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ARTICLE

Depo-Provera, Class, Race, and the Domiciliary Family Planning Services in Glasgow and Haringey, 1970–1983

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Abstract

In 1976, the Committee of Safety of Medicines (CSM) in Britain authorized the contraceptive injectable Depo-Provera (DP) for short-term use and for two main reasons only: if a woman had received a rubella vaccine or if her partner had just undergone a vasectomy. Although officially authorized on restricted grounds only, the drug appears to have been widely prescribed by doctors of the Domiciliary Family Planning Services (DFPS). This article takes the prescription of DP in the DFPS of Haringey, a multiracial neighbourhood in London, and Glasgow as a comparative case-study to explore the intersections of medical authority, race, and class. Drawing on the archives of the Wellcome Collection, London, and the NHS Archives of the Mitchell Library in Glasgow, we show that the DFPS offered the ideal setting to test and prescribe Depo-Provera widely. In the hands of the medical profession, the drug at times became a tool of violence towards women from disadvantaged backgrounds. In doing so, we contribute to the wider, global history of DP, and illustrate how racist, classist, and ableist prejudices could shape family planning services in the British context.

I

In 1979, Hyacinth, a seventeen-year-old Black single girl received a visit from Dr Elphis Christopher from the Domiciliary Family Planning Service (later DFPS) in the multiracial borough of Haringey in London. The DFPS was aimed at offering contraceptive advice to patients in their own home who would not attend a regular family planning clinic. According to the DFPS report written by Christopher, Hyacinth was one of seven children; her mother was English and her father from the West Indies. She had been rejected by her parents and spent most of her life in care. Hyacinth was referred to the DFPS

when she was fourteen as her social worker thought she was at risk of pregnancy. Christopher explained that Hyacinth was 'subnormal' and

> took the pill erratically and was frequently lost to follow-up. She had various sexual partners and the inevitable happened and she became pregnant. She had the child but neglected it: she would go out and leave it unattended and not bother to feed it. Eventually, the baby had to go into care. Depo-Provera seemed the best answer for Hyacinth; she has received DP for one year and is happy about it.[1]

This extract from Christopher illustrates how race, class, and ability were considered to be relevant in the prescription of Depo-Provera. Indeed, Christopher emphasized the origins of the girl, her chaotic upbringing, her learning difficulty, her socio-economic circumstances, and her sexual irresponsibility. These were thought to be legitimate grounds to prescribe a contraceptive method that was not officially endorsed by the Committee of Safety of Medicine. Yet, according to the doctor, the patient was 'happy about it'. This example is indicative of the tension between coercion and choice in relation to the history of contraception – Depo-Provera prescription could sometimes be perceived as empowering for some women while at other times it might have been coercive – highlighting how the prescription of contraceptives are stratified along race, ability, and class lines.[2]

Depo-Provera is a contraceptive that is administered through injection every three months. It releases the hormone progesterone, which prevents ovulation, meaning that there is no egg to be fertilized during sex and therefore no pregnancy should occur. Depo-Provera was developed by the US manufacturer Upjohn in the 1960s. In 1967, Upjohn applied for licence to commercialize Depo-Provera as a contraceptive to the Federal Drug Agency in the US. The licence was not granted because of fears around side effects and carcinogenic effects. In 1978, the FDA officially announced its rejection of Depo-Provera as a contraceptive in America and this lasted until 1992. But this contraceptive was endorsed and widely prescribed by major international family planning agencies in eighty countries.[3] In Britain, the drug was approved by the CSM in 1976 for short-term use and for two reasons only: if a woman had received a rubella vaccine or if her partner had just undergone a vasectomy. In 1983, the drug was given a long-term licence but only if other forms of contraception were unsuitable and provided women had given their consent.

In the last two decades, historians have started to document the sexual and reproductive behaviours of 'ordinary' men and women through sexual and

[1] Elphis Christopher, Depo Provera, January 1980, London, Wellcome Library (WL), SA/FPA/C/G/8/3.

[2] Johanna Schoen, *Choice & coercion: birth control, sterilization, and abortion in public health and welfare* (Chapel Hill, NC, 2005).

[3] Emily Callaci, '"Injectable development": Depo-Provera and creation of the Global South', *Radical History Review*, 131 (2018), pp. 82–104.

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demographic surveys, oral history interviews, recordings of sexual counselling sessions, or case-studies from sexual and reproductive health charities.[4] While this scholarship offers important insights into the gendering of reproductive behaviours and decision-making regarding contraception, it does not take a fully intersectional perspective into account, and there has been a tendency to focus on the lived experiences of white Britons. Recent studies have touched upon issues around sexuality and race, showing how political actors conflated race with anxieties about migrant fertility and sexuality, thus fuelling xenophobic politics.[5] As Anne Hanley has shown, concerns around migration and sexual health in the post-war period were part of a wider context of 'scaremongering and moral panic over Britain's immigration policies'.[6] At that time, a discourse around race emerged that focused on the alleged hyperfertility of the Black population. This discourse helped to create an ideal representation of home and family to which Black families did not belong.[7]

More broadly, within the history of abortion, Sheldon et al.'s recent biography of the 1967 Abortion Act has illustrated how women's experiences of accessing abortion through the NHS after the Abortion Act 'depended on their age, marital situation, race, class and geography'.[8] While Sheldon et al. found that the relevance of a woman's race or ethnicity was less discussed in accounts of women seeking abortions in Britain compared to the US, 'it undoubtedly played a role'.[9] As Cecily Jones has shown, Black women were affected by racialized stereotypes around their perceived promiscuity and hyperfertility which may have influenced white doctors to favour birth control methods that would 'remove their contraceptive agency', while there were also reports of Black women who were forced to agree to unwanted terminations as

[4] Hera Cook, *The long sexual revolution: English women, sex, and contraception, 1800–1975* (Oxford, 2004); Kate Fisher, *Birth control, sex, and marriage in Britain, 1918–1960* (Oxford, 2006); Simon Szreter and Kate Fisher, *Sex before the sexual revolution: intimate life in England, 1918–1963* (Cambridge, 2010); Katherine Jones, '"Men too": masculinities and contraceptive politics in late twentieth century Britain', *Contemporary British History*, 34 (2020), pp. 44–70; Laura Kelly, *Contraception and modern Ireland: a social history, c. 1922–92* (Cambridge, 2023); Caroline Rusterholz, '"You can't dismiss that as being less happy, you see it is different": sexual counselling in 1950s England', *Twentieth Century British History*, 30 (2019), pp. 375–98; Caroline Rusterholz, 'Youth sexuality, responsibility, and the opening of the Brook advisory centres in London and Birmingham in the 1960s', *Journal of British Studies*, 61 (2022), pp. 315–42.

[5] Roberta Bivins, *Contagious communities: medicine, migration, and the NHS in post-war Britain* (Oxford, 2015); Elizabeth Buettner, '"Would you let your daughter marry a negro?" Race and sex in 1950s Britain', in P. Levine and S. R. Grayzel, eds., *Gender, labour, war and empire: essays on modern Britain* (Basingstoke, 2009), pp. 219–37; Anne Hanley, 'Migration, racism and sexual health in post-war Britain', *History Workshop Journal*, 94 (2022), pp. 202–22; Gemma Romain, *Race, sexuality and identity in Britain and Jamaica: the biography of Patrick Nelson, 1916–1963* (London, 2017).

[6] Hanley, 'Migration, racism and sexual health', p. 202.

[7] Cecily Jones, '"Human weeds, not fit to breed?" African Caribbean women and reproductive disparities in Britain', *Critical Public Health*, 23 (2013), pp. 49–61; Wendy Webster, *Imagining home: gender, race and national identity, 1945–1964* (Abingdon, 1998).

