared a joint practice with her husband, the urologist Abraham Stone, MD.

Stone originally met Sanger when she attended the first national birth control conference in 1921 and expressed interest in the emergent birth control movement. In her role as medical director, Stone turned the clinic into something of an "über-clinic" that offered clinical care and generated empirical data about contraceptives.⁹ Her research provided other clinics being established across the country and internationally with the statistical and qualitative data needed to prescribe the most effective medical contraceptive care available.

This was the case even as contraceptive care providers continued to struggle for years to offer services within the bounds of an unfavorable legal backdrop. Although Sanger and Stone would win the right for physicians to send and receive contraceptives through the US mail in 1936 in *US v. One Package*,¹⁰ it was not until 1965 that the Supreme Court established the federal right to contraception for married couples, 1972 that it granted the right to contraception for unmarried individuals, and 1977 that it found unconstitutional all restrictions on the advertising, selling, or distributing of contraception.¹¹

Throughout the twentieth century, legal barriers to establishing contraceptive care were compounded by associated social and professional challenges. As Sanger recalled of the 1920s, “few doctors wanted to take the risk of identifying themselves with the birth control cause, the risk of becoming a martyr, of losing professional license or standing, of being expelled from their medical societies.”¹² As it happened, all of these fates befell Stone, who—as one of very few female practicing physicians at the time—had already experienced significant marginalization and discrimination throughout her early career. Upon signing on as medical director, a position for which she never accepted remuneration,¹³ Stone was dismissed from her position at the Lying-In Hospital, blocked from professional societies, and shunned by former colleagues.¹⁴

When she was attempting to publish her scientific findings on contraception, her professional correspondence provides evidence of the rejection she faced. In a letter from 1925, the editor of the *Medical Journal and Record* (the same outlet that eventually published her work three years later under a

different editor) reported, “I have made inquiries regarding the publication of articles on birth control, and I regret to be obliged to return your manuscript on ‘Contraceptive Methods of Choice,’ as our Journal would be unmailable with this article included.”¹⁵ Other letters illustrate that this type of professional rebuff reverberated into the public sphere as well. In 1937, a radio station’s legal counselor informed Stone that the station did “not wish to jeopardize its license from the Federal Communications Commission” to broadcast an address she was to give on contraception.¹⁶ At every turn, Stone’s ability to circulate her findings and facilitate care was hampered, sometimes publicly, but more often via interactions outside public view.

The legal and professional hardships that Stone encountered also overlapped with challenges posed at the levels of science and medical inquiry. When Stone began her directorship, there was inadequate scientific data to guide clinical contraceptive care. Several physicians from this time spoke to this effect, including practitioners such as Robert L. Dickinson, MD. As a renowned gynecologist in his own right and director of the at-times-competing Committee on Maternal Health,¹⁷ Dickinson’s assessment held weight. In his introduction to Stone’s 1928 medical publication, he explained:

the library of argument and invective on the subject of birth control was built on an absurdly small amount of medical information. At that time the Committee on Maternal Health did not find over thirty cases, properly accredited and followed up, on which to start clinical studies. The gynecological and obstetrical departments of medical colleges have been reluctant to bestir themselves in

accumulating records of cases requiring contraceptive advice for the safeguarding of life and health.¹⁸

Without existing data to consult, Stone gathered, analyzed, and presented her own data from the clinic’s patients to begin establishing contraceptive care as an empirically based pursuit.¹⁹

TRANSLATING WOMEN’S EMBODIED EXPERIENCES INTO EMPIRICAL DATA

In a remembrance of Stone delivered in 1941, Sanger said of her that “no one, certainly, has more thoroughly explored the clinical aspects of contraception.”²⁰ Long before the first randomized controlled trials, Stone oversaw and administered the country’s first large-scale clinical study of contraception by documenting her patients’ experiences with specific contraceptive regimes and compiling these considerable data into scientific reports. When she published one report in a US medical journal in 1928, she initiated the broader process of validating contraceptive care among US physicians by providing them with the empirical evidence needed to offer such care and delivering it in a professionally recognized outlet.

