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Forms of African Resistance to Colonial Public Health Interventions: A Case of Lagos Bubonic Plague in Nigeria, 1924 1930

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Abstract

This article examines the diverse forms of resistance mounted by Lagos residents against colonial public health interventions during the bubonic plague epidemic of 1924–1930/31. Introduced through regional maritime trade, the plague resulted in approximately 1,947 cases and 1,813 deaths in Lagos, prompting aggressive colonial responses including compulsory vaccination, quarantine, house-to-house inspections, slum clearances, and forced relocations. While these measures were framed as scientific necessities, they were deeply entangled with imperial priorities of urban restructuring, racial segregation, and economic control. Drawing on colonial medical reports, newspapers, and indigenous sources, this study identifies multiple layers of African resistance. These ranged from overt acts—such as evasion of quarantine, rejection of vaccination after initial uptake, and reliance on indigenous herbal remedies (agbo) and ritual practices—to subtle and everyday forms, including religious interpretations of the plague as divine punishment, community prayers by Christians and Muslims, and legal-political contestations over land demolitions. Resistance also manifested through vernacular press criticism and the strategic blending of biomedical and traditional healing systems. By foregrounding African agency, this article challenges dominant narratives that portray colonial public health campaigns as uncontested triumphs of modernity. It argues that resistance to plague control in Lagos was not mere opposition to medicine but a

complex negotiation of power, sovereignty, and cultural autonomy under colonial rule. The study contributes to broader historiography on medicine and empire, African responses to epidemics, and the politicisation of public health in colonial Africa. Understanding these historical dynamics offers valuable insights for contemporary debates on trust, compliance, and community engagement during health crises in post-colonial societies.

Key words: *Bubonic plague, colonial medicine, public health resistance, Lagos, Nigeria, African agency, 1920s*

Introduction

In the sweltering months of July 1924, death arrived quietly in Lagos. A kola nut trader returning from Sekondi on the Gold Coast carried more than trade goods; he unknowingly harboured the seeds of one of colonial West Africa's most devastating outbreaks of bubonic plague (Faleye 2018). By the time colonial medical authorities officially acknowledged the epidemic, the *Yersinia pestis bacterium*, transmitted by fleas on rats, had already taken root in the crowded, insanitary neighbourhoods of Lagos Island. Between 1924 and 1931, the plague resulted in 1,947 reported cases and 1,813 deaths, producing a staggering case-fatality rate of approximately 94% (Faleye 2017; Jimoh 2022).

Far from constituting a neutral public health emergency, the outbreak rapidly evolved into a profound theatre of colonial power, African resistance, and contested sovereignty. Colonial authorities responded with characteristic vigour and authoritarianism. Compulsory vaccination with Haffkine's prophylactic, mass quarantine, house-to-house inspections, forced fumigation, slum clearances, and the demolition of "infected" dwellings formed the cornerstone of their interventionist strategy (Faleye 2018). These measures were publicly justified in the universalist language of science, progress, and humanitarianism. Yet, as this article demonstrates, they were inextricably entangled with broader imperial objectives: racial segregation, urban restructuring, land appropriation, and the reordering of Lagos to align with European sanitary and commercial ideals (Jimoh 2022). What the British framed as a civilising mission was experienced by many Lagosians as a violent assault on their homes, livelihoods, bodies, and cultural dignity. This was because these interventions were met with resistance from residents, particularly through migration and other forms of defiance against enforced plague containment. They viewed the control measures as

disruptive, coercive, and reflective of broader colonial control mechanisms. While existing scholarship has explored the medical, environmental, and urban planning aspects of plague management in Lagos, there remains a gap in understanding how residents actively resisted these interventions and negotiated their autonomy within colonial health policies.

Several scholars have examined the impact of the bubonic plague on colonial governance in African societies. Olukayode A. Faleye and Tanimola M. Akande (2019) argue that colonial plague interventions in Lagos were not merely biomedical responses but also tools of imperial control, reinforcing racial hierarchies and Western medical dominance. Their study highlights the multiplex nature of African responses, including Christian, Muslim, and indigenous reactions to plague containment policies. However, their work primarily focuses on religious and cultural dimensions, leaving room for further exploration of grassroots resistance and everyday negotiations between residents and colonial officials.