[8] Sally Sheldon, Gayle Davis, Jane O'Neill, and Clare Parker, *The Abortion Act 1967: a biography of a UK law* (Cambridge, 2022), p. 45.

[9] Ibid., p. 40.

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well as sterilizations.[10] Class also had an important impact on access to abortion: as Sheldon et al. have shown, 'women in the semi-skilled and unskilled classes were more likely to face delays in receiving attention and treatment', and also more likely to be 'deemed better able to cope with an unwanted pregnancy'.[11]

Moreover, the last two decades have seen an increasing interest in the history of contraceptives. Scholars have explored the ways that drugs came to be created, their (problematic) clinical trials, and use in different locations.[12] As Michelle Murphy has argued, synthetic hormones hold different purposes and meaning in different places and locations.[13] Emily Callaci has shown that the idea of 'travelling technologies' was especially pertinent to the history of Depo-Provera; while unauthorized in the US the drug was widely prescribed in the Global South.[14] Dorothy Roberts has highlighted how in the US, before its approval, the drug was 'regularly administered to Southern Black and Native American women for birth control'.[15] Yet, we know less about the history of Depo-Provera in the UK, aside from a recent article by Caitlin Lambert which has shed light on the Campaign Against Depo-Provera in Britain.[16]

Drawing on the archives of the Wellcome Collection, London, and the NHS Archives at the Mitchell Library in Glasgow, this article takes the prescription of Depo-Provera in Britain as a case-study to explore the intersections of medical authority, race, and class. In doing so, we draw upon the framework of 'stratified reproduction' developed by Shellee Colen which argues that 'physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic and political forces'.[17] Using the two case-studies of Haringey and Glasgow, we show that the DFPS offered the ideal setting to test and prescribe Depo-Provera widely. In the hands of the medical profession, the drug at times became a tool of violence towards women who were deemed by medical professionals to be unsuited to having children, because of race, ethnicity,

[10] Jones, '"Human weeds, not fit to breed?"', pp. 53 and 55; and Stella Dadzie, Beverley Bryan, and Suzanne Scafe, *The heart of the race: Black women's lives in Britain* (London, 1985), p. 103, both cited in Sheldon et al., *The Abortion Act of 1967*, pp. 40–1.

[11] Sheldon et al., *The Abortion Act of 1967*, p. 40.

[12] Chikako Takeshita, *The global biopolitics of the IUD: how science constructs contraceptive users and women's bodies* (Cambridge, MA, 2011); Heather Munro Prescott, *The morning after: a history of emergency contraception in the United States* (New Brunswick, NJ, 2011); Elizabeth Siegel Watkins, *On the pill: a social history of oral contraceptives, 1950–1970* (Baltimore, MD, 1998); Lara Marks, *Sexual chemistry: a history of the contraceptive pill* (New Haven, CT, 2010).

[13] Michelle Claudette Murphy, *Seizing the means of reproduction: entanglements of feminism, health, and technoscience* (Durham, NC, 2012).

[14] Callaci, '"Injectable development"'.

[15] Dorothy Roberts, *Killing the black body: race, reproduction and the meaning of liberty* (2nd edn, New York, NY, 2017), p. 145.

[16] Caitlin Lambert, '"The objectionable injectable": recovering the lost history of the WLM through the Campaign Against Depo-Provera', *Women's History Review*, 29 (2020), pp. 520–39.

[17] Shellee Colen, '"Like a mother to them": stratified reproduction and West Indian childcare workers and employers in New York', in Faye D. Ginsburg and Rayna Rapp, eds., *Conceiving the new world order: the global politics of reproduction* (Berkeley, CA, 1995), pp. 78–102, at p. 78.

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class, perceived 'mental deficiency', or perceived lack of sexual responsibility. A study of the DFPS also provides a means of exploring how such prejudices intersected in the prescription of contraceptives.

II

Domiciliary Family Planning Services were set up in the late 1950s as pilot schemes by women doctors from the Family Planning Association (FPA) with the aim of supporting women who could not or would not attend the regular FPA clinics.[18] This development may be seen as part of a wider context of delivering care for people in their homes, such as through district nursing, which had its roots in the late nineteenth century, but was formalized under the establishment of the NHS in 1948.[19] At first, two experiments were conducted in Newcastle and Southampton and funded by the Eugenics Society. These pilot projects were aimed at 'problem families' and showed that the 'hard to reach' could be helped to control their fertility when visited at home by family planning personnel (doctors, nurses, or social workers).

The concept of 'problem families' emerged in the late 1940s, but had its roots in earlier concerns around 'mental deficiency'.[20] As Mathew Thomson shows, by the late 1940s, such concerns focused on 'the influence of the familial social and psychological environment, rather than genetic inheritance'; social problems within specific families were 'still frequently explained by the low intelligence of the parents'.[21] The term 'problem families' found its origin during the Second World War and in reference to the conditions of evacuated children. Quoted by the National Federation of Women, it refers to families who live 'on the edge of pauperism and crime, riddled with mental and physical defects, in and out of the Courts for child neglect, a menace to the community, of which the gravity is out of all proportion to their numbers'.[22] The Eugenics Society took an interest in this topic and conducted an investigation on the subject that led to the publication in 1952 of *Problem families: five inquiries*. In addition, as the historian Pat Starkey has shown, whether a family was considered 'normal' or 'problematic' depended on the performance of motherhood, which was observed and evaluated in terms of the child's well-being and the family's material conditions. Thus, 'problem families' actually meant 'problem mothers'. Starkey writes that the problem mother was 'at the intersection of eugenic, class and social anxieties, all concerned with the quality of post-war British life and represented by groups of professionals who had an interest in reforming her'.[23]

[18] Domiciliary Family Planning Services, A report from a working group of the family planning forum of the Royal College of Nurses, 1972.

[19] See Helen M. Sweet and Rona Dougall, *Community nursing and primary healthcare in twentieth-century Britain* (New York, NY, 2008).

[20] Mathew Thomson, *The problem of mental deficiency: eugenics, democracy, and social policy in Britain, c. 1870–1959* (Oxford, 1998), p. 281.

[21] Ibid.

[22] Women's Group on Public Welfare (England), *Our towns, a close-up* (Oxford, 1943), p. 13.

[23] Pat Starkey, 'The feckless mother: women, poverty and social workers in wartime and post-war England', *Women's History Review*, 9 (2000), p. 551. See also John Macnicol, 'From "problem

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In 1959 in Newcastle, Dr Mary Peberdy started to pay domiciliary visits to 'problem patients' referred to her by the Medical Officer of Health and set up a clinic geared towards the poor families. Women who were seen tended to belong to the 'lower socio-economic groups' and had more than five children. Similarly, in Southampton Dr Dorothy Morgan started a similar scheme in 1961. Both experiments were funded by the Eugenics Society and the Marie Stopes Memorial Foundation.[24] The birth control methods recommended were at first the sheath, the cap, and chemicals, then the pill became the main method while sterilization started to be increasingly used. In Southampton, derogatory language was used to describe the patients of these services. In a paper at a conference organized by the Eugenics Society, Morgan explained that 'a proportion of the population of our town and cities have failed to adapt themselves to the moral and social establishment, and have become an increasing burden and responsibility to the Statutory and Local Community'.[25] In a similar vein, Morgan patronizingly explained how she taught birth control to her 'problem patients': 'I tell my patients of very low intelligence – some registered mental defectives, to use the cap just as you would teach a child to brush his teeth.'[26] This example illustrates the classist and ableist prejudices that were already present when the scheme started and that would be reinforced and used as a rationale for the prescription of Depo-Provera in other parts of the UK. By 1964, fifteen families were part of the scheme. The initial 'success' of these projects prompted many local authorities, using the FPA as agents to start DFPS. By 1975, 140 such services were established but had to be handed over to the Area Health Authorities due to the NHS reorganization.[27]

In Glasgow, a DFPS was established in 1970 by Dr Elizabeth (Libby) Wilson (1926–2016). Born in London in 1926, Wilson studied medicine at King's College Hospital. Wilson married fellow doctor, Graham Wilson in 1949, and went on to have six children.[28] She initially worked as a GP and with the FPA in Sheffield in the 1950s. After the FPA voted to restrict their services to married women in 1964, she and some other female doctors in Sheffield established their own family planning clinic called the 408 Clinic. In 1967, she moved to Glasgow after her husband was appointed Regius Professor of Medicine at Glasgow University and began working at the Glasgow family

family" to "underclass", 1945–95', in Helen Fawcett and Rodney Lowe, eds., *Welfare policy in Britain: the road from 1945* (Basingstoke, 1999), pp. 69–93.