At that point, contraception had been rejected by polite society and physicians alike as the stuff of immorality and vice,²¹ and the task of legitimizing contraception as part of standard US medical practice remained far from complete until well into the 1970s.²² Stone’s 1928 publication helped to begin the long process of situating birth control culturally as aboveboard and within the expertise of authorized medical practitioners. Given it was only physicians who had the legal ability to

council on and prescribe contraception, their eventual willingness to perceive birth control care as a legitimate part of their work was the pivot upon which the US birth control movement rested for much of the twentieth century.

Stone's 1928 article performed its legitimacy by detailing how she designed her patient consultations to support a rigorous statistical study of available contraceptive regimes (Figure A, available as a supplement to the online version of this article at <https://ajph.org>). Stone explained that she reduced potential biases in design through extraordinary efforts that included overseeing every one of the 1655 patient consultations herself (with multiple consultations across patients) and performing the consultations over the same period (1925–1927). She described instituting a system of record keeping that allowed her to detail each aspect of her study design including the specific type of contraceptive regimen each participant was prescribed (primarily different formulas of spermicidal jellies combined with occlusive pessaries), exact chemical content of jellies employed, processes involved in measuring and fitting pessaries and diaphragms, precise instructions participants received during initial and follow-up consultations, period of adherence, qualitative feedback, and regime outcome. She noted, “each patient was asked to return at certain intervals, or else to report by mail the results with the method prescribed.”²³

Stone's report highlighted her efforts to obtain comprehensive information about the contraceptive experiences of as many women as possible.

Above all else, Stone's article contended that effective contraceptive care must be personalized and attendant to every patient's unique body,

circumstances, and experiences, and not just because pessaries and diaphragms required medical fittings. Scattered throughout Stone's numeric findings are notations about how “each patient was examined individually, and a contraceptive chosen according to the needs and indications of the particular case,”²⁴ and reminders that “much tact and care must be employed in obtaining reports from patients. The use of contraceptives is a very intimate problem with the woman.”²⁵ She reported that some patients found specific regimens uncomfortable, physically irritating, or requiring of more privacy than they had available. Stone upheld these responses as valid reasons for regime noncompliance and therefore as issues for other physicians to anticipate in their own consultations.

In her conclusion, Stone made recommendations about which contraceptive regimes were most effective. But rather than recommending the most statistically effective regimen across the board (a Ramses-type pessary with “Formula I” jelly), she endorsed a different regime (a Ramses-type pessary with “Formula V” jelly) for many cases because some patients reported “trouble” with the former.²⁶ In this way, Stone modeled how to balance statistical findings with qualitative patient feedback.

ESTABLISHING A SYSTEM OF COLLECTIVE PRACTICES

Although Stone composed the earliest of her reports from her own patient consultations alone, she knew the long-term establishment of robust contraceptive care would require incorporation of more diverse data and the explicit sharing of clinical information and experiences across contexts and

demographics. Stone's work to foster a network of contraceptive care knowledge was less visible than her clinical research because it was initiated largely behind the scenes. Beginning as early as 1927, Stone contacted physicians who were “actively engaged in contraceptive work” across the country and internationally to provide overviews of her data and the clinic's contraceptive resources. She distributed surveys asking them to share their emergent contraceptive insights, promising “due credit” for those “willing to contribute” to future reports.²⁷ In a letter from 1933, she explained:

We hope that this questionnaire may serve to develop a more regular exchange of information and data among the various clinics in this country. . . . We shall be glad to supply information on any of the methods which we have already tested, and to investigate in the laboratory any newer methods that other clinics might be interested in.²⁸

Additional correspondence, along with the more comprehensive evidence included in her subsequent medical reports, revealed that Stone's efforts to foster cooperative values were fruitful. In a 1935 letter addressed to a physician in Florida, for instance, Stone wrote, “I was very much pleased to receive your application blanks and to know that you are willing to cooperate with us in our new project,” before noting, “Our aim is to be mutually helpful in developing the practice of contraception and we shall, no doubt, find many occasions in the future to exchange data, findings and information.”²⁹ Stone's correspondence also revealed that she started a “Printed Matter Exchange” so that providers would not have to create materials from scratch