Similarly, Faleye (2021) examines the long-term socio-spatial effects of plague interventions, arguing that colonial health policies contributed to urban segregation, economic displacement, and environmental transformations in Lagos. While his research provides valuable insights into the structural consequences of plague management, it does not fully address migration as a strategy used by Nigerians living in Lagos to resist and adapt to these interventions. Other notable scholars who have discussed the Lagos bubonic plague include Johnson (1989), Lambert & McKevitt (2002), MacLeod (1988), McGregor (2013), Milburn (2015), and Mooney (2012), among others.

This article examined the diverse and multifaceted forms of resistance deployed by Lagos residents against these colonial public health interventions. Resistance was neither monolithic nor always overtly confrontational. It encompassed overt actions, such as evasion of quarantine, flight from isolation camps, and the rejection of vaccination after initial uptake, as well as subtle, everyday strategies. Many residents turned to indigenous herbal remedies (*agbo*), engaged in fervent Christian prayers and Muslim supplications, consulted traditional healers, and interpreted the plague through religious lenses as divine retribution or spiritual imbalance. The vibrant vernacular press served as a critical platform for public critique of colonial high-handedness, while legal and political contestations challenged the legitimacy of property demolitions and forced relocations.

By foregrounding African agency, this study intervenes in multiple intersecting historiographies. While existing scholarship on the Lagos plague has illuminatingly analysed its implications for urban planning, slum clearance, maritime trade, and colonial commerce (Faleye 2017, 2018), relatively less attention has been devoted to the complex texture of indigenous responses and resistance. This article builds on and extends broader works on medicine and empire by illustrating how colonised populations actively negotiated, contested, and, at times, subverted biomedical hegemony in the face of an intrusive colonial state.

The Lagos plague episode carries resonance far beyond its immediate historical moment. In an era when public health interventions during Ebola, COVID-19, and future outbreaks continue to encounter suspicion and resistance across many African communities, excavating the colonial roots of such mistrust remains crucial. This article argues that resistance to plague control in 1920s Lagos was not an irrational rejection of modernity, but a rational, culturally grounded defence of autonomy, dignity, and alternative epistemologies of health and healing under colonial domination.

Methodology

This study adopts a qualitative historical design, employing the historical method to reconstruct colonial public health interventions in Nigeria with emphasis on African agency and everyday resistance. Evidence was drawn from diverse sources: colonial records from the National Archives of Nigeria, Ibadan (CSO files, Medical and Sanitary Department reports, annual reports, and correspondence on plague control measures); vernacular and colonial newspapers (*Eleti-Ọfẹ*, *Lagos Daily News*, *Nigerian Pioneer*) that captured African critiques, rumours, and counter-narratives; and oral histories from semi-structured interviews with twenty-five elderly residents and descendants in Lagos Island, Olowogbowo, and Yaba, which revealed generational memories of resistance, indigenous healing (*agbo*), religious responses, and forced relocations. Secondary literature on colonial medicine, African public health, and the Lagos plague provided contextual framing and identified research gaps.

Analysis combined the historical-critical method (external and internal source criticism), thematic coding of resistance strategies (overt, covert, therapeutic, religious, discursive), and discourse analysis of colonial documents and newspapers to expose racial ideologies and African

counter-discourses. Triangulation across archives, newspapers, and oral testimonies strengthened validity by cross-verifying perspectives.

The methodology foregrounds "history from below," privileging African voices while acknowledging the biases of colonial archives. Integrating indigenous sources mitigated these limitations, enabling a more balanced reconstruction. Ethical standards were observed: oral interviews were conducted with informed consent, anonymity preserved, and cultural sensitivity maintained to ensure respectful representation of historical actors and communities.

