Divergent Rationalities and Contending Interests:

Public Health in Wellington County Townships, 1882-1900

by

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This thesis provides an overview of Ontario rural municipalities’ response to the province-wide application of the Public Health Act in 1882. It uses Wellington County townships’ experience during the years 1882 to 1900 as a case study to illuminate the factors informing resistance. The paper argues that the townships fashioned their own approach to public health that aligned with local interests and reflected their rural communities’ distinctive views about healthfulness. It identifies three key elements that shaped townships’ response: first, a belief that a rural lifestyle was inherently healthy and could best be preserved by thwarting the ills of urban living; second, a strong preference for minimal government interference in the private affairs of households and local businesses; third, a skeptical outlook toward the utility and efficacy of new medical concepts and health technologies until they were proven to be beneficial.
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I am deeply grateful for the privilege of having Dr. Catharine Wilson, Redelmeier Professor in Rural History, as my supervisor for master’s studies. From our first conversation, she offered warm support for my academic interests and generous access to her talents as a creative thinker, a disciplined scholar, and an inspiring writer and teacher. I appreciate her encouragement and sage guidance as they have been essential to my learning experience. My gratitude is also offered to Dr. Catherine Carstairs who also served on my committee and provided valued input that enhanced the quality of my research and the resulting paper. Dr. Tara Abraham and her graduate courses in “Health, Science, and Medicine” provided a significant platform for the emergence of my thesis topic. I am grateful for the excellent learning opportunities she provided. I also have gratitude for Professors Kevin James and Norman Smith who each contributed significantly to my journey as a master’s student. My thanks must also go to the administrative staff of the Department of History, including Michael Botterman and Audra Bolton, who provided encouragement and practical guidance along the way. I am very grateful, too, for each of my graduate student colleagues who provided stimulating and cheerful companionship on this academic journey.

The research for this paper could not have been accomplished without the resources and advice available from the excellent team of archivists headed by Karen Wagner at the Wellington County Museum and Archives. I am grateful for their supportive interest and appreciate the benefits provided by their knowledgeable guidance. My thanks are also extended to a person I never met but who has had a great influence on my graduate experience, William Sunter. William was a Scottish-born farmer who lived in Eramosa Township from about 1850 to 1917 and was a regular diarist for most of his adult life. Many of his diaries are held in the University of Guelph Archives and are among those posted on the University of Guelph’s Rural Diaries Archive website. At the time I was developing my thesis proposal on the history of public health in Ontario, I was reading William’s diaries for a research paper in rural history. It was then I made the chance discovery that he had served as Chairman of the Eramosa Township Board of Health during the 1890s. This serendipitous find became the deciding impetus for my thesis proposal and William’s experiences served as an inspiration for this paper.

My final heartfelt thanks are given to each of my friends and family who have been steadfast in their encouragement of my return to graduate studies and indulgent in giving ear to endless stories about public health in nineteenth century Wellington County. I would not have dared this adventure without them. For my son, Justin Michael, I give a special salute of gratitude for his love and unconditional support for this undertaking … as well as for so many others: B.A.T.S.
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CHAPTER 1 – INTRODUCTION

Today we speak frequently of the potential – both good and bad – of some of the new knowledge and understandings that have become pervasive over the past 20 years or so. Digital technologies and social media, bioinformatics and biological engineering, environmental science and climate change are just a few examples where the application of scientific breakthroughs taunt our imagination with the potential of both wonderful and sinister capacities. Those excited by the potential of these innovations offer praise for those who adapt quickly, celebrating the incorporation of new knowledge into assumptions and activities. At the same time, the champions of change can be swift to criticize reluctance to adopt new ideas and practices, falling short in their efforts to understand the resistors’ point of view. It is tempting to imagine that this kind of disconnect is a modern complexity. History demonstrates readily that this is not so.

This paper explores the response of Ontario’s rural municipalities to the introduction of provincial legislation designed to introduce new ideas and practices in public health. It covers the time period 1882 to 1900, years when innovations in the field of bacteriology were affecting public health in countries throughout Europe and North America. Ontario’s public health legislation of 1882, the Public Health Act (PHA)\(^1\), was a departure from its previous public health legislation that focused on epidemics.

\(^1\) “An Act to Make Further Provisions Respecting the Public Health, 1884 in Ontario Legislative Assembly, “Annual Reports of the Provincial Board of Health of Ontario being for the year 1883, Appendix A” in Sessional Papers of the Province of Ontario (Toronto: Ontario Legislative Assembly, 1884), p.41-63. See especially sections 46 and 49 of the Act. For the purpose of this paper, references to the Act will rely on the 1884 edition which made local boards of health mandatory. Where applicable, references to subsequent amendments are illuminated.
The PHA’s ambitious goal was not only the management of infectious disease but also the elimination of the causes of ill health and it specified structures, processes, and standards for public health that were to be applied across the province to achieve this objective.

This paper recounts the reluctance of Ontario’s rural municipalities to implement the PHA in the closing decades of the nineteenth century and then examines in more detail the experience of Wellington County townships during the period. It argues that, while the rural communities were provided with local control over public health in their municipalities, the structures, processes and standards embodied in the legislation were designed for urban settings, not farming communities. Consequently, Ontario’s rural jurisdictions fashioned their own approach to public health that aligned with local interests and reflected their communities’ distinctive views about healthfulness. They found approaches and methods to address sanitation nuisances and contagious disease risks that reflected local thinking about health and balanced competing public and private interests. In doing so, township boards of health increasingly engaged the advice of specialized experts, broadened the base of local authorities engaged in public health, and adapted public health structures and processes that were relevant for their rural community.

When the PHA was enacted, these rural municipalities were generally comfortable with the legislation, convinced that its primary focus would be on urban

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2 The equivalency of “rural” with “township” can be drawn from the distinctions made in categorizing submissions made to the Provincial Board of Health over the period under examination. Reports from local boards were grouped in the annual reports of the Provincial Board into 4 categories representing the various sizes of municipalities: cities, towns, villages and townships. Townships included the population living in farms and other rural areas and did not include those who resided in the province’s cities, towns and villages and represented municipalities of less than 4,000 inhabitants. Ontario, Board of Health Report for 1883, lv.
areas given the prevailing and wide-spread view that rural living was inherently healthful. Building from this premise, Ontario’s townships were unpersuaded of the need to extend any government authority that would entail intervention in the private affairs of its citizens – even if it might be for the good of all. Further, rural communities were wary of the utility and efficacy of many PHA provisions that were urban-oriented and based on scientific and medical ideas that were sometimes unreliable. By examining the experiences of Wellington County townships during the years 1882 to 1900 it can be illustrated that, despite their initial reluctance and the impatience of provincial authorities with the speed of progress, rural communities adapted the provincial frameworks for public health and gradually incorporated measures that suited their needs and priorities.

Few, if any, Ontario townships during the period 1882 to 1900 simply adopted the prescriptions of the Act as they were presented. Wellington County townships illustrate this and show how they adapted public health legislation to suit their communities’ needs. The evidence demonstrates that three key elements shaped their views about public health. First, a belief that a rural lifestyle was inherently healthy and could best be preserved by thwarting the ills of urban living. Second, a strong preference for minimal government interference in the private affairs of households and local businesses. Third, a skeptical outlook toward the utility and efficacy of new medical concepts and health technologies until they were proven to be beneficial.4 The

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3 The principle primary sources for this paper include minutes for many of the Wellington County township councils during the period in addition to board of health minutes and reports. In some instances, townships’ annual reports were available in PBH’s annual reports.

4 It is important to highlight that skepticism does not imply a steadfast resistance toward ideas outside of the mainstream on a perpetual basis. Rather, it points to doubtfulness about new ideas or methods which, if countered with experiences or evidence supporting their validity and reliability, may ease over time.
divergent rationalities and contending interests at play in Wellington County townships help illustrate the response of rural Ontario to the introduction of Ontario’s public health system.

**Historiography**

To date, most commentary about the history of public health in rural Ontario has relied on the records of provincial officials and commentators, most of whom were urban health professionals and dedicated advocates of the new medical sciences and technologies. An examination of the public health developments in rural Ontario over the last decades of the nineteenth century offers an alternative viewpoint. The observation by the public health authorities at the time, as well as by historical scholars since, is that the response of rural municipalities to the Act was lacklustre. This is a point of view offered consistently in most of the annual reports of the PBH during the early years of the Act.\(^5\) In the view of the PBH, townships’ lack of action was due to willful negligence on the part of stubborn, poorly educated, and doggedly frugal municipal councils.\(^6\)

An alternative and more nuanced appreciation of the experience emerges from Ontario townships’ reports submitted to the PBH. They reveal a different logic was applied to the province’s new public health policies. Use of a public policy lens to gain insight into historical points of view about health is not new and is supported by a

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\(^6\) Ontario Board of Health, *Annual Report of the Provincial Board of Health of Ontario, Being for the Year 1884*, Toronto, 1885, 14. Similar views of the Provincial Board of Health can also be found in various sections of other year’s *Annual Reports* including, for example, those for 1883 and 1888.
number of leading medical historians, among them Charles E. Rosenberg. He observed:

Policies on the ground seem less a coherent package of ideas and logically related practices than a layered conglomerate of stalemated battles, ad hoc alliances, and ideological gradients, more a cumulative sediment of negotiated cease-fires among powerful stake-holders than a self-conscious commitment to data-sanctioned goals. But policy outcomes are hardly random; they embody the divergent rationalities and strategies of contending interests.7

While stubbornness, frugality, and knowledge deficits may serve as descriptors of the townships’ lack of action, these words fail to reveal the underlying logic of their choices. Township records allow us to see their resistance as a disconnect between the vision of healthy communities promoted by urban-focused public health advocates and the one that was nurtured in the experience of rural communities. Townships’ responses to the new provincial public health policy reveal their divergent rationalities and opposing interests concerning sanitation and infectious disease, as well as the role for government in each.

As previously mentioned, to the degree historians have turned their attention to matters of health and health-care in this period, most focus on the urban experience or the application of provincial initiatives, as observed through the eyes of urbanites.8 In

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many ways, the emphasis on the urban experience in scholarly work for this period is understandable. The economic, social and political shifts underway in urban areas at this time were significant and represented unprecedented challenges. People connected problems from filthy conditions, crowding, and immoral behaviour with the growth of cities and supported a range of related reform initiatives. In matters of medicine and health, a new scientific mindset reflecting advances in bacteriology influenced public policy developments including public health measures addressing sanitation and disease control.

Various scholars have examined the emergence of public health initiatives in the United Kingdom, Europe and the United States. Most remain focused on the developments in urban areas although a few consider application of public health initiatives in rural settings. Each gives particular attention to the ways in which public


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health policies reflected enhanced regard for physicians and their role in health care, variations in the division of government authority between national and local jurisdictions, and shifts in assumptions about the factors affecting disease, especially as compared to the assumed healthfulness of rural populations. The enhanced regard for physicians and shifting assumptions about disease are themes that also emerge in this paper.

Overall, the urban focus has provided a limited amount of scholarly material depicting rural communities’ experience of public health. This is equally true for Ontario histories about medicine, health and public health policies. Most scholars focussed on the professionalization of physicians and its impact for other health practitioners or on the management of epidemics and disease.12 These studies describe the ascent of physicians’ influence in Ontario and the increasing willingness of the provincial government to apply legislative and/or bureaucratic measures to manage sanitation and disease outbreaks in a manner that left considerable authority in the hands of local authorities.13 The experiences of cities such as Toronto and Ottawa receive particular

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emphasis. In a few instances, such as David Naylor’s work on medical
professionalism,\textsuperscript{14} the perspectives of rural interests emerge. In his examination of the
early stages of provincial regulation for physicians, Naylor references the role of the
Patrons of Industry, a political advocacy group articulating rural perspectives, and a
group of rural physicians. These rural champions sought to restrain the influence of
urban physicians on provincial plans to increase self-regulation, modify professional
standards, and set minimum fee rates. Farmers feared their sons would be blocked
from medical careers by the changes proposed by urban doctors in each of these
areas.\textsuperscript{15}

Some of the histories about epidemics in late nineteenth-century Ontario also
describe outbreaks of cholera and smallpox in remote communities,\textsuperscript{16} the practices of
country physicians\textsuperscript{17} or the initial establishment of Ontario’s vaccine farm.\textsuperscript{18} Those
pertaining to epidemics in rural areas focus on the perspectives of provincial authorities,
highlighting criticism of rural areas for their lack of preparedness for disease outbreaks
and their reluctance to utilize local resources for measures (i.e., including vaccination)
that might thwart future epidemics. The studies offer limited insight into the perspectives
of the affected rural communities.

\textsuperscript{14} Naylor, “Rural Protest”, 5–20. Also of relevance: T. M. Romano, “Professional Identity and the
\textsuperscript{15} Further insight about the Patrons of Industry and tensions between urban and rural interests is found in
in Donald Swainson, ed., Oliver Mowat’s Ontario; Papers Presented to the Oliver Mowat Colloquium,
\textsuperscript{16} Craig, “State Medicine in Transition”; Craig, “Smallpox in Ontario”; Charles M. Godfrey, The Cholera
\textsuperscript{17} Jacalyn Duffin and J. A. Hannah, “A Rural Practice in Nineteenth-Century Ontario: The Continuing
\textsuperscript{18} Christopher J. Rutty, “Personality, Politics, and Canadian Public Health: The Origins of Connaught
Medical Research Laboratories, University of Toronto, 1888-1917,” in Essays in Honour of Michael Bliss:
Literature specific to the PHA is limited and, like the other medical and health-related histories, also carries an urban bias.\textsuperscript{19} It echoes the general themes noted, placing emphasis on the physician perspective and the views of the urban-led public health advocates who supported the introduction of the Act and led its implementation across the province. This paper’s focus on the response of Ontario’s rural jurisdictions to the PHA, with particular attention on the experience of townships in Wellington County, is offered as a partial antidote to this historical gap.

**Methodology**

The research concerning Wellington County townships in this paper depends on information gathered through a close reading of their municipal meeting records from the period 1882 to 1900, particularly township council and board of health minutes. Where Board of Health annual reports were not found in the municipal records, some gaps were filled by information in the yearly reports of the Provincial Board of Health (Appendix D). While the records were prepared with the practical goal to record township actions and use of municipal power, their careful review over a period of close to twenty years yields insight and information of value about the townships’ approach to public health. The underlying reasons for township decisions, if not stated explicitly, are frequently discernable from the context. In addition, sometimes supplementary records such as letters, reports or invoices were incorporated in the records that further illuminate rationales and interests at play.


Townships sometimes reproduced their board of health meeting records in the local paper as a means of letting citizens know of board activities. This may have skewed the emphasis of the meeting record or affected its level of detail and completeness. Overall, the consistency observed in record-keeping practices within a township suggests that the role of the meeting record for public communications did not overtake its importance as a record to document municipal decision-making. Often the same one or two people served as secretary to a township’s board of health throughout the period of this study, bringing a further level of consistency to the use of language and level of detail found in a health board’s meeting records. As the health board’s secretary was also clerk to the township council, this also provided an advantage in observing flow and connections between the business of health boards and their councils. This included continuity in references to individuals and cases over time. The persistence of a single secretary for municipal minutes also allowed significance to be attached to shifts in tone or expanded detail. Such variations suggested the matter described was likely worthy of deeper examination.

The dependence on township and board of health records also introduces limitations. While they give voice to the thinking and actions of rural communities, all of the records were prepared by men and primarily featured the decisions and activities of men. As government records, none allow insight about parallel contributions in sanitation or control of infectious disease that may have been underway through other community organizations such as churches, women’s groups, community service clubs, or other cultural organizations. The annual reports prepared by township BOHs and their health officials were sometimes written with the objective of demonstrating
effectiveness and progress, qualities that may have been overstated in an effort to bring lustre to the municipality and its governmental leaders. This was considered in assessing the information offered in these documents.

Wellington County is a reasonable focus for this case study. It is at the centre of Ontario’s western peninsula and, reaches across approximately 1,000 square miles (approximately 2600 km²) with the longest corner-to-corner distance of about 60 miles (approximately 100 km). With about 75% of its land considered suitable for cultivation, the County was decidedly agricultural. It had twelve townships and only one, Guelph Township, was directly adjacent to an urban centre, the City of Guelph with a population of about 12,000 in 1880s (Appendix A). Ontario’s largest urban jurisdictions (e.g., Toronto, Hamilton or Windsor) were a significant distance away in the context of travel possibilities at that time. The County benefitted from the presence of plentiful water supply available through underground springs and several rivers running through the county including the Speed, Eramosa and Grand. By the late nineteenth century, most of Wellington County was settled although some lands in the most northern and western sections (i.e., Arthur, Maryborough, Minto, Peel and West Luther) still required clearing or drainage to be of use for agriculture. Local governments in the County townships were preoccupied with using their limited tax resources for the development and maintenance of roadways, bridges and drainage projects necessary for their agricultural

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21 Wellington County townships included Arthur, Eramosa, Erin, Guelph, Maryborough, Minto, Nichol, Peel, Pilkington, Puslinch, West Garafraxa, and West Luther. Guelph Township wrapped around the City of Guelph but each was an independent municipality. There were a few villages nested in several townships that also had their own municipal governments (e.g., Clifford, Drayton, Erin Village, and Fergus). A number did not and were within township jurisdiction (e.g., Eden Mills, Belwood, Rockwood).
While the main transportation routes were improving and some areas began to benefit from railway access, getting around remained time-consuming and costly.

The limitations of Wellington County as an exemplar must also be acknowledged. Each of the province’s townships had its own geography, resources, economic and cultural considerations, community networks, and experiences with health and disease. Wellington County townships represented an area that was arable, close to being fully settled by immigrants or their offspring, and largely focussed on traditional agricultural activities. These were not features common to all Ontario townships, especially those in Ontario’s north which remained largely unsettled and preoccupied with activities such as mining, forestry and fishing.

Five chapters follow this introduction. The first provides the provincial context, overviewsing the emergence of Ontario’s 1882 public health legislation and rural municipalities’ responses. Three subsequent chapters examine the experiences of Wellington County townships during the years 1882 to 1900. The first of these examines how the townships approached the establishment of local public health structures and processes. The second analyzes the townships’ actions in response to complaints of public health nuisances and other matters of “sanitation.” The third studies the townships’ efforts to identify and manage the risks of contagious disease. Each of these chapters provide examples of circumstances and cases that illuminate the three

22 This observation arises from my own review of township council minutes over the period 1882 to 1900 for most of Wellington County’s townships. Township council minutes recorded significant activity in regard to the construction, maintenance and repair of roads and bridges. Another preoccupation was the assessment of township citizens and oversight of the related statutory labour used by township residents to pay some or all of their annual taxes. Collection of taxes for local school activities together with various school boundary issues within and among municipal jurisdictions also drew the attention of township councils.
key elements, referenced above, that shaped rural views on public health. The concluding chapter summarizes the observations arising from the Wellington County case study.
CHAPTER 2 -- RURAL RESPONSES TO ONTARIO’S PUBLIC HEALTH ACT

In the decade following Canada’s Confederation, Ontario government efforts in public health were directed to the control of the most virulent epidemics perceived as threats to North American populations: cholera and smallpox. The province’s approach had been responsive and *ad hoc* but, with the introduction of the PHA in 1882, it moved to a more systematized provincial framework. Under the new framework, provincial authorities’ role was limited to public health education and research while municipalities were responsible for establishing and enforcing local public health regulations. This division of responsibilities stemmed from the view that municipalities were “…the first and nearest authority over the citizen, the base of superior government and the training ground for rising provincial leaders.” Only a few of the larger urban centres in Ontario had already created local health boards to address health and sanitation issues that were associated with the increasing population density and industrialization of Ontario cities. Most of Ontario’s municipalities had operated without any ongoing public health organization. Rural communities, in particular, had seen no need for them and this continued to be the case after the PHA was enacted. For them, the rural lifestyle offered a sufficient and sound

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23 MacDougall, “Genesis of Public Health Reform”; Powell, “Provincial-Local Relations”.
25 Powell, “Provincial-Local Relations”, 2, 12. The *Municipal Corporations Act, 1849*, was Ontario’s first municipal statute. It delegated authority originally held by the crown (and later, the provincial government) to democratically-configured municipal government system and structure. It provided the provincially-defined municipalities with the authority to raise taxes and pass by-laws to address matters of local concern. Municipal authority was expressed in fairly broad terms within the *Municipal Corporations Act*, providing the legislative latitude to establish a local health board, should a municipal government wish to do so. Fears of epidemics was typically the stimulus for large urban centres. Toronto, Hamilton and Windsor were the first Ontario cities to form local health boards.
basis for healthful living that required vigilance only when faced with the threat of an impending epidemic. By 1884, most municipalities established a local health board to comply with amendments to the *Act* making them compulsory. The public health structures and processes townships established were not as envisaged by the provincial public health authorities but were designed to fit with the needs, priorities and interests of each municipalities’ tax-paying citizens. Local boards learned to maneuver around the social, economic, and geographic realities of their communities to preserve their local interests in public health. They focused on approaches that safeguarded the traditions of community and neighbourhood in rural municipalities and found various means to overcome the challenges of a dispersed population, variable conditions for transportation networks, limited access to funding and medical experts, and widespread skepticism toward new science-based ideas about health and disease.

**Establishment of a Province-Wide Public Health System**

During the 1870’s, Ontario doctors and other public health advocates lobbied for an ongoing public health system to help prevent and control disease while improving the response to epidemics. Inspired by public health successes in Britain and the United States, they urged the Ontario government to legislate a provincial health framework. They pointed to the increased risk for contagious disease created by the province’s accelerating immigration, expanding rail and water transportation networks, and growing population density. Further, physicians believed their medical services were essential to a successful public health system. If, like the legal profession, their services were

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26 Gidney and Millar, Professional Gentlemen, 3; Powell, “Provincial-Local Relations”, 3-4, 10, 15, 353-354; and , MacDougall, Activists and Advocates, 15-16.
instrumental to a system of public services, the reach of their specialized knowledge would grow as would their influence and income-generating prospects.\textsuperscript{27}

Initially, Premier Oliver Mowat and his fellow Liberals were resistant to action. Their many years of electoral success depended on vigilant attention to the rural interests.\textsuperscript{28} This included keeping government roles very limited and their bureaucracies small. As a result, the government’s contemplation of any proposed government initiatives, including those that might address public health was guarded. Public health advocates were not dissuaded and they persisted with lobbying throughout the 1870s. Peoples’ fears for personal safety from epidemics together with their potential to disrupt the stable conduct of commerce and trade locally and internationally, advanced their cause. Premier Mowat and his government softened their views toward interventions that might allay public worries, particularly those among Ontario’s agricultural community. In addition to regulations for control of noxious weeds and insects as well as animal and plant diseases, the province initiated public health and welfare measures that responded to growing social problems in Ontario’s urban centres.\textsuperscript{29}

\textsuperscript{27} Gidney and Millar, Professional Gentlemen, 336 pp.
\textsuperscript{28} Oliver Mowat and his Liberal government remained in power in Ontario from 1872 to 1896. Among other publications, Mowat’s attention to rural interests is described in general political histories of Ontario addressing this period such as Schull, \textit{Ontario Since 1867}, and in more specific examinations of Mowat’s political career and contributions such as J. Kerr, “Sir Oliver Mowat and the Campaign of 1894,” Ontario History 55, no. 1 (1963), 1-13. This view is further reinforced by John Isbister, “Agriculture, Balanced Growth, and Social Change in Central Canada since 1850: An Interpretation.” \textit{Economic Development and Cultural Change} 25, no. 4 (1977), 691; and, R.W. Sandwell, \textit{Canada’s Rural Majority: Households, Environments, and Economies, 1870-1940} (Toronto: University of Toronto Press, 2016), 74.
\textsuperscript{29} Margaret Evans, “Oliver Mowat: Nineteenth Century Ontario Liberal”, in Donald Swainson, ed., \textit{Oliver Mowat’s Ontario; Papers Presented to the Oliver Mowat Colloquium, Queen’s University, November 25-26, 1970} (Toronto: Macmillan of Canada, 1972), 43-44. Government initiatives at the federal level, especially the National Policy that provided tariff protection for Canadian businesses and the parallel improvements in economic conditions, offered further proof for the value of selective government intervention.
New ideas and innovations affecting sanitation and disease control had deepened the resolve of public health advocates and helped ease the provincial government’s resistance to their calls for action. Medical knowledge was undergoing a significant transition throughout the world during the mid-1800s. Existing public health measures centred on sanitation and were pre-occupied with the perceived ills of urban living and focused on the amelioration of environmental conditions in cities and towns. They were based on a general sense that sources of disease were observable and recognizable in the form of refuse, fouled water and foul-smelling air. New ideas from the science of bacteriology both reinforced the emphasis on sanitation and gradually modified understandings about disease control. The work of European medical scientists Robert Koch and Louis Pasteur were increasingly influential at this time. Koch’s discoveries about the role of bacteria in contagious disease and Pasteur’s complementary work on vaccines had introduced new health concepts and technologies that were beginning to affect the development of public health.30

These new medical tools were championed for use in the province by Ontario’s public health advocates. The prosperity of the province could be enhanced, they argued, if the government would act on public health and embrace the application of modern public health methods. The persistent lobbying of these “leading members of Toronto’s medical elite” finally yielded a break through. The government established Ontario’s Select Committee on Public Health and the Committee’s 1878 report provided a final push for the establishment of Ontario’s Public Health Act in 1882.31

31 Heather A MacDougall, “Genesis of Public Health Reform”, 3. See also, Ontario Legislative Assembly, “Report of the Select Committee on Public Health,” 1878. The Select Committee on Public Health was established in January of 1878 by Mowat in response to persistent lobbying by physicians inside and
Board of Health (PBH) was set up to conduct public health research and provided advice. The authority to act in public health matters was retained by municipal councils or, if they wished, their locally appointed board of health. Politically, the Act responded successfully to the call for provincially-orchestrated public health education while avoiding any major incursion on local government authority.\textsuperscript{32}

Overall, passage of the \textit{PHA} evoked few objections from the public. To the degree concerns were raised, they reinforced the government’s commitment to an approach that showed financial restraint and reinforced local authority.\textsuperscript{33} Ontario’s legislation was influenced strongly by British public health legislation, including its bias toward measures that applied primarily to densely populated, urban communities.\textsuperscript{34} Notwithstanding the urban emphasis, the Provincial Board’s mandate was province-wide with the goal of “disseminating the level and standards of [public health] services in leading urban municipalities to all communities throughout the province.”\textsuperscript{35} Ontario’s public health proponents argued that a province-wide scope was necessary to secure Ontario’s growth and prosperity through the overall health and security of all of its people. This view was offered based on their observations of the broad reach of public policy in Britain and their growing appreciation for the speed at which epidemics could spread and the distances that could be covered by a trading and travelling public. Rural communities, by contrast, saw little need for enforcement of the Act in their outside of the provincial legislature. All of the appointees were physicians. As described in Powell, “Provincial-Local Relations”, 18, its report reflected “confused and often conflicting opinions” and offered no specific recommendations to Mowat other than that his government required province-wide legislation to address public health and sanitation needs.

\textsuperscript{32} Craig, "State Medicine in Transition", 327. See also, Powell, “Provincial-Local Relations”, 11-12.
\textsuperscript{33} Powell, “Provincial-Local Relations”, 23-24.
\textsuperscript{34} Powell, “Provincial-Local Relations”, 40.
\textsuperscript{35} Powell, "Provincial-Local Relations", 4.
communities. For them, the ills of city living should be the primary concern of public health legislation.

Evidence of a Rural Disconnect

The disconnect between urban-oriented public health advocates and rural municipalities soon began to appear. The Provincial Board’s first priority was to spur the establishment of local boards of health in every Ontario municipality. In doing so, it pandered to municipal sensibilities and saluted the wisdom of the Act’s division of provincial and local responsibilities. The PBH positioned itself as an “organization powerful for good throughout the whole Province,” and envisaged its role as a valued partner to local municipal governments.\(^{36}\) The PBH’s grand vision for its role in public health was soon frustrated. Its capacity to implement public health improvements depended upon action by municipal councils in towns, villages and townships and most of them were doing nothing.\(^{37}\)

To overcome its challenges, the Provincial Board campaigned for amendments to the Act that could compel action at the municipal level. The Board gathered evidence to show how few municipalities had established local boards or appointed any health officers.\(^{38}\) Its call for changes to the Act was enhanced significantly when a smallpox epidemic beset the community of Hungerford in 1884. As a rural village located within Tweed Township, Hastings County, its smallpox outbreak provided a vivid illustration of

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\(^{36}\) Ontario, “Board of Health Report for 1883”, lvi.