and could compare their processes and procedures with other clinics.³⁰

In addition, Stone's correspondence demonstrated that she fostered collaboration by interacting one on one with other physicians concerning the ins and outs of contraceptive care. In some instances, Stone had to forgo niceties to critique others' regimes or products. In 1935, she wrote to a collaborating physician, "The jelly which you sent us, which is made up from the Dupont product, I found to be too irritating. Women complained of burning and irritation very soon after the insertion of the jelly. It is likely that the percentage is too strong, or that irritation could be obviated by changes in the form of manufacture."³¹ In a 1938 correspondence with Dickinson, she explained that a series of trials she conducted revealed that a particular pessary's "construction of its rim makes it too stiff and apt to cause too much pressure," concluding that "it still requires a certain amount of technical improvement."³² Stone coupled calls for cooperation with a willingness to engage honestly about what would serve individuals' needs best, drawing from patient feedback as evidence for objections. If she found existing products and regimes unsatisfactory, she called for collaborative efforts to make improvements.

Moreover, for Stone, persuading others to collaborate involved demonstrating that she, too, would meet individual patients where they were and provide them with what they needed. She regularly responded—via letter and often with requested materials such as medical directories—to women who were desperate for contraceptive information.³³ She gave them sometimes lengthy, always personalized advice and encouraged them not to

"hesitate to write again at any time we can be of any help."³⁴ Stone's care for individuals led her to send contraceptive supplies to, in one case, a woman in Barranquilla, Colombia, who wrote her and was without access.³⁵ In this way, she modeled her belief that personalized, direct engagement was imperative for providing contraceptive care that would work in any given case.

CONTRACEPTIVE CARE TODAY

Today, much can be garnered from Stone's record of contraceptive care advocacy. Comparatively, the good news is that contemporary providers and public health advocates are facing different, and arguably fewer, headwinds than did Stone in their fight to create and sustain safe and effective contraceptive care. Unlike in Stone's time, there exists vast scientific, empirical evidence about contraceptive uses, outcomes, and risks across a variety of circumstances and demographics, evidence that is generated by pharmaceutical companies rather than already overtaxed practicing physicians. Moreover, contraceptive methods today are more varied, available, and effective. Yet, there are still significant obstacles to providing reproductive health care in the twenty-first century. These involve factors such as evolving federal and state legislative restrictions, inadequate clinical guidelines and training, vast health care-access inequities and biases, and a lack of "person-centered approaches" to contraceptive care.³⁶

Given that contraceptive care remains precarious, Stone's approach to providing and advocating care in a fraught reproductive health climate offers guidance for today. First, even in contexts in which generating statistical

results was necessary, Stone saw that her patients' embodied experiences with contraceptive regimes were accounted for. She argued that effective care depends on personalized engagement with patients as much as on prescribing methods grounded in statistical outcomes. To highlight the importance of finding this balance, she included in her 1928 statistical report references to the embodied experiences of individuals in her care, and she incorporated specific ideas generated from those references in making recommendations about prescribed contraceptive regimes. Stone did so to such an extent that the integral role clinic patients themselves played in shaping subsequent medical practice becomes clear.

Today's physicians do not need to prove contraceptive regime effectiveness as Stone did, but the success of their work depends no less on individualized, patient-centered clinical care and contraceptive counseling. Such an approach, grounded in listening and dedicated attention to patients' unique situations and positionalities, aligns with efforts to foster reproductive justice. A reproductive justice framework centers individuals' intersectional identities considering systemic inequalities to provide increasingly safe, effective, and equitable care.³⁷ It involves upholding patient experiences and histories as agentic, as did Stone, and illuminating hard truths related to, for instance, the history of coercion and deception employed against Black, Latinx, and Indigenous individuals by medical authorities in the context of US contraceptive care.³⁸

Second, Stone's work involved advocating a system of sharing and collaboration among fellow physicians. She built bridges, speaking and acting in

ways that emphasized cooperation and a mutual vision. Her surviving professional correspondence reveals how she initiated large-scale campaigns that involved sharing information among contraceptive care providers. It also reveals her efforts to engage openly with other providers about patient experiences. Throughout her career, Stone made it clear that the effective provision of contraceptive care always starts and stops with attention to the experiences and needs of individual patients. In the twenty-first century, as in the early twentieth, there can be no more important lesson to be taken from her body of work. **AJPH**

ABOUT THE AUTHOR

Robin E. Jensen is a professor in the Department of Communication, University of Utah, Salt Lake City.