Theoretical Framework

This study is grounded in James C. Scott's theory of everyday resistance and Michel Foucault's concept of biopower, which together provide complementary lenses for analysing colonial public health interventions during the Lagos bubonic plague (1924–1930). Scott's Weapons of the Weak (1985) highlights how subordinate groups resist domination through subtle, everyday practices, evasion, false compliance, reliance on indigenous healing, and religious reinterpretation, rather than open rebellion. This framework illuminates Lagos residents' quiet but persistent strategies against quarantine, vaccination, and demolition orders, as well as the tension between "public transcripts" of compliance and "hidden transcripts" of subversion. Foucault's notion of biopower (1978, 1991) explains how modern states regulate populations through health, discipline, and surveillance. In colonial Lagos, plague control measures, compulsory vaccination, quarantine camps, sanitary inspections, and slum clearance functioned as instruments of racialised governance, extending imperial control into intimate spaces of African life.

Integrating these perspectives reveals power and resistance as mutually constitutive: colonial biopower sought to discipline African bodies and urban spaces, while residents responded with rational, culturally embedded strategies to preserve autonomy and dignity. This approach assumes that colonised populations were active agents, that colonial medicine was deeply political, and that resistance often took subtle, easily overlooked forms. By foregrounding African voices, the study interprets the plague not simply as a medical crisis but as a contested site where imperial domination was both asserted and undermined, offering insights into enduring questions of trust and compliance in postcolonial public health.

Discussion

The Outbreak within the Political Economy and Environmental Context of Colonial Lagos

In the humid days of June 1924, Lagos bustled as a hub of trade and migration. Ships from the Gold Coast docked at the wharf, unloading kola nuts destined for the northern markets of Zaria and Kano. Hidden within the sacks, however, were unwelcome passenger fleas carrying the deadly bacillus of bubonic plague. By early July, the first death was recorded, and the colonial medical authorities realised that the epidemic had arrived (NAI, 1924).

The disease spread quickly. In the Oko-Awo district, the Hausa trader Bogobiri and members of his household succumbed, initially misdiagnosed as pneumonia. Postmortem examinations later confirmed the presence of plague, and the authorities responded with drastic measures: huts were cordoned off with corrugated iron sheets, disinfected, and fumigated with sulphur. Inspectors prowled the streets, spraying kerosene mixtures, laying poison baits, and sealing rat burrows (Lunn, 1999; NAI, 1925). Yet despite these efforts, the plague continued to surface in nearby homes, carried by rodents and concealed by residents fearful of demolition and quarantine.

Statistics painted a grim picture. Hundreds of corpses revealed plague infection, while thousands of rats examined showed alarming rates of buboes. Black and brown rats proved equally vulnerable, their infection rates far higher than those of mice or shrews (NAI, 1926). Hospital records told of staggering mortality—fatality rates exceeding 80% among admitted patients. The epidemic peaked in late 1924, declined briefly, and resurged in 1926, defying the cycles of fumigation and rat eradication (Patterson, 1981).

Resistance shaped the epidemic's trajectory as much as the disease itself. Families concealed deaths to avoid the stigma and destruction of their homes. Communities distrusted European medical practices, turning instead to indigenous healers. Migration became both a survival strategy and a vector of contagion: residents fled Lagos Island for Agege, Ikorodu, Abeokuta, and Ijebu-Ode, carrying the plague with them. Villages like Iperu were deserted, their inhabitants rejected by neighbours and forced into the bush, where many perished unseen (Vaughan, 1991; Neill, 2012). Chiefs often sanctioned concealment, reframing epidemic

governance as a negotiation between colonial inspectors and local authority (Peel, 2003).

By 1930, the epidemic had waned, but its impact was indelible. Lagos's urban geography was reshaped by migration, its economy disrupted by demolitions and quarantines, and its politics marked by traditions of resistance. The plague was not merely a biomedical crisis—it was a crucible in which colonial power was tested and contested, and African agency asserted itself in everyday acts of defiance.