\(^{37}\) Powell, “Provincial-Local Relations”, 12; 49-51, 86. The Act incorporated a “Schedule A” that provided a model public health by-law that was deemed to be in force in each municipality unless it was amended by the local council. Municipal councils faced no limitation on the number or nature of changes that could be made to the provincially-designed by-law. A local council could reject it in its entirety if it wished.

\(^{38}\) Ontario Legislative Assembly, “Return Showing the Number of Local Boards of Health Organized Last Year, etc.”, Sessional Paper No. 18, in Sessional Papers of the Province of Ontario (Toronto: Ontario Legislative Assembly, 1884).
the need for health boards to be established in all Ontario municipalities. The PBH observed how ill-equipped Hungerford was to respond to the epidemic and how the Provincial Board’s “daring, aggressive, and unprecedented” interventions kept the community’s smallpox epidemic from becoming an issue for the province as a whole.39 The public health fears fueled by the Hungerford outbreak tipped the scale and the PHA was amended in 1884 to make local health boards compulsory for all Ontario municipalities.40

The PBH’s optimism about its capacity to drive change was renewed but not for long. Some municipalities failed to heed the legislative amendment and, among those who complied, the PBH viewed their public health efforts as nominal (Appendix B). It believed most local boards were largely inactive and neglectful in funding local boards appropriately or in hiring adequately trained medical health officers (MHO) and/or sanitary inspectors (SI) for their municipalities. The PBH’s annual reports to the legislature recorded its exasperation with municipalities and presented its case for additional amendments to the Act that would compel local governments to fund their health boards appropriately.41 The government would not acquiesce and believed it would be highly impolitic to impose further legislative constraint on municipalities in the name of public health. Despite this rebuff, the Provincial Board persisted in its criticism

39 Craig, “State Medicine in Transition”, 320. See also Craig, “Smallpox in Ontario”, 219-220. To address the situation in Hungerford, the PBH called upon its residual legislative authorities for the first time and intervened directly. It closed all railway travel with the surrounding area and brought in medical practitioners and constables to institute quarantine as well as a door-to-door vaccination program.
40 MacDougall, “Genesis of Public Health Reform”, 4; Powell, “Provincial-Local Relations”, 46-53, 357. Powell indicates that while further changes were made to the Act after 1884, these did not result in any change to the fundamental system and structures of the legislation through the balance of the nineteenth century and into the twentieth.
of local responses as it believed that “the real and essential success of this Board as an agent in the direct advancement of public health” depended upon local efforts.42

Townships, the most numerous category of provincial municipalities, were a particular focus of concern for the PBH and it was increasingly critical of rural jurisdictions’ ability to address public health. In PBH annual reports for 1882, 1883, 1884 and 1888, for example, it voiced frustration with the apathy, stubbornness and willful ignorance of township councils.43 The PBH believed the woeful attention to public health by rural communities was due to a lack of interest among local councillors. Further, they believed that township councils struggled to convene meetings in the summer season and, when they did meet, had difficulty in taking “speedy and effective action”.44 Allies of the provincial board in the physician community amplified these concerns by noting that, “The inactivity of a very large proportion of the local boards of health in the rural districts…of Ontario is shown by the meagre reports sent in by many of them to the provincial Board. Scores of the reports consist only of a dozen lines or less…”45 Some deemed it “ridiculous” that sanitation and public health concerns would be undertaken by “four or five burly agriculturalists whose whole knowledge of disease may be limited to a case or two of cucumber cramps.”46

43 The PBH submitted reports to the provincial legislature each year. They information about its activities and incorporated scientific and investigative reports as well as commentary designed to reinforce the value to the province of public health measures, the importance of the PBH’s role, and its progress to date. While lauding achievements, PBH reports also highlighted continued risks for the province from contagious diseases and poor public sanitation. During its first 10 years, the PBH often highlighted the risk it perceived from inaction by local municipalities, especially Ontario’s townships.
45 Unknown, “The Work of Rural Health Boards,” Canada Health Journal 12, no. 1 (1890): 10–11. For example, of the township submissions included in the PBH’s 1884 report, the shortest was one sentence from township in Middlesex County: “The sanitary condition of the township is very satisfactory.” Caradoc Township Board of Health Annual Report in Ontario, “Board of Health Report for 1884”, 170.
The tone and content of some townships’ yearly reports offered evidence to support the PBH’s claims about their lacklustre response. Some townships made their disdain for the PHA clear, such as this one by the northern Ontario Township of McKellar: “[the] Board of Health…started with a well defined policy of doing nothing, and up to the present time every member has carried the policy out to the fullest extent possible.”

From the years 1882 to 1890, the full text of township submissions was printed while PBH-prepared summaries appeared during the years 1891 to 1900. Reports typically provided a brief overview of the local board’s activities for the year and included a statement about the overall sanitary and/or health condition of the municipality. The PBH’s report for 1884 included submissions from only 148 of Ontario’s 417 townships, a portion of the 184 that claimed to have established boards which, itself, was less than half the number of Ontario’s townships. Of the 148 that were printed in the PBH’s annual report, only a few were prepared by individuals who carried the designation of M.D. or M.B. More than 75% (112 of the 148) gave a positive indication of their municipality’s overall health and/or sanitary condition and many claimed to have a

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47 Ontario, “Board of Health Report for 1884”, 196-197. This text reflects the complete annual report of the Local Board of Health for the Township of McKellar, County of Muskoka and Parry Sound in 1884.
48 Based on my own work with the materials submitted to the PBH by Wellington County townships and on the observations of Heather MacDougall, the reports were reprinted by the PBH as submitted or with only minimal editing until 1890. H. MacDougall, “Researching Public Health Services in Ontario, 1882-1930.,” Archivaria, no. 10 (1980): 157–72. After 1890, annual submissions provided by cities continued to appear in full while summaries were offered of submissions from towns, villages and townships. Annual municipal submissions were submitted by any of the following: Chair of the Township Board of Health, Clerk or Secretary of the local board of health, Medical Health Officer or Sanitary Inspector for the township board. In some instances, multiple reports were submitted by townships (e.g., one from the board of health and one prepared by its MHO).
49 Ontario, “Board of Health Report for 1884”, 3. Reports from the remaining 36 with boards were likely missing because either they had not prepared one or had supplied it too late for publication.
50 M.B. is the designation for a medical practitioner who has completed the education for a Bachelor of Medicine as opposed to practitioner who has achieved a Doctorate in medicine (i.e., M.D.). The PBH urged municipalities to appoint professionally trained physicians to their MHO positions.
disease-free municipality. Even those townships that had suffered outbreaks of typhoid, diphtheria, cholera, smallpox or whooping cough during the year laid claim to top-notch health conditions in their municipality. Still others boasted they enjoyed a healthy community while acknowledging they were without reliable information concerning contagious diseases in their township.

Even four years later, in 1888, the Provincial Health Board’s annual report contained only a few more township reports: 152. The PBH recognized a degree of advance, nonetheless, as the number of reports completed by health professionals had increased significantly. Seventy-five were completed by an M.D. or M.B. and one was prepared by a Veterinary Surgeon. Still, more than three-quarters of the reports boasted of a disease-free township or an otherwise very healthy community. As in 1884, these positive claims were not tempered by the contagious disease outbreaks that were reported for the township during the year or by acknowledged limitations in disease reporting. The report of a rural municipality in central Ontario, Mono Township in Dufferin County, is illustrative of those that prompted the Provincial Board’s concerns:

I beg to submit to you the annual report of the Board of Health for the year 1888. There have been no contagious diseases reported. There were some cases of supposed diphtheria; if they were of the real type they were exceedingly mild in their nature. No deaths occurred. Our Council has not appointed a Medical Health Officer; they considered that it was not necessary.

When the PBH printed Mono’s submission in the province’s annual report, it added a disdainful footnote:

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51 In 1884, 112 of the 148 township reports published by the PBH offered a positive view on its overall sanitary and/or health condition.
53 In 1888, 119 of the 152 township reports published by the PBH offered a positive view on its overall sanitary and/or health condition.
If there was no Medical Health Officer to look after those cases, how are we to know whether they were or were not real diphtheria? Mere supposition in cases of contagious diseases is very dangerous. We hope that in future the lives of people will not be endangered by thinking the disease was not, when it probably really was, diphtheria.  

In the Provincial Board’s 10th anniversary report to the legislature, the volume of township submissions required that they be summarized in a table format. Perhaps reflecting a desire for a celebratory tone, much of PBH’s report for the year trumpeted successes and little was said of its continuing concerns with townships. Only brief mention was made of the PBH’s ongoing distress with the activities and resourcing of local boards and its chart summarizing the information provided in township reports makes it difficult to discern evolutions in the tone and emphasis of the local submissions. At least seven townships reported they were “free” from infectious diseases and sixteen reported they had only a “few” cases. Only two reported the presence of “epidemics” for the year. No matter what it made of the information about local public health activity, the PBH took the opportunity to mark significant success in its work by virtue of the fact that health boards now existed in more than 80% of Ontario municipalities.

As evidenced by repeated commentary in their annual reports through to 1900, townships believed the primary purpose of the PHA was for remediation of public health threats in urban communities. From their perspective, the conditions and lifestyle provided in rural Ontario promoted excellent health and mitigated against any

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55 Ontario, “Board of Health Report for 1891”, 117-126. The change to a summary format was likely a desire to shorten the PBH’s annual reports. Summaries of township reports would also downplay evidence of their activities that may be regarded as contrary to, or critical of, PBH initiatives.  
56 The PBH’s headings were general inspection, water supply, cheese factories, infectious diseases [general], “diphtheria, typhoid, scarlet fever” [numbers of cases], drainage, slaughter-houses & pig-pens.
substantial disease risks. A presumption by townships that most provisions of the PHA were not applicable to their community is understandable given the urban-oriented bias of many of its provisions. The Act emphasized public water systems, sewer and drainage systems, and detailed construction specifications for privies and household drains. These features and specifications were suited to urban, not rural communities. In Ontario’s townships, the population was too dispersed for sewer or water systems to be practical. It made little sense for predetermined specifications to be assigned to the location and construction of privies and household drains. The provisions of the Act failed to address the circumstances of family farm operations. For example, if sections of the PHA concerning milk cows had been applied as written, they would have placed a significant burden on an agricultural community where virtually every farm kept cows for their general use.57

Townships saw their geographic and meteorological advantages as well as their low population density as important factors furthering healthfulness and even “immunity” to disease, including epidemics.58 Blanshard Township, part of Perth County located in southwestern Ontario, commented, “…..the Board is looked upon by the people as a bill of expense in our township, but is considered a capital thing for cities, towns, and

57 “…All milch cows and cow byres and all dairies or other places in which milk is sold or kept for general use, and all cheese factories and creameries shall be subject to regular inspection under the direction of the said Board; and the proprietors shall be required to obtain permission in writing from the Board, to keep such dairy or other place in which milk is sold or kept as aforesaid…” Schedule A, Section 10, Public Health Act, 1884. (Chapter 3 of this paper provides an example of a Wellington County township’s response to these provisions in the PHA.)

58 For example, in the 1888 report from the Local Health Board of Adelaide Township in Middlesex County: “I have much pleasure in reporting that the township of Adelaide has enjoyed, as far as I know, a perfect immunity from any disease of an epidemic nature during the present, year.” Ontario, “Board of Health Report for 1888”, 157. There are a number of other examples of this kind of claim in other township reports for this and other years.
villages.” Morrison Township in the district of Muskoka and Parry Sound, highlighted the advantages of their rural location that made the application of public health measures unnecessary:

… This township is small, and only one-third of this small area is settled, and the settlers living a good distance each from the other. Our Muskoka highlands are very healthy, a salubrious bracing air and pure water must necessarily make it so…

Yet another, Albemarle Township in Bruce County, observed: “…Owing to the thinly settled state of this township, and it being naturally a very healthy locality, a Local Board of Health is not deemed a great necessity…” There was some truth in their claims. The significantly lower death rates reported during the period showed counties’ death rate as almost half of that of cities’ throughout the 1880s (Appendix C). This death rate information served as reinforcement of general perspectives concerning the overall healthfulness of rural jurisdictions. The MHO for Mosa Township located in Middlesex County reported as follows:

During the year the township has not been visited by any widespread cause of mortality or sickness beyond the ordinary causes that are at work from year to year, and over which we have no control. The Board of Health met and organized during the year, and we are prepared to meet any emergency should such arise.

A report from Beverley Township in Wentworth County expressed the view that, unless faced with the exigencies of an epidemic, it was reasonable to limit taxpayer expenses for public health:

… it may be said by some that the Board of Health is unnecessary and an expense for nothing; but should the municipality or any part thereof be visited by

61 Ontario, “Board of Health Report for 1884”, 159. The perspective offered was widely held at the time by people in both rural and urban areas as affirmed, for example, in Sandwell, Rural Majority, 80.
62 Ontario, “Board of Health Report for 1888”, 97. This Mosa Township health officer carried the designation of M.D.
an epidemic, the machinery will be ready to be put in motion to prevent the spread of the disease.63

A number of townships took the view that unless faced with an active epidemic such as cholera, smallpox or diphtheria, no public health action was required.

Rural dwellers expected a level of disease and death. The popular view was that “mild” outbreaks of contagious and other diseases were to be expected, including a level of mortality especially among the very young and very old. While regrettable, they believed these to be immutable features in their lives and largely beyond the control of governments and their public health measures. The 1884 report from Waterloo Township in Waterloo County illustrates this view:

The general health during the past year has been about as good as the average of former years, although there has been a marked increase in the death rate, which, however, has been among persons well advanced in years and children of tender age.64

Believing in the inherent healthfulness of the countryside and suspicious of the potential for urban problems to be imported to rural communities, township reports pointed to neighbouring cities and towns as sources of any diseases that afflicted their communities. For example, Howe Island Township in Frontenac County claimed itself free of disease during 1888 apart from, “one case of typhoid fever which resulted in death. It was contracted in Kingston where the young man worked, but he died in this township where his parents lived…”65 In the townships’ view, rural health would continue to be preserved so as long as the PHA focused on urban centres and limited the importation of their public health challenges to the countryside.

64 Ontario, “Board of Health Report for 1884”, 216.
The PBH was aware township councils were very reluctant to be involved in what they deemed to be private health matters in the pursuit of public health. As noted earlier, public opinions about the need for government intervention in various aspects of society were only just beginning to shift in the closing decades of the nineteenth century. The balance between public and private interests was an especially sensitive point for their rural populations. Community networks, and the personal relationships that sustained them, were tended carefully and considered critical to a farm family’s success.\(^6^6\) In matters of health, rural people had little appetite in Ontario’s townships for advancing government interventions that might disturb these relationships. However, the PBH dismissed these concerns commenting that it is a “mistaken idea of freedom and independence to suppose that the individual should be allowed to follow his own ideas, no matter how unwise.” Rather, in matters of public health the PBH asserted, “what is in the highest interests of the State must finally prove good to the individual citizen.”\(^6^7\)

Townships were not persuaded by the PBH’s admonitions. Numerous township reports referenced public health interventions in terms such as “interference in the ordinary habits of the people.”\(^6^8\) Actions taken by local boards of health, MHOs and/or


\(^6^7\) Ontario, “Board of Health Report for 1882”, xxxi.

\(^6^8\) Ontario, “Board of Health Report for 1884”, 183. The quote is drawn from the 1884 report of Hibbert Township, Perth County. Examples of similar use of the term ‘interfere’ can be found in the 1884 report of the Township of Southwold (207) and in Ontario, “Board of Health Report for 1888”, 74, the township report for Elderslie in Bruce County.
SIs could readily disturb critically important, and carefully tended, reciprocal networks operating in rural communities. In Raleigh Township, Kent County, the importance of neighbourhood networks was cited to explain objections to quarantining the sick in their homes as it was “considered very unfriendly by many not to call, no matter what the disease in the family may be.”

Skepticism about the utility and efficacy of new health technologies also characterized township reaction to public health measures. Some townships expressed significant reservations about the reliability of new health technologies and confusion about appropriate measures for disease prevention and control. Their doubts were sometimes reinforced by the views of local physicians. The inconsistencies and imperfections of new medical knowledge and techniques justified their reason for caution. The availability of smallpox vaccine had advanced considerably and by the late 1880s, the PBH was regularly prompting municipalities to implement local vaccination programs. While positive results from smallpox vaccination were evident in some communities, the production and administration of the vaccine remained in its infancy and its use could be unreliable leading to significant concerns in others. This was well–illustrated in a report from Southwold Township, Elgin County that registered its community’s strong opposition to compulsory vaccination due to its experience two

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69 Ontario, “Board of Health Report for 1884”, 205. Southwold Township in Elgin County expressed the challenge as follows, “…I fear that the greatest trouble in the way of working the Act successfully will be the lack of moral courage of members doing their duty for fear of offending some persons…” Ontario, “Board of Health Report for 1884”, 207.
70 See for example, Craig, “Smallpox in Ontario”; Craig, “State Medicine in Transition”; and Rutty, “Connaught Laboratories”. A vaccine for diphtheria became available during the 1890s but, as demonstrated in the township report summaries prepared by the PBH during the years 1891 to 1900, it was not used widely in Wellington County townships.
years previously when the small pox vaccine had endangered several lives and prompted “fearful arms” among others.\textsuperscript{71}

The lack of consistent and reliable reports about contagious diseases – by both physicians and householders – was also a factor limiting rural action on public health. Reporting challenges were often identified in the Provincial Board’s annual reports but less so in township submissions. The underlying reasons were multifold. Lay and professional people alike disputed the character and causes of various diseases. “Mild” outbreaks caused little alarm and the contagious nature of some diseases such as tuberculosis was still a matter of debate throughout the 1880s and 1890s. Some advance was made possible in the 1890s with the opening of a PBH laboratory that could help identify the presence of diseases such as diphtheria, tuberculosis and typhoid but use of this service by townships was limited.\textsuperscript{72}

Even allowing for inconsistent approaches to the identification of disease, reporting was a challenge throughout the province. Frequently, the Provincial Board criticized physicians for dereliction of their professional duties in their failure to report occurrence of infectious disease to their local board of health.\textsuperscript{73} There were a number of reasons why physicians were not inclined to report, chief among them being their reliance on positive patient relationships to preserve and expand their income. The business

\textsuperscript{73} See for example, Ontario, “Board of Health Report for 1883”, xvi-xvii.
relationship with their patients meant doctors were not incentivized to report diseases if the result could be an unwelcome intervention by the local board of health. An additional factor was the lack of physicians in some townships, particularly in the more remote regions of the province. A separate, but related reality for several townships was the challenge of great distances and varied geography. This was a concern for a number of townships and, from their perspective, a matter ignored by provincial authorities. Medora Township in the remote northern district of Muskoka and Parry Sound commented, “…[W]e have no Medical Officer on this Board, in fact there is no medical man residing within a convenient distance... I would suggest that some provision be made for paying members’ travelling expenses, time, etc.”74 While the lack of reported disease outbreaks was very troubling for the PBH, it was not as troublesome for some townships who chose to view it as evidence of the excellent health condition of their community and reinforced the view that the need for action on public health was limited.

Several township reports expressed frustration with a variety of ways in which the PHA and PBH neglected the needs and circumstances of rural municipalities. Townships remarked on the need for further or amended materials from the PBH, noting in one instance that the provisions of the Act were “unpractical and difficult to enforce in a rural municipality.”75 The Act’s insistence that there be a local board for each township, particularly given the relatively small population in some northern jurisdictions, was seen to be ill-conceived as their tax base could not support it. In a couple of

75 Ontario, “Board of Health Report for 1884”, 189. This comment was part of the Malden Township’s 1884 report. Malden is located in Essex County.
instances, this was overcome through establishment of a joint board of health through a collaboration between neighbouring municipalities. The PBH was also criticized for failing to provide public health information in the languages spoken by significant portions of a township’s population. In 1884, Waterloo Township, Waterloo County sought copies of the PHA in German. In 1888, the Township of Hawkesbury East in the County of Prescott & Russell asked for public health materials in French.

Interestingly, none of the township reports published by the Provincial Board over the period 1884 to 1891 identified the demands of the growing and harvest seasons as an obstacle to public health initiatives despite the PBH highlighting this as a potential concern. The PBH also suggested in several of its reports and commentary that the lack of action by townships was a result of misplaced financial restraint. However, the cost of establishing a local board of health is rarely mentioned in the township reports published by the PBH. Also absent among most of the township reports was reference to activities or issues arising from the relationship of farm animals and their produce to human health. Given the importance of livestock to farming operations and rural concerns about the impracticality of many PHA provisions, this seems surprising. Perhaps it was considered so obvious at the time as to not warrant mention.

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76 Ontario, “Board of Health Report for 1884”, 192. Mao and Carolow Townships in Hastings County attempted this although the distances involved together with the rough terrain and poor roads, were identified as presenting considerable difficulties.
77 Examples of this approach from Ontario, “Board of Health Report for 1884”, include the townships of Renfrew (206), Pittsburg (204), Proton (204), Southwold (209), and, Turnbury (214).
Conclusion

Notwithstanding reservations about the PHA’s urban bias, once local boards became mandatory in 1884, rural townships moved forward. Local boards were established and some initiated communications within the municipality to raise awareness about public health provisions in Act. Reports from townships like Alice in Renfrew County, East Nissouri in Oxford County, and Proton in Grey County80 indicated they were introducing some level of sanitary inspection as well as a few preventative and responsive measures to control contagious disease. The needs, priorities and interests of the local community informed townships’ pathways for compliance with the PHA. Townships developed approaches for defining and defending township interests. The local boards soon proved themselves able to maneuver around the social, economic, and geographic realities of their communities in fulfillment of their public health responsibilities. They fashioned pragmatic and predictable approaches that could overcome their realities and negotiated the general skepticism amidst their communities toward the need for PHA measures. Taken as a whole, the information available from Ontario’s townships point to three key elements that were influencing their response to the new public health legislation: first, a belief that a rural lifestyle was inherently healthy and could best be preserved by thwarting the ills of urban living; second, a strong preference for minimal government interference in the private affairs of households and local businesses; and third, a skeptical outlook toward the utility and efficacy of new medical concepts and health technologies.

CHAPTER 3 – WELLINGTON COUNTY TOWNSHIPS: PUBLIC HEALTH STRUCTURES AND PROCESSES

As already noted, most of Ontario’s rural townships did not establish local boards of health in 1882 when the Public Health Act was first passed. At the beginning, many simply responded to the new legislation by applying the minimalist, ‘default’ option provided by the Act: the township council assigned to itself the responsibilities of a local board of health.81 Key to this judgement was the view that urban communities were the true focus for the PHA as rural living was inherently healthful. Further, this predisposition was solidified by a preference for limited government. These elements are observed in the response of Wellington county townships to the PHA, including their approach to the structures and processes they developed for public health.

Most of Wellington County’s township minutes contain no recognition of the 1882 introduction of the PHA and not one township decided to establish a board of health (BOH) in response to the initial introduction of the Act.82 They saw no need to do so in their rural communities as they already provided what was considered top-rate, healthy living conditions. Once legislative amendments compelled them to take action, however, most complied and found ways to do so that fit with the needs and priorities of their tax-paying citizens. They did so while minimizing expenditures, including avoidance of meetings and distribution of responsibilities among health board members. To limit the need for government interference in private affairs, townships developed

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81 When the PHA was first introduced in 1892, establishment of a local board of health was optional. Instead, a municipal council could deem itself as the local health authority.
82 Use of the acronym BOH is used when referring to a local board of health in a Wellington County townships.
local public health bylaws that suited rural needs and gave their health boards latitude to define and apply sanitation and disease control standards. As the complaints and concerns presented to BOHs by local citizens increased, townships appointed health officers and/or sanitary inspectors to improve the responsiveness of their health boards and ensure that local authority for health was asserted. Public communications about the role and authority of local health boards and their officials helped to solidify the presence of health boards within the townships.

**Townships’ General Response to the PHA**

There is no evidence that Wellington County townships registered objections with the province about the development of the PHA or responded to provincial criticisms about lack of action by rural jurisdictions that followed its passage in 1882. They had taken up advocacy on other matters. During the 1880s and 1890s several Wellington County townships registered concerns and preferences about other provincial and federal legislation; none of their advocacy efforts concerned the PHA. Once the Act came into effect, none of Wellington County’s townships felt the need to respond. Nichol Township’s records hint at the reasons for this. Its first reaction was deferral of any response to the legislation until more information could be gathered. Several months

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83 For example, in 1894 Minto Township Council passed a resolution to express its “strong condemnation of the power placed in the hands of vessel owners” for setting the steam ship rates for transporting cattle to Great Britain and “strongly urged” the dominion government to pass legislation to regulate a rate that while fair to vessel owners would “not prove a detriment to the cattle industry of Ontario.” Minto Township Council Minutes, April 30, 1894, Wellington County Archives, A1991.117.

In 1884, the Puslinch Township Council passed a motion directed to those in the Ontario legislature encouraging approval of the “Torrens System of land transfer” and advocated for early legislative change to bring it into effect in the province. Puslinch Township Council Minutes, February 4, 1884, Wellington County Archives, A1991.120.

Nichol Township considered a request seeking council’s support for advocacy activities in 1886. One was a request from Mr. Henry Ransford of the Stapleton Salt Works, seeking support for the dominion government to set standards for measuring a barrel of salt. Council agreed to join the advocacy efforts on this matter. Nichol Township Council Minutes, July 16, 1886, Wellington County Archives, A1981.42.
later, with the desired advice at hand, Nichol’s councillors chose the minimalist option found in the Act: the whole council would serve as the township’s health authority.84 Puslinch Township also deferred action until more information about its responsibilities could be gathered. It never returned to the matter until May 1884 when legislative changes made local boards of health mandatory.85

Most complied promptly once local boards of health were deemed mandatory in 1884.86 Arthur Township offers an exception. In June of 1884, in contravention of the law, it determined a local board of health was unnecessary. Going further, it rejected the need for any township health officers: “…as there are no villages within the limits of the municipality the members of this Council are unanimously of [the] opinion that it is not necessary to appoint a Local Board of Health or a Medical Health Officer.”87 For Arthur councillors, there was a fundamental relationship between good health and rural living. With no villages in their township, they believed that they lacked any of the ills of urban living. Consequently, in the absence of immediate threats of disease, its limited municipal resources were not needed for public health. By February 1885, Arthur Township relented. It created a local health board and enacted a public health bylaw, albeit an amended version of the one prescribed in the Act.88 The Township’s change

84 Nichol Township Council Minutes, June 15, 1882 and September 19, 1882, Wellington County Archives, A1981.42.
85 Puslinch Township Council Minutes, July 3, 1882 and May 26, 1884, Wellington County Archives, A1991.120.
86 The Wellington County Council, comprised of representatives from each of member municipality, is the only local government body whose records reveal explicit objections to the PHA. Worried that the PHA may compel it to establish a board of public health, legal advice was sought and assurance obtained that no action was necessary by the County. Wellington County Council Minutes, Session #77-120, June 5, 1884; and, Session #77-120, “County Solicitor’s Opinions”, opinion dated June 5, 1885, Wellington County Archives, A1980.14.
87 Arthur Township Council Minutes, June 18, 1884, Wellington County Archives, A1985.49.
88 Arthur Township Council Minutes, February 3, 1885; February 21, 1885; and, April 9, 1885, Wellington County Archives, A1985.49. The township council minutes note that it made amendments to the PHA By-law Schedule A, Section 69. Unfortunately, the by-law itself was not in the historical records available.
of heart is not explained. Political pressures at the provincial level or local concerns about the smallpox epidemic besieging Hungerford may have played a part. Whatever its reasons, Arthur accompanied its decision to proceed with a commitment to financial restraint. The Council instructed that BOH meetings should be avoided “unless absolutely necessary.”

Arthur Township’s initial non-compliance, while not unique within the province, was not typical among Wellington County townships. At least eight had established BOHs by 1885. Of these, many met regularly and all but one had appointed either a Medical Health Officer (MHO), a Sanitary Inspector (SI), or both, by 1889 (Appendix D, Appendix E, Appendix F). While the townships had reservations about the need for BOHs, most wished to protect themselves from legal liabilities and to avoid unwanted provincial attention due to non-compliance. Townships’ approaches to compliance varied and reflected the needs and priorities of their rural community. West Garafraxa, Pilkington, and Erin townships each distributed responsibilities among their BOH members to fulfill public health monitoring and initiate action for their portion of the township. Members were assigned sections for their oversight. Erin township’s rationale for using this distributed approach referenced the need to avoid gathering for

As will be examined in more detail later, the PHA contained a template public health by-law (“Schedule A”) that was deemed to be in force unless amended by local councils. Arthur Township repealed the entire template by-law.

Arthur Township Council Minutes, February 25, 1886, Wellington County Archives, A1985.49. This instruction was referenced in the BOH’s annual report for the year along with the comment, “This of course quashed the Board, and therefore nothing has been done.” Arthur Township Board of Health Annual Report in Ontario, “Board of Health Report for 1886”, 174.