[24] John Peel and Faith Schenk, 'Domiciliary birth control: a new dimension in negative eugenics', *The Eugenics Review*, 57 (1965), p. 67.

[25] Dorothy Morgan, 'The acceptance by problem parents in Southampton of a domiciliary birth control service', in J. E. Meade and A. S. Parkes, eds., *Biological aspects of social problems: a symposium held by the Eugenics Society* (London, 1965), p. 199.

[26] Ibid., p. 201.

[27] Elphis Christopher, Leonie A Kellaher, and Andree von Kock, *A survey of the Haringey Domiciliary Family Planning Service 1968–1975*, Research Report no. 3 July 1980, Polytechnic of North London, p. 1.

[28] Sheila Wilson, 'Obituary: Libby Wilson', *Guardian*, 12 Apr. 2016, accessed online 7 June 2023: www.theguardian.com/society/2016/apr/12/libby-wilson-obituary.

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planning clinic.[29] Discussions around the introduction of a DFPS began at a 1966 meeting of the Glasgow Clinic Committee where the secretary reported on the Southampton DFPS run by Dr Dorothy Morgan. According to the minutes of the committee meeting, 'Dr. Morgan considered the IUD was the most suitable contraceptive device for problem families.'[30] The Glasgow service eventually emerged out of discussions by the Executive Committee of the West of Scotland Branch of the FPA in June 1969 where the committee decided to establish the service 'to give contraceptive advice to under-privileged families where further children are not wanted and who are not able to organise this effectively for themselves'.[31] The West of Scotland Branch, like others, was under the remit of the FPA. Between 1975 and 1976, Scottish clinics were transferred to the NHS under the Area Health Boards. This included the Domiciliary Service for the Greater Glasgow area which was transferred to the Area Health Board in 1975.[32]

Glasgow Corporation provided a grant of £2,000 in February 1970 to the FPA to enable them to 'start a pilot scheme offering contraceptive help to families in their home'. According to Wilson, the DFPS was needed in Glasgow because those who worked in family planning recognized 'that there is a section of the community who want contraceptive help, but who do not attend clinics or their doctors to get it'. Wilson described Glasgow as a city with 'immense social problems' and that a large section of the population needed urgent help 'to prevent the birth of unwanted children, to avoid recourse to termination, legal and illegal, to alleviate the suffering of the mothers and their families, to lighten the economic and social burden these families present to the community generally'.[33] Glasgow also had a high Roman Catholic population and the impact of the city's Catholic administration helped to result in historically high maternal mortality, and excessive childbearing, as well as restricting family planning information and access to abortion.[34] There was considerable stereotyping of Catholic families, as Annmarie Hughes has shown for the 1930s, 'drunkenness and "rough" behaviour' were 'strongly associated with Irish Catholics and the poorer areas that Catholics resided in'.[35]

A similar rationale underpinned the creation of the DFPS in Haringey in 1968. Dr Elphis Christopher (1936–2023) was the key doctor involved in this

[29] 'Obituary: Elizabeth (Libby) Wilson, 1926–2016', *Journal of Family Planning and Reproductive Healthcare*, 42 (2016), p. 301.

[30] Family Planning Association Glasgow Clinic: Minutes of Glasgow Clinic Committee, 17 Aug. 1966, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/3/19].

[31] Family Planning Association West of Scotland Branch: Domiciliary Service Report, Feb. 1970 – Jan. 1971, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/3/18].

[32] Report from Branch Doctors' Group in: Family Planning Association West of Scotland Branch, Annual Report for year ending 1975, dated May 1976, p. 2, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/1/6].

[33] Report on Domiciliary Family Planning in Glasgow, Mar. 1977, p. 1., Glasgow, Mitchell Library, FPA Scotland Archive [12/FAM/PLAN/Vol3].

[34] Roger Davidson and Gayle Davis, *The sexual state: sexuality and Scottish governance, 1950–80* (Edinburgh, 2012), p. 100.

[35] Annmarie Hughes, *Gender and political identities in Scotland, 1919–1939* (Edinburgh, 2010), p. 71.

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service. Christopher was the daughter of Greek Cypriot immigrants, and studied medicine at University College Hospital, London, graduating in 1961. Christopher was married to Donald Jenkinson, a professor of pharmacology, and had three daughters. She began working for the FPA in the London borough of Haringey in 1966, later working for the NHS from 1974. She became consultant for family planning and reproductive care in Haringey in 1996.[36] As explained by Christopher, Haringey in the mid-sixties contained 'pockets of housing stress, overcrowding, unemployment, a high immigrant population and a high illegitimacy rate (one in six live births)',[37] characteristics which meant, in her view, that a DFPS was needed. It had a population of about 240,000 and according to Christopher, 13 per cent of the families were one parent compared to 9 per cent on the average national level. This service was said to be essential since 'the women who really needed family planning help did not attend clinics'.[38] At first, the DFPS aimed to help individuals from 'large families, single parents, families in which there was a physical or mentally handicapped member and families who had social difficulties – the multi problems family'.[39]These social difficulties included poor housing, low incomes, and insecure marital or cohabiting situations. Here again, this service was meant to deal with the fertility of 'problem families'. Over time, the demographics were younger, and the DFPS tended to gear towards unmarried young mothers or single mothers with an average of 2.3 conceptions.

In Glasgow, Wilson argued that there were several reasons why domiciliary patients failed to attend clinics or their own doctors. This included fear of examination, 'most are very ignorant and afraid of the functioning of their own bodies', fear of doctors 'especially males, white coats, hospital smells etc.', fear of contraceptive techniques, fear of appearing with inadequate clothing and 'inadequate social ability in a potentially critical environment', fear and/or dislike of 'authority', unhappy relationship with their local clinic, their health visitor, or GP. Wilson also ascribed other challenges, including 'personal difficulty – mental retardation, mental illness, illiteracy, alcoholism, health – chronic or temporary disability, being housebound with several very young children, inability to look, let alone plan, ahead caused by the pressures of acute poverty and usually combined with one or several of the above', as other reasons as to why women failed to reach out to their local clinic or doctor.[40]

Christopher also identified the key reasons for not attending a clinic as being that women had 'emotional reservations about using contraception or discussing sexual matters or were ignorant about or afraid of the method themselves'.[41] Indeed, commenting on an article written by Wilson published in the *British*

[36] 'Obituaries: Elphis Christopher', *British Medical Journal*, 380 (2023), p. 64.

[37] Christopher, Kellaher, and von Kock, *A survey*, p. 1.

[38] Ibid.

[39] Elphis Christopher, *Domiciliary Family Planning Services, a doctor's view with special reference to the Haringey Domiciliary Services*, May 1979, London, WL, SA/FPA/C/E/16/4/4.

[40] Report on Domiciliary Family Planning in Glasgow, Mar. 1977, p. 2.