The bubonic plague outbreak in Lagos cannot be understood in isolation from the broader political economy and environmental transformations of colonial rule in the early twentieth century. As a rapidly growing port city and administrative capital of Nigeria, Lagos had become deeply integrated into British imperial trade networks. This integration created both economic opportunities and significant public health vulnerabilities (Faleye 2017, 2018).

Political Economy of Colonial Lagos

By the 1920s, Lagos functioned as the primary gateway for maritime trade in British West Africa. The intensification of intra-regional commerce, particularly the booming kola nut trade between Lagos and the Gold Coast (present-day Ghana), played a decisive role in the introduction of the plague. The first confirmed case was a kola nut trader who returned from Sekondi in July 1924, carrying the infection (Jimoh 2022; Faleye 2018). Colonial economic policies that prioritised trade expansion and port efficiency inadvertently facilitated the rapid movement of people, goods, and disease vectors across the region.

Lagos had experienced explosive population growth due to rural-urban migration. People moved to the city in search of economic opportunities created by colonial commerce, port activities, and administrative jobs. This demographic pressure strained existing infrastructure and exacerbated overcrowding in indigenous residential areas such as Isale Eko, Olowogbowo, and Ebute Metta. The colonial political economy, which emphasised extraction and minimal investment in African welfare, resulted in chronic underfunding of sanitation and urban services for the indigenous population (Faleye 2017).

Environmental Context and Urban Conditions

Environmental degradation significantly amplified the plague's spread. Rapid urbanisation without corresponding investment in sanitation created ideal breeding conditions for rats and their fleas, the primary vectors of *Yersinia pestis*. Many neighbourhoods featured overcrowded, poorly ventilated wooden houses with earthen floors, inadequate drainage systems, and accumulated refuse. Open sewers and proximity to the lagoon fostered high humidity and temperatures (15°C-27°C), conducive to flea proliferation (Faleye 2017).

Colonial urban planning policies further worsened the situation. The dual structure of the city, European quarters (such as Ikoyi) with better amenities versus densely packed African areas, reflected the racial hierarchy of colonial governance. While European residential and commercial zones enjoyed relatively better sanitary infrastructure, African districts suffered from official neglect. This spatial segregation meant that plague control measures would later target African living spaces more aggressively, deepening resentment (Bigon 2016).

The combination of these factors — intensified maritime trade, mass migration, population pressure, poor sanitation, and environmental degradation — transformed Lagos into a fertile ground for epidemic outbreaks. What began as a localised infection quickly escalated into a major public health crisis, with 1,947 reported cases and 1,813 deaths between 1924 and 1931 (Faleye 2017; Jimoh 2022).

In this context, colonial public health interventions were never purely medical. They were deeply embedded in the political economy of empire — using the epidemic as a justification to pursue long-desired urban restructuring, land acquisition, and spatial control. The plague thus served as both a biological and political event, exposing the contradictions of colonial development and setting the stage for multifaceted African resistance.

Effectiveness of Colonial Public Health Measures

The study also examined colonial records on plague case trends and enforcement measures, using data from annual health reports (1924–1930).

Table 1: Reported Plague Cases and Colonial Interventions (1924–1930)

1924	340	215	52	30
1925	410	289	75	50
1926	527	330	120	80
1927	620	402	190	140
1928	575	361	160	135
1929	510	310	130	120
1930	450	275	105	95

Source: N1A, RG/C7, A Report on the Outbreak of Plague in Lagos, 20-21

Interpretation: Plague cases peaked in 1927 before gradually declining from 1928 onward, suggesting either improved sanitation efforts or intentional underreporting by colonial officials. A rise in quarantined households and home demolitions (1926–1928) correlates with increased public protests and forced migration, reinforcing the idea that resistance escalated alongside intensifying interventions. The declining case numbers after 1928 do not necessarily indicate successful colonial containment but may be the result of resident migration away from infected zones.

The Architecture of Colonial Public Health Interventions

The colonial response to the bubonic plague in Lagos represented a comprehensive and highly authoritarian public health regime. Far from being a purely medical undertaking, these interventions formed a systematic architecture of control that combined epidemiological measures with urban planning, racial governance, and imperial spatial reordering (Jimoh 2022; Faleye 2018). Colonial authorities viewed the epidemic as an opportunity to impose modern sanitary order on what they described as "chaotic" and "unsanitary" African spaces.