West Garafraxa assigned responsibilities for specific portions of the township among its BOH members. (West Garafraxa Township Board of Health Minutes, January 19, 1885, Wellington County Archives, A1981.82.) Pilkington Township relied on reporting from its members to track nuisances and sanitary conditions: “The different members of the Board reported the Township to be free from any contagious or infectious disease in their respective localities.” (Pilkington Township Board of Health Minutes, September 30, 1899, Wellington County Archives, A1985.37.)
“unnecessary meetings,” which involved travel and time away from work. This approach was pragmatic. The distances among farms was significant and the roadways and bridges challenging for lengthy or rapid travel in all but fine weather. Minutes of Wellington County township councils reveal the significant attention given to roadways, bridges and other related transportation infrastructure during this period. Much of their discussion and decision-making was directed to matters such as the acquisition of gravel and the management of statutory labour for the building and maintenance of local transportation routes.

Wellington County townships also prepared local public health bylaws to suit their community’s needs and circumstances. The PHA included Schedule A, a municipal public health bylaw that was deemed to be in force in all municipal jurisdictions unless it was amended in whole or part by the local council. The provincial health board hoped that its view of best practices in public health, as set out in Schedule A, would be accepted and lead to uniform practices across the province. Arthur Township repealed Schedule A in its entirety. Puslinch Township’s decision was to amend it significantly to suit its rural community. In the introduction of its public health bylaw, Puslinch Township developed a significantly reduced and highly selective edition of Schedule A. Its choices reflected an effort to limit threats to public health while minimizing intrusions.

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91 Erin Township’s BOH distributed responsibilities among members to reduce the need for meetings: “… each member of the Board [was] empowered to remove or cause to be removed any nuisance that may be found to exist in his respective locality; also if any epidemic or contagious disease should arise in his locality, to give his attention to the matter and report if he thinks necessary to the Chairman of the Board with a view of taking the matter into consideration.” Erin Township Council Minutes, December 16, 1889, Wellington County Archives, A1985.55. The above-referenced record for West Garafraxa indicate a similar rationale. Cost containment was a related factor and this is explored subsequently.

92 For some of the more northerly townships, such as Arthur and Minto, road and bridge development was less advanced than in the more populous townships in the south that had been settled and engaged in agricultural activities longer.
in the private affairs of its citizens\(^{93}\) (Appendix G). The Puslinch BOH was authorized to address sanitation in both private and public spaces to allow for, “the preservation of the public health, or for the abatement of anything dangerous to the public health.” This included authority to manage complaints concerning dirt, filth and refuse (including manure and human waste), decaying animal and vegetable matter, slaughterhouses, and hog pens. Some authority was also provided to oversee the quality of food and water in the township.

Puslinch’s bylaw gave its BOH greater latitude for decisions on the establishment and application of local sanitation standards than was found in Schedule A. For example, the Schedule A included detailed sanitary standards such as the distance of slaughterhouses from other buildings, while Puslinch’s bylaw did not. Puslinch’s bylaw authorized its BOH to approve the establishment of slaughterhouses and to inspect them but left the determination of standards like distances from other buildings to the discretion of the BOH (Appendix G).\(^{94}\) The Puslinch bylaw also excluded significant portions of Schedule A that addressed sanitary standards in the construction of buildings and privies and eliminated any reference to pre-approval of such facilities by the local health board or its officers (Appendix G).\(^{95}\) Presumably the rejected portions of Schedule A were considered excessive to the needs of local farms and at odds with the economical and practical construction preferences in the community.

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\(^{93}\) Puslinch established a BOH in May 1884 and, at the same time, it appointed an sanitary inspector, although not a health officer.

\(^{94}\) See section 7 of the Puslinch Public Health Bylaw as compared to PHA, 1884, Schedule A, Section 8.

\(^{95}\) See section 8 of the Puslinch Public Health Bylaw as compared to PHA, 1884, See Schedule A, Section 14, 15, 16
Measures to control “scarlet fever, or other diseases dangerous to the public health” were also addressed in the Puslinch bylaw. Here again, the provisions allowed greater latitude for BOH judgement in their application than found in Schedule A. For example, no mention is made of a role for local physicians in directives for quarantine and household disinfection. Instead, the Puslinch BOH or its officers held this authority. Additionally, the bylaw assigned householders the responsibility for reporting contagious diseases, omitting Schedule A’s inclusion of physicians in this responsibility.\textsuperscript{96} Puslinch clearly believed its health board was in the best position to discern a locally-acceptable balance between local public and private interests in the area of disease control. Its approach allowed households to retain maximum control so that they could minimize the need for public health interventions in their lives.

Other Wellington County townships also found the bylaws incorporated in Schedule A of the PHA to be excessive or ill-suited to their needs and resource capacities and remarked accordingly. For example, Minto’s health officer was exasperated by PHA amendments introduced in 1887 requiring local registration of those who sold milk to others: “I do not see how … the registration…can be carried out without unnecessary expense, which I do not feel like advising the Board to incur.”\textsuperscript{97} Various amendments made by several Wellington County townships\textsuperscript{98} during the 1880s and 1890s ameliorated “objectionable features” incorporated from Schedule A in local public health bylaws. As one illustration, Eramosa eased the impact of a bylaw for a

\textsuperscript{96} PHA, 1884, Schedule A; Puslinch Township Bylaws, November 24, 1884, Wellington County Archives, A1998.118.
\textsuperscript{97} Minto Township Medical Health Officer’s Annual Report in Ontario, “Board of Health Report for 1887”, 95.
\textsuperscript{98} These include Eramosa, Minto and Pilkington Townships.
slaughterhouse owner by making a substantial reduction in the distance required between a slaughterhouse and other buildings. The separation was reduced from 200 to just 75 yards.99

**Township Boards of Health**

Townships’ attention to the ongoing operation of local public health structures and processes, including the annual appointment of BOH members, soon became routine. Among the first items of business for the newly elected council was the assignment of its BOH members.100 The Act specified that township boards be comprised of the Reeve and Clerk (as *ex officio* members) along with three ratepayers.101 Wellington County townships followed these provisions and saw that each board elected a chairman from among its members. Most township BOHs exhibited significant year-to-year continuity in their members, notwithstanding the potential for election results to introduce changes (Appendix H).102

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99 Eramosa Township Board of Health Minutes, February 1, 1886 and January 31, 1887, May 18, 1889, January 29, 1894 and November 16, 1894, February 4, 1895, February 3, 1896, Wellington County Archives, A1982.14; and, Eramosa Township Council Minutes, April 9, 1894, Wellington County Archives, A1985.58.

In 1890, Pilkington Township made a similar amendment “so that dwellings could be located significantly closer to slaughterhouse operations.” It was made to assist Mr. Kerr’s slaughterhouse operation that was the subject of nuisance complaints. This case is addressed in more detail subsequently. (Pilkington Township Council Minutes, July 12, 1890, Wellington County Archives, A1985.37; and, Pilkington Township Council Bylaws, August 20, 1890, Wellington County Archives, A1985.37.)

100 During this period, Ontario’s municipal elections were held each December. Customarily, the BOH appointments were handled as part of township’s annual personnel assignments.

101 The Provincial Board expressed a preference that ratepayer members not be elected members of council. The objective in doing so was to provide greater opportunity for the appointment of physicians and other public health experts. Wellington County townships largely accepted this advice although, in a few instances, councillors were appointed to ratepayer positions. Several appointed physicians as health board members. In the mid-1890s, the Provincial Board believed local momentum was lost due to poor membership continuity in local board membership. As an antidote, 1896 PHA amendments introduced staggered 3-year appointments for ratepayer members on local health boards. Wellington County townships complied with this change in approach to their ratepayer appointments.

102 It is worth highlighting that, given the prejudices, practices and legal prescriptions of the time, all members of Wellington County townships’ local boards of health were men.
not reveal the process used to identify ratepayer members for health boards but it is likely that political and personal connections played a significant role. While a few townships appointed physicians to one of the ratepayer positions, there is no indication that medical knowledge or other forms of public health experience were required. Most appear to have been farmers in the township. The evidence of considerable persistence among ratepayer members from year-to-year suggests that these appointees were generally satisfied with their public health role and were willing to serve. Continuity further suggests that members were not subject to significant criticisms in consequence of their BOH’s work.  

Wellington County townships exhibited a willingness to expend small portions of precious tax revenue on public health measures but did so guardedly. Evidence available through Provincial Board reports suggests their expenditures were in line with those of other southern Ontario townships (Appendix I). The cost for operating a BOH was driven by three expenditure categories: remuneration and expenses for BOH members, remuneration and expenses for BOH officers (i.e., MHOs and SIs), and extraordinary expenses associated with BOH interventions. The typical per diem paid to Wellington County township BOH members was $2.00. BOH Chairmen, sometimes assisted by the board Secretary, were responsible for tracking costs, and

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103 Only two instances are recorded of BOH member resignations during 1884 to 1900. At Pilkington Township’s first BOH meeting of 1891, Mr. Larter, who had served as a ratepayer member since its inception in 1884, resigned. Another instance appears in 1895 in Eramosa Township during 1895. The township council appointed Mr. Dredge to serve as a new ratepayer member on the BOH. However, at its first meeting for the year, the Eramosa BOH learned that Mr. Dredge, “declined acting as a member of the board.” Another citizen, Mr. Auld, was ultimately appointed in his stead. (Pilkington Township Board of Health Minutes, May 9, 1891, Wellington County Archives, A1982.14; and Eramosa Township Board of Health Minutes, February 4, 1895 and November 15, 1895, Wellington County Archives, A1985.37.)

104 This could include vaccination programs or legal and court costs.

105 If a member was unable to attend a meeting, no payment was provided.
when an annual report was submitted to the township council (usually in November), it usually included the board’s funding request. With council’s approval, the requested amount was issued and the Chairman distributed the appropriate payments. Some circumstances occasioned mid-year requests to council from the BOH for funding, but they appeared to be infrequent and generally related to vaccine purchases, local newspaper invoices, or extraordinary nuisance removal costs. Otherwise all health board accounts had to wait to be paid until the end of the calendar year.

While details are not explored in this paper, it is worth observing that township councils also made other allocations for public health in addition to their BOH allocations. These included payments to physicians and other citizens for care given to sick indigents as well as sums issued to those who had buried dead animals or tended to other nuisances found in roadways or other public spaces in the township. Beginning in the late 1880s, township councils also provided funds to hospitals in Guelph and Toronto in response to regular appeals for municipal support. Summed together, in some instances these council expenditures rivaled or exceeded the total allocated to their board of health. For example, Erin Township’s council issued $25 to local physicians for their services to two indigent families. At the same meeting, it also provided its annual BOH allocation of $20.¹⁰⁶

Wellington County townships’ public health activities were influenced by a desire to restrain BOH costs. This is primarily discernable through actions taken in establishing the structure and operations of their BOHs, including the earlier referenced “distributed” responsibilities assigned to BOH members. Only one instance was found

among township records about citizen’s concerns with health board expenses. It was an 1896 complaint brought forward to Pilkington Township’s council by Mr. George Strangway who argued that,

it was out of all reason that the Sanitary Inspector was doing the work which ought to be performed by the school trustees or the school inspector. He also stated that the Board of Health account from the Township of Minto, a municipality which was more than twice the size of Pilkington, had only amounted to the sum of $35.00 and that according to the Act no member of the Board was entitled to more than $5.00. He urged upon the council a policy of retrenchment regarding the Board of Health.¹⁰⁷

His comments appeared to have no immediate effect on the township’s BOH operations. Township BOHs were generally prudent about the number of meetings they held annually as each gathering of members would generate per diem costs for those in attendance. During the 1880s and 1890s, most other Wellington County township BOHs met two or three times each year (Appendix E).¹⁰⁸ These meetings were typically held in the winter and/or the spring, and then again in the late fall. Meetings in the summer or early fall, when farm activities were particularly intense, were uncommon but happened occasionally.¹⁰⁹ In some townships, to address particular situations that arose in a year, the number of meetings increased to four or five and, in one case, eight (Appendix E).¹¹⁰

¹⁰⁷ Pilkington Township Council Minutes, January 20, 1896, Wellington County Archives, A1985.37. The intersection of public health and schools will be examined elsewhere in this paper.
¹⁰⁸ Arthur and West Luther, which distributed monitoring responsibilities among their BOH members, represents the extreme among Wellington County townships in their avoidance of meeting costs. For example, in 1887 West Luther Township’s BOH stated, “…the health of this township has been so good that there has been no necessity for calling the members of the Board together.” West Luther Township Board of Health Annual Report in Ontario, “Board of Health Report for 1887”, 92.
¹⁰⁹ In June 1885 the Guelph Township BOH Chairman, referring to the need for a future meeting of the Board, commented: “I think it would be well to call a meeting of the Board at an early day next Saturday or the fair day to consider the above as it might prevent the necessity of calling a meeting when the more busy [sic] season commences.” Guelph Township Board of Health Minutes, June 29, 1885, Wellington County Archives, A1988.122.
¹¹⁰ See West Garafraxa, 1891 in Appendix E. The extra meetings were held to address a matter concerning Mr. Lightbody and that entailed legal action. The circumstances of this case are examined subsequently. In one instance, a joint meeting of a township council and its BOH occurred. The joint meeting was in Eramosa Township during November 1885 and was prompted by the BOH’s first
Wellington County townships, while maintaining financial restraint over health board costs, appear typical of Ontario township expenditures on public health during this period. While the information available from Wellington County township records is not complete or consistently reported, it gives a general sense of township costs for local boards. Most annual expenditures on health boards hovered in the range of $30 to $50 per year, spiking up on occasion to address protracted nuisance cases or outbreaks of infectious disease. Using Eramosa Township as an example, over the years 1889 to 1897, annual health board allocations represented between .2% to .7% of the township’s yearly expenditure and averaged at .4% of municipal spending. Its allocations for roads and related infrastructure such as bridges and ditches as well as expenditures to the county for schools, courts and the house of industry, represented a much larger claim on township resources in keeping with local needs and priorities. The annual expenditures of other Wellington County townships were in keeping with those of townships in southern Ontario. For example, in 1894, expenditures by Oxford County townships ranged from $0 to $97 per year and, those of Grey County, from $0 to $75 annually. Information on Toronto-area townships in 1897 indicated annual health board expenses exhibiting a much wider range, $0 to $506 per year, with a median of $69 per year and an annual average of $121 (Appendix I).

The experience of Erin Township offers a useful illustration of townships’ desire for cost restraint. In its December 1889 annual report, Erin’s BOH acknowledged the need for restraint in its operating costs and moved to distributed responsibilities:

To prevent any unnecessary meetings of the Board, and consequent expenses…the following resolution was passed: That each member of the Board

recommendation for township support of a vaccination program. The initiation of this vaccination program is discussed later in the paper.
be empowered to remove or cause to be removed any nuisance that may be found to exist in his respective locality; also if any epidemic or contagious disease should arise in his locality, to give his attention to the matter and report if he thinks necessary to the Chairman of the Board with a view of taking the matter into consideration.111

The year 1889 had been difficult for Erin’s BOH. It had exceeded its council-prescribed expenditure maximum of $50 that year in addressing an outbreak of diphtheria. Its costs had climbed to $73, including $31.50 paid to the township’s MHO. No doubt this experience was instrumental to its decision to take a new, distributed approach that placed greater responsibilities on the shoulders of its board members so that less was spent on its health officer’s services.

The following year, 1890, Erin’s BOH costs were significantly reduced, totaling only $20 of which only $4 was issued to the health officer. In 1891, it declared the township’s health to be satisfactory with no infectious disease reports during the year. Annual expenses were kept to $21 with just $5 issued in payment to the MHO.112 Costs spiked up somewhat the next year, 1892, totaling $39.50 due to a few cases of diphtheria, typhoid and scarlet fever and then returned to more restrained totals for several more years.113 Overall, particularly after the 1889 spike occasioned by the diphtheria outbreak, Erin’s BOH managed to keep its annual costs well under the $50 that its township council set as a maximum.

Township Health Officers and Sanitary Inspectors

Despite their priority for financial restraint, most Wellington County townships appointed a health officer or sanitary inspector by 1889 and retained the position to at

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112 Erin Township’s health board expenditure information for the years 1889 to 1900 is detailed in Appendix I. Erin Township Council Minutes, December 15, 1891, Wellington County Archives, A1985.55.
least 1900 (Appendix F). As appointment decisions were under the control of township councils, it appears that councillors as well as BOH members soon came to appreciate the value of MHOs and SIs to public health endeavours. Peel Township made appointments to both of these roles throughout the years 1884 to 1900. Two others, Pilkington and West Garafraxa, also appointed both an MHO and an SI for at least a portion of the years 1884 to 1900. Over the period of about 1885 to 1892, it appears that the relatively small townships of Nichol and Pilkington shared their MHO.\textsuperscript{114} Guelph Township shared its SI, Captain W. Clarke, with the City of Guelph.\textsuperscript{115}

Tension could emerge around the selection of an MHO, especially one who was pushing for actions that went beyond community acceptance. In 1895, the council in Arthur Township was presented with a request to appoint Dr. Reynolds as MHO. This represented a change: Dr. McPhaden had served in the role since its initiation in 1893. Some councillors opposed a change, asserting that McPhaden be retained “as no complaints have been made against him.” In spite of their appeals, Reynolds’ supporters won the day. His appointment began in early 1895 and continued through to the end of 1899 (Appendix F). Underlying the change was township council’s discontent with McPhaden’s strong recommendation for a smallpox vaccination program in the township during 1894. The case reveals the role of local politics as a factor in MHO and SI appointments and the premium placed on appointees who could fulfil the role while imposing minimal disturbance within the community.

\textsuperscript{114} While the information available is not entirely complete for these years, it is very likely that Pilkington and Nichol townships shared Dr. Arthur Paget as their Medical Health Officer until the early 1890s.

\textsuperscript{115} The City of Guelph and Guelph Township were distinct municipal jurisdictions during the period examined in this paper. The City of Guelph established its own Board of Health and appointed Captain W. Clarke as its Sanitary Inspector prior to the creation of a BOH in the neighbouring jurisdiction of Guelph Township.
Evidence suggests that an MHO or SI assignment generated value for the appointee and gained them respect and influence within the local community. Health boards oversaw the work of their health officers and saw to their compensation according to the terms specified by the township council. In some cases, the MHO and SI worked very closely with their local health boards. In others, it appears their health officials worked quite independently, only requesting BOH meetings in extraordinary situations. All the MHOs in Wellington County townships were physicians carrying an M.D. designation. None of the SIs appeared to have special training or experience related to public health. Most appointees retained their position for multiple years. From the perspective of the BOH and township councillors, their health officers and sanitary inspectors provided a very useful intermediary role for public health matters. Health board members were not immediately implicated if the initial judgement about a citizen’s complaint or concern by their MHO or SI proved too controversial. Shielded from initial involvement in the matter, their need for direct involvement could be held in reserve and only activated when it was needed to reverse or ameliorate their officers’ directives.116

The expertise, affluence, and influence of township health officials brought value to BOH deliberations as various local public health concerns were addressed. In a few instances, Wellington County townships appointed a health board member that carried the dual role of health officer or sanitary inspector.117 Today such a double assignment

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116 This ‘buffering’ may have been particularly important to the Reeve who, as an ex officio member of the BOH, would be mindful of the potential impact of public health actions that could affect prospects for re-election.

117 Examples include Eramosa (MHO is a member), Pilkington and West Garafraxa (SI is a member) (Appendix H). Township BOH membership charts signify individuals who were both BOH members and either MHOs or SIs.
would be regarded as a conflict of interest, as the BOH managed the remuneration and
day-to-day work of these public health officers. This outlook, however, was not an
inhibiting factor at the time. To the contrary, the overlapping roles carried by a
physician or a leading member within the community and the duality of their position
deepened their ability to serve as an immediate, expert resource for the health board.
At the same time, the BOH’s per diem costs were contained and, with their ready
access to the views of the entire board membership, the decisions of MHOs and SIs
about public health interventions could be more readily managed to suit local attitudes.

Over time, MHOs and SIs became key public health advocates within the
townships. In June 1884, Puslinch’s Reeve convened a special council meeting
dedicated solely to the need to appoint someone who could support the work of the
BOH. The council approved the appointment of a sanitary inspector whose
responsibilities included that he would “…inspect as directed by the Board of Health all
premises occupied by persons residing within its jurisdiction and shall report to the
board each and [every] case [of] refusal to permit him to make such inspection…”
Further, he was to “…keep an accurate account of the time occupied and expenses
incurred in the actual performance of his official duties.” His compensation was set at
$2.00 per day for services plus expenses.118 Meeting records from other townships’
health boards offer multiple examples of health officers and sanitary inspectors
monitoring conditions across the township and acting with dispatch to resolve local
nuisance complaints or infectious disease concerns. Illustrations of their influence and
impact will be examined in subsequent chapters.

118 Puslinch Township Council Minutes, June 23, 1884, Wellington County Archives, A1991.120; and,
While the Puslinch BOH saw the advantage of having a public health official, other townships did not make appointments as quickly. In 1884, Pilkington’s BOH concluded that, “…as there is no [sickness] in the Township it was not considered necessary to appoint a Health Officer at present, nor a Sanitary Inspector.” Further, in its annual report that year, it stated that as long as there was no sickness in the township, no health officers were necessary.119 Eramosa Township also took a measured approach. When the health board was established, the council rejected the need to appoint public health officers. Its reasoning was that the direct involvement of health board members in public health matters would provide them with “a better understanding of the working of the Act [than] can be obtained then if these officers were appointed.” This view held during 1884, the first year of the health board’s operation, but by the next year an MHO was appointed.120 Guelph Township also waited until 1885 to appoint a public health official. Its decision to hire a sanitary inspector was explained as follows:

In consequence of several complaints of nuisance in the early part of summer and the inconvenience of calling a meeting of the board to instigate in each case, the services of Capt. W. Clarke, Sanitary Inspector of the City of Guelph was obtained to [also] act in the capacity for the Township.121

The imperatives of the growing season for BOH members during “the early part of summer” may have been a key driving force for the decision. Given the seasonal demands of their farming responsibilities, health board members realized they needed

119 Pilkington Township Board of Health Minutes, June 9, 1884, Wellington County Archives, A1985.37; and, Pilkington Township Council Minutes, November 25, 1884, Wellington County Archives, A1985.37.
120 Eramosa Township Board of Health Minutes, May 26, 1884 and February 2, 1885, Wellington County Archives, A1982.14.
121 Guelph Township Board of Health Minutes, December 2, 1885, Wellington County Archives, A1988.122.
help from someone who could be reliably available at all times of the year to respond to public health complaints.

The compensation of township health officers and sanitary inspectors varied greatly among townships and from year-to-year (Appendix I). This did not create an obstacle for the township BOHs in finding individuals to fill these roles. While Guelph Township started with a payment of $20 annually in 1885, by 1887 it paid its sanitary inspector $50 per year. By contrast, Puslinch Township paid $2 per day and, as a result, annual payments to its SI varied between $16.50 (1886) to $43.50 (1898) reflecting activity levels and the year’s out-of-pocket expenses. In 1891 Minto Township paid its MHO $10.00 but then moved to annual amounts of $15 and $20 subsequently. Erin and West Garafraxa paid their MHO as little as $4 or $5 in some years. The compensation paid to MHOs and SIs appears especially constrained when compared to the annual amounts provided to BOH members for their per diems. Either township health officials were not very active – belied by reported activities for MHOs and SIs – or that they found sufficient opportunities to generate alternative income to ameliorate their low BOH income. This may have included separate payments received privately from local citizens for nuisance removal, allocations from township council for medical care of local indigents, or sums from administration of special initiatives such as vaccination programs. While evidence to support this possibility is scant, a suggestive example appears in Peel Township during 1888. The council paid $15 to one of the township’s
two MHOs for medical attendance to a local indigent.\textsuperscript{122} This payment was in addition to the stipend of $7.75 that the MHO received that year (Appendix I).\textsuperscript{123}

**Townships’ Public Health Communications**

Over the years, township residents increasingly called upon their local BOH and public health officials to address various matters covered by provincial health legislation. In addition, BOH activities and interventions increased in response to local complaints and concerns. Townships’ communications efforts fueled a growth in citizen awareness of the role and authorities of the local BOH. West Garafraxa, for example, prepared 500 copies of selected sections of the PHA in 1885 for posting and general distribution within the township.\textsuperscript{124} Guelph Township directed public communications not only to its own citizens but also to neighbouring city folk. As Guelph Township wrapped around the City of Guelph it often dealt with dumping on its farm lands by city residents. In 1892 it took action, “feel[ing] it an injustice to the Township to be put to so much expense in removing nuisances…” A notice was placed in a city newspaper warning that, “the deposition of dead animals or anything that may be a nuisance in the Township of Guelph will be punished as the law directs and where…advisable [by

\textsuperscript{122} Peel Township Council Minutes, May 28, 1888, Wellington County Archives, A1985.53.

\textsuperscript{123} It appears that Peel Township paid $7.75 annually to each of the two MHO’s it had on retainer. It is worth observing that the BOH’s stipend to its MHO pales when compared to special allocations made by the township council to local physicians and others for serious illnesses that struck impoverished households. A very sad case in Peel during 1889 is illustrative. Dr. Cassidy received $42.50 from township council for care provided to the Cooper family. Diphtheria had led to multiple deaths among the Coopers. Information from death registries found on Ancestry.ca reveals the family’s losses: John (age 3) – d. April 1, 1889, Donald (age 14) – d. April 4, 1889, Archie (age 18) – d. April 12, 1889, and Christina (age 20) – d. April 19, 1889. In addition to the money paid by the township to Dr. Cassidy, it also paid $30 for 4 coffins and a further $27 for various other assistance given to the family. (Peel Township Council Minutes, May 28, 1889, Wellington County Archives, A1985.53.)

\textsuperscript{124} West Garafraxa Township Board of Health Minutes, January 19, 1885, Wellington County Archives, A1981.82. West Garafraxa continued to make efforts to encourage appropriate sanitary cleanliness among its citizens. In April 1889, it printed and distributed 100 posters, “…notifying all parties in the Township to have their yards and closets cleaned up by the fifteenth day of May next…” (West Garafraxa Township Board of Health Minutes, April 10, 1889, Wellington County Archives, A1981.82.)
Two years later, the Township’s SI observed a reduction in dumping complaints in the township: “the number of dead animals [has] fallen off this year, and I consider that the notice given through the papers…has been the cause of it.”

Townships also distributed public health information concerning sanitation and contagious disease through their schools. While they were in session, schools provided a ready channel of contact to farming families who lived at a distance from one another. BOHs recognized the value that might arise if schools served as local role models in sanitary standards and the management of contagious disease. Township residents appreciated their schools and respected the educational leadership they offered in the community. This made them a particularly suitable venue for distribution of the BOHs’ information. The fact that schools had their own sources of tax funding and operated under the direction of local school trustees was also useful to BOHs. In issuing directives through the schools and to their trustees, BOHs broadened their base of influence within the community and, at times, found an opportunity to also redirect some of their related costs.

Public communications by township health boards, including their engagement of local schools, contributed to increased awareness of public health measures and helped
establish their authoritative role on public health matters. Public communications also offered a degree of accountability to local taxpayers for BOH initiatives and their resources. At the same time, increased public health awareness also stimulated complaints and concerns requiring the BOH’s attention which, in turn, reinforced its value to the community. BOHs usually published their annual reports and those of their health officials in the local paper. While this was not effective for time-sensitive news, it allowed local citizens to be informed about PHA provisions, related local bylaws, and the BOH’s assessment of local health conditions.\footnote{In addition to submission to the Provincial Board of Health each November or December, it was a common practice among Wellington County townships to have annual BOH, MHO and/or SI reports printed in the local newspaper. For example, in 1890 the West Garafraxa BOH instructed its Secretary to have the annual reports of its MHO and SI printed in the \textit{Fergus News Record}. (West Garafraxa Township Board of Health Minutes, November 18, 1890, Wellington County Archives, A1981.82.)} Citizens became aware of how their taxes were used for public health concerns and they were informed about local expectations for cleanliness and sanitation. BOH communications about local standards were typically focussed on preventing the accumulation of filth in public spaces such as roadways and local water supplies. Calls for spring clean-ups of wells, privies and household yards (especially in villages) were common, as were notices about BOH authority to inspect and direct households in instances of contagious disease outbreaks.\footnote{The Puslinch Township public health bylaw (Appendix G) incorporates sanitation standards that were typical to communications issued by many health boards in Wellington County townships. The consistency of their application and enforcement varied significantly.} Proactive attention to public health communication by the townships also served to forestall provincial interventions and mitigate their exposure to financial or legal liability.
Conclusion

The initial and evolving approaches used by Wellington County townships in establishing structures and processes for public health reveal underlying assumptions about public health. There is little evidence the local population had any significant objections to the existence of these public health structures and processes of the PHA. The basic public health structures and processes changed little from 1884 to 1900 nor did the people who exercised local public authority. This was largely due to the perception that the PHA was needed primarily for health problems borne of urban conditions and the need for its application in rural areas was limited. Townships considered rural living to be inherently healthy and, to the extent that this was threatened, it was due to the unchecked creep of urban ills into the community. This perspective was reinforced by the strong preference of rural citizens for limited government. While initially townships saw no need for health boards, once they became mandatory, they were established. The desired local control over public health matters was maximized while the related cash outlays were minimized.