CORRESPONDENCE

Correspondence should be sent to Robin E. Jensen, PhD, Department of Communication, University of Utah, 255 S Central Campus Drive, Salt Lake City, UT 84112 (e-mail: r.e.jensen@utah.edu). Reprints can be ordered at <https://ajph.org> by clicking the "Reprints" link.

PUBLICATION INFORMATION

Full Citation: Jensen RE. The first publication on contraception in a US medical journal, 1928: Hannah Mayer Stone's case for contraceptive care before the pill. *Am J Public Health*. 2023; 113(4):390–396.

Acceptance Date: December 15, 2022.

DOI: <https://doi.org/10.2105/AJPH.2022.307215>

ACKNOWLEDGMENTS

Funding for this study was provided by a National Endowment for the Humanities Faculty Fellowship (FEL-267498-20).

I am grateful to archivists Kate Long and Maureen Callahan at Smith College's Special Collections, as well as archivist Stephanie Krauss at the Center for the History of Medicine in the Francis A. Countway Library of Medicine at Harvard University, for helping me to obtain access to the materials cited in this essay. Many thanks, also, are extended to the editor and four anonymous reviewers for their engagement and dedication to this research.

Note. Any views, findings, conclusions, or recommendations expressed in this article do not necessarily represent those of the National Endowment for the Humanities.

CONFLICTS OF INTEREST

The author declares no conflicts of interest.