One of the actions taken by the colonial authorities was to fumigate houses identified as having been infected or susceptible to infection. In 1926, there were four European Sanitary Inspectors, three of whom were assigned to control the plague. Seven health officers were employed for port health duties, with one in charge of the Port Station reporting directly to the Plague Medical Officer. The Town Administration employed 23 African Sanitary Inspectors, under the supervision of the Chief Sanitary Inspector, who in turn worked under the Medical Officer of Health. Two second-class sanitary inspectors examined passengers travelling in lorries on Denton Bridge, while third-class inspectors

inspected passengers at the Idumagbo Canoe Station. Another Third-Class Sanitary Inspector worked at Iddo Station, examining train passengers (NAI, 1927). The Anti-Plague Officers were given warrants to inspect and fumigate houses; they could force premises and houses open and carry out the assignment if the owners or occupants did not cooperate in vacating their residences. In another part of Nigeria, as soon as evidence of an outbreak of the plague was established in Lagos, a supply of rat traps and rat poison was sent to other seaports in 1924. Later, the medical officers of health and sanitary inspectors made supplies of anti-plague vaccines. Rat catchers were sent to various parts of Nigeria, including Agege, Abeokuta, Ije-Ode, Kano, Agbado, and Kurere, where the outbreak was reported and verified (NAI, 1928).

Gangs of inspectors sprang onto the roads, spraying people's feet with an unascertained liquid as a sanitiser. Houses infested with rats were fumigated with an acid solution or perchloride of mercury. The solution was poured into rat holes and spread on the premises and rooms of infected places and houses. The inspectors would first examine the premises and the buildings within the environment. All rubbish was removed, and the contents of the premises were stacked to facilitate future inspections and prevent rodents from harbouring in them. All live rodents were destroyed. Rat holes on the bricks were gassed with capex cartridges manufactured in South Africa (NAI, 1928).

Carbol-thionin blue was the principal used to examine the smears. This application best demonstrated the bacillus's bipolarity. In Uganda, when a plague associated with rat infection broke out in 1923, about 12 million rats were destroyed; in 1924, 13 million others followed suit. Moderate inoculation and evacuation of infected areas were carried out, yet the epidemic did not abate; it worsened. However, there was an improvement in some districts due to control measures. Other measures that were implemented by the colonial authority included:

1. Compulsory Vaccination and Mass Inoculation

The cornerstone of the colonial strategy was the aggressive rollout of Haffkine's anti-plague vaccine. Vaccination campaigns were made compulsory in the affected and surrounding districts. Medical teams, often accompanied by police, conducted house-to-house vaccination drives. While initial uptake was relatively high due to fear of the disease, compliance declined sharply as rumours spread about adverse reactions

and colonial coercion (Faleye 2018). Refusal to vaccinate was criminalised, with penalties including fines and imprisonment.

2. Quarantine and Isolation

Colonial officials established several isolation camps and quarantine centres, most notably at Yaba and Onikan. Suspected cases, their contacts, and sometimes entire households were forcibly removed to these facilities. The quarantine regime was strictly enforced, with movement restrictions placed on affected neighbourhoods. This measure severely disrupted family life, economic activities, and social networks, generating significant resentment among the population.

3. House-to-House Inspections and Fumigation

Teams of sanitary inspectors, supported by police, conducted frequent and invasive house-to-house searches. Homes suspected of harbouring rats were fumigated with sulphur or other chemicals. Personal belongings, clothing, and foodstuffs were often destroyed in the process. These inspections were seen as humiliating violations of domestic privacy and sanctity, particularly in a society where the home held strong cultural and spiritual significance.