[41] Christopher, *Domiciliary Family Planning Services*.

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Medical Journal in 1972, Christopher mentioned that 'fecklessness' was not the main reason why couples did not use contraception. Instead, it was often because

> some couples found the cap messy to use, the sheath interferes with the spontaneity of the sex act, the newspaper reports of deaths on the pill have done much harm in creating unnecessary anxiety in just those couples least able to evaluate the risks associated with taking the pill. The I.U.D. often results in heavier periods which poorly motivated women refuse to tolerate.[42]

Other women did not attend the clinic because they were 'stranded at home with small children or uncooperative husband or partner or found medical attitudes and explanations off-putting'.[43] Some found it difficult 'to plan ahead and just live from day to day, unwanted pregnancies being part of the general chaos of their life'.[44] In addition, she also identified a small 'difficult' group of families in which having babies appeared to be their 'raison d'être'.[45] She also pointed out that in Haringey special problems existed since 'there is a large immigrant population, mostly West Indian, Irish and Greek Cypriot, with differing cultures which have to be taken into account when birth control advice is given'.[46] However, Christopher did not expand on how she considered different cultures. These excerpts indicate that class and race were central elements in identifying those in need of DFPS.

Wilson suggested that the DFPS offered a 'completely "patient orientated" service', as well as a 'non-authoritarian' and 'non-critical' approach, with rapid and flexible action, continuity of staff, and routine follow-up appointments which ensured that the work was effective.[47] According to Wilson, 'the rejection of an authoritarian approach to these inherently unreliable patients and the acceptance of virtually any behaviour by them without criticism, is a testing process'.[48] Some similar arguments were made by Christopher who stated that domiciliary services provided a continuity of personnel since it was believed that a 'supportive relationship had to be fostered if the patient was to adopt some contraceptive method and continue to use it reliably'.[49]

Yet, in spite of the claim that a 'non-critical approach' was adopted, Wilson categorized the patients into twelve groupings which included 'high parity mothers', 'mothers with marital problems', 'inadequate mothers', 'mentally defective women and girls', 'physically handicapped women', 'young promiscuous girls', and 'the less competent of the "professionals"'.[50] These groupings

[42] Elphis Christopher, 'Domiciliary Family Planning Services', *British Medical Journal*, 1, 5800 (1972), p. 629.
[43] Ibid.
[44] Ibid.
[45] Ibid.
[46] Ibid.
[47] Report on Domiciliary Family Planning in Glasgow, Mar. 1977, p. 3.
[48] Ibid., p. 6.
[49] Christopher, *Domiciliary Family Planning Services.*
[50] Ibid., p. 4.

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effectively 'othered' patients of the service into distinct categories that shed light on who Wilson deemed to be unsuitable to have children, predominantly poor women. Moreover, the inclusion of women who were deemed to be 'mentally ill' or 'mentally defective' illustrates the persistence of eugenic concerns around such individuals which emerged in the early twentieth century.[51]

In both Glasgow and Haringey, the DFPS functioned thanks to referral by other social agencies, such as health visitors, social workers, hospitals, and GPs. The domiciliary doctor visited the patient at their home to give them advice on contraception. In Haringey, Christopher explained that a medical obstetric and contraceptive history was taken together with 'an attempt to identify past and present barriers to contraception and to assess the degree of motivation. An attempt was also made to assess the quality and stability of the relationship and attitude towards children and sex.'[52] This visit, which could last up to one hour, was a norm-producing conversation where doctors and nurses assessed the degree of sexual 'responsibility' of the patient, in other words the patient's ability and willingness to use a contraceptive method systematically. A contraceptive method was then chosen and the patient's GP was notified.[53]

The Glasgow DFPS report from February 1970 to January 1971 provides detailed information on the clients of the service and attitudes of the medical staff towards them, shedding light on the way through which contraceptive prescription was stratified along the line of class. Of the patients accepting advice, the youngest was 18 and the oldest was 42, with the mean age of the group 30. Most clients were between the ages of 26 and 35. 26 were Protestant, 23 were Catholic, and 1 was Muslim. In the first year of the service's work, 60 women were referred and of these 59 were visited and contacted by 1 January 1971. 50 of these 59 women were stated as 'accepting advice', '49 acting on advice', with a further 1 noted under 'discussions still taking place', 3 'not requiring advice', 2 'attending general practitioner', and 1 'attending Brook Advisory Centre'. 6 clients were listed as 'refusing advice', because one member of the couple wanted further children, the 'wife was severely retarded', or because the 'couple wish to continue coitus interruptus'. The clients who refused advice were described in harsh terms. Two of the women were described as 'educationally sub-normal, refused help', while another was described as 'mentally defective and cannot care properly for the three

[51] For example, see Mathew Thomson's work on discussions around the 1913 Mental Deficiency Act in Britain and Erika Dyck's study of the aggressive sterilization policy in Alberta, Canada. Thomson, *The problem of mental deficiency*; and Erika Dyck, *Facing eugenics: reproduction, sterilization and the politics of choice* (Toronto, 2013). On the US, see Paul A. Lombardo, ed., *A century of eugenics in America: from the Indiana experiment to the human genome era* (Bloomington, IN, 2011); Randall Hansen and Desmond King, *Sterilized by the state: eugenics, race, and the population scare in twentieth-century North America* (Cambridge, 2013). On forced sterilizations and eugenics in Europe, see Véronique Mottier, 'Eugenics and the state: policy-making in comparative perspective', in Alison Bashford and Philippa Levine, eds., *The Oxford handbook of the history of eugenics* (Oxford, 2010), pp. 134–53.

[52] Christopher, Kellaher, and von Kock, *A survey*.

[53] Report on Domiciliary Family Planning in Glasgow, Mar. 1977, p. 7.

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children she has'. Two other cases were described of two husbands who 'refused to allow their wives to use any form of contraception'. A final woman was described as

> living with a reformed alcoholic much older than herself. She became almost hysterical when the subject of further pregnancies was raised and she said, 'I'm no having any of that an' I'm no having any mair weans neither.' She was already attending the local authority clinic with her baby and further attempts by the doctor there to advise on family planning were also hysterically refused. The consort was provided with sheaths. Whether he uses them or not, she has not so far become pregnant.[54]

The report stated that only eight women were not married to the man they were living with while two 'had never been married although they had eight children between them' and the others were separated or divorced. This included 'a girl of twenty-two, who had had nine children (including two sets of twins), had married at sixteen when she was pregnant for the second time and divorced her husband two years later. Almost immediately she remarried him and then left him for the second time to co-habit with her present partner'.[55] The report also commented on 'household management' describing 15 of the households as 'adequate', 23 as 'poor' and 12 as 'indescribable', with these families living in conditions 'of such squalor, filth and deprivation that they would not be tolerated for any animal except perhaps the rats which flourish in them'.[56] This again highlights classist prejudices and judgement. The report also described associated problems that these families experienced including disease, debt, alcohol abuse, and issues with the law. It provided statistics on the rate of pregnancy among the group of women and discussion of their health issues. Notably, the mental health and intelligence of mothers was also commented on; 26 were deemed to be of 'reasonable intelligence', 18 'poor', 3 'educationally sub-normal' and 3 experiencing 'mental illness'.[57] This report suggests continuing anxieties around the idea of 'problem families'. In terms of the methods chosen, Wilson stated:

> The method was decided only after a full discussion with the patient and in more than half the cases, with her consort as well. The type of woman referred to our service is particularly likely to have many preconceived ideas about contraceptive methods, mostly erroneous, and deeply rooted in sexual taboos which it is unlikely she can verbalise clearly. Stories told by her relatives and acquaintances are as likely to make as deep an impression as reasoned information.[58]

[54] Family Planning Association West of Scotland Branch: Domiciliary Service Report, Feb. 1970 – Jan. 1971, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/3/18].
[55] Ibid.
[56] Ibid.
[57] Ibid.
[58] Ibid.