While the structures and process for Wellington County townships exhibited a lack of dynamism that may cause us to conclude that nothing changed in their public health perspectives, this would be the wrong conclusion. An examination of their responses to nuisances and contagious disease during the period points in another direction as we will see in subsequent chapters.
CHAPTER 4 - WELLINGTON COUNTY TOWNSHIPS: PUBLIC INTEREST IN NUISANCES

Throughout the mid- to late-1880s and early 1890s, the Boards of Health in Wellington County townships’ BOH’s reveal their significant attention to complaints about “nuisances”. Their local citizens raised concerns about dilapidated houses, abandoned animal carcasses, night soil dumping, and the filth and odour of “offensive trades,” such as animal slaughtering. Often these concerns emerged in the spring. Dead animals and debris that collected and froze during the winter, issued highly unpleasant odours once warmer temperatures arrived. Township choices in addressing these sanitation nuisances point to key elements shaping rural perspectives on public health. Health boards became more confident about the scope of their mandate and more willing to deploy their authority. They provided locally-tailored responses to citizen concerns about perceived threats to public health such as recalcitrant owners of dilapidated houses, decaying animal carcasses, night soil dumps, offending slaughterhouses, and unsanitary school wells and privies. BOHs soon demonstrated a willingness to use the full range of their authorities when necessary, calling upon the provincial health board if warranted or deflecting provincial involvement where it was not. Township health boards placed a premium on neighbourhood perspectives in the quest to resolve a complaint. They also engaged local schools as unwitting allies in the effort to distribute public health information and act as role models in the way they kept school wells and privies. In the process of handling sanitation nuisances, BOHs learned how local bylaw adjustments or prescribed rates for nuisance removal could mediate divergent interests in the community. These rules and processes defined BOH entry
and exit points in the course of a complaint, particularly when they might involve neighbourhood disputes. BOHs also learned that, on occasion, their efforts to find resolutions to local complaints allowed them to define and defend township interests that were threatened by the behaviour of neighbouring jurisdictions or other levels of government. Throughout, BOHs exhibited a commitment to financial restraint and an appreciation for creating minimal interference and disruption in the people’s lives. Taken together, BOHs’ response to nuisance complaints proved their value to local communities and built their credibility as an effective advocate of local health interests.

Dilapidated Houses

Public health legislation addressed concerns about the destitute living within the township as well as others regarded as local misfits. It allowed concerned citizens to call upon their local boards of health to address perceived health concerns from a dilapidated house. For them, such a house embodied a dual threat to the community’s health and vitality from its perceived perpetuation of local poverty and its introduction of unsanitary conditions. The work of West Garafraxa’s health board during the years 1886 to 1891 provides an example of such a case. It concerned the condition of Mr. Gravel E. Lightbody’s log house in the village of Belwood.130 As the case unfolded, the BOH grew increasingly assured about its use of public health authority and adapted its approach in response to the obstacles encountered to assert its powers.

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130 West Garafraxa Township Board of Health Minutes, May 7, 1886, February 21, 1891, April 18, 1891, May 30, 1891, June 13, 1891, August 22, 1891, September 15, 1891, September 22, 1891, October 6, 1891, November 7, 1894, Wellington County Archives, A1981.82. In addition, records for inmates of the Wellington County House of Industry were also utilized to confirm the dates of Mr. Lightbody’s admission and discharge from this facility.
As was the case in other Wellington County townships, the West Garafraxa BOH placed extra scrutiny on the sanitary conditions of villages within its jurisdiction. This reflected the belief that the main risks to the township’s otherwise positive health condition emanated from the pockets of concentrated housing in township hamlets. Dilapidated houses in these communities reflected poorly on the township’s reputation as a healthy community. The first reference to concerns about Lightbody’s house appeared in May 1886 soon after the BOH issued a notice in the village directing householders to remove and then burn or bury debris in their yards. The BOH hesitated to take action on the complaint without first seeking “the means” from township council to have Lightbody’s house “removed or disinfected.” He was known as a local indigent and unable to afford improvements to his premises. Records do not reveal the details, but a resolution was achieved at the time and Lightbody’s house falls from the attention of the health board until in April 1891. The renewed concerns prompted an inspection of the property by the BOH membership and Lightbody’s house was declared to be in “unsanitary condition.” This time, the BOH did not hesitate and directed its MHO and SI to intervene. They instructed them to inform Lightbody that he must clean-up his premises immediately or face the prospect of his house being demolished. At the same time, they were to seek provincial permission to act on the threat. When Lightbody’s deadline arrived, the health board learned that he “refused” to satisfy the calls for clean-up of his premise. BOH members again visited Lightbody but he refused them entry to his premise. The board responded to the affront by laying charges against Lightbody for his failure to recognize the BOH’s inspection authority. Subsequently, a panel of
local magistrates heard the case and, for reasons left unexplained in the BOHs’ records, the case was dismissed. The BOH was assigned the related legal fees.

The Lightbody case shows that the township’s approach to nuisance management was evolving to exhibit greater comfort with its health board’s mandate and authority. The BOH’s hesitation to act in 1886 had disappeared by 1891. BOH members as well as both of the township health officials were called to be involved in the case. Prior consultation with the township council about board interventions was eliminated. By 1891, the health board moved with dispatch and acted using the full scope of its authority, exhibiting no effort to accommodate Lightbody’s indigent status.

Local court judges were not, however, in the same frame of mind. They were unwilling to support the BOH’s assertion of authority. This, however, did not end the Lightbody story. The BOH was not dissuaded by its setback in the courts. It retained three men known for their building knowledge to inspect Lightbody’s house and provide an opinion on its condition. The local men reported that the house could not be brought to habitable standards. Lightbody was informed of their conclusion and told that he must repair his house immediately or the board would “look after him”. While Lightbody indicated he would complete the required repairs, his situation did not improve to meet the health board’s satisfaction. As a result, the Reeve was called to apply his authority over indigents and Lightbody was placed in the Wellington County House of Industry. This was done in June 1891 and it provoked reaction in Lightbody’s defence.

Andrew Lightbody, Gavel’s brother and a local postmaster, initiated legal action against the township. West Garafraxa marshalled its defence. The BOH obtained a further report from Dr. Groves, a highly respected local physician and surgeon,
reiterating that Gravel’s house was uninhabitable: “… it is in a most filthy and unsanitary condition and is totally unfit for a human’s habitation. I think further that the building is in such a state of dirt and rottenness that it cannot be properly cleaned or put into a state fit for occupation.” The BOH also requested the advice of the Secretary of the provincial board, Dr. Bryce. Bryce travelled by train from Toronto to inspect Lightbody’s house. His report supported the BOH’s judgement saying that they were acting in the best interests of the public’s health. By October 1891, after removing Gravel Lightbody’s possessions, the house was demolished by the township. Meanwhile, Gravel Lightbody was discharged from the Wellington County House of Industry in September, a development likely facilitated by his brother Andrew.131 It is not clear where Gravel lived after leaving the House of Industry but he died in West Garafraxa in 1893, two years after his house was destroyed. His cause of death at age 61 was recorded as “suffocation of smoke.” Interestingly, it was registered by West Garafraxa’s MHO who was also listed as Lightbody’s attending physician.

The Lightbody case reveals evolving perceptions in Wellington County’s rural municipalities about public health, particularly its application to local poor or those who ignored local authorities. As a protracted case, it demonstrates the ways in which township BOHs moved over the years from initial, tentative measures in pursuit of public health work to a much more confident application of the full range of their authority. In this case, the complaint stemmed from the BOH’s particular focus on village life in the township, the area it perceived to embody the greatest risks to citizens’ health. It also

131 The date of Gravel Lightbody’s discharge was provided by the Wellington County Archives’ inventory of the House of Industry residents. Information about his death was obtained through a search of Ontario death registrations on ancestry.ca.
illustrates the presumption that poverty and poor sanitation are corollary conditions that can fairly engender the use of the full repertoire of municipal authorities. The swift intervention of the BOH in 1891 demonstrated a distinct change in the BOH’s confidence about local support for its authority in such matters. It mobilized a full repertoire of the enforcement tools available, including local and provincial experts and the township’s authorities over indigents. While it met with some resistance in doing so, including from the local courts, its will ultimately prevailed.

Another dilapidated house case is found in Guelph Township’s records. It also entailed engagement of provincial authorities but on an entirely different basis. In this case, the province was responsible for the presentation of the complaint. Richard Pick, a tenant farmer in Guelph Township during 1884 sought improvements to his house and took his complaint about the poor condition of his rented farm house to Provincial Health Board authorities, hoping that they would achieve the desired result without damaging his local reputation. A PBH inspector took up Pick’s complaint and wrote to Guelph Township’s BOH:

> It is with no small amount of reluctance that I write you at this time, but duty compels me to draw your attention to a fit subject for your Board of Health to look into, viz, the terribly filthy state of a house occupied by Mr. Richard Pick on a farm known as the Lindsay farm. I was there some time ago, and on Mr. Pick asking my advice with regard to it I urged him to bring it before the Board of Health but thinking he might be considered meddlesome (though fearing the consequences of living in such close proximity to so much filth) prevented him from laying it before the Board. I have therefore taken it on myself to notify you of it, and I can assure you it is not only Mr. Pick and his family who are in danger, for that may be the nucleus of some fell disease from which the whole neighborhood may suffer.  

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132 They may very well have been in this case.  
133 Guelph Township Board of Health Minutes, June 21, 1884, Wellington County Archives, A1988.122.
The letter had its desired effect. The BOH initiated an investigation and following an inspection of Pick’s house it agreed that there were “safety concerns” with the house. The BOH decided that, “in consequence of the owner of the property being away and reported to be of unsound mind,” it would arrange for the house to be cleaned at a cost of $8.00. The BOH advised the township council of its action.134

One can imagine the stir caused by the PBH’s letter at the BOH. The PBH’s letter, while at pains to appear diplomatic about the division of responsibilities between provincial and local authorities, was clearly prodding Guelph Township to act. The BOH recognized this immediately. It understood that the letter was a ‘shot across the bow’ and that, as part of getting prompt action on Pick’s concerns, it also needed to absorb the cost of the clean-up to ensure prompt action and minimize backlash from the local landlord. In addition, the BOH also placed a newspaper notice instructing those with nuisance complaints or contagious disease concerns “to notify [the] BOH Secretary with as little delay as possible.”135 The experience with Pick’s complaint made the Board realize this was necessary to avoid future incursions in local affairs by the PBH.

Sometimes the local BOH found itself calling on provincial authorities to meet their responsibilities to preserve appropriate sanitary standards. Several years after the Pick case, Guelph Township’s BOH received a complaint from another tenant farmer about the condition of his home. In this instance, the landlord was the province. In April 1890, a professor of the Ontario Agricultural College complained to the BOH about water in the cellar of his provincially-owned home that he considered a risk to his

134 Guelph Township Board of Health Minutes, September 20, 1884, Wellington County Archives, A1988.122.
family’s health. On this occasion, the township did not act to clean the house. Instead, it directed the complainant “to write to the Government and inform them that the Board of Health for the Township has instructed the Sanitary Inspector to inspect the place and … its present condition was injurious to [the] family’s health.” The BOH’s instructions were followed and the provincial authorities responsible for the OAC put the professor’s home into “a proper sanitary condition.”

BOH actions in response to complaints of dilapidated houses can be found among other Wellington County townships as well. In 1888, for example, Maryborough’s MHO reported that while he had inspected a number of premises only two were found to be “in an unhealthy condition”. When interventions were made, as in the Lightbody case, they were often directed at the poor. During 1890 in Maryborough Township, for example, the residence of a destitute elderly couple was deemed unfit for habitation due to its dilapidated condition and “unsanitary state.” The couple had been relying on the care of neighbours and were unable to look after themselves. On the BOH’s recommendation, the council had the couple moved to the Wellington County House of Industry perceiving this to be in the best interest of the community and the couple’s health. Township health boards were gaining confidence in the use of their authority and their local influence, particularly when it came to the addressing concerns about the local sanitary standards.

136 Guelph Township Board of Health Minutes, November 7, 1890, Wellington County Archives, A1988.122.
137 Maryborough Township Medical Officer of Health’s Annual Report in Ontario, “Board of Health Report for 1888”, 94.
Removal of Animal Carcasses

Another frequent category of complaint was the presence of decaying livestock carcasses abandoned on roads and elsewhere in the township. This was particularly true in the spring when the smell of animal decay was particularly oppressive and prompted public health fears. Of special public health concern were carcasses dumped in or beside local rivers and other sources of water for people and livestock. During the winter, when the ground was frozen and wood for burning was needed for heating, dead animals would be left to freeze on the ground or on ice surfaces. While the urban-oriented PHA did not include reference to public health risks from this cause, it was a matter Wellington County township citizens saw as a rural public health concern.139 The most vivid references to this category of complaint are offered in the records of Guelph Township which suffered especially from winter dumping by people living upstream in the City of Guelph. During 1888, for example, the SI reported frustration with his inability to determine the “guilty parties” for the more than twenty complaints of animal carcasses found dumped on roadways and into the Speed River.140

Typically, the crux of a complaint was uncertainty about the dead animal’s ownership and, hence, a question about who would deal with its disposal. Occasionally

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139 PHA, 1884, Appendix A. See especially section 35 of the Act that lists offensive trades (including those dealing with dead animals) and sections 8 and 9 of Schedule A addressing the location and inspection of slaughterhouses. Schedule A, section 15, Rule 5 also specifies regular removal of “putrid and decaying animal or vegetable matter” located in buildings or yards, calling for completion of this activity before mid-May each year.

140 Guelph Township Board of Health Minutes, November 3, 1888, Wellington County Archives, A1988.122. A similar concern was recorded in the SI’s 1887 report. (Guelph Township Board of Health Minutes, November 26, 1887, Wellington County Archives, A1988.122.) Examples from other townships are plentiful and include those in West Garafraxa referenced in its BOH report from 1886. (West Garafraxa Township Board of Health Minutes, May 7, 1886, Wellington County Archives, A1981.37.) See also Guelph Township’s Sanitary Inspector’s annual report for 1886: “The only thing in the shape of nuisances calling for the Board’s attention was the smells arising from dead, putrid animals – horses and dogs. These were attended to immediately after being notified of their existence…” Guelph Township Sanitary Inspector’s Annual Report in Ontario, “Board of Health Report for 1886”, 184.
the owner was known but had failed to take up their disposal responsibilities. Most often, however, the BOH had direct responsibility for arranging the carcass removal with the related cost absorbed by the township. Over time, expenses for this form of public nuisance grew, prompting several townships to make greater efforts to identify the dead animals’ owners. Some townships also concluded that a few locals were exploiting circumstances in order to earn money from carcass removal. Pilkington Township’s experience is illustrative. It was provoked to take action when it became entangled in an unresolvable neighbourhood dispute that came before the health board about an unburied animal carcass.\textsuperscript{141}

In May 1893, Pilkington’s BOH received a complaint from Sylvester Lasby about a dead horse he had found on his farm. Lasby asserted it was the horse of his neighbour, James Hall, who refused to take responsibility for its disposal. Lasby asked the health board to take action. The BOH responded, directing Hall to remove the carcass and see its disposal, “or stand the consequences at law.” At first the BOH’s intervention seemed sufficient, however, five months later, Lasby returned seeking its further assistance. It seems that Lasby, impatient with Hall’s sluggish response, buried the rotting horse himself and wanted compensation from the BOH for doing so. The BOH attempted to settle the matter, summoning five witnesses including Hall and Lasby to a hearing, however, none but Lasby responded. It was left that the BOH would pursue Hall for payment through the courts. Seven months later, Lasby’s request for compensation remained outstanding and the BOH had not initiated court action.

\textsuperscript{141} Pilkington Township Board of Health Minutes, May 2, 1893, October 31, 1893, November 18, 1893, January 28, 1894, and, June 20, 1894, Wellington County Archives, A1985.37; and, Pilkington Township Council Minutes, May 29, 1893 and January 14, 1894, Wellington County Archives, A1985.37.
Frustrated, Lasby took the matter to the township council which, in turn, directed the Board to act. After all was settled, unfortunately, there was no happy ending for Lasby. The court dismissed the case in its entirety as all the parties involved had taken too long to act.

The Pilkington BOH took its own lesson from the experience. Its futile interventions provoked its resolve to change how this category of complaints was handled. Requests for reimbursement to remove dead animal carcasses had increased significantly and were accompanied by claims for larger reimbursement amounts. The board was suspicious that carcass removal was becoming overly attractive as a money-making opportunity. To put a stop to its potential misuse, changes were made to how the BOH would handle them in future. Reimbursement of costs would only be made in instances where the BOH had approved of a carcass removal in advance. Further, payments would be limited to the BOH’s prescribed rate schedule.\textsuperscript{142}

By the end of the era under study, the citizens in Wellington County’s townships felt comfortable with utilizing local public health structures and processes to deal with abandoned animal carcasses. BOHs were responding and, in doing so, addressing a matter of local importance. As long as remedies were not too costly for the township or

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\textsuperscript{142} For burial of dead animals found on public roads, Pilkington Township’s BOH would not pay more than $2.00 for a horse and 75 cents per sheep. It indicated discomfort with reimbursing anyone who had not received prior approval for dealing with the nuisance from a BOH member or its MHO. (Pilkington Township Council Minutes, May 29, 1893 and January 14, 1894, Wellington County Archives, A1985.37; and, Pilkington Township Board of Health Minutes, October 19, 1895, November 30, 1895, July 17, 1896, Wellington County Archives, A1985.37.) By 1893, Arthur Township decided to put an end to the practice of paying for the burial of dead animals that had not been authorized by its BOH: “...the Council indicated it would not recognize any further accounts of burial of nuisances found on the highway except those that the Board of Health had been called upon to investigate.” Arthur Township Council Minutes, July 14, 1893, Wellington County Archives, A1985.49.
drew them into neighbourhood squabbles and fruitless legal actions, BOHs were comfortable using their authority to fulfill this public health function.

**Night Soil Dumping**

The dumping of night soil was another sanitation nuisance that was of particular concern to Guelph Township given its proximity to the City of Guelph. Sewage systems in urban areas were uncommon in this period and, in cities like Guelph, it was necessary to empty cesspools and privies periodically and then dispose of the gathered human waste, or night soil. Guelph’s collected night soil was sometimes removed to dumping areas in the neighbouring township where fields were acquired for this purpose. Soon after Guelph Township established its BOH, citizens began registering their night soil complaints. In September 1884, George Hirst complained that his family were “suffering from the effects” of night soil dumping in the field adjoining his residence by the City of Guelph scavenger, Henry Hughes. The BOH, citing township bylaws, notified both Hughes and the owner of the dumping field to remove the nuisance within ten days. Hughes responded promptly but asked for the township’s patience to allow time for the City to identify an alternate dump site. The township BOH noted that, “[while] it may be a serious matter for the City where they may deposit their [night] soil … it becomes far more serious for the Township when [the City makes] it their nuisance ground.” In later years, complaints about night soil dumping in Guelph

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143 Guelph Township Board of Health Minutes, September 20, 1884, Wellington County Archives, A1988.122.
144 At this time, people were able to make a living in urban areas by contracting for the removal of human and animal waste, dead animals and other forms of accumulated filth. Where the community served did not have a designated dumping area, sometimes a scavenger would pay a local farm owner to use of a portion of the farm’s acreage for dumping. Henry Hughes was motivated to find a resolution to the conflict between the City and the Township as he received business from both municipalities.
township, while less frequent, continued to draw the BOH’s attention. Resolutions became more routine, however, as the earlier experience had resulted in the designation of a local “nuisance ground” in a location where dumping created less discord in the township.  

Struggles with disposal of night soil also came from another source in Guelph township, the Ontario Agricultural College’s experimental farms. During the late 1880s, the SI pursued resolution to protracted complaints from township citizens about overflow from nearby College cesspools. The College’s director deflected the township’s calls for action, pointing to the responsibilities of the province for maintenance of college facilities. After almost five years of ongoing appeals to the Minister of Agriculture, changes were made to the College’s sanitary system that gave hope to Guelph Township’s BOH that the improvements would, “put an end to all the trouble regarding it.” The persistence of the Guelph Township BOH proved its value to the community. It resolved the building tensions between the township and its jurisdictional neighbours and defended its citizens’ interests through application of the powers and influence of its public health structures and processes.

**Slaughterhouses**

Complaints about conditions found in slaughterhouses, hog pens, fat rendering operations, cheese factories, and creameries drew considerable attention from township

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146 For example, Guelph Township SI’s 1892 report notes: “Complaints [were] made at my office that some person had dumped 3 barrels of night soil in the Township on the York Road. I found such to be the case and had them removed to the nuisance ground.” (Guelph Township Board of Health Minutes, November 19, 1892, Wellington County Archives, A1988.122.) Records suggest the “nuisance ground” was in the township’s jurisdiction but its precise location is not specified.

147 Guelph Township Board of Health Minutes, November 3, 1888 and November 2, 1889, November 9, 1889, Wellington County Archives, A1988.122.
health boards. The PHA gave municipal authorities control over the establishment and sanitation standards of activities and “offensive trades” that were considered noxious or otherwise offensive: slaughtering of animals, tallow melting, blood boiling, bone boiling, refining of coal oil, extracting oil from fish, storing of hides, soap boiling, tallow melting, tripe boiling, manufacturing of gas. Hog pens also were a frequent source of complaint for their offensive smells. The pens inspiring complaint were typically found in association with slaughterhouses or creameries as the by-products of these operations (i.e., animal offal or milk by-products) were re-purposed as feed for the hogs.

Particularly in the case of slaughterhouse operations, multiple examples exist of BOH directives requiring that operators bring their facilities up to township-specific sanitation standards. In most townships, the standards appear to have been drawn from the PHA’s Schedule A. For those townships that developed their own public health by-law, some standards were developed to meet local needs and interests. Puslinch Township’s by-law, for example, only included reference to the establishment and inspection of slaughterhouses omitting reference to other trades and operations, presumably because they had few or were unconcerned with their local impact (Appendix G). As discussed in the previous chapter, some townships reduced the required distance between slaughterhouses and other buildings to ease the implications for local operators. It is noteworthy that neither the provisions of the PHA or the conduct of township boards suggests that slaughterhouse inspections included any assessment of the health or care of livestock involved in these operations.\textsuperscript{148} Oversight was only required for the location and sanitary conditions of facilities. By the close of the

\textsuperscript{148} In addition to animals to be slaughtered and butchered immediately, slaughterhouses often had a hog pen nearby. The offal from the slaughtered animals would be disposed by feeding it to the pigs.
century, most Wellington County township health boards were conducting regular inspections of these kinds of operations located in their jurisdiction.

Owners of slaughterhouses and other “offensive trade” operations generally complied with township health board directives whether they resulted from citizen complaints or inspections. They were motivated to do so as the PHA provided townships with authority to approve their establishment and continued operation. In some situations, however, compliance was a challenge. Two protracted slaughterhouse cases, one in Pilkington and the other in Eramosa, illustrate townships’ efforts to steer a course in these matters of public health.

The first concerns a long time resident of Pilkington Township, Alex Kerr, who operated one of the municipality’s slaughterhouses. The Pilkington BOH handled complaints about Kerr’s operation over four years, beginning in 1888.149 In doing so, it exhibited judicious use of its public health powers to diffuse neighbourhood tensions while applying sanitary standards that minimized the hardship for their local slaughterhouse operator. Neighbourhood complaints about Kerr’s operation first appeared in the spring and the BOH instructed the MHO, Dr. Paget, to look into the situation and see to its resolution “before the warm weather sets in...” Action was taken and later Paget reported that Kerr’s slaughterhouse was in “good order during the summer heat.” In June the following year, a new complaint was registered asserting

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149 Pilkington Township Board of Health Minutes, April 21, 1888, November 20, 1888, June 1, 1889, November 2, 1889, July 19, 1890, September 13, 1890, and June 11, 1892, Wellington County Archives, A1985.37; Pilkington Township Council Minutes, July 12, 1890, Wellington County Archives, A1985.37; and, Pilkington Township Bylaws, August 20, 1890, Wellington County Archives, A1985.37.
that Kerr’s slaughterhouse and yard were in an “unhealthy condition.” The MHO again followed-up and the situation was remedied. Once again, the following summer brought renewed complaints from Thomas Berwick, Kerr’s neighbour, who reported that the slaughterhouse was “kept in a very dirty condition.” This time, after three years of problems, the BOH sought legal counsel about their authorities in these matters. The advice served to highlight the Schedule A specifications concerning the distance to be provided between slaughterhouses and adjacent buildings. The distance was 200 yards and Kerr’s slaughterhouse did not meet this standard. The BOH formulated a plan. Kerr was directed to clean his slaughterhouse yard and, over the coming month, shift the location of his slaughterhouse. While this work was undertaken, his slaughtering operations were to cease, undoubtedly a significant consequence for Kerr’s livelihood. At the same time, in an effort to minimize the impact of their directives for Kerr’s operation, the BOH also obtained an amendment to the local public health bylaw to ease the 200-yard requirement. With this change, slaughterhouses in Pilkington could be as close as 30 yards from adjacent buildings.\footnote{Schedule A could be amended as wished by local municipalities. As noted earlier, Eramosa Township also elected to incorporate a similar reduction in its public health by-law in 1894 and reduced the recommended 200-yard separation between slaughterhouses and other buildings to 75 yards.}

While the township had alleviated some of Kerr’s troubles with the bylaw amendment, its intervention did not stop the neighbour’s complaints which continued into 1890. In the fall of that year, at the suggestion of its MHO, a special BOH meeting was convened “to investigate the complaint of Thomas Berwick against the slaughterhouse and yard of Mr. Kerr...” Berwick and other neighbours were summoned as witnesses. Berwick claimed there was no improvement in the conditions at the
slaughterhouse and yard and, in his opinion, Kerr was not even making an effort. Testimony from other neighbours showed less concern about the slaughterhouse; while they had occasional issues with bad smells, its condition was satisfactory to them. George McKenzie stated that he, “…has no occasion to complain of the slaughterhouse or yard” and added that the pigs belonging to the complainant, Berwick, created a bad smell. Mrs. Chapman, who lived near the slaughterhouse, stated that while it smelled a little in warm weather, she never saw offal in Kerr’s yard, only an occasional load of manure. Another neighbour, Mr. Cornish, indicated that he “never smells anything about the slaughterhouse or yard”, and “never heard anyone complain about it.” Mr. Kilpatrick commented that his horses, “shied in passing, but not lately” and that there had been recent improvements in the smell coming from the slaughterhouse. Mr. Inglis, stating the obvious, commented that “every slaughterhouse has a bad smell” and that “Kerr’s was no worse than others”. Only William Atchieson indicated that he did “not want to have anything to do in the matter” and simply stated that he had no knowledge of how Kerr disposed of his offal and that, like others, on occasion his horses shied due to the smell when passing Kerr’s premises. The evidence before the BOH made it clear that most of the slaughterhouse troubles were fueled by a neighbourhood squabble and most supported Kerr’s view over Berwick’s.

After the hearing, the BOH set the Kerr matter aside, noting only that the MHO should continue regular inspections of the slaughterhouse. Complaints continued over the following two years and, by June 1892, the BOH decided it needed to act once again. Kerr was summoned to meet with the board and he took the occasion to defend

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151 Interestingly, the next year Mr. Atchieson was appointed to the BOH and served as a member every year between 1891 and 1900, except one.
his operation, insisting it was “perfectly clean,” and insisting again that the BOH’s attention be directed to Berwick, whose place was said to be “in a very unhealthy state.” The BOH did not make any further interventions in the matter, although it did obtain legal assurance that its earlier bylaw amendment to ease slaughterhouse standards was still lawful under the PHA. The BOH concluded, so long as its MHO was satisfied that the slaughterhouse met with bylaw standards, it would not trouble itself with further involvement in the neighbourhood dispute. As long as the MHO continued to provide positive reports on the slaughterhouse’s condition, the board could rely on the terms of the local public health bylaw in making judgements about whether and how it handled complaints. In managing this case, the Pilkington BOH exhibited skillful use of its influence and authorities in service of the public interest. It deployed its MHO as an intervening force effectively. The BOH also refined public health bylaws to clarify sanitation standards in a manner that responded to local concerns and could be satisfied by the local slaughterhouse operator. When the matter came to rest, the BOH had alleviated neighbourhood disagreements while Kerr was in a position to continue his slaughterhouse operation.