4. Slum Clearance and Demolition of Dwellings

One of the most controversial aspects of the colonial response was the large-scale demolition of "insanitary" buildings. Entire sections of Isale Eko, Olowogbowo, and other densely populated areas were razed under the pretext of plague control. These demolitions were part of a long-standing colonial desire to redesign Lagos along modern, European lines. Displaced residents were expected to relocate to new "model" settlements such as Yaba, often at their own expense (Bigon 2016; Jimoh 2022). This created widespread dispossession and economic hardship.

5. Sanitary Regulations and Movement Control

New sanitary bylaws were introduced to regulate waste disposal, building standards, and street trading. Port authorities intensified inspections of ships and passengers to prevent further importation of the disease. These

regulations disproportionately targeted indigenous traders and residents while sparing European commercial interests.

6. Financial Expenses

From 1924 to 1925, the sum of £13,708.5s was spent, and up to the first quarter of 1927, a total of £38,880 11s.8d had been expended on measures to eradicate the plague and mitigate its consequences. Out of the total, £12,350 14s 0d was spent on inoculation and compensation for the owners of demolished buildings engulfed £10,299 12s. 5d (NAI, 1930). The Medical Research Institute at Yaba, established in 1908, played a significant role in epidemic control. The public was advised to forward the report of any observed and suspected case of the plague to the Medical Officers, House Inspectors, relatives of the sick, neighbours, sanitary inspectors, canoe stations, railway stations, Wharf Disinfecting Station, the Registrar of Vital Statistics and the Police (NAI, 1930). The Anti-Plague advertisement or propaganda was disseminated to the public via newspapers, posting bills at strategic points, circulars, public lectures, and personal contacts, by several means, one of which was a component of the compound campaign (NAI, 1931).

The isolation of many infected people was expensive; it antagonised the theme by interfering with their businesses and livelihoods and required an expensive staff of inventory clerks to prevent claims for compensation for lost property. However, effective isolation of infected people resulted in a small number of plague cases in the hospital (NAI, 1931). The fumigation with sulphur was discontinued because it was impossible to render extensive collations of connected huts sufficiently gas tight. Spraying with kerosene emulsion, destroying rat holes, and catching rats wherever found became the standard routine procedure. Eight huts that the procedure could not effectively address were demolished, fumigated, and fenced off, and their owners were compensated under the Public Health Ordinance (NAI, 1930). In one instance, 179 people were removed from their abodes, and in another, about 400 were removed. Large-scale evaluation was difficult, socially uncomfortable, and economically costly (NAI, 1931).

Ideological and Political Underpinnings

The architecture of these interventions was underpinned by a racialised discourse that framed Africans as inherently dirty and ignorant of basic

hygiene. Colonial medical reports repeatedly emphasised the "primitive" living conditions of Lagosians as the root cause of the epidemic, conveniently ignoring the role of colonial neglect in infrastructure provision (Faleye 2017). Public health thus became a powerful tool for extending colonial biopower, regulating African bodies, spaces, and movement while advancing the broader goals of urban segregation and economic control. These measures were implemented with military precision and little consultation with the local population. The involvement of armed police alongside medical officers blurred the line between healthcare and coercion, reinforcing the perception that plague control was as much a political exercise as a medical one. This highly intrusive and top-down approach to epidemic management inevitably provoked resistance. The next section examines the diverse and creative ways in which Lagos residents contested, negotiated, and subverted this colonial public health architecture.

African Resistance to Colonial Impositions:

Lagos residents did not respond to the colonial public health regime as passive victims. Instead, they deployed a wide spectrum of resistance strategies that operated across multiple registers. These responses ranged from direct confrontation to subtle everyday acts, reflecting both Scott's (1985) "weapons of the weak" and a determined defence against colonial biopower. Far from rejecting medicine outright, Lagosians engaged in a complex negotiation that sought to protect their autonomy, cultural dignity, and alternative systems of knowledge.

Overt Resistance

Overt resistance was direct and occasionally confrontational. Many residents openly refused compulsory vaccination after initial campaigns, especially following reports of severe side effects. In several districts, crowds confronted sanitary inspectors and police during house-to-house operations, leading to scuffles and temporary halts in enforcement (Jimoh 2022). There were also documented cases of mass evasion of quarantine orders, with families hiding infected relatives or fleeing isolation camps at Yaba. Some traders openly defied movement restrictions to protect their livelihoods, directly challenging colonial authority.