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This account clearly illustrates Wilson's views that her patients were uninformed, uneducated, and inarticulate.

In Haringey, the report covering the years 1968–75 presented a detailed study of 1,300 women referred to the DFPS. In the first few years of the service, women over 30 years were more commonly referred than were teenagers or women in their early twenties. Between 1968 and 1975, the proportion of women aged over 26 when referred had fallen from 60 per cent to 30 per cent. The percentage of women aged 17–19 increased from 12 per cent in 1968 to 26 per cent in 1975. The proportion of patients from different ethnicities was stable over the years: 39 per cent were English/Scottish/Welsh against 85.6 per cent in all Haringey; 36.6 per cent were West Indian against 4 per cent in all Haringey; 11.2 per cent were Irish, against 3 per cent; 5.2 per cent originated from Cyprus, Greek Cyprus, and Turkey against 5 per cent in all Haringey and 2.2 per cent were Indian/Pakistani against 1.6 per cent in all Haringey. As these statistics show, women from ethnic minorities were referred to the DFPS in higher numbers than English, Scottish, or Welsh women. In addition, the focus shifted from 'problem families' to young women from ethnic minorities. Christopher speculated and tried to justify the higher proportion of 'non-indigenous women'. Reasons given for this situation ranged from language issues which prevented patients from attending FPA clinics, religious attitudes especially from the Catholic Irish who might be afraid or embarrassed to attend a clinic publicly, since it was an expression of the acceptance of the idea of contraception. For West Indian women, Christopher explained that

> partly due to cultural attitude and socio-economic circumstances the West Indian girls conceive at earlier ages than other groups. They are more likely to be unmarried and have two or more fathers for their children. As a result of often unstable unions, they are at risk of unwanted pregnancies. The older West Indian women often adhere to cultural and religious patterns observed in the West Indies where contraception may not be seen as an integral part of a sexual relationship. They consequently have larger families that they may intend or want.[59]

The two groups were referred in greater numbers since their motivation to use contraception was said to be weak or mixed. This excerpt shows that, for Christopher, being married and having wanted children through the use of contraception were central to responsible sexual behaviours.

In the period before the introduction of Depo-Provera through the Glasgow DFPS, it was reported that oral contraception (34) was the most popular form of contraception, followed by IUD (11), female sterilization (8), condoms (2), rhythm method (1), and vasectomy (1). Of these, 1 couple were using condoms prior to the wife being sterilized, 4 women were using the pill before sterilization, and 2 had to change to other methods because they were unable to remember to take the pill. 2 women who were fitted with IUDs were awaiting sterilization. The condom was viewed as the 'cheapest method' while the rhythm

[59] Christopher, Kellaher, and Kock, *A survey*, p. 74.

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method was classed as the most expensive because of 'unintelligent patients requiring monthly visits in first year'.[60] In the case of a 17-year-old homeless woman who Wilson encountered in the Gorbals in 1971 and described as

> wretched Janey, it was before Depo-Provera was available and she had an IUD fitted. It was not the ideal method because of the risks associated with infection especially if she went back on the streets, but we both knew she would never remember to take a pill every night. Some of the other women in the refuge were kindly enough and did their best to keep an eye on her but I felt Janey was one of life's born losers.[61]

This harsh statement shows that despite the risk of infection, Wilson decided on a potentially dangerous method of birth control for a young woman that she deemed sexually irresponsible.

In the report on the Glasgow DFPS for 1973 it was stated that there had been an increase in numbers for the whole Glasgow area. In Glasgow North, under the remit of Wilson, Sisters Wallace, Irvine, Macnaughton, and Holroyd, 208 people had been referred to the service in 1973, compared to 141 in 1972, 107 in 1971, and 57 in 1970. Of these, 123 were given oral contraception, 22 were sterilized, 52 were given an IUD (41 of which were in the patient's home), 6 condoms, 5 rhythm method, and 5 vasectomy. A DFPS was established in Glasgow South at the end of 1972, with 36 referrals in 1973, and a similar statistical breakdown in terms of the methods of contraception prescribed.[62] The communities targeted by the Glasgow DFPS tended to be socially disadvantaged and vulnerable and included the tenants of stigmatized council housing schemes such as Blackhill and Ferguslie Park, in Paisley, a town a few miles west of Glasgow.[63] Ferguslie Park, for example, was described in a 1975 report by Paisley Community Development in the following way: 'The scheme is well known as the least attractive in Paisley and its stigmatisation by outsiders is very real.'[64] Blackhill had a high proportion of tenants of Irish Catholic descent while most of the families originally housed in Ferguslie Park had come from the slums in the centre of the city and were '"the poorest" and had the largest families, features associated with Catholicism'.[65]

In Haringey, the methods adopted were affected by marital status and ethnicity. The unmarried tended to choose the pill, followed by the IUD. The married chose the pill, IUD, sheath, and sterilization in somewhat similar proportions – 36 per cent, 17 per cent, 22 per cent, and 21 per cent.

[60] Family Planning Association West of Scotland Branch: Domiciliary Service Report, Feb. 1970 – Jan. 1971.

[61] Libby Wilson, *Sex on the rates: memoirs of a family planning doctor* (London, 2004), p. 149.

[62] Ibid.

[63] For an overview of the history of Glasgow's council housing schemes, see Sean Damer, *Scheming: a social history of Glasgow council housing, 1919–1956* (Edinburgh, 2018).

[64] *A profile of Ferguslie Park* (Paisley Community Development, 1975), p. 2, accessed online via: https://indianamemory.contentdm.oclc.org/digital/collection/CDP/id/3971/rec/1.

[65] Ibid., p. 82; and W. J. McKechin, *Politics: Paisley pattern* (London, 1969), pp. 21–2, cited in Hughes, *Gender and political identities in Scotland*, p. 71.

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The IUDs and female sterilization were popular with West Indians according to Christopher.[66] Half of the women sterilized were West Indian. These numbers reflect some concerns expressed by Black feminists that sterilization and abortions were especially encouraged amongst West Indians.[67] While there was no reason given for explaining the high rate of sterilization amongst West Indians, one can nevertheless hypothesize that this number reflected an inclination from the doctor or nurses to privilege this option amongst others for West Indians, presumably based on racial prejudices about their inability to use other less radical methods. Here again, this example shows the stratification of contraceptive prescription where specific forms of contraceptive were prescribed to groups of women to prevent their fertility.

The 'cost-effectiveness' of the DFPS was clearly of importance to Wilson. The service claimed to have prevented approximately 16 pregnancies in its first year of work and that none of the patients who had accepted their advice had become pregnant. It was estimated that, thanks to the DFPS, £25,000 had been saved to the tax-payer.[68]

In a 1974 letter to Dr G. D. Forwell, chief administrative medical officer of Greater Glasgow Health Board, Wilson wrote:

> I do not think there is any doubt that it has prevented several hundred unpropitious pregnancies in the most deprived section of the community. This has increased well-being or at least stopped deterioration in over 500 families and has saved the City of Glasgow and taxpayers a great deal of money.[69]

In 1977, Dr Wilson wrote to the chief administrative medical officer, Dr G. D. Farrell, to request more staff to supply the demand of the clinic. According to Wilson, there had been an increase in referral rates because of the 'growing appreciation by health visitors of the domiciliary service's functions'. She felt that it was unlikely that the increase in the case-load would slow down in the near future and 'it is a great anxiety to us that now the domiciliary service is capable of making some impact, the present stringencies facing the NHS should hinder the work we are doing'.[70]

III

While the CSM officially approved Depo-Provera for short-term use from 1976, in Glasgow experiments with the drug were conducted earlier. In 1973, Dr Elizabeth Wilson conducted the first clinical trial on the acceptability of Depo-Provera. Following a trip to Hong Kong in the early 1970s, Wilson became

[66] Christopher, *Domiciliary Family Planning Services.*

[67] Valerie Amos and Pratibha Parmar, 'Challenging imperial feminism', *Feminist Review*, 17 (1984), p. 13; Dadzie, Bryan, and Scafe, *The heart of the race*.