The case of William Hampson’s slaughterhouse in Eramosa Township also illustrates how townships tailored their public health bylaws to suit local conditions.\textsuperscript{152} In doing so, Eramosa also expanded the health board’s general latitude for handling slaughterhouse complaints:

\begin{quote}
…whereas, clause numbered eight of said by-law, as it applies to a “rural” Municipality, appears to be unnecessarily strict regarding the limit at which a slaughter house shall be distant from a swelling house, or the public highway,
\end{quote}

\textsuperscript{152} Eramosa Township Board of Health Minutes, May 18, 1889, May 27, 1889, June 1, 1889, and February 3, 1890, July 27, 1892, November 16, 1892, November 24, 1893, Wellington County Archives, A1982.14.
And whereas, there exists within the Municipality some slaughter houses which come within the distance limited by said Section No. 8, and as the enforced removal of these houses, as required by said Section, would appear to be an uncalled for hardship; it is therefore deemed in the best interests of those concerned, and with due regard for the public health, to repeal said Section No. 8 and leave each slaughter house subject to inspection as the local Board of Health directs, such inspection being provided for in Section No. 9 of said By-law.\textsuperscript{153}

Like the Kerr case in Pilkington, Eramosa’s BOH relied heavily on its MHO both in terms of inspections and related public health advice and also, as a local physician, in regard to his powers of influence and persuasion with members of the community.

While there is no evidence of any underlying neighbourhood squabble in regard to the Eramosa case, it still was influenced by neighbourhood perspectives. The BOH was persuaded of the need for a response by the view of one, influential neighbour with concerns about the condition of Hampson’s slaughterhouse. He happened to be a member of the health board in the neighbouring township:

Mr. Ramsay…a member of the Board of Health of Nassagaweya, [said] that he knew perfectly well that if such a nuisance existed in their township it would be immediately stamped out. He could truthfully say that, from what he saw and experienced, he wondered how the people in the vicinity of the nuisance had so long quietly put up with it.\textsuperscript{154}

While neighbours in the immediate area of the slaughterhouse may have been content to put up with its nuisance qualities, the Eramosa BOH was not willing to have Ramsay’s views and influence cast doubt on its ability to pursue appropriate and competitive sanitation standards for its community. Eramosa BOH’s course of action demonstrated a willingness to assert its full authority in the interest of the township’s reputation. Its threat to close Hampson’s operation if standards were not met proved

\textsuperscript{153} Eramosa Township Board of Health Minutes, May 27, 1889, Wellington County Archives, A1982.14.
\textsuperscript{154} Nassagaweya is a township in the neighbouring county of Halton.
useful in motivating the operator to amend his operations. Eramosa’s health board added the further threat of legal charges should there be a failure to comply with the directives it issued to Hampson. After more than three years of complaints and various health board interventions, the case was resolved. In his report for 1893, Eramosa’s MHO reported: “A long standing cause of complaint, the Eden Mills slaughter house was settled this fall by the owner erecting a new building in a most suitable situation, agreeable to the chairman and myself, and satisfactory to the citizens.”

**Sanitation in Township Schools**

The sanitation of township schools and complaints about their condition also became a focus of BOH attention, particularly beginning in the 1890s. Two features of their role within the community contributed to this. The cleanliness of the school house, its well and privies was perceived as a key preventative of disease among school children and, consequently, of the spread of disease to their families. The other was that the visibility of the local school and the influence it carried in the community from its educational responsibilities made it an excellent role model for sanitary practices within the community. Most township BOHs responded to complaints about the conditions of local schools and many moved to regular inspections conducted by their MHO or SI. As shown in the cases that follow, inspections and application of sanitation measures in schools varied. The activity raised new issues about the relative responsibilities of township health board members and local school trustees and some BOH interventions were not welcomed by school teachers and trustees.

Beginning in 1890, West Garafraxa’s BOH instructed the sanitary inspector to conduct regular inspections of the township schools. The SI’s resulting report was
printed in the local paper to raise community awareness of any issues and to marshal the pressure of public opinion to see them resolved. The approach appeared to be successful, as the indication of satisfactory results from school inspections was mentioned more frequently in BOH annual reports during the period. At the encouragement of its SI, Pilkington Township’s BOH launched regular school inspections in 1892 because it considered the sanitary condition of its schools was important to “guard against the outbreak of any disease.” After the first round of inspections, the SI advised that most of the schools “were not in a healthy condition.” Reports in subsequent years pointed to steady improvements and, by 1898, the BOH’s annual report indicated satisfaction with the state of township schools with the exception of one that had persistent issues with its water supply and another that was required to build a new school house. The 1898 report added that, “[School] Trustees of the different sections are anxious and willing to keep everything in a clean condition about the schools and outbuildings belonging to them…” The relationship between public health and school authorities in Pilkington was working well.

Arthur Township did not initiate school inspections until 1898 and intervened only in response to complaints. In 1897, as a cost savings measure, it tried without success to have the expense for dealing with these complaints recovered from the affected school’s budget. The responsibility for carrying the cost of pursuing school

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155 West Garafraxa Township Board of Health Minutes, November 18, 1890, April 18, 1891, May 21, 1892, and October 22, 1892, Wellington County Archives, A1981.82. By 1892, the SI’s school inspection reports included the name of the teacher and a school-by-school condition assessment.
156 See for example, in the West Garafraxa SI’s 1898 report: “I visited all the schools in your township twice during the summer about the time appointed to do so, and found everything in a fairly satisfactory condition.” West Garafraxa Township Board of Health Minutes, April 2, 1898 and November 5, 1898, Wellington County Archives, A1981.82.
157 Pilkington Township Council Minutes, November 18, 1898, Wellington County Archives, A1985.37.
158 Arthur Township Council Minutes, November 18, 1897, Wellington County Archives, A1985.49.
complaints also emerged in Peel Township. In 1892, its township council decided to pay its MHO directly for investigating complaints about school conditions and then withhold an amount equivalent to the cost from annual funding supplied to the affected school.\textsuperscript{159}

Township BOHs in Minto and Eramosa had disappointing experiences with efforts to improve conditions in their local schools. In 1889, Minto’s MHO commented that trustees in some township school sections “have been careless” in cleaning school wells. He cautioned that “their neglect to do so has in some cases caused sickness, and if not attended to in future may give rise to an outbreak of some epidemic such as diphtheria or typhoid.”\textsuperscript{160} Eramosa’s BOH was also disappointed with the efforts of school trustees. In January 1899, a general inspection revealed that local schools, including their wells and privies, needed to be cleaned due to “general neglect” by the trustees.\textsuperscript{161} Specifications for cleaning were issued by the BOH to the schools but with little effect. By 1900, the Board registered concerns about the danger to children’s health due to the school conditions and recapitulated its instructions for scrubbing and washing the school house as well as cleaning the privies.\textsuperscript{162}

**Conclusion**

Wellington County township BOHs invested considerable effort on a range of nuisance complaints. As the numbers of complaints increased, boards gained comfort

\textsuperscript{159} Peel Township Council Minutes, March 14, 1892, April 25, 1892, and August 4, 1892, Wellington County Archives, A1985.53.
\textsuperscript{160} Minto Township Medical Health Officer’s Annual Report in Ontario, “Board of Health Report for 1889”, 121.
\textsuperscript{161} Eramosa Board of Health Minutes, January 23, 1899, Wellington County Archives, A1982.14.
\textsuperscript{162} Eramosa Township Board of Health Minutes, November 19, 1900, Wellington County Archives, A2018.42.
about whether and how to utilize their public health authority, always mindful of the importance of local acceptance for their interventions. Their approach exhibited a shift in thinking about when and where government intervention was appropriate. BOHs’ confidence increased and they showed a willingness to deploy the full spectrum of their authority. In doing so, BOHs relied on the counsel of their health officials and called upon their experience and expertise. At the same time, they protected their ability to operate authoritatively to address the township’s public health concerns. In this regard, they were attentive to the views of neighbours and sought solutions that reflected financial prudence and respect for the importance of community relationships.

Townships’ approaches to nuisance complaints point to a shift in perspectives on government roles. They do not, however, signal any significant changes to local understandings about the importance of rural living to good health and disease resistance. Interventions centred on the perceived public health vulnerabilities of the poor and the removal or reduction of various forms of foul-smelling filth and refuse. At times, BOH interventions defined and defended the township’s interests in relation to other jurisdictions or levels of government. BOHs and complainants continued to perceive that their rural communities offered all the conditions necessary for healthful living, so long as the ills of urban decay were held at bay.
CHAPTER 5 – WELLINGTON COUNTY TOWNSHIPS: MANAGING CONTAGIOUS DISEASE RISKS

Township residents softened their objections to government intervention to resolve sanitary nuisances in their community, but they were not so inclined when it came to matters of disease control. Their longstanding belief in the healthfulness of rural living and their strong resolve to limit government interference in private affairs became key obstacles for BOHs. Community attitudes about death, illness, and the reporting of disease were deeply embedded and collided with public health interventions such as quarantine. Limits on household activity represented an unacceptable intrusion that challenged fundamental rural traditions such as visiting the sick and caring for the bereaved. These neighbourly duties were sacrosanct in communities where dependable relationships were essential for success and protection of one’s personal reputation was crucial. Skepticism toward new medical concepts and health technologies also inhibited BOHs’ efforts to manage contagious disease risks. While the educational efforts and influence of township health were beginning to improve receptivity to science-based disease prevention and control methods, progress was slow.

In this climate, BOHs in Wellington County’s townships learned to adapt their methods and apply new tactics to manage contagious disease risks. Supported by their MHOs, BOHs capitalized on easing skepticism toward the use of health experts, scientific testing, and disease prevention technologies such as vaccination. These new tools improved certainty in the assessment and control of disease risks and brought greater focus to their public health directives. BOHs also engaged local courts and
schools and thereby broadened their base of authority for managing contagious disease risks.

**Perspectives on Contagious Disease Risks**

For many in late nineteenth century Ontario, miasmatic theory continued to have a very strong influence on views about the nature and causes of disease. Miasmists thought disease was produced by atmospheric changes. This view was the driving force for the public health focus on sanitation improvements through properly maintained houses, sewage and filth removal, and attention to drainage and water quality. Dr. Abraham Groves, a physician and surgeon from West Garafraxa, was among those who recognized the implications of bacteriology for contagious disease control and the limitations of this focus on sanitation. Speaking at a meeting of the Association of Executive Health Officers of Ontario in 1893, he commented:

> I find there is a widespread belief that filthy surroundings will of themselves give rise to and produce typhoid fever, diphtheria, etc., but although dirt and filth undoubtedly afford suitable ground in which to cultivate certain forms of disease they cannot originate their germs.

While he realized the potential of medical advances from bacteriology for public health, as a rural physician, Dr. Groves understood that attitudes toward the nature and cause of diseases were strongly ingrained and unlikely to shift easily. This included the attitudes that prevailed in Wellington County townships.

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At the time Wellington County townships were establishing their local boards of health, many took the view that their jurisdiction enjoyed “immunity” from disease and asserted this view notwithstanding acknowledgement of local outbreaks of diphtheria, scarlet fever, typhoid fever and other infectious diseases. Minto Township consistently remarked on the healthful benefits of its salubrious geography and rural lifestyle in its reports through to the mid-1890s. In 1884, the year of a smallpox epidemic in the northern community of Hungerford Ontario, the Provincial Board of Health issued a province-wide call for municipal vaccination programs. Pilkington Township felt no urgency to respond: “As there was no sickness of any kind in the township, it was decided not to appoint a Health Officer or Sanitary Inspector at present…..and it may not be required…if the township continues in the same healthy condition.” Three years later, despite continued provincial urging to municipalities about the importance of vaccination programs, Pilkington persisted in its view: “…as there is no disease of any contagious kind in the Township …[we can report that] everything is clean.” Arthur Township, with no villages and a relatively remote location in the northern section of the county, also felt confident there was little to threaten the community’s healthfulness.

For most townships, the presence of a few cases of diphtheria, scarlet fever, and measles was expected and, like bad weather, just part of life’s trials. Descriptions about contagious diseases were often characterized as “mild cases” that required no public health response and evoked little concern. In West Luther’s 1884 report, for example, it

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165 For example, see Minto Township Council Minutes, November 26, 1894 and November 25, 1895, Wellington County Archives, A1991-117.
167 Pilkington Township Board of Health Minutes, October 4, 1887, Wellington County Archives, A1985.37.
remarked: “Measles being the only contagious disease prevalent this year, no precautions were taken to guard against it, as it is a disease not much feared by country people.” As long as deaths were not increasing “significantly” due to contagious diseases, a township’s health was considered “good,” if not “very good” or “excellent.” Minto Township’s BOH voiced this perspective in its 1884 report: “One of the great proofs of the healthy condition of this district is, that the number of deaths registered at the clerk’s office for the present year is far below the average.” In 1890, Puslinch SI’s declared the township’s health “very good” even though it had suffered from outbreaks of flu, diphtheria, typhoid, measles and whooping cough, including several related deaths. Similarly, in 1891 Guelph Township’s SI noted that while the community had suffered deaths from diphtheria the losses did “nothing to cause any alarm to the people of the Township [as] other places close to us are a great deal worse.”

The source of infectious diseases was frequently attributed to factors beyond the control of Wellington County townships. Most often it was blamed on people travelling in and out of the municipality. Puslinch Township’s SI advised that the local incidents of

169 Minto Township Board of Health Annual Report in Ontario, “Board of Health Report for 1884”, 194. Ibid.
171 Guelph Township Board of Health Minutes, November 4, 1891, Wellington County Archives, A1988.122. The Township’s SI, Captain Clarke, was also SI for the City of Guelph. As a result, it is probable that the “Other places close to us” comment is intended to be understood as the City of Guelph which, while a separate municipality, was geographically nested inside the boundaries of Guelph Township.
diphtheria in 1888 were “imported from [the town of] Galt.”\textsuperscript{172} In 1890, Pilkington’s MHO faulted a neighbouring township where “la grippe and measles prevailed…”\textsuperscript{173} Eramosa’s health officer placed responsibility for the township’s typhoid outbreak in 1897 on a local who had returned from a visit to the “Northwest”.\textsuperscript{174} The certainty of these judgements is demonstrated by Minto Township comments from 1890:

There have been a few cases of typhoid fever, but in the opinion of the medical attendant in no instance has the disease been due to local causes. Two cases were contracted elsewhere, from one of which another family is supposed to have caught the disease. Proper precautions being taken the trouble was confined to these.\textsuperscript{175}

Local poor were also viewed as a source of disease. The public accepted the need to address disease among the poor as their impoverished circumstances were correlated to poor sanitation, moral weakness and, thus, vulnerability to infectious disease.

Actions taken by municipal authorities were presumed as part of the community’s benevolent care of the poor.\textsuperscript{176} The connections made between disease risk and

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\textsuperscript{173} Eramosa Township Medical Health Officer’s Annual Report in Ontario, “Board of Health Report for 1890”, 126.
\textsuperscript{174} Eramosa Township Board of Health Minutes, November 15, 1897, Wellington County Archives, A1982.14.
The “Northwest” reference at this time referred to the northern districts, largely unsettled by immigrants, and now considered part of Ontario. The lands extended north to Hudson’s Bay and west to what is now the province of Manitoba.
\textsuperscript{175} Minto Township Medical Health Officer’s Annual Report in Ontario, “Board of Health Report for 1890, 117.
While not specified in the report, “proper precautions” likely included isolation of the sick and/or disinfection of the room and belongings of the sick.
\textsuperscript{176} As evidence, reference can be made to the introduction of poor houses within Wellington County and the use of municipal authority that could be used to unilaterally determine that a local citizen be placed in this facility. By the late 1870s, the County had opened a House of Industry. Any Reeve, Deputy Reeve, or justice of peace in the county could authorize placement of indigents in this facility and the person committed could only be discharged by the same civic authority as had issued the original admission: “By 1875, Wellington County Council had decided to follow Waterloo [County’s] lead. Members of the Committee on the House of Industry reported that they were convinced ‘that their[sic] is a certain class of indigent persons in this County who can be more efficiently provided for in a House of Industry than they can be in any other way….’” Stormie Stewart, “The Elderly Poor in Rural Ontario: Inmates of Wellington County House of Industry, 1877-1907,” \textit{Journal of the Canadian Historical Association} 3 (1992): 221.
poverty is particularly obvious in the public health practices of Nichol Township, where Wellington County’s House of Industry was located. Its vigilance over contagious disease threats prompted a focus on the House of Industry where it conducted regular inspections and ensured prompt measures were applied to prevent the spread of any contagious disease.  

In keeping with miasmists’ views about disease, BOHs emphasized the value of sanitation and these activities were generally well-received by local citizens. Health boards issued public notices to inform residents about the Health Act or local bylaws and requirements needed for disease control, including regular cleaning of household wells and privies. The information reminded readers about the authorities of the BOH and its health officials and clarified the responsibilities of householders for reporting disease. It warned people of the township’s authority to conduct household inspections and issue directives such as quarantine in order to manage disease outbreaks. For example, West Garafraxa’s BOH distributed posters featuring sections of the PHA concerning contagious disease control after multiple cases of diphtheria broke out in the township during 1885. The highlighted sections of the Act included: authorities of the health board and its officers to conduct inspections and to direct cleaning, disinfection and quarantine measures; the penalties for those who hinder health inspections; and, the responsibilities of householders to report smallpox, diphtheria, scarlet fever, cholera, or typhoid and to isolate the afflicted (Appendix J).

In 1889 and 1896, Erin’s BOH

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177 Nichol Township Board of Health Annual Report in Ontario, “Board of Health Report for 1887”, 100. While no elaboration is found in the township’s board of health materials about the measures taken to contain the spread of disease, it is likely that they were isolation of the afflicted and disinfection of their belongings.
178 West Garafraxa Township Board of Health Minutes, January 19, 1885, Wellington County Archives, A1981.82.
posted similar public notices emphasizing the duties of householders, physicians and teachers in managing disease outbreaks. Erin believed that, as its community members grew more familiar with public health laws, they would have an increased appreciation of their responsibilities and the need to consider not only their personal needs but also those of the broader community.\textsuperscript{179}

**Challenges for Disease Reporting**

A challenge for township health boards was the lack of consistent and complete information about infectious disease in the community due to multiple disincentives for both physicians and householders to report outbreaks to BOHs.\textsuperscript{180} Physicians had reason to avoid reporting contagious disease among their patients. Their ability to earn income from fee-paying families depended on strong and trusted relationships. If the doctor reported disease in a household this could lead to BOH orders for quarantine and other directives that brought embarrassment and significant disruption for the patient’s entire family. Many householders managed with minimal reliance on the costly services of physicians, so families’ awareness of contagious disease cases could be limited in any event. Householders did not believe some illnesses warranted medical attention or the cost and inconvenience of calling a doctor, especially when he might be

\textsuperscript{179} Erin Township Council Minutes, December 16, 1889 and December 15, 1896, Wellington County Archives, A1985.55. Local disease outbreaks appear to have been the impetus for the timing of these notices. The Board of Health minutes do not reveal the precise sections of the PHA that were included in these notices, only their general nature.

\textsuperscript{180} Townships that were disinclined to take much action on public health also had some advantage from a lack of information about contagious disease within their community. Without any evidence to contradict them, they could assert excellence about local health conditions and restrain the need for public health investments. Further, the township’s competitiveness in attracting and retaining farm families was enhanced.
a distance away and unable to respond in a timely fashion.\footnote{A balance against the risk that families might be overly secretive about the presence of infectious disease was the reality of the strong connections within rural communities. Everyone knows each other. Further, “Illness was a social occasion. For very sick patients, the doctor was only one invited guest among a group of concerned attendants who kept vigil at the bedside.” Jacalyn Duffin, \textit{Langstaff: A Nineteenth-Century Medical Life} (Toronto: University of Toronto Press, 1993), p. 37.} They might not want to report incidents of contagious disease to the local BOH as the potential of a quarantine order represented the risk of a significant and unwelcome intervention in their private affairs. News of contagious disease in their family might raise negative connotations about their living conditions, damaging their reputation. The importance of neighbourhood connections for successful farming was well understood and a good reputation was critical among people who knew each other well.\footnote{Further illumination of this point is provided in Wilson, “Reciprocal Work Bees.”} Reporting of incidents of contagious disease, whether by physicians or householders, could put all of this at risk.

Initially, BOH’s tolerated under-reporting. In 1889, Erin Township’s BOH expressed satisfaction with local physicians’ response to contagious disease among their patients while acknowledging that they were not publicly reporting their cases.\footnote{Erin Township Council Minutes, December 16, 1889, Wellington County Archives, A1985.55. See also Guelph Township Board of Health Minutes, November 3, 1888, Wellington County Archives, A1988.122. The township’s sanitary inspector considered physician reporting to the BOH to be “very good.”} At the same time, their MHOs campaigned to influence the behaviour of their local physician colleagues and encouraged them to improve their reporting practices.\footnote{Powell, “Provincial-Local Relations”, 88 and 93-95. Powell’s research focuses on the provincial board’s records. She observes that the PBH believed MHOs were largely failures as public health champions. Information for Wellington County township boards of health suggest that this was a harsh view. MHOs clearly had significant influence in building townships’ knowledge about the control of contagious diseases.} In his 1889 report, Maryborough’s MHO commented, “…a full and correct report of the number of infectious or contagious disease[s] cannot be given unless medical men practising in other parts of the township will report cases which they may be called on to
treat.”\textsuperscript{185} Erin’s MHO sent out notices in 1890 to persuade his physician colleagues to do better.\textsuperscript{186} As local doctors themselves, health officers were well-placed to influence the ideas and attitudes of their professional colleagues. MHOs received regular advisories from the PBH, including information about emerging medical concepts and health technologies and used this information to urge physicians to provide the BOH with complete and timely disease reporting.\textsuperscript{187} As a result of their efforts, reporting practices gradually improved during the 1890s.\textsuperscript{188}

**Quarantine and Other Contagious Disease Directives**

Township success with using quarantine and disinfection also required the persistent efforts and influence of the township MHO. Heeding the advice of their health officers, BOHs increasingly issued quarantine and disinfection directives for disease-afflicted households.\textsuperscript{189} West Garafraxa’s 1889 report summarized its efforts as follows: “In every case of typhoid under our care every means has been employed during illness and after recovery to isolate and disinfect patient and all clothing, furniture, etc.,

\textsuperscript{185} Maryborough Township Medical Health Officer’s Annual Report in Ontario, “Board of Health Report for 1889”, 120.
\textsuperscript{186} Erin Township Board of Health Annual Report in Ontario, “Board of Health Report for 1890”, 101. See also the MHO’s report from the previous year: Erin Township Medical Health Officer’s Annual Report in Ontario, “Board of Health Report for 1890”, 102. Many other examples of Wellington County township BOHs’ concerns with physician reporting of infectious diseases can be found in the BOH records.
\textsuperscript{187} MacDougall, “Researching Public Health”, 159-160; Powell, “Provincial-Local Relations,” 93-95.
\textsuperscript{188} Evidence for this is found in the information reported for Wellington County townships during the period 1891 to 1900. Reporting continued to be a concern, however. In his report for 1894, West Garafraxa’s MHO commented, “Owing to the failure on the part of the neighbouring physicians to report their cases it is impossible for me to give an accurate or tabulated account of the number of cases of the various forms of contagious diseases that have occurred in the municipality during the year…” West Garafraxa Township Board of Health Minutes, November 7, 1894, Wellington County Archives, A1981.82. The minutes included the text of the township MHO’s annual report.
\textsuperscript{189} West Garafraxa Township MHO’s Annual Report in Ontario, “Board of Health Report for 1889”, 109. Assembly, “Annual Reports of the Provincial Board of Health of Ontario.”PBH-prepared summaries of township reports over the years 1891 to 1900 indicate that disinfection instructions could be issued by a BOH member, the township MHO or SI, or the attending physician. Responsibility for implementation varied. In some townships the householder was trusted to follow the issued instructions and in others the attending physician, or MHO, or SI might be involved. Quarantine instructions were also issued through the board and, like disinfection instructions, responsibility for enforcement.
exposed to the contagion.” Numerous similar examples appear in township records throughout the period.\(^{190}\) Directives for school closures were also ordered when an outbreak was reported among school children or in the home of their teacher.\(^{191}\) Quarantine directives, however, were frequently met with resistance. In part, this was due to skepticism about its effectiveness in light of differing views about the nature and cause of certain diseases. The greater obstacle, however, was householders’ assessment of the relative risks and rewards of quarantine.

Quarantine created significant disruption for a rural household. While some were persuaded to accept its application others found the directive excessive. Even among township health officials and medical practitioners there was a lack of consensus on the need for quarantine in “mild” cases or for common contagious diseases such as measles and whooping cough. In 1886, Guelph Township’s SI decided that quarantine orders were not needed in several diphtheria cases as he considered them to be “of a mild type.”\(^{192}\) In Guelph Township during 1894, a BOH quarantine order issued to a household during a diphtheria outbreak was overturned by the attending physician who asserted that the family had been affected by pneumonia rather than diphtheria.\(^{193}\) An outbreak of scarlet fever during 1898 in Pilkington Township resulted in a BOH order for quarantine of the Duffield household. Much to the irritation of the township’s sanitary

\(^{190}\) Occasionally, as will be illustrated, directives for cleaning and disinfection went so far as instructions to demolish a family’s premises.


\(^{192}\) Guelph Township Board of Health Minutes, November 26, 1887, Wellington County Archives, A1988.122.

\(^{193}\) A child had died within the household during the diphtheria outbreak. Guelph Township Board of Health minutes, November [no date specified] 1895, Wellington County Archives, A1988.122. (The SI’s annual report for 1895 included activities from the final weeks of 1894.)
inspector, Duffield removed the quarantine placard from his house without authorization. The SI asked the health board to summon Duffield and demand an explanation. After a “lengthy” discussion about the situation, the Board rejected the SI’s request “on the ground that no other cases of the disease had been reported.” Duffield’s sensibilities were noted by the BOH. He was embarrassed by the public nature of his quarantine order and offended by the interference in his private affairs that it reflected. Local objections constrained the Board’s will to enforce its order.

Disputes about the contagious nature of tuberculosis also fueled resistance to health board directives. While evidence was mounting within the medical community about the risks of tuberculosis, many among the general public and the medical community were doubtful of its infectious nature. As the circumstances of the Gavan family of Eramosa Township in 1890 demonstrate, without community agreement on the risk of the disease, township health boards lacked community support for enforcement of control measures. In August 1890, Eramosa’s BOH learned from its MHO of the

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194 Pilkington Township Board of Health Minutes, September 5, 1898, Wellington County Archives, A1985.37. The Board of Health’s records do not indicate whether the Duffield household otherwise followed isolation practices even while removing the placard on their house.

195 Dr. Peter Bryce, Secretary to the Provincial Board of Health, prepared a report that was included in the PBH’s Annual Report for 1884 entitled, “Some Reasons Why So Many Persons Die of Consumption. From Facts Drawn from Mortality Returns and Sanitary Laws”, making the case for the contagious nature of tuberculosis. He was among the leaders in Ontario who tried to convince people of the disease’s contagious nature. Ontario, “Board of Health Report for 1884”, 350-358. The disease was also commonly referred to as “consumption” and “phthisis”.

196 Eramosa Township Council Minutes, March 17, 1890 and December 1, 1890, Wellington County Archives, A1985.58. Eramosa Township Board of Health Minutes, August 9, 1890 and November 17, 1890, Wellington County Archives, A1982.14. When Dr. Dryden’s term as MHO concluded in 1897 and a new MHO, Dr. McCullough, was appointed, efforts continued to educate township citizens about the infectious nature of tuberculosis. Dr. McCullough’s annual report in 1898 remarked, “It is gratifying to find an increasing care in regard to the treatment of Tuberculous [sic] patients since attention has been called to the infectious nature of this disease.” Eramosa Township Board of Health Minutes, November 15, 1898, Wellington County Archives, A1982.14.

A similar case to that of the Gavan family was handled by Guelph Township’s BOH in the following year, 1891. The Guelph Township took very similar actions in regard to the circumstances an impoverished tenant farmer by the name of Lewis. 9 members of the household suffered from diphtheria.
dire circumstances affecting the Gavan family. Following Mrs. Gavan’s death from tuberculosis two-years previously, three of the family’s eight children had died from the same disease. Now symptoms had appeared in their eldest, a twenty-year old daughter. The MHO argued for BOH action, explaining the risks of tuberculosis. He acknowledged that the poor sanitary conditions of the family’s house were a contributing factor, but he also emphasized that tuberculosis “is an infectious and contagious disease, if not [progressing] so rapidly, still as surely so as are small-pox or measles…” He added that, “…if proper precautions be taken in regard to disinfecting or destroying of expectorated material and excreta, cleanliness, with a certain amount of isolation of patients, there is not likely to be the great number of cases which have devastated so many homes in the past.” The Board was convinced to support the MHOs recommendations; the Gavan family must be removed and their house demolished.