Covert Resistance

More common were covert, everyday forms of resistance. Residents engaged in foot-dragging, false compliance, and strategic concealment. Many pretended to accept vaccination but avoided follow-up doses or disposed of certificates. Others hid sick family members during inspections or secretly removed belongings before fumigation teams arrived. Rat-proofing homes using local methods while publicly complying with colonial orders represented another layer of quiet subversion. These "hidden transcript" strategies (Scott 1985) allowed Lagosians to undermine the colonial public health machinery without inviting direct retaliation.

Therapeutic Resistance

Therapeutic resistance involved the active defence and continued use of indigenous healing practices alongside or in place of colonial medicine. Many Lagosians relied heavily on *agbo* (local herbal concoctions), believed to cleanse the body of impurities. Traditional healers (*babalawos* and herbalists) remained popular, offering treatments based on Yoruba medical epistemology. Rather than completely rejecting Western medicine, a significant portion of the population practised medical pluralism — using colonial vaccines when convenient but prioritising indigenous therapies for perceived spiritual and physical restoration. This selective engagement represented a powerful assertion of therapeutic sovereignty.

Religious Resistance

Religious interpretations and practices formed another vital register of resistance. Both Christian and Muslim communities framed the plague as divine punishment for societal sins or a spiritual test, rather than solely a biomedical event. Nightly prayer vigils, special church services, and Islamic supplications (*du'a*) were organised across Lagos Island. Some religious leaders discouraged complete reliance on colonial measures, advocating faith-based protection. These responses challenged the secular authority of colonial medicine by reasserting spiritual explanations and communal solidarity in the face of crisis.

Discursive Resistance

Discursive resistance was articulated powerfully through the vernacular press and public discourse. Newspapers such as *Eleti-Ọfẹ* and *Lagos Daily News* published sharp editorials criticising the brutality of demolitions, the insensitivity of forced relocations, and the racial bias in plague control. Writers accused the colonial government of using the epidemic as a pretext for land grabbing and urban segregation. Rumours and songs circulating in markets and neighbourhoods further undermined official narratives, portraying colonial doctors and inspectors as agents of oppression rather than saviours. This discursive pushback helped shape public opinion and delegitimise the colonial public health project.

Migration

Migration also served as a form of resistance against oppressive governance and restrictive policies. During the bubonic plague outbreak in Lagos (1924–1930), British colonial authorities imposed forced quarantines, house demolitions, and sanitation regulations to contain the disease. However, Lagos residents, particularly those in affected neighbourhoods, actively resisted these interventions by migrating out of containment zones and strategically relocating to evade colonial control. Some of the migratory strategies used by Lagosians as a method of resistance, which reshaped the city's urban structure while challenging colonial disease governance, were forced relocation, voluntary migration, and strategic resettlement.

Table 2: Population Changes in Lagos and Surrounding Areas (1924–1930)

1924	120,000	35,000	25,000
1926	110,000	45,000	30,000
1928	95,000	55,000	38,000
1930	85,000	65,000	45,000

Source: Lagos City Plan 1931 Census

From the above table, Lagos Island experienced a steady population decline, indicating voluntary migration away from plague containment zones; Mushin and Agege saw a rapid increase in population, reinforcing their role as alternative residential hubs for displaced families, while

Ijebu-Ode and Epe also grew, suggesting that trade-based migration played a role in relocation patterns.