[68] Family Planning Association West of Scotland Branch: Domiciliary Service Report, Feb. 1970 – Jan. 1971.

[69] Letter from E. Wilson to G. D. Forwell, dated 6 Mar. 1974, Glasgow, Mitchell Library, FPA Scotland Archive [12/FAM/PLAN/0/Vol1].

[70] Letter from Dr E. Wilson to Dr G. D. Farrell, dated 1 Apr. 1977, Glasgow, Mitchell Library, FPA Scotland Archive [12/FAM/PLAN/Vol3].

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acquainted with Depo-Provera and recognized its potential for use among disadvantaged women in Glasgow.[71] She got in touch with two gynaecologists at the Glasgow hospital who provided her with the medicine which was at that time used to treat cancer.[72] The dosage seemed to have been much higher (200) than the one later recommended by the CSM (150). Wilson used patients from the DFPS to test the drug.[73] In an article on this trial published in the *British Medical Journal* in 1976, Wilson referred to the way she chose her sample: 'Unemployment, debt, imprisonment, truancy, homelessness, alcoholism, wife and child abuse, and degrading poverty were common factors in the lives of those referred.'[74] She clearly explained that the method was well-suited for 'promiscuous girls', 'psychiatric patients', and 'retarded patients'.[75] In an interview in the *Guardian* in 1985, Wilson defended her use of Depo-Provera in Glasgow, stating:

> frankly many simply have a lifestyle which seems to make it impossible for them to remember to take the pill. You give them a pack of pills and when you go back and examine it, it looks like a drunken woodpecker's breakfast with random holes punched. Or else they've forgotten for a while and they've downed a handful at once.[76]

In her *British Medical Journal* article, Wilson also commented on patients' intelligence, stating that of the 162 patients in the trial, 'most were of below average intelligence but 47 were noticeably retarded. Many feeble-minded girls drift around urban ghettos from one temporary address to another. It is almost impossible to be a consistent pill-taker in these circumstances.'[77]

These remarks show two things: first, that Wilson had a moral framework in mind where she assessed patients based on the nature of their sexual responsibility to determine who were deemed in need of controlling and where biases around class and perceptions of low intelligence played a key role. If we apply the stratified reproduction framework here, it is evident that certain forms of contraceptive technology (such as the pill) were only viewed as appropriate for certain groups, namely those who behaved 'responsibly'. In this instance, responsibility meant systematic contraceptive use. Deprived families were considered 'irresponsible' since they had difficulties in using contraception regularly and therefore needed long-term contraceptive intervention such as Depo-Provera or sterilization. Second, it also showed that informed consent proved problematic and the bypassing of this idea by doctors who were

[71] 'Obituary: Elizabeth (Libby) Wilson, 1926–2016', p. 301.

[72] Wilson, *Sex on the rates*, p. 184.

[73] Elizabeth Wilson, 'Use of long-acting depot progestogen in domiciliary family planning', *British Medical Journal*, 2 (1976), pp. 1435–7, on p. 1435.

[74] Ibid.

[75] Ibid.

[76] Ruth Wishart, 'The injection of confidence: controversy over the contraceptive Depo-Provera', *Guardian*, 27 Feb. 1985.

[77] Wilson, 'Use of long-acting depot progesterone in domiciliary family planning', p. 1435.

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convinced of knowing what was in the best interest of their patients.[78] Wilson argued in her paper that Depo-Provera was a choice for the women she selected. But this assertion is challenged by one example in her memoir where she described an episode where she injected a 15-year-old girl, Jube, in the back of her car. Jube had received a first dose of Depo-Provera through the Glasgow DFPS. Jube was in Wilson's words the 'youngest of three sisters who earned their living on the street'. She was meant to have her second jab but did not turn up at the appointment. Wilson went to her home. Jube's sister opened the door and Wilson 'dispensed whatever contraceptives was appropriate but she said I had to find an excuse to see Jube on her own'. One of the sisters complained of feeling itchy around her genitals. Wilson explained that she took this pretext to ask Jube to accompany her to her car to give a cream for the infection. She got into the passenger seat and Wilson wrote, 'I duly gave the injection into her thigh before she jumped out of the car.'[79] Here, Wilson seems to have tricked Jube. Moreover, the fact that Wilson chose women said to be 'disabled', 'below average intelligence', and 'psychotic' clearly indicates that these patients might not have been able to give their consent. Some might not have understood the potential of adverse side effects, and it seems that Wilson only warned them about not having their period again but did not mention other potential adverse effects. Second, due to the unbalanced power relationship between the doctor and the patient, some might not have felt able to oppose their involvement. Based on the trial where 162 patients were involved, Wilson convinced other family planning clinics in Glasgow to recommend the method.

At a meeting in April 1977, Dr Wilson reported that she had written to Dr Michael Smith, chief medical advisor to the FPA to ask him to authorize the use of Depo-Provera in the family planning clinic since it was 'a good contraceptive for some people (not only domiciliary cases)'.[80] At a meeting in September, 1977, a letter from Dr Smith was circulated to the committee which stated that the FPA 'could not endorse its use in Clinic patients until a long term licence had been granted by the CSM'.[81] At the meeting, Dr Wilson commented that Depo-Provera 'was used widely in the Domiciliary Service'.[82] However, she had evidently been using the drug on women in the DFPS without it having received a long-term licence regarding safety. At a subsequent meeting the following month, an amendment was added to the minutes to read 'The committee felt that the decision whether to use it [Depo-Provera] or not should be left to the individual doctor's clinical

[78] On the tension between informed consent and the prescription of Depo-Provera, see Caroline Rusterholz, 'Depo-Provera and medical controversies in Britain', in Nils Kessel, Joseph Gabriel, and David Herzberg, eds., *Risk and benefit: stories from the borderlands of medicines and illegal drugs in 20th century North America and Western Europe*, forthcoming.

[79] Wilson, *Sex on the rates*, p. 187.

[80] Minutes of the Family Planning Medical Committee meeting, Thursday 21 Apr. 1977, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/3/5].

[81] Minutes of the Family Planning Medical Committee meeting, 8 Sept. 1977, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/3/5].

[82] Ibid.

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judgement.'[83] At a Doctors' meeting of the Greater Glasgow Health Board Eastern District Family Planning Service, obstetrician and gynaecologist and professor at Glasgow University Malcolm Campbell Macnaughton stated that they were 'prepared to "back up" any Doctor giving depo-provera in the best interest of the patient (as a method of contraception)'.[84] A memorandum produced by the Greater Glasgow Health Board Eastern District Family Planning Services also reiterated some of these ideas, stating 'In spite of the recent adverse publicity Depo-Provera has had in the current press, the use of it is still important to certain patients who "can't or won't" use other methods of contraception. Its use should be reserved for this group and not used indiscriminately.'[85] The memorandum further stated that 'the patient should be warned of menstrual irregularities and I enclose Forms (3) which could be given to patient...If the patient is worried re amenorrhoea, reassurance is usually all that is required and P.D.T., if particularly anxious.'[86] In her memoir, Wilson wrote that Depo-Provera often resulted in women's periods stopping completely and that this often caused anxiety for users unless they were warned about it, because 'if the blood is bad it must obviously be got rid of, otherwise it will poison the body and cause all manner of unpleasant consequences. These beliefs were held as strongly in West Africa as they were in the deprived populations of Glasgow.'[87] This remark testifies to the othering process taking place whereby socially deprived women in Glasgow were compared in a racist way with women in West Africa.