ENDNOTES

1. See, for instance, Elaine Tyler May, *America and the Pill: A History of Promise, Peril, and Liberation* (New York, NY: Basic Books, 2011); Elizabeth Siegel Watkins, *On the Pill: A Social History of Oral Contraceptives, 1950–1970* (Baltimore, MD: Johns Hopkins University Press, 2001). The history of US birth control more generally and especially before the pill is a vast field explored extensively in Ellen Chesler, *Woman of Valor: Margaret Sanger and the Birth Control Movement in America* (New York, NY: Simon & Schuster, 2007); Linda Gordon, *The Moral Property of Women: A History of Birth Control Politics in America* (Urbana, IL: University of Illinois Press, 2007); Carole R. McCann, *Birth-Control Politics in the United States, 1916–1945* (Ithaca, NY: Cornell University Press, 1999); and James Reed, *From Private Vice to Public Virtue: The Birth Control Movement and American Society Since 1830* (New York, NY: Basic Books, 1978).
2. Cathy Moran Hajo, *Birth Control on Main Street: Organizing Clinics in the United States, 1916–1939* (Urbana, IL: University of Illinois Press, 2010); Melissa R. Klapper, *Ballots, Babies, and Banners of Peace* (New York, NY: New York University Press, 2013). By 1937, there were approximately 320 functioning birth control clinics in the United States: "A New Day Dawns for Birth Control" (New York, NY: National Committee Federal Legislation for Birth Control, 1937).
3. Hannah M. Stone, "Therapeutic Contraception," *Medical Journal and Record* (March 1928): 9–17. After this initial publication, US medical journals such as the *American Journal of Public Health* and the *Journal of the American Medical Association* began publishing articles on contraception with increasing regularity.
4. *People v. Sanger*, 222 NY 192 (1918).
5. Margaret Sanger, "Hannah M. Stone—In Memoriam," *Human Fertility* 6, no. 4 (August 1941): 109.
6. See, for instance, Anu Manchikanti Gomez, Liza Fuentes, and Amy Allina, "Women or LARC First? Reproductive Autonomy and the Promotion of Long-Acting Reversible Contraceptive Methods," *Perspectives on Sexual and Reproductive Health* 46, no. 3 (2014): 171–175; Michelle H. Moniz et al., "Inpatient Postpartum Long-Acting Reversible Contraception: Care That Promotes Reproductive Justice," *Obstetrics and Gynecology* 130, no. 4 (2017): 783–787.
7. Act of the Suppression of Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use, Ch 258, 17 Stat 596–600 (1873).
8. *People v. Sanger*.
9. Hajo, *Birth Control on Main Street*, 6.
10. *United States v. One Package*, 86 F 2nd 737 (1936).
11. *Griswold v. Connecticut*, 381 US 479 (1965); *Eisenstadt v. Baird*, 405 US 438 (1972); and *Carey v. Population Services International*, 431 US 678 (1977).
12. Sanger, "Hannah M. Stone—In Memoriam," 109.
13. Robert L. Dickinson, "Hannah M. Stone—In Memoriam," *Human Fertility* 6, no. 4 (August 1941): 111.
14. Chesler, *Woman of Valor*, 278–279.
15. Gregory Stragnell to Hannah Mayer Stone, 15 December 1925, box 36, folder 4, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
16. Irving H. Jurow to Hannah M. Stone, 12 January 1937, box 36, folder 5, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
17. Gordon, *The Moral Property of Women*, 181–182.
18. Robert L. Dickinson, "Open Forum: Birth Control," *Medical Journal and Record* (March 1928): 7.
19. Clinic patients were required to be married and not pregnant. Services were offered for free to those who could not afford to pay, and members of immigrant communities were recruited with informational materials translated into multiple languages. A small percentage of Black women visited the clinic, many of whom commuted from Harlem: McCann, *Birth-Control Politics*.
20. Sanger, "Hannah M. Stone—In Memoriam," 109.
21. Janet Farrell Brodie, *Contraception and Abortion in 19th-Century America* (Ithaca, NY: Cornell University Press, 1994); Nicola Beisel, *Imperiled Innocents: Anthony Comstock and Family Reproduction in Victorian America* (Princeton, NJ: Princeton University Press, 1997).
22. Ellen S. More, *The Transformation of American Sex Education: Mary Calderone and the Fight for Sexual Health* (New York, NY: New York University Press, 2022).
23. Stone, "Therapeutic Contraception," 12.
24. Stone, "Therapeutic Contraception," 11.
25. Stone, "Therapeutic Contraception," 13.
26. Stone, "Therapeutic Contraception," 17.
27. Hannah M. Stone to Doctor, 27 June 1933, box 36, folder 4, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
28. Ibid.
29. Hannah M. Stone to Lydia Allen DeVilbiss, 25 September 1935, box 36, folder 4, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
30. Hannah M. Stone to birth control organizations in the United States, 2 May 1938, box 36, folder 5, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
31. Hannah M. Stone to Lydia Allen DeVilbiss, 1 June 1935, box 36, folder 4, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
32. Hannah M. Stone to Robert L. Dickinson, 22 March 1938, box 36, folder 5, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
33. Woman's Activities to Hannah Stone, 8 March 1932, box 12, folder 28, Abraham Stone Papers, Francis A. Countway Library of Medicine, Harvard University.
34. Hannah M. Stone to Frieda L. Greenon, 4 February 1937, box 36, folder 5, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
35. Hannah M. Stone to Lily Sendra, 12 September 1938, box 36, folder 5, Margaret Sanger Papers, Sophia Smith Collection of Women's History, Smith College.
36. Nikita M. Malcolm et al., "Using Evidence to Expand Contraceptive Access," *American Journal of Public Health* 112, no. S5 (June 2022): S470–S472.

37. Loretta J. Ross, "Reproductive Justice as Intersectional Feminist Activism," *Souls* 19, no. 3 (2017): 286–314; Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Berkeley, CA: University of California Press, 2017).
38. Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York, NY: Pantheon Press, 1997); Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present* (New York, NY: Broadway Books, 2006).

is your organization an **APHA** member?

Nonprofits, government agencies and educational institutions play an important role in public health. But did you know they can also be members of APHA?

As an APHA agency member, you get discounts on ads in APHA publications and job postings on Public Health CareerMart.

And your employees receive registration discounts for APHA's Annual Meeting and Expo and savings of up to \$150 on individual APHA membership.

Become an APHA agency member today!



For details, call 202-777-3914
or visit www.apha.org/membership.



Copyright of American Journal of Public Health is the property of American Public Health Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.