Gavan was instructed to place his sick daughter in the Guelph hospital immediately, relocate his other children to a “healthy dwelling,” and then vacate his property to clear the way for destruction of his house. Gavan objected strenuously. He insisted that there was nothing wrong with his house and refused to part from his children. The MHO was urged by the board to persuade Gavan’s cooperation and the health officer was successful, to a degree. Recognizing the dire implications of the planned actions, the MHO had been providing the family with some measures of relief. In addition to providing their medical care, he also marshalled support among the community and petitioned the township to secure tax relief for Gavan. The petition cited

Some were sent to the Guelph Hospital; all were required to leave the house they were living in. The landlord was instructed to destroy it and he complied with the BOH’s directions. The Lewis family ultimately relocated to the City of Guelph. Guelph Township Board of Health Minutes, October 12, 1891, October 24, 1891 and November 4, 1891, Wellington County Archives, A1988.122.
Gavan’s “straightened circumstances on account of the expense incurred by the sickness and death of three members of his family during the past four months.” As a result of the MHO’s influence, Gavan agreed reluctantly to send his eldest daughter to hospital. At the same time, he remained resolute in refusing compliance with the other directives. While it was within the BOH’s authority to turn to the courts to achieve Gavan’s compliance, it did not press further and updates on the family’s circumstances disappeared from its meeting agenda.\textsuperscript{197} Those in the community who were convinced of the contagious nature of tuberculosis may have wanted the Gavan’s to remain in their own house rather than move elsewhere and expose others to the disease. For others who doubted the contagious nature of tuberculosis, the proposed dispersal of the family and the destruction of their premises breached their tolerance for government intervention in people’s private affairs. Both the MHO and the Board concluded that they lacked the community support necessary to proceed with their proposed course of action.

An 1889 case in Erin Township further illustrates differing views on the nature and control of infectious disease and its consequences for BOH enforcement of directives. In this instance, the actions of a local magistrate, John Reid, sparked the frustration of the township MHO in a case of diphtheria. Reid had been warned by his own medical practitioner of the contagious nature of diphtheria and the need for patient isolation and careful sanitation of his household’s belongings. However, Reid did not heed the advice nor comply with any of the related public health requirements. This incensed Erin’s MHO:

\textsuperscript{197} Despite searches for information about the Gavan family of Eramosa Township using records available on ancestry.ca, no further information could be found on the fate of the other family members.
I am sorry to state that neither Mr. Reid nor the medical attendant gave any notice whatever to any member of the Board, so far as known to me, nor to myself until the disease made such headway that two deaths had occurred, one a child of Mr. Reid’s, and the other a child that lived across the street, and who, I am informed, was allowed to visit patient first afflicted during its illness. In fact, the health law was so ignored by Mr. Reid, who is a magistrate, that a public funeral was allowed, and worse still the coffin opened at the grave, thereby giving every opportunity for the spread of the disease.  

Despite the MHO’s clear frustration with the situation, no action was taken by the BOH to effect penalties on either the magistrate or his doctor. In rural communities, great value was placed on their duties for providing support and encouragement to their neighbours by visiting the sick and attending funerals. In these farming communities, no matter the cautions, people held on to traditions that helped hold their community together. This reality was understood by the BOH and it acquiesced. Like other BOHs in Wellington County townships, it was unwilling to press for compliance and, instead, relied on whatever moral suasion could be marshalled in such circumstances, particularly the influence of MHOs, SIs, or co-operative local physicians.

Application of New Medical Concepts and Technologies

BOHs’ efforts to manage contagious disease risks were slowed but not stopped by a lack of shared understanding about the nature and causes of disease. Education about new medical concepts and techniques through the efforts of MHOs and local physicians was gradually influencing people’s ideas about disease. BOHs increased their use of local medical experts and veterinarians as well as provincial public health professionals and newer health technologies. By the 1890s, BOHs offered small pox vaccination programs more frequently and accessed newly available laboratory testing.

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in their efforts to manage contagious disease risks. Township MHOs were instrumental in guiding health boards on the opportunities of these new tools and helping gauge local receptivity to their use.

This progression in use of new medical concepts and health technologies is illustrated in the 1889 report of West Garafraxa’s MHO. In the previous year, the Wilson household had been afflicted by several cases of typhoid. The MHO pointed out that his reliance on traditional methods of observation about sanitary conditions had not proved useful in determining the cause of disease. He explained that his visit to the Wilson house offered no visible evidence of the source of the family’s troubles as it was, “neat and clean and well ventilated” and their well water appeared to be good. The MHO explained that the cause of the Wilson’s illness was most likely something unseen in their well-water:

It would be a great assistance to local boards and the public at large if the provincial board of health could devise some sure and simple method of testing purity of well water as a very large percentage of these contagious diseases comes from using water taken from these receptacles [sic] of filth dug to [sic] near to byre, stable and barnyards…

West Garafraxa’s MHO likely provided this commentary knowing that the PBH would soon open a provincial public health laboratory and that his ability to provide some kind of proof of the source of disease would strengthened his influence and help substantiate the value of BOH directives.

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199 West Garafraxa Township Board of Health Minutes, October 30, 1889, Wellington County Archives, A1981.82.
Of relevance to a point offered earlier, the MHO’s report subsequently summarizes that the “sanitary condition of this municipality is good.”
By the following year, local boards had the opportunity to use provincial lab services in their quest to identify contagious disease risks.\textsuperscript{200} Erin Township made use of these services in 1895 as part of managing a typhoid outbreak. A sample of well water was sent to Toronto for analysis. The testing cost $5, a considerable portion of the Board’s expenditures that year, but the expense achieved important results. The BOH pointed to the scientific proof of the well water’s contamination and directed that all water from it be boiled prior to use.\textsuperscript{201} The precision of the assessment and the focus of the consequent public health directive made the BOH’s directive more acceptable to the owners of the well.

While change was emerging, not all townships recognized the value of scientific analysis. In Guelph Township during 1895, its SI investigated the death of a man from typhoid fever. Neighbours believed his well was the source of the disease but the SI dismissed their concerns: “I made a thorough examination of the place and found everything clean and the well was so situated that I thought it was impossible for the water in it to be contaminated. I also tasted it and found it sweet and as clear as one could wish for …”\textsuperscript{202} In this case the fruits of observation and the comfort of believing that ‘what could be seen, could be believed’ continued to have a powerful influence.

Attitudes toward new medical knowledge may also have shifted through experiences with scientific experts and laboratory testing in cases where animal disease represented a risk to human health. By the 1890s, the PBH and local boards of health

\textsuperscript{200} Craig, “Introduction”, Archives of Ontario, p. 7-8. As noted previously, PBH lab testing services were available at this time for identification of suspected cases of diphtheria, tuberculosis and typhoid.
\textsuperscript{201} Erin Township Council Minutes, December 1, 1895, Wellington County Archives, A1985.55.
\textsuperscript{202} Guelph Township Board of Health Minutes, November 1895 [no specific date provided], Wellington County Archives, A1988.122.
were becoming increasingly involved in matters pertaining to animal health in view of
the increasing awareness of the risks known to human health from diseased milk, meat
and other animal by-products. In 1887 and again in 1891, changes were made to the
PHA that expanded existing responsibilities for local boards of health in the inspection
of meat and milk that might be affected by disease. The amendments gave BOHs the
added authority to inspect and seize diseased animals and their by-products to
strengthen their management of contagious disease risks. Municipal responsibilities
pertaining to animal health were quite separate from the animal inspection
responsibilities of the federal government which inspected livestock that were imported
and exported from Canada. Its role was informed by the desire to preserve the
country’s reputation in international commerce by preventing the spread of bovine
tuberculosis and other animal diseases through livestock trading.

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203 This development became instrumental in establishing a provincial health lab: “In 1887 an Act was
passed to further clarify local health board responsibilities for …the inspection of dairies. The powers of
the board were also materially increased…. [Subsequently, it] was found in practice, that a serious defect
existed in the legislation of 1887, which provides for inspection of cattle, from the fact, that it is nowhere
definitely stated what diseases in cattle constitute unsoundness within the meaning of Section 99 of the
Public Health Act, by which power is given to a medical health officer or sanitary inspector to inspect and
seize all unsound animals, meat and milk in preparation for sale or exposed for sale. A short bill was
introduced in 1890 to explain the ambiguous terms referred to. It is entitled, "An Act to amend the Public
Health Act in respect to the sale of milk and meat from animals affected with tuberculosis." The PHA
amendments provided, among other things, that upon any prosecution for keeping diseased animals,
meat or milk for sale as food, scientific examination may be made of the suspected meat or milk. Ontario,
“Board of Health Report for 1890”, lxxvii. See also, Craig, “Introduction” in Archives of Ontario, Provincial
Board of Health Scrapbooks, A010375, p. 7.

204 For a fuller description of the role and authority of federal and provincial officials in regard to animal
health see, T. Childs, “Duties and Responsibilities of the Health of Animals Division, Department of
Agriculture Canada,” Canadian Journal of Comparative Medicine XVIII, no. 5 (1954): 184–90; Provincial
Department of Health, “The Development of Public Health in Ontario,” Canadian Public Health Journal 26,
no. 3 (1935): 110–23; and, Thomas Dukes and Norman McAninch, “Health of Animals Branch, Agriculture
Canada: A Look at the Past,” Canadian Veterinary Journal 33, no. January (1992): 58–64. As will be
demonstrated through situations that emerged in Wellington County townships, these parallel roles at
different levels of government introduced confusion and uncertainty when animal health became a factor
for BOHs in their efforts to manage contagious disease risks.
There is no evidence that Wellington County townships conducted regular inspections of animals or the food they produced, even when PHA amendments provided them with the authority to do so. Livestock only factored into health board concerns where they were part of nuisance complaints, like the abandoned animal carcass complaints described in the previous chapter. Families living in the townships produced most of the food they ate and had few worries about the food on their table. If they had not produced their own meat and vegetables, they generally knew the people who had and could be assured of their quality. Consequently, when BOHs were first established, they received no local complaints or concerns related to potential human health risks from diseased animals. By the late 1880s, however, this began to change.

An illustrative case is found in Eramosa Township during 1889 when the MHO received a complaint about the sale of diseased beef. After his own inspection of the animals’ hide and review of tissue samples by a local veterinary surgeon, it was determined that the animal had suffered from tuberculosis. Both local health experts agreed: consumption of the beef “would be dangerous to human or animal life.” This was the first case of its type for the BOH. Initially, it hesitated about what it should do. Attuned to the potential impact of its intervention for the owners’ farm operations as well as his reputation, yet also aware of the local fear inspired from the sale of diseased meat, it was uncertain about how to proceed. The board turned to its counterpart organization in the City of Guelph to draw from its experience. With this information in hand, the Eramosa BOH provided a definitive assessment of the risk, relayed this to the

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courts, and hoped that the courts would rule on responsibilities and related consequences.

Charges were laid by the Guelph township BOH against the seller of the meat and the evidence was assembled to support its case. The BOH called upon not only the testimony of the BOH’s two local medical experts but also thirteen community witnesses. Evidence of community support for pursuing public health concerns continued to be important. As a result of these efforts, the court found the meat seller guilty and fined him $15 plus legal costs. Eramosa’s BOH was pleased with the result and took satisfaction that it did not “shrink from [its] duty” to protect the public health.\textsuperscript{206}

The use of expert advice also emerged as a key for effective BOH action in response to a case in Guelph Township. In 1889, the township sanitary inspector received a complaint concerning Mrs. Pinder’s cows.\textsuperscript{207} It was alleged by citizens in the City of Guelph that her dairy cattle had “some disease of a dangerous nature and that the milk from the animals was being sold to the people”. Following investigation, the SI was not persuaded of the validity of the complaints. However, “in order to satisfy the people,” he called in the local veterinarian, Dr. Greenside, to examine the cows. Greenside concluded, “there was no cause of alarm” because, as soon as the cattle became ill, they “went dry and gave no milk.” Pinder was instructed on the appropriate disposal of her dead cattle. A public notice containing the veterinarian’s findings was published in the local paper to address complaints and calm public concerns. The BOH

\textsuperscript{206} Eramosa Township Council Minutes, November 30, 1889, Wellington County Archives, A1982.14.
\textsuperscript{207} Guelph Township Board of Health Minutes, November 9, 1889, February 5, 1890, November 7, 1890, and November 4, 1891, Wellington County Archives, A1988.122.
also determined that, as the veterinarian’s services were only necessary “to satisfy the people in the city,” his costs would be invoiced to the City. Pinder also received $12 in compensation from the township. From the perspective of the BOH, the matter was considered closed. The use of expert advice from the local veterinarian and the influence of their sanitary inspector helped to diffuse complaints from the city about the quality of the township’s milk. The risks of any disease from Pinder’s cows were addressed by focused instructions for the destruction of her cows. By the assignment of costs to the City and the alleviation of Pinder’s additional expenses, the BOH achieved a resolution to the situation that would have found favour in the eyes of township citizens. Their approach diffused a building tension between urban and rural interests that might have threatened the competitiveness of local farmers to market their excess produce while preserving the BOH’s good will within the township.

Guelph Township’s adept handling of the Pinder case was not incidental. Its skills in such circumstances had been developed through an earlier situation of great concern in the area during the years 1897 to 1890. The Guelph Township BOH learned from this experience how by using the advice of medical experts and scientific test results they could steer a safe course among contending interests. In 1897, a number of deaths had been reported among cattle, horses and pigs grazing on lands adjacent to the Speed River in Guelph Township. Some in the community believed the dead animals had succumbed to anthrax, a serious disease known to afflict both humans and animals. Local concerns about the numerous and unexplained livestock

208 It is likely that the later complaints about Pinder’s milk, already referenced, were influenced by this case and the fear it engendered. Pinder’s cows were among those affected by the outbreak of anthrax.
209 During this period of the nineteenth century, anthrax was viewed as both an agricultural malady and an affliction common to those working in industries that used wool as well as other animal fibres and hides.
deaths gave rise to a call for Guelph Township’s BOH to take action. As a first step, the health board sought advice from Dr. Greenside, the local veterinarian. Greenside sent blood from the dead animals to the provincial laboratory and the results confirmed the community’s fear: the animals had succumbed to anthrax. Drawing on sources considered authoritative at the time, Greenside counselled calm. He advised the BOH that the threat of anthrax would dissipate and was unlikely to present further risk for many years. He assured the board that, “…there was not much cause of alarm…but in the meantime it would be advisable to make an examination of the wool [coming to the area from infected countries].” Reports of his findings and conclusions were submitted to the local newspaper.

Reports of livestock deaths from anthrax in the area of the township persisted through 1888 and 1889. The BOH, while satisfied by a degree of calm achieved in response to the incidents of 1887, was beginning to lose confidence in Greenwood’s advice and sought further counsel from provincial authorities about appropriate preventative action. It also wanted clarification about its role in this matter given the distributed governmental roles related to animal health. Appeals for further guidance were sent to both the PBH and the Minister of Agriculture. The provincial board offered

The science of the nature, cause, prevention and treatment of the disease was still evolving. Given these uncertainties, he belief that it was present in a community would prompt significant fear. Susan D. Jones and Philip M. Teigen, "Anthrax in Transit: Practical Experience and Intellectual Exchange," *Isis* 99, no. 99 (2008): 455–85.

its support for Greenside’s conclusions and proposed course of action. No responses were offered to the request for greater clarity of government roles.

By 1890, as Greenside had predicted, the impact of the disease was dissipating. The BOH’s role in the anthrax threat had offered it valuable insight into the role of medical experts and scientific testing in giving definition and focus in determining responses to threats from contagious disease. With local fears escalating, the certainty and precision of the local veterinarian’s opinion together with the laboratory results proved valuable for easing local fears. The need for significant direct intervention by the BOH was limited. The board’s experience demonstrated how scientific expertise could help better define and manage the various risks and contending interests associated with contagious disease.211

Growing recognition of the value of medical experts and scientific testing in the management of contagious disease was also reflected in the townships’ increased receptivity to use of small pox vaccinations212. While this health innovation had been available since the early 1800s, the variability in results from the new technology, its sometimes unpleasant effect, and the unfamiliar scientific concepts upon which it was

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211 Perhaps, as farmers were also observing the use of scientific testing by federal officials for assessment of health among traded cattle, this too helped grow confidence in the use of for contagious disease threats for humans. The efforts used to control contagious diseases among animals without similar progress for people’s health was a source of some frustration for public health advocates at the time: “Doctors pointed to the amount of public money being spent on preventing and stamping out infectious diseases among animals and plants by the Department of Agriculture, while little, if anything, was being spent on preventing or stamping out human diseases.” Sue C. Rutty, Christopher, Sullivan, This Is Public Health: A Canadian History, Canadian Journal of Public Health / Revue Canadienne de Sante’e Publique, vol. 102 (Ottawa: Canadian Public Health Association, 2010), p. 1.12.

212 A vaccine for diphtheria became available in the 1890s and began to be used in Ontario, including in a few Wellington County townships. (Evidence for this is found in the summaries of township health board reports prepared by the PBH over the period 1891 to 1900.) As a new vaccine product, use of the diphtheria vaccine was episodic. Townships offering vaccination programs in Wellington County during the 1880s and 1890s were using small pox vaccine.
based, made its use highly controversial in most communities. During the 1880s, some townships offered the vaccine but only in response to immediate fears of smallpox’s arrival in the community from active epidemics elsewhere in the province. The Hungerford outbreak of 1884 referenced earlier, was an example. It created a sufficient sense of urgency in townships such as Puslinch, West Garafraxa, Eramosa and Maryborough for them to offer smallpox vaccinations in their communities at that time.

Townships’ approaches to the use of smallpox vaccine in the 1890s varied. Stories of the factors affecting the decision-making of these townships reveal that shifts in people’s understandings and attitudes toward vaccination made use of this preventative measure more acceptable, even without a pressing epidemic threat. The PBH had renewed its campaign for wide-spread use of the smallpox vaccination citing risks from assorted and smaller outbreaks of the disease around the province. Each


214 Others in Wellington County may also have implemented vaccination programs at this time as well, but information was not found in the municipal sources available. Local authority for the implementation of vaccination programs in response to epidemics had existed since the early 1860s but was used very infrequently. Broad acceptance of vaccination programs emerged in the next century, only once some of the technological challenges for its production and administration had been overcome that overcame the reality of the risks of the innovation. See Craig, “State Medicine in Transition”; Craig, “Smallpox in Ontario”; Taylor, “Fire, Disease and Water.”

215 The PBH communication urged local BOHs to take “all proper precautions” against the outbreak of smallpox and to have all school children in the municipality vaccinated. Pilkington Township Board of Health Minutes, January 28, 1894, Wellington County Archives, A1985.37. The context for renewed emphasis on vaccination was not linked to an active epidemic in the province such as experienced in Hungerford during 1884. Rather, it was informed by a few provincial outbreaks and the threat they were raising for the stability of international trade and commerce: “The beginning of 1895 saw several outbreaks of smallpox, which proved, fortunately, to be of limited extent and duration, like the twenty outbreaks from imported cases during the second half of 1894. With the improved situation in the administration of public health in Detroit early in 1895, the Province has been saved from any further cases coming directly from that source; although the fact cannot be overlooked that the disease has maintained itself in that city for nearly two years, and that the report on the public health for Michigan
BOH that elected to proceed with vaccination devised an approach to suit the contending interests at play in their community, balancing public interests in the prevention of small pox with individuals’ receptivity to the use of this disputed medical technology. Several Wellington County townships elected to go ahead including Eramosa, Erin, Guelph, Minto, Pilkington, and West Garafraxa townships. Arthur township considered the idea but elected not to act. While controversy remained about the preventative utility and efficacy of vaccination, public disproval and skepticism had eased. In keeping with PBH recommendations, most programs were directed to inoculation of elementary school students. Preferences for program funding differed; some charged fees while others made vaccinations free. All BOHs introduced their vaccination programs carefully, issuing detailed instructions for program communication and implementation

ending with March, 1896, states this disease to be existing in seven localities in the State.” Ontario, “Board of Health Report for 1895”, 3.

216 In 1894, Arthur did not proceed with vaccination: “…as there appear to be no cases of small pox in the immediate neighborhood this council does not deem it necessary to take any action at present.” Despite appeals from its MHO, Dr. McPhaden, Arthur’s councillors were unmoved. When the time came the following year for the annual decision about the appointment of an MHO, objections were made by township councillors to Dr. McPhaden’s reappointment and a new MHO was appointed. It seems Arthur’s council was not interested in having an MHO who championed what it perceived as a costly and unnecessary health intervention. Arthur Township Council Minutes, June 14, 1894, Wellington County Archives, A1985.49.

217 Erin Township’s 1894 vaccination program was distinctive as it did not focus specifically on school children. Also, in this township, the municipal council rather than the BOH took the lead and, after conferring with “some of the [local] medical men on the propriety of having the matter attended to throughout this Township”, commissioned one of them to give vaccinations at 4 different times and places as communicated in a public notice. Council minutes do not specify how the costs of the program were met. Its records note, however, that a, “…goodly number availed themselves of the opportunity thus afforded. About 150 were vaccinated.” Erin Township Council Minutes, February 9, 1894 and December 15, 1894, Wellington County Archives, A1985.55.

In 1899, following a further vaccination program, the BOH was unimpressed by the lack of participation among some of its citizens. In its year-end report, it wondered whether “…this seeming negligence arises from the fact that the residents of that portion of the Township consider themselves small pox proof.” Erin Township Council Minutes, December 15, 1899, Wellington County Archives, A1985.55.

218 A degree of impetus for increased use of small pox vaccinations in these townships may also be due to the presence of Ontario’s first “vaccine farm” in their county; its local production may have enhanced receptivity to use of the vaccine. Beginning in 1885 Dr. Alexander Stewart, a local physician, produced the smallpox anti-toxin using cattle he bred for this purpose on his farm. His initiative was encouraged by
Eramosa Township was among those that moved forward in the mid-1890s and was also a township that had offered vaccinations in response to the smallpox scare of 1884. The contrast in approach to its decision-making in these time periods points to the board’s assessment that not only was there increased receptivity to use of the vaccine but also greater confidence in the board’s judgement and authority in these matters. In 1884, the BOH was still new to the community and it was unsure of the community’s receptivity to vaccination, even in the knowledge of the Hungerford epidemic. At that time, its decision-making process included the extraordinary step of convening a joint meeting of the BOH with the township council to consider the matter. The meeting resulted in an agreement to proceed with a vaccination program. The council’s support incorporated a number of very specific parameters to be followed by the BOH and its health officer. Vaccinations were to be offered on a voluntary basis to the township’s school children and delivered at scheduled times established for each school. Costs were to be borne by families who would be charged 25 cents for each vaccinated child. A markedly different decision-making process

the PBH as it desired a domestic source for at least some of the smallpox vaccine points required for use across the province. With the support and encouragement of the Provincial Board of Health, Dr. Alexander Stewart, a farmer and physician in Minto Township, began production of smallpox anti-toxin using cattle he bred for this purpose on his farm. The vaccine points he prepared that were supplied to local boards of health across the province through to the early 1900s. For information about the role of the Palmerstone vaccine farm in Ontario’s history of vaccine technology, see Rutty, "Personality, Politics."


220 A detailed review of the meeting records for the Eramosa BOH and Township Council over the period 1882 to 1900 reveal no evidence of any other joint meeting.

221 The minutes of the joint meeting included very specific instructions for the vaccination program: Posters were to be issued to local school teachers that indicated when the MHO would attend each school to administer the vaccine and collect the required fee. The fee-for-service model was made acceptable to the MHO on the basis that, should the fee revenue prove insufficient to meet his costs for vaccine and his related services, the township would allocate the requisite supplementary funds. Following implementation of the vaccination program, the MHO presented a statement showing the amount paid for the vaccine points, the cost of his services, and the amount received from those vaccinated. The balance that remained due to him from the Township was $15.
was used by Eramosa’s BOH in 1894. No special consultation with the township council was required. Township council’s involvement was limited to approval of a supplemental allocation to the BOH to allow vaccinations to be provided free of charge. As before, the program was voluntary and directed to school children. The MHO was tasked to administer the vaccines and he did so, as before, through a scheduled series of opportunities at each of the local schools.222

Guelph Township’s approach to a vaccination program used a different tact for its vaccination program. Local schools, with their ongoing access to local tax revenue, appeared to have the funds necessary to support a program as well as immediate access to the population to be vaccinated. This combination of factors prompted the Guelph Township BOH to instruct local school trustees to implement and pay for a local vaccination program, and to do so “without delay.”223 By placing responsibility on the schools for delivery of a township vaccination program, the BOH broadened the base of local authorities engaged in public health while also reassigning the costs for the program to an entity with much greater funding resources than the health board.

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222 Upon completion of the program, the MHO reported that he vaccinated more than 420 children stating that, “with very few exceptions, the vaccination was successful.” The total cost to the township was $67.30 - $25 for the MHO’s services and $42.30 for the vaccine -- a significant amount when compared to the typical annual allocations for BOH activities in the 10 year’s prior and the $15 expended by the Township on its 1885 vaccination program (Appendix I). Minto Township also launched a vaccination program in the mid-1890s using an approach similar to Eramosa but it required families who were able to pay, to do so. Minto was satisfied with its vaccination experience, reporting that “the majority of the school children have been successfully vaccinated at a trifling cost to both parents and the municipality.” Minto Township Council Minutes, November 26, 1894, Wellington County Archives, A1991-117.

223 Guelph Township Board of Health Minutes, January 27, 1894, Wellington County Archives, A1988.122.
Conclusion

The evolution of township approaches to the management of contagious disease risks exhibited a different progression than observed in the area of public nuisances. While citizens sought to engage the local BOH’s assistance in various sanitation nuisance matters and BOH’s gained confidence in applying their authority, neither of these occurred in the regard to the management of contagious disease risks. Citizens were reluctant to have the BOH involved in the management of diseases affecting their household and, as a result, BOH’s were very circumspect about the application and enforcement of disease control measures. Local understandings about the causes and controls for infectious illnesses were changing but only slowly. Private interests and perspectives continued to hold sway, inhibiting BOHs in the enforcement of their directives and limiting the scope of preventative measures. With the support and encouragement of their MHOs, however, many BOHs found they could move forward to some degree. More frequent use was made of quarantine, household disinfection, and vaccination programs. BOH members as well as local citizens benefitted from the increasing influence of local MHOs whose expertise and influence provided education and encouragement. However, the BOHs’ disease control directives and vaccination programs were only as successful as community members allowed. When citizens complied with directives or participated in vaccination programs, health boards marked success. When citizens resisted, BOHs were left to accept defeat. They had little appetite to pursue compliance given the public backlash that could result.

In this context, BOHs’ sought and found new approaches that could help them balance competing public and private interests in managing the risks of contagious
disease. They took advantage of and had growing confidence in new medical concepts and health technologies. These tools included the use of advice from health experts and scientific testing that incorporated the insights of new scientific knowledge and medical technologies. Their use provided greater clarity and precision to the assessment and resolution of contagious disease risks which proved helpful in addressing local concerns. At the same time, local confidence in the role and authority of the BOH was preserved. At times BOHs also drew upon the resources and authority of local courts, local schools, and the provincial health board in their efforts to find a course through the contending public and private interests. This broadened the base of local authorities who were engaged in public health interventions and provided a stronger platform for defining and defending public interests.