The nurses employed in the DFPS carried out home visits referred by Dr Wilson. In 1982, the Greater Glasgow Health Board decided to discuss ways of 'regularising the dispensing of drugs by nurses which have not already been prescribed in writing by a doctor'. On the advice of Dr Wilson, it was agreed that in future, and 'in order to comply with the law and at the same time, to ensure that every patient will be able to receive appropriate therapy at the time she needs it', each patient would have a prescription sheet inserted into her notes. The doctor was to 'sign the prescription for Depo Provera 250 mgs. X 4 and one year's supply of all oral contraceptive pills. Please sign and date the bottom of the column for 1983.'[88] This essentially meant that Depo-Provera or the pill could be readily prescribed.

It is unclear if wider concerns were raised in Glasgow around the prescribing of Depo-Provera to women through the DFPS. In her memoir, Wilson wrote of an encounter with a priest, Father Jacinelli from St Philomena's in Blackhill. As mentioned earlier, Blackhill was a housing scheme in Glasgow built under

[83] Minutes of the Family Planning Medical Committee meeting, 27 Oct. 1977, Glasgow, Mitchell Library, FPA Scotland Archive [HB77/3/5].

[84] Greater Glasgow Health Board, Eastern District, Family Planning Service, Minutes of Doctors' meeting, dated 22 Jan. 1980, Glasgow, Mitchell Library, FPA Scotland Archive [HB45/8/3].

[85] Family Planning Procedures, undated, but likely 1980, Greater Glasgow Health Board, Eastern District, Family Planning Service, Glasgow, Mitchell Library, FPA Scotland Archive [HB45/8/3].

[86] Ibid.

[87] Wilson, *Sex on the rates*, p. 185.

[88] Letter from Greater Glasgow Health Board to District Nursing Officers, Greater Glasgow Health Board, dated 22 Dec. 1982, Glasgow, Mitchell Library, FPA Scotland Archive [HB 55/4/111].

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the provisions of the 1935 Housing Act which was aimed specifically at slum clearance.[89] It had a high Irish Catholic population. As Sean Damer has argued, by the 1950s Blackhill 'had a city-wide reputation which could only be described as pernicious. It was without doubt the most stigmatised housing scheme I had ever encountered.'[90] Wilson recalled Father Jacinelli phoned her at 10.15pm at home stating, 'I want to know what business you have in using my parishioners as guinea pigs.' Jacinelli went on to state that Wilson had been 'giving experimental injections paid for by a drug company to these vulnerable women'. Wilson met Jacinelli the following day and explained to him that 'far from using his parishioners as experimental fodder to obtain results that could be used to promote this new contraceptive in the third world as he had suggested, I had seen it used in the Far East and wanted my patients in Glasgow to benefit from it'. While Wilson felt that their relationship had thawed by the time she left, Jacinelli stated that he could not agree with what she was doing but respected her motives for doing it.[91] It appears that that some women's health activists were also concerned about the prescription of Depo-Provera to marginalized communities, such as the women of Ferguslie Park in Glasgow, one of the areas where Wilson prescribed Depo-Provera, and which also had a high Catholic population. In an interview for the British Library Sisterhood and After project, Rowena Arshad, who worked for Scottish Education and Action for Development, stated:

> I can remember very clearly being sent to work in Ferguslie Park, which is a very poor area in Scotland, very very poor, and learning there that the women had been given Depo-Provera, which was a contraception drug at that time, and thinking, hey, hang on a minute, women in India are being given this as well. Hm, this is very curious. And then realising of course that the drug was being used to control women who society deemed to be irresponsible, shouldn't be having children et cetera.[92]

When Arshad raised this with the women she worked with in Ferguslie Park, she explained that 'they were just angered, really angered to know this. But it was so good, because they were in solidarity with the women in India, and they were saying, "Why should the women in India be treated like that? We shouldn't be treated, they shouldn't be treated like that."'[93] Similarly, in 1985, Patricia Moran, a community education officer in Glasgow, wrote to Libby Wilson to request information about Depo-Provera. Moran's letter does not survive in the archive but judging from Wilson's response, she clearly had several concerns around the drug. In her reply, Wilson assured Moran that Depo-Provera was suitable for 'any woman who wishes to use it and

[89] Damer, *Scheming: a social history of Glasgow council housing*, pp. 73–102.
[90] Ibid., p. 98.
[91] Wilson, *Sex on the rates*, pp. 189–90.
[92] Interview with Rowena Arshad, Sisterhood and After Project, accessed 8 June 2023: www.bl.uk/collection-items/rowena-arshad-contraception-and-controlling-poor-womens-bodies.
[93] Ibid.

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has no medical contraindications. The type of women who choose it are usually those who find they cannot remember to take the pill and some who like not having periods (eg air stewardesses).' Wilson wrote that women who choose the method were given an information sheet to read before the first injection was given. Wilson wrote:

> It is very effective (safe). If you mean 'safe' in reference to harmful side effects it is remarkably free from these as far as we know at present. It has no effect on blood clotting and therefore, unlike the combined pill, can be used by older women and those who smoke without the risk of heart attacks or strokes. No connection with cancer has been demonstrated but long term studies on a very big scale are being planned throughout the UK to elucidate this.[94]

In addition, in her memoir Wilson compared the refusal of the Department of Health to issue a licence for Depo-Provera in 1982 with the Dalkon Shield tragedy stating

> it was a re-run of the Dalkon Shield story, a mishmash of distorted science, scare stories and accusations of racial abuse. A much-publicised version of a pseudoscientific paper purported to prove that it caused cancer, resulted in permanent infertility and caused birth defects. It was also said that white male doctors were forcing black women in Haarlem [sic] to have the injection against their will.[95]

In 1977, Dr Elphis Christopher also started to use Depo-Provera through the Haringey DFPS following the reading of Wilson's 1976 article in the *British Medical Journal*. Christopher's preliminary research convinced her that this method would be appropriate for a small number of her patients and that it was harmless. She justified this decision based on the freedom of a doctor to decide what is in the best interest of the patient. She stressed that the ruling of the CSM was not mandatory, the 'responsibility then rests with the doctor to use the drug with due care'.[96] According to Christopher, there existed no perfect method of contraception and some people were relatively satisfied with existing methods while others had troubles with every method but were 'not ready for the finality of being sterilised'.[97] For this group, another method was essential, she affirmed. She found Depo-Provera to be a 'very useful method' and she believed that it had brought 'peace of mind to many of the women to whom [she] had given it who would have been at risk of unintended and unwanted pregnancy'. Christopher claimed to have prescribed the method

[94] Letter from E. Wilson to Patricia Moran, dated 6 Nov. 1985, Glasgow, Mitchell Library, FPA Scotland Archive [HB55 REG/12/FAM/PLAN/O/VOL4].

[95] Wilson, *Sex on the rates*, p. 190.

[96] Elphis Christopher, Depo Provera, 1980, London, WL, SA/FPA/C/G/8/3.

[97] Depo Provera, Statement to the panel by Dr Elphis Christopher, Public Hearing on Depo Provera, London, WL, SA/FPA/C/G/8/3.

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in two situations only: when the woman actually requested it and knew something about it, and when the woman had tried the other methods and was unhappy about them. In the former case, the CSM's recommendations were not followed. Indeed, in 1982, the CSM recommended the long-term use of DP as a contraceptive for use only in women for whom other contraceptives were contraindicated or had caused unacceptable side effects or when other methods were unsatisfactory.[98] This was not the case for women who asked for the method.