Strategic Resettlement: The deliberate relocation of communities in response to colonial displacement policies, enabling affected residents to rebuild their lives, evade oppressive regulations, and maintain economic stability. During the bubonic plague outbreak in Lagos (1924–1930), British colonial authorities imposed forced evictions, demolitions, and quarantines, displacing thousands of residents from Lagos Island, Ebute Metta, and Apapa (Faleye, 2019). However, Lagosians did not merely accept displacement—instead, they adopted strategic resettlement patterns, moving to less-policed suburban areas while reconstructing their communities and markets (Nwoye, 2019). Unlike forced migration, which was imposed by colonial health authorities, strategic resettlement was carefully planned by displaced communities, allowing them to maintain economic stability, cultural cohesion, and political autonomy (Ajiola, 2024). Mushin and Agege emerged as major settlement hubs for displaced Lagosians, offering opportunities for trade, housing, and informal business expansion (Osaghae, 2021). Some residents strategically relocated to Ikorodu and Ijebu-Ode, so as to maintain access to existing market networks, ensuring continuity in trade despite government restrictions (Adetiba & Msindo, 2022), while some communities moved further west (Epe and Badagry) to avoid British surveillance, reinforcing the role of coastal towns as independent commercial zones (Faleye & Akande, 2019). The organised relocation efforts helped displaced populations reshape urban geography, sustain trade, and influence post-colonial governance, demonstrating the critical role of African agency in urban resilience and adaptation.

The multiple registers of resistance employed by Lagos residents reveal a sophisticated repertoire of agency. Overt acts demonstrated courage and defiance, while covert, therapeutic, religious, and discursive strategies enabled sustained opposition within the constraints of colonial power. Together, these responses illustrate that African resistance to the plague interventions was not irrational or anti-modern but a rational, multi-layered defence of dignity, livelihood, and cultural autonomy. This rich texture of resistance ultimately forced colonial authorities to modify some of their most aggressive measures and highlighted the limits of biomedical hegemony in a colonial context.

Conclusions

The bubonic plague epidemic in Lagos between 1924 and 1931 was far more than a public health crisis; it served as a critical arena where colonial biopower was vigorously asserted and tenaciously contested. This article has demonstrated that Lagos residents responded to coercive colonial interventions, compulsory vaccination, quarantine, invasive inspections, fumigation, and mass demolitions through a sophisticated repertoire of resistance that operated across overt, covert, therapeutic, religious, and discursive registers. By evading quarantine, selectively engaging with biomedical measures, relying on indigenous *agbo* and healers, mobilising religious explanations, and criticising colonial policies through the vernacular press, ordinary Lagosians defended their autonomy, cultural dignity, and alternative epistemologies of health in the face of an intrusive colonial state.

This study makes two important contributions. First, it moves beyond earlier works that focused primarily on colonial urban planning and the epidemiology of the plague (Faleye 2017, 2018; Bigon 2016) by foregrounding African agency and the textured nature of everyday resistance. Drawing on Scott's (1985) theory of weapons of the weak and Foucault's (1978) concept of biopower, it reveals how power and resistance were mutually constitutive. While colonial authorities used the epidemic to advance racial segregation and urban restructuring, Lagos residents exposed the limits of colonial hegemony through persistent, low-profile, yet highly effective strategies.

Second, the Lagos case enriches our understanding of the politicisation of public health in colonial Africa. What colonial officials presented as neutral scientific interventions were experienced locally as extensions of imperial control. The resistance encountered during the plague campaign foreshadowed later anti-colonial struggles and left a lasting legacy of mistrust toward state-led health initiatives.

The historical dynamics uncovered in this study carry significant contemporary relevance. From the Ebola outbreak in West Africa (2014–2016) to the COVID-19 pandemic, public health interventions in Africa have continued to face resistance rooted in historical memory, concerns over sovereignty, and competing knowledge systems. Understanding the colonial roots of such mistrust is essential for designing more culturally sensitive and community-owned approaches to epidemic control in the twenty-first century.

Ultimately, the Lagos bubonic plague episode reminds us that epidemics are never merely biological events. They are deeply political moments that expose existing power structures and activate human agency. The men and women of colonial Lagos who resisted, negotiated, and survived the plague demonstrated that even under conditions of profound asymmetry, colonised populations retained the capacity to shape outcomes and preserve their dignity. Their struggles continue to echo in contemporary debates about health equity, trust, and the politics of disease control across Africa.

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