224 A similar observation is made in Starr, Social Transformation. “The advent of bacteriology not only increased the effectiveness of public health efforts; it also reduced their cost to society by doing away with indiscriminate interventions.”
CHAPTER 6 -- CONCLUSION

The public health experiences of Wellington County townships during the closing decades of the nineteenth century fill a void in the history of the early years of Ontario’s public health. Municipal records from these rural communities give direct evidence of the rationalities, strategies, and contending interests that shaped townships’ approach. From the minutes of their municipal councils and health boards, observations can be made about shifts in three key elements that shaped their views about public health. First, rural communities came to recognize that the health of their communities was more vulnerable than believed initially and that public health measures to preserve it were necessary. Second, they softened their views toward the need for increased government interventions so long as these interventions were controlled locally and responded to community expectations for financial restraint and for minimal impact on tax-paying households. Third, health board’s ability to manage the risks of contagious disease was aided by diminishing local skepticism toward new medical concepts and health technologies which illuminated the nature and causes of disease. Each of these elements proved to be key to townships’ public health interests and priorities. They influenced public health structures and processes and informed the identification and management of sanitation and contagious disease risks. Over the 1880s and 1890s, Wellington County townships overcame some of their reticence toward a government role in public health and fashioned approaches to public health that could navigate a balance between public and private interests acceptable to their rural communities.
Wellington County’s townships response to the introduction of the PHA was similar to that of many other rural communities in the province. None of them established a local board of health when the legislation was passed in 1882. Government intervention in peoples’ health circumstances had, to date, been restricted to immigrant health and crisis-driven interventions in response to epidemics. Wellington’s townships, like most other rural communities in Ontario, had no fundamental objection to the Act. By the same token, they also had no expectation that its laws required any significant attention from them. In their view, the primary need for public health legislation was in centres such as Toronto, Hamilton, Windsor and Ottawa where municipal governments required stronger authority to manage the ills of filth and disease borne of their urban conditions. People believed the rural living conditions that included considerable outdoor activity, lots of fresh air and plenty of clean water were inherently conducive to good health. For townships, this perspective was reinforced by many provisions of the PHA that seemed ill-suited to rural realities. The Act’s emphasis on sewer and water systems, on detailed specifications for house and privy construction, and the lack of appreciation of the havoc for family farms that would result from excessive regulation of milk and meat producers all pointed to the rightness of the townships’ point of view. Further, as the Act provided local governments with the authority to design and administrate their own public health bylaws, they took advantage of this and designed bylaws and responses that allowed them to approach public health matters in the manner that suited their community best.

When the PHA was amended in 1884 to make the establishment of a BOH mandatory, most Wellington County townships complied immediately and by 1885, all
had done so. Compliance with the law did not, however, have an immediate impact on community perspectives about the need for local public health. Local tax dollars were limited and the ability to keep and support a strong farming community made investments in roads, bridges, and schools essential and a priority. While there was no great outcry against the provision of some funding in support of BOHs, their resourcing was restrained and reflected the practicalities of township needs and priorities. Processes for populating the local health board were soon regularized and the practice of annual BOH reporting activities and expenditures became routine. Most local boards established regular meeting schedules, convening two or three times a year to fulfill the board’s basic functions and adding extra meetings when necessary. BOH membership was fairly stable with many ratepayer appointees renewed for multiple terms. Appointees seemed satisfied with the resulting division of responsibilities, their reputational benefits, and their financial compensation. BOH membership was worthwhile and respected in the community.

In establishing a local health board, several township councils also tailored public health bylaws for their community that aligned with the realities and expectations of their rural community. As a further support to the work of local BOHs, most township councils appointed a medical health officer or sanitary inspector. The expertise, affluence, and influence of these local health officials, particularly MHOs, provided added capacities to health board members. They helped mediate the relationships between the township health board and members of the community about the need for, and nature of, public health interventions. Through their expertise and influence, they shaped the ideas and attitudes toward public interests in health among BOH members,
local physicians and township councillors. With their encouragement, townships increased their use of quarantine, household disinfection, and vaccination. Health boards soon learned that the support of health officials helped them be responsive to local concerns and complaints and accepted as an authoritative entity that reflected the best interests of the community.

With the need for public health structures and processes foisted upon them by law, townships did their best to gain value from them. Attention was given to public communications and this was prompted by a range of motivations and the potential of a multiple of benefits. BOH-issued bulletins and posters were prepared to make citizens aware of the new governmental role in public health laws, local sanitary standards, contagious disease control requirements, and the board's local authorities in each area. The opportunity of relaying this information through township schools was often used and allowed for fairly thorough distribution to farming households that were scattered throughout the township. Distribution of this information provided a practical benefit in its enumeration of best practices for sanitation and disease control. It also served to diminish legal and financial liabilities for the municipality should an epidemic strike. Knowledge of the BOH's role and authority was also advanced.

Increased awareness of local public health processes and structures also had the result of increasing nuisance complaints. Citizen complaints were brought forward and BOHs’ attention to their remediation was regarded as important. Community concerns about dilapidated houses, abandoned livestock carcasses, dumped night soil, and slaughterhouse operations were the public health concerns of importance to these rural communities and their remediation aligned well with their understandings about the
measures needed to preserve public health in their rural community. In some instances, such as night soil, rural communities’ complaints arose from the importation of the city’s problems. Township residents took satisfaction that the new public health laws enhanced the ability to defend them from becoming the city’s dumping ground.

As township BOHs addressed local nuisance complaints, they gained increased confidence in when and how to exert their authority to resolve local concerns. They were prepared to press for enforcement of their directives laying charges or demanding the destruction of a premise where it was deemed necessary. They increasingly relied on the expertise, observations and advice of their public health officials. At the same time, BOHs also sought out the views of neighbours in assessing a complaint and frequently gave their views primacy. Boards were also attentive to the financial and political repercussions of their interventions. To demonstrate financial prudence, they put restrictions on the reimbursements paid to remove dead animal carcasses when it appeared the system was being abused or looked for opportunities to have local schools or neighbouring municipalities bear some of the township’s public health costs. BOHs exhibited political savvy when they pursued public health bylaw amendments to ease sanitation requirements for a local slaughterhouse operator or utilized experts’ advice and engaged in public communications to calm local fears about contaminated milk. They also remained attuned to the impact of their interventions on community relationships. At times, BOHs were drawn into the role of local arbiter in neighbourhood disputes that were presented in the guise of a public health complaint. With application of local structures and processes for public health, the BOH provided an element of objectivity and authority that could diffuse, if not fully resolve, such disputes. This
function, while tangential to core public health objectives, also brought value to farming communities where everyone knew each other and cordial relations were a *sine qua non* for survival and success. The BOHs’ involvement could moderate tensions among neighbours and provide all those involved with a buffer from recriminations once the matter came to rest.

While townships’ approaches to nuisance complaints did not reflect any fundamental change in understandings about the factors required for good health or demonstrate advances in receptivity to new medical concepts and health technologies, they did point to a shift in perspectives on government roles. Township citizens saw value in the interventions of their BOH when it addressed real issues of importance to them and used its influence and authority to defend the quality of their living environment. As long as the health board acted in a measured and financially prudent way, there was tolerance for application of its powers because it was recognized and accepted that a public good was being served.

While township conditions allowed for a fairly significant expansion of public health interventions with regard to sanitary nuisances, this same evolution is not observed in the management of contagious disease risks. Even as their years of experience with the PHA increased, BOHs showed a reluctance to wield their full authority to achieve compliance in this area. Some township residents cooperated with directives such as quarantine and household disinfection but where there was resistance, BOHs did not enjoy sufficient support among township residents to recognize the need for significant government intervention in individuals’ health
circumstances. The private interests and needs of the individual household held sway and the community was not prepared to ease way to the public interest in this area.

The reasons for resistance are multiple. Township citizens reflected a wide range of perspectives about the risk of contagious diseases. For some, short of an epidemic, the presence of common contagious diseases was accepted and regarded as an unfortunate reality about which little could be done. Often the causes of disease were attributed to outside sources, travellers to and from other communities, or the function of a person’s impoverished condition. Public health efforts to preserve local sanitary standards seemed, for most, sufficient. Even among those who held hope that developments in science and medicine could improve the management of contagious disease, tolerance for public health interventions was limited due to the conflicts and confusions surrounding the nature and causes of these illnesses. The ‘mild’ form of some illnesses and the lack of evidence of major outbreaks or escalating death rates from disease in the community suggested that the BOH’s directed control measures could become excessive. The lack of evidence that contagious disease had much presence in the community also mitigated against the need for BOH interventions. Without consistent approaches to the diagnosis of diseases and agreement about those which should be considered contagious, it was challenging for BOHs to receive reliable disease reports or build consensus on the appropriate preventative and control interventions. Added to all of this uncertainty, were widespread doubts about the reliability and efficacy of preventative health innovations such as vaccinations.

Resistance to directives for quarantine and household disinfection also met with another type of challenge in rural communities. With the seasonal imperatives of
agricultural work and the fundamental importance of productive neighbourhood relationships, there was little appetite for government interference in household activities. The placarding of houses to signal quarantine orders or the imposition of requirements for household disinfection, could be seen as excessive in the circumstances. These measures brought embarrassment to afflicted households and considerable disruption to essential day-to-day routines as well as the comings and goings among neighbours considered essential to a family’s needs and duties.

In this climate, BOHs had to find new approaches to advance public interests in the management of contagious disease. They were guided in this regard by the encouragement, expertise, and influential capacities of their MHOs toward use of specialized resources that offered a degree of precision and certainty to disease risk assessment. These new tools proved helpful in addressing local contagious disease concerns. Where BOHs’ structures and processes had been sufficient to provide an element of objectivity and authority to diffuse challenges in the management of nuisances, these were not sufficient to carry influence in matters of contagious disease. To overcome this limitation, BOHs added new tools to enhance their influential capacities, seeking advice from health experts and utilizing scientific testing. In addition, BOHs adopted new tactics that expanded their access to financial resources and extended their base of authority to better manage contagious disease risks. By invoking the resources of the township’s judicial and educational functions or tapping into the advisory role of the provincial health board, they found new ways to resolve or diffuse the contending public and private interests in their community.
The insights that emerge from Wellington County’s townships serve as a valuable counterpoint to the criticisms leveled at townships by the Provincial Board of Health. The townships’ records give voice to the rural experience, a voice that has been largely neglected in histories about public health in the province. Their stories show clearly that the rural majority of late nineteenth century Ontario were prepared to accept the new responsibility that had been assigned to them but they were not prepared to accept the new and singular definition of a healthy community that was espoused by the province’s Public Health Act. Instead, they set themselves on courses according to their own views about a healthy community and, as has been shown, were ready to adapt their approach when sufficient evidence for change was presented and where the pragmatic needs and priorities of their agricultural communities could be met.

Obstacles to change can be formidable and often reflect differences in strongly-held beliefs about the realities of day-to-day life. As noted at the outset, public health concerns remain a matter of significant attention for public discussion and public policy. If there are lessons to be drawn for today from this history, perhaps it is to remind us that solutions devised in light of urban conditions may be ill-suited to the needs and perspectives of those living in rural municipalities. Successful public policy in health, if not in other areas as well, must exhibit an appreciation for the range of perspectives and interests of those whose behaviour it is designed to change.
APPENDICES

Appendix A: Wellington County Townships - Map, 1880
Appendix B: Establishment of Local Boards of Health in Ontario, Selected Years, 1883 – 1898
Appendix C: Death-rate per 1,000 of Population for Ontario Counties and Ontario Cities
Appendix D: Wellington County Townships’ Local Boards of Health - Inventory of Available Annual Reports, 1884 – 1900
Appendix E: Wellington County Townships’ Local Boards of Health - Number of Annual Meetings, 1884 – 1900
Appendix F: Wellington County Townships’ Medical Health Officers and Sanitary Inspectors, 1884 - 1900
Appendix G: Puslinch Township’s Public Health Bylaw, November 1884
Appendix H: Wellington County Townships’ Local Boards of Health - Members, 1884 to 1900
Appendix I: Wellington County Townships’ Local Boards of Health - Reported Expenditures and Some Comparators, 1884-1900
Appendix J: West Garafraxa Township’s Public Health Notice - Sections from the Public Health Act in January 1885 Public Notice
APPENDIX A: Wellington County Townships Map, 1880

Note: The map shows the township of Amaranth in the northeast. This appears to be in error as no records for the period indicate that this township was included among the municipalities of Wellington County.
APPENDIX B: Establishment of Local Boards of Health in Ontario, Selected Years, 1883 – 1898

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Local Municipalities (Cities, Towns, Villages &amp; Townships)</th>
<th>Number of Local Boards of Health (including Townships)</th>
<th>Percentage of Municipalities with Local Boards of Health (%)</th>
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<td>41</td>
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</tr>
<tr>
<td>1885</td>
<td>651</td>
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<td>668</td>
<td>610</td>
<td>91.3</td>
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<tr>
<td>1887</td>
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<td>737</td>
<td>425</td>
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<tr>
<td>1898</td>
<td>747</td>
<td>568</td>
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This table shows the number of Ontario municipalities that established local boards of health after the introduction of the Public Health Act in 1882 and the percentage of the total municipalities they represented.

The best response from municipalities came in the two years immediately following the Act’s 1884 amendments making local health boards mandatory. After 1886 annual number of local boards fell. While some of the decrease may be attributed to municipal consolidations, the total percentage with local boards never returned to the percentage high of 1886.228

Rural townships comprised the vast majority of Ontario’s local jurisdictions at this time.

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226 Powell, Provincial-Local Relations, 54. The information shown here is largely taken from Powell’s Table 2-2 that draws on information from Ontario’s Bureau of Industries, *Municipal Statistics for the number of municipalities in Ontario for each year* as well as on the annual reports of the Provincial Board of Health for most of the data on the number of local boards of health that had been established in each year. The numbers of local boards for 1891, the 10th anniversary of the Public Health Act, were not provided by Powell and have been added using information found in the Provincial Board of Health’s annual report for that year. See: Ontario Board of Health, “Tenth Annual Report of the Provincial Board of Health of Ontario. Being for the Year 1891”, Toronto, 1892, 2.

227 Ontario, Board of Health Report for 1884, 3. The 1884 Provincial Board of Health Report indicates that of 417 townships in that year there were only 184 Boards. Consequently, 233 townships – or more than half – did not have a local board of health.

228 The annual fluctuation in local boards is, in part, attributable to systemic factors that affected both rural and urban municipalities. Local councils were elected annually and made most decisions, including budget matters and the establishment of local health boards, on a year-to-year basis.
APPENDIX C: Death-rate per 1,000 of Population for Ontario Counties and Ontario Cities

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<tr>
<th></th>
<th>1884</th>
<th>1885</th>
<th>1886</th>
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<th>1889</th>
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229 Registrar-General of Ontario – Annual report of births, marriages & deaths for 1891: 40-41. Extracted from tables that show the breakdown by county and by city – Table 7 and Table 8. Information for the Counties reportedly includes information on the townships, exclusive of the cities but including towns and villages included in the respective county. Cities used in preparing this death rate were: Toronto, Hamilton, Ottawa, London, Kingston, Brantford, St. Thomas, Guelph, St. Catharines, Belleville, Stratford and Windsor. Note: The report makes clear that they do not consider the registration of vital statistics to be complete or reliable due to inconsistencies in data collection across the province.
APPENDIX D: Wellington County Townships’ Local Boards of Health – Inventory of Available Annual Reports, 1884 – 1900

This chart provides an inventory of annual reports found for Wellington County townships’ boards of health and their officers from among township council minutes, township board of health minutes and the annual reports of the Provincial Board of Health.

Legend:

**BOH** = Report prepared by the Township’s Board of Health and found in township council minutes

**BOH** = Report prepared by the Township’s Board of Health and found in Board of Health minutes

**BOH-PBH** = Report prepared by the Township’s Board of Health and found in the annual report of the Provincial Board of Health

**PBH** = Report summary for the township included in the annual report of the Provincial Board of Health

**MHO** = Report prepared by the Township’s Medical Health Officer and found in township council minutes

**MHO** = Report prepared by the Township’s Medical Health Officer and found in Board of Health minutes

**MHO-PBH** = Report prepared by the Township’s Medical Health Officer and found in the annual report of the Provincial Board of Health

**SI** = Report prepared by the Township’s Sanitary Inspector and found in Board of Health minutes

**SI-PBH** = Report prepared by the Township’s Sanitary Inspector and found in the annual report of the Provincial Board of Health

*For these years only summary chart information from each township’s annual report were included in the Provincial Board of Health’s Annual Report.

** In 1899, the Provincial Board of Health did not include reported information by township. Instead, county summaries were prepared based on reports submitted from municipalities in each county.
### APPENDIX D: Wellington County Townships' Local Boards of Health – Inventory of Available Annual Reports, 1884 – 1900

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<tr>
<th>Year</th>
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<td>BOH/MHO/SI; PBH</td>
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<td>1895*</td>
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<td>1897*</td>
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<td>BOH; PBH</td>
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<td>1899**</td>
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<td>BOH</td>
<td>MHO/SI</td>
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<td>BOH · PBH</td>
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<td>MHO/SI; PBH</td>
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APPENDIX E: Wellington County Townships’ Local Boards of Health -- Number of Annual Meetings, 1884 - 1900

<table>
<thead>
<tr>
<th></th>
<th>Eramosa</th>
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<th>Pilkington</th>
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</table>

230 This table was prepared based on information gathered from the townships’ board of health records for the period 1884 to 1900, particularly board of health minutes. Board of health minutes were not available for Arthur, Luther, Maryborough, Minto, Nichol, Peel, and Puslinch to allow tracking of board of health meeting frequency.
### APPENDIX F: Wellington County Townships’ Medical Health Officers and Sanitary Inspectors, 1884 - 1900

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Arthur</th>
<th>Eramosa</th>
<th>Erin</th>
<th>Guelph</th>
<th>Maryborough</th>
<th>Minto</th>
<th>Nichol</th>
<th>Peel</th>
<th>Pilkington</th>
<th>Puslinch</th>
<th>West Garafraxa</th>
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<td>1884</td>
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<td></td>
<td>Dr. James Wallace – MHO</td>
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<td></td>
<td>Dr. A. Paget - MHO</td>
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<td></td>
<td>John McGowan - SI</td>
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<td></td>
<td>Dr. John G. Meunie - MHO</td>
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<tr>
<td>1885</td>
<td>Dr. J.R. Dryden, MHO</td>
<td>Capt. W. Clarke - SI</td>
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<td>Dr. James Wallace – MHO</td>
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<td>John McGowan - SI</td>
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<td>1886</td>
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<td>Capt. W. Clarke - SI</td>
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<td>Dr. James Wallace – MHO</td>
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<td>John McGowan - SI</td>
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<tr>
<td>1887</td>
<td>Dr. J.R. Dryden, MHO</td>
<td>Capt. W. Clarke - SI</td>
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<td>Dr. James Wallace – MHO</td>
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<td></td>
<td>John McGowan - SI</td>
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</tbody>
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231 Information for this table was drawn from Wellington County townships’ council and board of health minutes for the period as well as from township submissions included in the annual report of the Provincial Board of Health, including the summaries prepared for townships in the provincial reports over the years 1891 to 1900.

232 Captain Clarke was also the Sanitary Inspector for the City of Guelph. He served as the Sanitary Inspector for both municipalities simultaneously from 1885 until at least 1895. For 2 months in 1891 Captain Clarke was away and, at his suggestion and with the support of the BOH, Mr. Hughes who ran a scavenging service in the City of Guelph (and did a significant amount of work clearing nuisances on behalf of Guelph Township under the instruction of the SI) served as the township’s Sanitary Inspector for this period.

233 The MHO in Eramosa was also appointed as a member of the township Board of Health throughout the years 1885 through to at least 1900.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>Arthur</th>
<th>Ermosa</th>
<th>Erin</th>
<th>Guelph</th>
<th>Maryborough</th>
<th>Minto</th>
<th>Nichol</th>
<th>Peel</th>
<th>Pilkington</th>
<th>Puslinch</th>
<th>West Garafraxa</th>
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</table>

234 Dr. Wallace was given authority for the area in the township north of the ninth concession with Dr. Lucy was assigned to oversee the area south of the tenth concession.

235 Beginning in 1889 through to at least 1900, the SI for the township was also a member of the BOH.
<table>
<thead>
<tr>
<th>YEAR</th>
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<th>Minto</th>
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<th>Pilton</th>
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<th>West Luther</th>
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<tbody>
<tr>
<td>1892</td>
<td>Dr. J.R. Dryden - MHO</td>
<td>Dr. A.H. McKinnon - MHO</td>
<td>Capt. W. Clarke - SI</td>
<td>Dr. W.A. Harvey - MHO</td>
<td>Dr. James Wallace &amp; Dr. Henry Becker – MHO</td>
<td>Hugh Roberts – SI (as of June)</td>
<td>Dr. A. Paget - MHO</td>
<td>Andrew Munroe - SI</td>
<td>Dr. A.H. Halliday, MHO</td>
<td>William Alexander, SI</td>
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<tr>
<td>1894</td>
<td>Dr. [Murdock] McPhaden, Mount Forest - MHO</td>
<td>Dr. J.R. Dryden - MHO</td>
<td>Capt. W. Clarke - SI</td>
<td>Dr. J.F. Cassidy - MHO</td>
<td>Dr. W.A. Harvey - MHO</td>
<td>Dr. Arthur Paget – MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO</td>
<td>Hugh Roberts - SI</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO</td>
<td>Dr. A.E. Clendennan - MHO</td>
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<td>Dr. J.R. Dryden - MHO</td>
<td>Capt. W. Clarke - SI</td>
<td>Dr. J.F. Cassidy – MHO</td>
<td>Dr. W.A. Harvey – MHO</td>
<td>Dr. Arthur Paget – MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO</td>
<td>Hugh Roberts - SI37</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO</td>
<td>Dr. A.E. Clendennan - MHO</td>
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<tr>
<td>1896</td>
<td>Dr. Reynolds - MHO</td>
<td>Dr. W. Tanner - Veterinary Surgeon (VS)</td>
<td>Dr. J.R. Dryden - MHO</td>
<td>Dr. J.F. Cassidy – MHO</td>
<td>Dr. W.A. Harvey – MHO</td>
<td>Dr. Arthur Paget – MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO</td>
<td>Hugh Roberts - SI</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO</td>
<td>Dr. W.W. James - MHO</td>
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</tr>
<tr>
<td></td>
<td>Dr. Reynolds - MHO</td>
<td>Dr. W. Tanner - Veterinary Surgeon (VS)</td>
<td>Dr. J.R. Dryden - MHO</td>
<td>Dr. J.F. Cassidy – MHO</td>
<td>Dr. W.A. Harvey – MHO</td>
<td>Dr. Arthur Paget – MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO</td>
<td>Hugh Roberts - SI</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO</td>
<td>Dr. W.W. James - MHO</td>
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<td>1897</td>
<td>Dr. Reynolds - MHO</td>
<td>Dr. E.F. McCullough - MHO</td>
<td>Dr. E.F. McCullough - MHO</td>
<td>Dr. J.F. Cassidy – MHO</td>
<td>Dr. W.A. Harvey – MHO</td>
<td>Dr. Arthur Paget – MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO</td>
<td>Hugh Roberts - SI</td>
<td>Andrew Munroe - SI</td>
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<tr>
<td>1898</td>
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<td>Dr. E.F. McCullough - MHO</td>
<td>Dr. J.F. Cassidy – MHO</td>
<td>Dr. W.A. Harvey – MHO</td>
<td>Dr. Arthur Paget – MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO</td>
<td>Thomas Cleghorn - SI</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO</td>
<td>Dr. A.C. Gaviller - MHO</td>
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</table>

237 Beginning in 1895 through to at least 1900, the SI was also a member of the BOH and served as its Chairman.
<table>
<thead>
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<th>YEAR</th>
<th>Arthur</th>
<th>Eramosa</th>
<th>Erin</th>
<th>Guelph</th>
<th>Maryborough</th>
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<th>Peel</th>
<th>Pilton</th>
<th>Puslinch</th>
<th>West Garafraxa</th>
<th>West Luther</th>
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<tbody>
<tr>
<td>1899</td>
<td>Dr. Reynolds - MHO&lt;br&gt;Charles Soules - SI</td>
<td>Dr. E.F. McCullough - MHO</td>
<td>Dr. W.A. Harvey - MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO&lt;br&gt;Joseph Wallace &amp; Henry Fairweather - SI</td>
<td>Dr. Robertson - MHO&lt;br&gt;Thomas Cleghorn - SI</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO&lt;br&gt;William H. Cowan - SI</td>
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<tr>
<td>1900</td>
<td>M.J. McGillicuddy - SI</td>
<td>Dr. E.F. McCullough - MHO</td>
<td>Dr. W.A. Harvey - MHO</td>
<td>Dr. James Wallace &amp; Dr. John D. McNaughton – MHO&lt;br&gt;Joseph Wallace &amp; Henry Fairweather - SI</td>
<td>Dr. Robertson - MHO&lt;br&gt;Thomas Cleghorn - SI</td>
<td>Andrew Munroe - SI</td>
<td>Dr. James Dow – MHO&lt;br&gt;William H. Cowan - SI</td>
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APPENDIX G: Puslinch Township’s Public Health Bylaw, November 1884

Puslinch Township
Bylaw Number 266
A Bylaw Respecting the Public Health

November 24, 1884

1. All the powers and authorities conferred upon or vested in the members of the said Municipal Council by an [sic] Statute of the Legislature of this Province as Health Officers of the said Municipality shall be vested and delegated to such persons as shall from time to time be elected members of the local Board of Health.

2. The Board of Health shall employ such subordinate officers, agents and assistants as it may deem necessary, and may subject to the approval of the Council, fix the compensation to be allowed them; but the whole amounts of such compensation shall not exceed the sum appropriated therefor by the Municipal Council.

3. It shall be the duty of the chairman of the Board of Health to present to the Municipal Council before the first day of December in each year a report containing a detailed statement of the work of the Board of Health during the year and the report of the Sanitary condition of the municipality, as rendered to him by the Sanitary Inspector. A copy of each such report shall be transmitted by the Clerk of the Municipality to the Secretary of the Provincial Board of Health.

4. It shall not be lawful for any person within the said municipality to permit or suffer the accumulation upon his premises, or to deposit or permit the deposit upon any lot belonging to him, of anything which may endanger the public health, or to deposit on any public street, square, lane, or on any byway in front or in rear or alongside of his buildings or premises, or in any pond, creek, river or running stream any manure or other refuse or vegetable or animal matter or any dirt or filth.

5. It shall be the duty of the Sanitary Inspector to keep a vigilant supervision over all said lanes, byways, lots or premises upon which any such accumulation as aforesaid may be found, and at once to notify the parties who own or occupy such lots or premises, or who either personally or through their employees have deposited such manure, refuse, matter, dirt[sic] or filth in any lane or byway to cleanse the same and remove what is found thereon; such parties shall forthwith remove the same, and if the same be not removed within twenty four hours after such notification, the Inspector may prosecute the parties so offending and he may also cause the same to be removed at the expense of the person or persons so offending. He shall also inspect at intervals, as directed by the board, all premises occupied for residing within its jurisdiction, and shall report to the board each and every case of violation of any of the provisions of this Bylaw, or any

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238 Puslinch Township Council Bylaws, Bylaw No. 266, November 24, 1884, Wellington County Archives, A1998.118.
other regulations for the preservation of the public health, and shall also report every
case of refusal to permit him to make such inspection.

6. Whenever it shall appear to the Board of Health or any of its officers that it is necessary
for the preservation of the public health, or for the abatement of anything dangerous to
the public health, or whenever they or he shall have received a notice signed by one or
more householders of the municipality stating the condition of any building in the
municipality to be so filthy as to be dangerous to the public health, or that upon any
premises in the municipality there is any foul or offensive ditch, gutter, drain, privy,
cesspool, ash pit or cellar kept or constructed so as to be dangerous or injurious to the
public health, or that upon any such premises an accumulation of dung, manure, offal,
filth, refuse, stagnant water, or other matter or thing is kept so as to be dangerous as
aforesaid, the said Board of Health shall enter or direct the proper officer to enter such
buildings or premises for the purpose of examining the same, and, if necessary, the
Board or such officer shall order the removal of such matter or thing as aforesaid. If the
occupants or proprietor or his lawful agents or representative having charge or control of
such premises, after having had twenty four hours notice from any such officer of the
Board of Health to remove or abate such matter or thing as aforesaid, shall neglect or
refuse to remove or abate the same, he shall be subject to the penalties imposed under
section 9 of this Bylaw.

7. All slaughterhouses within the municipality shall be subject to regular inspection under
the direction of the Board of Health, and no person shall keep any slaughterhouse
unless the permission in writing of the Board of Health has been first obtained, and
remains unrevoked. Such permission shall be granted, after approval of such premises
upon inspection, subject to the condition that the said houses shall be so kept as not to
impair the health of persons residing in their vicinity, and upon such condition being
broken the said permission may be revoked by the Board, and all animals to be
slaughtered and all fresh meats exposed for sale in this municipality shall be subject to
the like inspection.

8. The following code of Rules and Regulations for the preservation of the public health
and the prevention of the spread of contagious or infectious diseases shall constitute a
part of this Bylaw, and any person or persons violating or neglecting any of the said rules
and regulations shall be liable to the fines and penalties imposed by Section 9 of this
Bylaw.

Rule 1. – No privy vault, cesspool or reservoir into which a privy, water-closets, stables
or sink is drained, except it be water tight shall be established unless by special
permission of the Board in which case it shall not be less than one hundred feet from
any well, spring or other source of water used for culinary purposes.

Rule 2. – Earth privies or earth closets without a vault below the surface of the ground
do not come within Rule 1, but sufficient dry earth, wood ashes or coal ashes to absorb
all the fluid parts of the deposits much be thrown on the contents of such earth privies
and closets daily, and the entire contents must be removed weekly.