Christopher mentioned that she had prescribed the method to 'women whose partners have thrown away their pill or insisted they had their coils removed'. She also used it with women who wanted a '100% effective method, did not want to be sterilised and had deep vein thrombosis with the Pill'. She tended to prescribe this method to women who had proven their fertility, because of the controversy surrounding the drug but this was not always the case, as exemplified earlier since the demographics of the DFPS became younger in the late 1970s. She explained that she had not prescribed the drug as a routine method but when she used it, she counselled the woman carefully, as she did with other methods she explained. She seemed to have warned women of potential side effects, such as irregular bleeding, amenorrhea, and slight weight gain. No mention was made of headache, loss of libido, or depression. She also warned clients that it may take six months to a year to regain their fecundity after stopping the method. She also told them that there was no clear evidence that the drug produced cancer.[99]

In 1979, 116 women in Haringey had used Depo-Provera; 53 Depo-Provera patients were West Indian compared to 49 British and 4 Irish and 8 from India and Pakistan. 46 were current users while 70 were past users. Of the 46 current users in 1979, 19 were single West Indian women compared to 9 single British women. Christopher reckoned that the discontinuation rate for this method was much higher than for other methods and she attributed this situation to the fact that women who were prescribed Depo-Provera 'may be less motivated to use contraception or family planning at all, the adverse publicity generating anxiety and fear and the side effects'.[100] These remarks are interesting since they did show that women who were prescribed Depo-Provera were 'less motivated to use contraception'. In addition, one might wonder the extent to which these women were 'encouraged' not to say 'forced' to use the method, questioning the notion that women made informed decisions. As well as this, the discontinuation rate indicated that many women experienced side effects, more so at least than with other methods since so many of them discontinued its use, challenging the assertion that the method was harmless. Christopher also suggested that women who had stopped using Depo-Provera because of side effects have often done so because of certain

[98] CSM advice to licensing authority, 1982, in Depo-Provera, Hearing under Section 21 Medicines Act 1968, Preliminary Statement.

[99] Depo Provera, Statement to the panel by Dr Elphis Christopher.

[100] Elphis Christopher, 'The Haringey Domiciliary Family Planning Services 1968–79', in SA/FPA/C/E/16/4/4.

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'cultural myths. These have to do with the idea that a good menstrual flow is needed to clear the system and prevent headaches (this is seen particularly amongst West Indian women).'[101] She also stated that adverse publicity, rumours, and old wives' tales may result in bizarre side effects. These remarks once again hinted at the doctors' perceived irrationality of their patients.

Yet, in contrast to the dismissive tone adopted by Wilson, Christopher appeared to have been more cautious in the way she justified the use of Depo-Provera, being aware of the criticism made against the method and paying particular attention to counter accusations of abuse and racism. Indeed, in a report on the DFPS in Haringey in 1979, Christopher explained that this type of work had been the object of scrutiny and ongoing criticism. In particular, some criticism had been raised in connection with what she termed a 'eugenic fear, i.e. that domiciliary services exist to prevent poor people breeding'.[102] This fear, she went on, prevented some workers from referring women for family planning help. While aware of this criticism, Christopher seemed to be more concerned about the detrimental impact this criticism had on the referring system, rather than trying to counter this eugenics argument.

In another report dated from 1980, Christopher mentioned that there had existed instances where Depo-Provera was prescribed without 'adequate explanation'.[103] She referred to a study of 200 women conducted by Dr Wendy Savage at the London Hospital in Mile End and Whitechapel in 1978 which found that a disproportionately large number of Asian women were being prescribed the drug rather than other forms of contraception and without being informed about the side effects.[104] Christopher mentioned this same incident in a 1982 article, in which she explained that the medical profession cannot 'support such a cavalier use of drugs, particularly on healthy women'. However, she tried to temper down accusation by explaining that 'we are all aware that poor communication exists between doctors and patients, not always due to language difficulties or neglect but often the result of having to convey scientific evidence in such a way that will not terrify the patient'.[105] This assertion implicitly justified the withdrawal of information to patients.

As Lambert has shown, the Campaign Against Depo-Provera utilized a framework of anti-imperialism to situate the drug 'within a narrative of abhorrent racism'.[106] Christopher was aware of this campaign and in a report on the Haringey DFPS, she stressed that 'describing problems amongst ethnic groups may lead to accusation of racial prejudices. However, failure to do so may lead to unnecessary suffering.'[107] She also argued that more West Indian girls referred themselves to the service than any other groups, usually on a friend's recommendation, showing that this was an acceptable way of receiving family

[101] Ibid.
[102] Ibid.
[103] Christopher, Depo Provera, 1980.
[104] Wendy Savage, 'The use of Depo-Provera in East London', *Fertility and Contraception*, 2 (1978), p. 41.
[105] Elphis Christoper, 'Depo Provera', *Socialism and Health*, March–April 1982, p. 1.
[106] Lambert, '"The objectionable injective"', p. 532.
[107] Christopher, 'The Haringey Domiciliary Family Planning Services 1968–79'.

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planning help.[108] While these statements showed that Christopher was aware of the criticisms expressed around the high percentage of young West Indians seen by the service, she nevertheless prescribed Depo-Provera to them in higher numbers. She also took care to emphasize the responsibility of the doctor in ensuring that women were 'counselled and free to make their own choice once the pros and cons of each method has been put to them'.[109] In her statement to the public hearing, Christopher concluded that 'I feel very strongly that doctors should continue to have professional freedom to exercise their discretion in prescribing drugs.'[110]

IV

This article has attempted to sketch the history of the contraceptive injection Depo-Provera through a focus on two case-studies. In doing so, we hope to have contributed to the wider, global history of Depo-Provera, and illustrated how racist, classist, and ableist prejudices could shape family planning services in the British context. As these two examples have shown, despite the restricted status of Depo-Provera in 1976, it is evident that some doctors were prescribing the drug in other instances than those recommended by the Committee of Safety of Medicines, and for more than three months. In the cases of both Wilson and Christopher, the freedom of clinical judgement was invoked. Our article has illustrated that vulnerable women in both Haringey and Glasgow were the key targets of DFPS. In both contexts, these women were considered sexually 'irresponsible', their fertility was deemed problematic, and derogatory language was used to describe them in the reports of the services. More research is needed to integrate the voices and testimonies of women who were prescribed Depo-Provera in this period; we hope in future to conduct oral histories which might help to address this gap and reinstate these women's voices.

In addition, these comparative case-studies illuminate how doctors othered women who they deemed unsuited to having children; in the Glasgow case-study, this othering process relied on classist prejudices and included women with mental health issues, 'inadequate' mothers, disabled women, women with 'marital problems', and 'young promiscuous girls', highlighting the continuities of early twentieth-century eugenic ideas in Wilson's prejudices and the persistence of anxieties around 'problem families'. In the case of Haringey, race was a central marker and women of colour were the most affected. Moreover, applying the stratified reproduction framework here shows the importance of an intersectional approach to contraceptive prescription in 1970s Britain and illustrates how race, class, and disability could impact on the type of contraceptives deemed appropriate for different demographics. While Christopher was more cautious in the way she described the method and more receptive to criticisms voiced against Depo-Provera, the higher incidence

[108] Ibid.
[109] Ibid.
[110] Depo Provera, Statement to the panel by Dr Elphis Christopher.

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of its use in young women of colour might reflect some racist prejudices around these women's ability to use other types of contraception. In both contexts, the doctors utilized their clinical judgement and a claim that they were 'helping' these women to justify their actions. In some instances, the issue of consent is blurry, and it is unclear whether all women who were prescribed the drug were adequately informed or able to consent.

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