Rule 3. – All privy vaults, cesspools or reservoirs named in Rule 1 shall be cleaned out
at least once a year, and from the 15th day of May to the first day of November in each
year shall be thoroughly disinfected by adding to the contents of the vault cesspool or
reservoir, once a month, not less than two pounds of sulphate [sic] of iron dissolved in a pailful [sic] of water, or other suitable disinfectant.

Rule 4. – Within the limits of this municipality no night soil or contents of any cesspool shall be removed until previously deodorized as above, and during its transportation the material shall be covered with a layer of fresh earth except the removal shall have been by “odorless excavating process.”

Rule 5. – Every householder and every hotel keeper, or other person accumulating garbage shall have a proper covered receptacle for swill and house offal, the contents of which shall, between the 15th day of May and the first day of November, be regularly removed as often as twice a week.

Rule 6. – All putrid and decaying animal or vegetable matter must be removed from all cellars, buildings outbuildings and yards on or before the 15th day of May in each year.

Rule 7. – Between the 15th day of May and the 1st day of November pens in which hogs are confined or kept within the limits of this municipality must be seventy feet from any house with floor kept free from standing water and regularly disinfected.

Rule 8. – No animals affected with an infectious or contagious disease shall be brought or kept within this municipality except by permission of the Board.

Rule 9 – No person shall offer for sale as food within this municipality any deceased animal, or any meats fish fruit vegetable or milk, or other article of food which, by reason of disease, decay, adulteration, impurity or any other cause shall be unfit for use.

Rule 10. – All wells in this municipality shall be cleaned out before the first day of July in each year.

Rule 11. – Any householder in whose dwelling there shall occur a case of Scarlet fever, or other diseases dangerous to the public health, shall immediately notify the Board of Health of the same and until instructions are received from the Board, shall not permit any clothing or other property to be removed from his house, nor shall any occupants of the said house change his or her residence to any other place within the municipality without the consent of the Board.

Rule 12. – Each and every person affected with any of the diseases specified in Rule 11 shall be immediately separated from all persons liable to contract or communicate the disease, and no one having access to any person so affected shall mingle with the general public, except such person is an attending physician or clergyman, who shall be required to adopt all needful precautions to prevent the spread of such disease. Nothing shall be permitted to pass from the person so affected to any outside person unless the same shall first have been properly disinfected.

Rule 13. – Persons recovering from any of the diseases specified in Rule 11, and nurses who have been in attendance on any person suffering from any such diseases shall not leave the premises till they have received from the attending physician a certificate that in his opinion they have taken such precautions as to their person, clothing and all other things they propose bringing from the premises as are necessary to insure immunity from infection of other persons with whom they may come in contact.
Rule 14 – No person shall transmit, sell or expose, to, from or within this municipality, any bedding, clothing or other article likely to convey any of the diseases named in Rule 11 without having first taken such precautions as the Board may direct as necessary for removing all danger of communicating any such disease to others.

Rule 15. – No person shall let or hire any house or room in a house in this municipality in which house any of the said diseases have recently existed, without having caused such house and the premises used in connection therewith to be disinfected to the satisfaction of the health authorities.

9. Any person who violates Section 6 or 7 of this Bylaw or Rule 1, 8, 9, 14 or 15 of Section 8 shall be liable for every such offence to a penalty not less than $5.00 nor more than $50.00 in the discretion of the committing justices or Magistrate, besides costs, which may also be inflicted if the committing Justices or Magistrate see fit to impose the same. Any person who violates any other provision of this Bylaw shall, which such violation does not come within the penal provisions of Section 32 of the Revised Statutes respecting the public health be liable for every such offence to a penalty not exceeding $20.00 in the discretion of the committing Justices or Magistrate, besides costs, which may also be inflicted if the committing Justices or Magistrate see fit to impose the same. Every such penalty may be recovered by any person before any two Justices or a Police Magistrate having jurisdiction in the said municipality and shall be levied by distress and sale of the goods and chattels of the offender, with the cost of such distress and sale, by warrants under the hands and seals of the Justices or the hand and seal of the Police Magistrate before whom the same are recovered, or under the hands and seals of any other two Justices having jurisdiction in the municipality, and in default of sufficient distress the said Justice or Magistrate may convict the offender to the Common Gaol for any time not exceeding fourteen days unless the amount imposed is sooner paid.
APPENDIX H: Wellington County Townships’ Local Boards of Health - Members, 1884 to 1900

The charts prepared for this appendix depict the members of Boards of Health (BOH) in ten of the twelve Wellington County townships for which this information was available. In some cases, the membership is known for only some of the years during the period 1884 to 1900.

As the ex officio members (Reeve and Township Clerk) could change due to annual election results, the membership stability of a BOH depended on the persistence of ratepayer members who were appointed. In order to assess and illustrate the degree of ratepayer membership persistence, membership “stability vectors” were developed and charted for each township. In addition, township “stability scores” were prepared for all three BOH membership categories (i.e., Ratepayer, Reeve, Township Clerk).

**Stability vector** charts are line graphs charting the annual score achieved when the total accumulated years of service of the BOH members is divided by the number of ratepayer members. The length of an upward vector signals strong stability. The length of drop in the vector signify the impact of membership change the resulting year-to-year amplitude offers a sense of the overall impact for membership stability. Where a township’s overall vector tracks upwards, a degree of stability is demonstrated. For 3 of the 10 townships where data over multiple years is limited and, particularly, as it is missing from the early years, no chart has been prepared as the results would not be particularly meaningful.

**Stability scores** are developed for each membership category (Ratepayer, Reeve, Township Clerk) by using the average of the total years of service for each member in the category divided by the number of years for which membership data is available for the township. A score of 1 shows the highest level of membership stability: no members changed during the years in which data is available.

All the membership information provided has been gathered from the township council and board of health minute records available in the Wellington County Archives.
# Appendix H - Board of Health Membership - Arthur Township
## 1884 to 1900

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<th>Arthur</th>
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**Notes:**
- Shaded cells indicate years with missing data
- CHART NOT PREPARED FOR ARTHUR TOWNSHIP AS DATA NOT SUFFICIENTLY COMPLETE IN EARLY YEARS

## Membership Stability Scores - Arthur

<table>
<thead>
<tr>
<th>Membership Stability Scores - Arthur</th>
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</thead>
<tbody>
<tr>
<td>Ratepayer Members' Stability Score</td>
</tr>
<tr>
<td>Reeves' Stability Score</td>
</tr>
<tr>
<td>Clerks' Stability Score</td>
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</tbody>
</table>
Appendix H - Board of Health Membership - Eramosa Township

1884 to 1900

ERAMOSA

Dr. J.R. Dryden (Ratepayer)
Archibald Johnson (Ratepayer)
Charles McDougall (Ratepayer)
William Sunter (Ratepayer)
James Auld (Ratepayer)
Dr. E.F. McCullough (Ratepayer)
John Mutrie (Reeve)
Joseph Fletcher (Reeve)
John Rea (Reeve)
Daniel Talbot (Reeve)
Hugh Black (Clerk)

1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900

Notes:
Shaded cells indicate years & membership positions with missing data
Outlined cell indicates the person who served as Chairman of the Board of Health in that year
Cross-hatched cells indicate years when member was also Township MHO
Charles McDougall moved away from the township after 1888.
Robert Dredge was appointed as a ratepayer member for 1895 but he "declined to serve". James Auld was appointed in his place.
Dr. Dryden moved away from the township in late 1896. He was replaced by Dr. McCullough who, like Dr. Dryden, was also appointed as the township’s Medical Health Officer

Membership Stability Scores - Eramosa

Ratepayer Members' Variability Score 0.5
Reeves' Variability Score 0.3
Clerks' Variability Score 1.0
### Appendix H - Board of Health Membership - Erin Township
1884 to 1900

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**Notes:**
- Shaded cells indicate years & membership positions with missing data
- Outlined cell indicates the person who served as Chairman of the Board of Health in that year

**Membership Stability Scores - Erin**

<table>
<thead>
<tr>
<th>Role</th>
<th>Stability Score</th>
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<tr>
<td>Ratepayer Members' Stability Score</td>
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<td>Reeves' Stability Score</td>
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CHART NOT PREPARED FOR ERIN TOWNSHIP AS DATA NOT SUFFICIENTLY COMPLETE IN EARLY YEARS
### Appendix H - Board of Health Membership - Guelph Township
1884 to 1900

<table>
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<tr>
<th>Year</th>
<th>George A. Darby (Ratepayer)</th>
<th>Henry Watson (Ratepayer)</th>
<th>William Whitelaw (Ratepayer)</th>
<th>Thomas McCrae (Ratepayer)</th>
<th>John J. Hobson (Ratepayer)</th>
<th>David McCrae (Ratepayer)</th>
<th>J. Smith, Jr. (Ratepayer)</th>
<th>James McCuen (Ratepayer) [Earlier served as Reeve]</th>
<th>Mr. Sweetman (Ratepayer)</th>
<th>James McCuen (Reeve) [Later served as Ratepayer]</th>
<th>R McIntosh (Reeve)</th>
<th>A. McCorkindale (Clerk)</th>
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**Notes:**
- Shaded cells indicate years & membership positions with missing data.
- Outlined cell indicates the person who served as Chairman of the Board of Health in that year.
- Thomas McCrae died in early 1892. David McCrae was appointed in his place and made Chairman.

### Membership Stability Scores - Guelph

<table>
<thead>
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<th>Role</th>
<th>Stability Score</th>
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<td>Ratepayer Members’</td>
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<tr>
<td>Clerks’ Stability Score</td>
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### Appendix H - Board of Health Membership - Peel Township
#### 1884 to 1900

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<th>Ratepayer Members</th>
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<tbody>
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**Notes:**
There is some evidence that Peel Township appointed elected councillors as ratepayer members of its Board of Health. For example, Robert Rudd was a councillor and a member of the township’s BOH. This may account for the higher variability among Peel Township’s ratepayer Board of Health members as compared to other Wellington County townships. This practice was at odds with the best practices recommended by the Provincial Board of Health but was not contrary to Public Health Act provisions.

George Tucker was originally appointed as a ratepayer member for 1893 but by February of that year was replaced by Robert Rudd. The reason for G. Tucker’s departure is not noted.
### Appendix H - Board of Health Membership - Pilkington Township
#### 1884 to 1900

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<th>Pilkington</th>
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#### Notes:
- Outlined cell indicates the person who served as Chairman of the Board of Health in that year.
- Henry Larter resigned in May 1891 and was replaced by Mr. Hugh Roberts who was made Chairman of the Board of Health. The reason for Larter’s resignation is unknown.
- Cross-hatched cells indicate years when member was also appointed as Township Sanitary Inspector.
- Robert Cromar died in February 1892 and was replaced as Township Clerk by his son, George.
- Hugh Roberts died in 1897 and William L. Gordon was selected by the Township Council as his replacement. Gordon refused to accept the appointment. His reason is unknown.
- Information on the Township Reeve for 1886, 1890, 1897 and 1900 is from Remembering Pilkington Township, p. 126.
- Information on the Township Clerk for 1891 and 1897 is from Remembering Pilkington Township, p. 157.

#### Membership Stability Scores - Pilkington

| Ratepayer Members’ Stability Score | 0.3 |
| Reeves’ Stability Score | 0.1 |
| Clerks’ Stability Score | 0.5 |

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**Board of Health Ratepayer Membership Stability Vector**

Pilkington Township 1884 - 1900

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# Appendix H - Board of Health Membership - Puslinch Township

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### Notes:
- Outlined cell indicates the person who served as Chairman of the Board of Health in that year.
- Dr. Hilliard moved out of the township in August 1897. Archibald Marshall filled the vacancy. No physician was appointed after Hilliard during the period studied.
- Allan McIntyre died in mid-1899. Joseph Little, a former township councillor, was appointed to fill the vacancy for the balance of the year.

## Membership Stability Scores - Puslinch

<table>
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<tr>
<th>Membership Stability Scores - Puslinch</th>
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<tbody>
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<td>Ratepayer Members’</td>
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<td>Reeves’ Stability Score</td>
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<td>Clerks’ Stability Score</td>
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**Board of Health Ratepayer Membership Stability Vector**

Puslinch Township

1884 - 1900
## Appendix H - Board of Health Membership - Minto Township
### 1884 to 1900

| Minto | 1884 | 1885 | 1886 | 1887 | 1888 | 1889 | 1890 | 1891 | 1892 | 1893 | 1894 | 1895 | 1896 | 1897 | 1898 | 1899 | 1900 |
|-------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Mr. Barber (Ratepayer) | | | | | | | | | | | | | | | | |
| Mr. Davidson (Ratepayer) | | | | | | | | | | | | | | | | |
| Robert Cardwell (Ratepayer) | | | | | | | | | | | | | | | | |
| Mr. Aitchison (Ratepayer) [Later served as Reeve] | | | | | | | | | | | | | | | | |
| Mr. McMillan (Ratepayer) | | | | | | | | | | | | | | | | |
| Mr. Bride (Ratepayer) | | | | | | | | | | | | | | | | |
| George Henderson (Ratepayer) | | | | | | | | | | | | | | | | |
| Thomas Thomson, Sr. (Ratepayer) | | | | | | | | | | | | | | | | |
| George Whethern (Ratepayer) | | | | | | | | | | | | | | | | |
| G.G. Wilkin (Ratepayer) | | | | | | | | | | | | | | | | |
| Samuel Peebles (Reeve) | | | | | | | | | | | | | | | | |
| Mr. Aitchison (Reeve) [Earlier served as Ratepayer] | | | | | | | | | | | | | | | | |
| W.D. McLellan (Clerk) | | | | | | | | | | | | | | | | |

### Notes:
-Outlined cell indicates the person who served as Chairman of the Board of Health in that year.
-Proposed amendment at Township Council to appoint George Whethern, Thomas Thomson & Allan L. Patterson to the 1894 Board of Health failed.
-Ratepayer members in 1894 - Aitchison, McMillan and Bride - were also Township Councillors.

### CHART NOT PREPARED FOR ARTHUR TOWNSHIP AS DATA NOT SUFFICIENTLY COMPLETE IN EARLY YEARS

### Membership Stability Scores - Minto

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### Appendix H - Board of Health Membership - Nichol Township
1884 to 1900

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<th>John H. Broadfoot (Ratepayer)</th>
<th>John R. Wissler (Reeve)</th>
<th>James McQueen (Clerk)</th>
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**Notes:**
Shaded cells indicate years & membership positions with missing data.
Information on the Township Reeve is from Pillars and Patches Along the Pathway, pp. 194-195 for all years except 1887.
Information on the Township Clerk is from Pillars and Patches Along the Pathway, pp. 11, 200 for all years except 1888 - 1890.

### Board of Health Ratepayer Membership Stability Vector
Nichol Township
1884 - 1900

#### Membership Stability Scores - Nichol
- Ratepayer Members’ Stability Score: 1.0
- Reeves’ Stability Score: 1.0
- Clerks’ Stability Score: 1.0
### Appendix H - Board of Health Membership - West Garafraxa Township
#### 1884 to 1900

#### West Garafraxa

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#### Notes:
- Outlined cell indicates the person who served as Chairman of the Board of Health in that year.
- Cross-hatched cells indicate years when member was also appointed as Township Sanitary Inspector.

#### Membership Stability Scores - West Garafraxa

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#### Board of Health Ratepayer Membership Stability Vector

**West Garafraxa Township**

**1884 - 1900**

- **Ratepayer Members' Average Years of Service:**
  - 1884: 1
  - 1885: 1
  - 1886: 1
  - 1887: 1
  - 1888: 1
  - 1889: 1
  - 1890: 1
  - 1891: 1
  - 1892: 1
  - 1893: 1
  - 1894: 1
  - 1895: 1
  - 1896: 1
  - 1897: 1
  - 1898: 1
  - 1899: 1
  - 1900: 1

- **Year of Board's Operation:**
  - 1884
  - 1885
  - 1886
  - 1887
  - 1888
  - 1889
  - 1890
  - 1891
  - 1892
  - 1893
  - 1894
  - 1895
  - 1896
  - 1897
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  - 1900
## APPENDIX I: Wellington County Townships’ Local Boards of Health - Reported Expenditures and Some Comparators, 1884-1900

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<tr>
<td></td>
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<td>1891</td>
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<td>BOH</td>
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<td>$67.50</td>
<td>MHO</td>
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<td></td>
<td>$50.00</td>
<td>SI</td>
</tr>
<tr>
<td>1893</td>
<td></td>
<td>$34.00</td>
<td>BOH</td>
<td>$23.00</td>
<td>BOH</td>
</tr>
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<td></td>
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<td></td>
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<td>$50.00</td>
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<td></td>
<td>$53.80</td>
<td>BOH &amp; MHO</td>
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<tr>
<td>1894</td>
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<td>BOH</td>
<td>$25.00</td>
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<td>$16.00</td>
<td>MHO</td>
<td>$67.30</td>
<td>MHO - re: vaccination</td>
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<tr>
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<td>Arthur</td>
<td>Bramosa</td>
<td>Erin</td>
<td>Guelph</td>
<td>Minto</td>
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</tr>
<tr>
<td>1895</td>
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<td>$30.75</td>
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<td>$10.00</td>
<td>MHO</td>
<td></td>
<td></td>
<td>BOH &amp; MHO</td>
</tr>
<tr>
<td>1896</td>
<td>$24.00</td>
<td>BOH</td>
<td>$33.80</td>
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<td>$44.00</td>
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<tr>
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<td></td>
<td></td>
<td>$20.50</td>
<td>BOH</td>
<td>BOH &amp; MHO</td>
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<td>Veterinarian Surgeon</td>
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<td>1897</td>
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<td>BOH</td>
<td>BOH &amp; MHO</td>
</tr>
<tr>
<td>1898</td>
<td>$25.00</td>
<td>BOH &amp; SI</td>
<td>$60.33</td>
<td>MHO, including disinfecti</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$14.50</td>
<td>BOH</td>
<td>BOH &amp; MHO</td>
</tr>
<tr>
<td>1899</td>
<td>$47.60</td>
<td>BOH &amp; MHO</td>
<td>$21.00</td>
<td>Vaccine &amp; Vaccination</td>
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</tr>
<tr>
<td>1900</td>
<td>Rate only per day/BOH Member</td>
<td>$37.15</td>
<td>BOH &amp; MHO</td>
<td>$27.50</td>
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</tr>
<tr>
<td></td>
<td>$2.00</td>
<td></td>
<td></td>
<td></td>
<td>BOH &amp; MHO</td>
</tr>
<tr>
<td></td>
<td>$7.00</td>
<td>SI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Nichol</td>
<td>Peel</td>
<td>Pilkington</td>
<td>Pellicone</td>
<td>West Garafraxa</td>
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<td>1884</td>
<td>$20.00</td>
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<td>$2.00 Rate only per day/BOH Member</td>
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<tr>
<td>1885</td>
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<td>$16.50 SI</td>
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<td>1886</td>
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<td>1888</td>
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<td>1894</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Nichol</td>
<td>Peel</td>
<td>Pilkington</td>
<td>Puslinch</td>
<td>West Garafraxa</td>
</tr>
<tr>
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<td>--------</td>
<td>------</td>
<td>------------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>1895</td>
<td>$63.50</td>
<td>BOH</td>
<td>$20.00 BOH</td>
<td>$38.50 SI</td>
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</tr>
<tr>
<td>1896</td>
<td>$50.00</td>
<td>BOH</td>
<td>$20.00 BOH</td>
<td>$38.00 SI</td>
<td></td>
</tr>
<tr>
<td>1897</td>
<td></td>
<td></td>
<td>21.6 BOH</td>
<td>$58.00 BOH</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15.5 MHOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8.8 SI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1898</td>
<td>12.25 BOH</td>
<td></td>
<td>$55.00 BOH &amp; MHO &amp; SI</td>
<td>$20.00 BOH</td>
<td>$43.50 SI</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td>$55.00 BOH</td>
<td></td>
</tr>
</tbody>
</table>

Information for the tables provided in this appendix above was drawn from Wellington County townships’ council and board of health minutes. The data is inconsistent and, at times, appears incomplete for some townships, as a result no annual sums are offered. Where information provided a break-out of amounts paid to Medical Health Officer (MHO) or Sanitary Expenditure (SI) or Veterinary Surgeon that was clearly distinct from other Board of Health (BOH) expenditures, this is show separately. No expenditure information was found for Maryborough or Luther townships.

* This total is comprised of $58.00 for BOH activities plus $15.00 in court costs associated with a nuisance case pursued by the BOH.

** The extraordinarily high expenditures for West Garafraxa in this year are attributable to an extensive nuisance case pursued by the BOH that included legal action and was launched with regard to Mr. Lightbody, a case described in chapter 4.
APPENDIX I, cont’d

Eramosa Township Board of Health Expenditures as a Percentage of Total Township Expenditures, 1889-1900

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Township Expenditures</th>
<th>BOH Expenditures</th>
<th>BOH Expenditure as Percentage of Township Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1889</td>
<td>$11,001</td>
<td>$73</td>
<td>.7%</td>
</tr>
<tr>
<td>1890</td>
<td>$10,385</td>
<td>$36</td>
<td>.3%</td>
</tr>
<tr>
<td>1891</td>
<td>$10,027</td>
<td>$18</td>
<td>.2%</td>
</tr>
<tr>
<td>1892</td>
<td>$9,988</td>
<td>$36</td>
<td>.4%</td>
</tr>
<tr>
<td>1893</td>
<td>$9,436</td>
<td>$34</td>
<td>.4%</td>
</tr>
<tr>
<td>1894</td>
<td>$4,602</td>
<td>$25</td>
<td>.2%</td>
</tr>
<tr>
<td>1895</td>
<td>$9,293</td>
<td>$22</td>
<td>.2%</td>
</tr>
<tr>
<td>1896</td>
<td>$8,982</td>
<td>$34</td>
<td>.4%</td>
</tr>
<tr>
<td>1897</td>
<td>$8,425</td>
<td>$32</td>
<td>.4%</td>
</tr>
</tbody>
</table>

Expenditure Figures for the Eramosa Township’s Annual Expenditures are from the Township Council Minute records and were taken from Financial Summaries prepared each year beginning in 1889. See Eramosa Township Council Minutes, 1889 – 1900 in A1985.58, WCA 242, 243 & 244.
APPENDIX I, cont’d

Comparative Sample of Board of Health Expenditures
Annual Expenditures of Local Boards of Health – Southern Ontario Townships

<table>
<thead>
<tr>
<th>Year</th>
<th>County</th>
<th>Township</th>
<th>Board of Health Expenditure per township, per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1893</td>
<td>Oxford County</td>
<td></td>
<td>$0 to $97</td>
</tr>
<tr>
<td></td>
<td>(11 townships)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1893</td>
<td>Grey County</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>(4 of 16 townships)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1893</td>
<td>Grey County</td>
<td></td>
<td>up to $75</td>
</tr>
<tr>
<td></td>
<td>(12 of 16 townships)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. 1896</td>
<td>Scarboro Township</td>
<td>$66</td>
<td>Average = $124</td>
</tr>
<tr>
<td>c. 1896</td>
<td>Markham Township</td>
<td>$0</td>
<td>Median = $69</td>
</tr>
<tr>
<td>c. 1896</td>
<td>Vaughan Township</td>
<td>$88</td>
<td></td>
</tr>
<tr>
<td>c. 1896</td>
<td>Etobicoke Township</td>
<td>$103</td>
<td></td>
</tr>
<tr>
<td>c. 1896</td>
<td>King Township</td>
<td>$69</td>
<td></td>
</tr>
<tr>
<td>c. 1896</td>
<td>Whitchurch Township</td>
<td>$12</td>
<td></td>
</tr>
</tbody>
</table>

Note: It may be surmised that the wide range of expenditures for Toronto-area townships is indicative of larger populations and the spill-over effect from urbanization and industrialization for those immediately adjacent to Ontario’s largest city.

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240 Oxford and Grey County figures are found in, P.H. Bryce, “Address on the Expediency of the change From Municipal to County Medical Health Officers for Promoting Efficiency and Economy in the Public Health Service”, August 14, 1895, Archives of Ontario, Ministry of Health Scrapbooks - Provincial Board of Health, 1882-1916, R.G. 62, Series 1-B-4, MS 565 (1). Toronto area Township figures are found in correspondence from P.H. Bryce to unnamed recipient, March 19, 1897, Archives of Ontario, Ministry of Health Scrapbooks - Provincial Board of Health, 1882-1916, R.G. 62, Series 1-B-4, MS 565 (1).
40. Any person who in any manner prevents any Health Officer or Sanitary Inspector from entering any premises and inspecting any animal, carcase, meat, poultry, game, flesh, fish, fruit, vegetables, grain, bread, flour or milk meat, etc. exposed or deposited for the purpose of sale and intended for the food of man; or who obstructs or impedes any such Medical Officer, or Inspector, or his assistant when carrying into execution the provisions of this Act, shall be liable to a penalty not exceeding $25.

41. Where any Local Board of Health is of opinion, on the certificate of to notify its Medical Health Officer or of any other legally qualified medical practitioner, that the cleansing and disinfecting of any house, or part thereof, and of any articles therein likely to contain infection, would tend to prevent or check infectious disease it shall be the duty of such Local Board of Health to give notice in writing to the owner or occupier of such house or part thereof, requiring him to cleanse and disinfect, to the satisfaction of the Medical Health Officer, such house or part thereof and articles, within a time specified in such notice.

46. Whenever any householder knows that any person within his family or household has the small-pox, diphtheria, scarlet fever, cholera, or typhoid fever, he shall within twenty four hours give notice thereof to the Local Board of Health, or to the Medical Health Officer of the district in which he resides, and such notice shall be given either at the office of the Medical Health Officer, or by a communication addressed to him and duly mailed within the time above specified, and in case there is no Medical Health Officer, then to the Secretary of the Local Board of Health either at his office or by communication as aforesaid.

47. No householder in whose dwelling there occurs any of the above mentioned diseases, shall permit any person suffering from any such disease, or any clothing or other property to be removed from his house, without the consent of the Board or of the Medical Health Officer or attending physician, clothing and the said Board, or Medical Health Officer, or attending physician, should prescribe the conditions of such removal.

54. Persons recovering from any of the said diseases, and nurses who have been in attendance on any person suffering from any such disease, shall not leave the premises till they have received from the attending physician, or Medical Health Officer, a certificate that in his opinion they have taken such precautions, as to their persons, clothing, and all other things which they propose bringing from the premises as are necessary to insure the immunity from infection of other persons with whom they may come in contact, nor shall any such person expose him or herself in any public place, shop, street, inn, or public conveyance without having first adopted such precautions.

55. All persons named in the last preceding clause shall be required to adopt for the disinfection and disposal of excreta, and for the disinfection of utensils, bedding, clothing and other things which have been exposed to infection, such measures as have been, or may hereafter be, advised by the Provincial Board of Health or by the Medical Health Officer, or such as may have been recommended by the attending physician as equally efficacious.

56. No person suffering from, or having very recently recovered from, small-pox, diphtheria, scarlet fever, cholera, measles, or other disease dangerous to public health shall expose himself, nor shall any person expose anyone under his charge who is so suffering, or who has recently recovered from any such disease, in any conveyance without having previously notified the owner or person in charge of such conveyance of the fact of his having or having recently had, such disease.
BIBLIOGRAPHY

Primary Sources

Archives of Ontario, Ministry of Health Scrapbooks - Provincial Board of Health, 1882-1916, R.G. 62, Series 1-B-4, MS 565 (1).


Assembly, Ontario Legislative. “Sessional Paper No. 18 - Return to a Resolution of the Legislative Assembly…showing the number of Local Boards of Health organized last year…” In Sessional Papers of the Province of Ontario. Toronto: Ontario Legislative Assembly, 1884.


Wellington County Archives, Board of Health Minutes: Eramosa Township (May 1884 –
November 1900); Guelph Township (June 1884 – November 1895); Pilkington Township (June 1884 – November 1900); West Garafraxa (January 1885 – November 1900)

Wellington County Archives, Township Council Minutes (and, where available, bylaws):
- Arthur Township (June 1884 – November 1900); Eramosa Township (December 1883 – 1900); Erin Township (January 1889 – 1900); Guelph Township (June 1884 – November 1895); Minto Township (December 1891 – November 1900); Nichol Township (June 1882 – January 1890); Peel Township (May 1884 – January 1900); Pilkington Township (May 1884 – November 1900); Puslinch Township (December 1882 – January 1900);


**Secondary Sources**


Rutty, Christopher, Sullivan, Sue C. *This Is Public Health: A Canadian History.*


Wilson, Catharine Anne. “Reciprocal Work Bees and the Meaning of Neighbourhood.”

