

Managing Mpox Outbreak in a Congested Correctional Facility: Lessons from Rivers State, Nigeria

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Abstract

Mpox (formerly monkeypox) is a re-emerging zoonotic viral disease that poses significant public health challenges in congregate settings. Correctional facilities are particularly vulnerable due to chronic congestion, shared living spaces, limited infection prevention and control (IPC) capacity, and constrained access to healthcare services. During the 2017 Mpox outbreak in Nigeria, a cluster of cases was identified within a congested correctional facility in Rivers State, highlighting critical gaps in outbreak preparedness and response in custodial environments.

This chapter documents the management of the Mpox outbreak in this facility, with the aim of describing its epidemiological characteristics, emergency response actions, and system-level lessons for outbreak control in resource-limited settings.

A retrospective descriptive review of outbreak investigation and response activities was conducted using data from the Rivers State Ministry of Health, the Public Health Emergency Operations Centre, and collaborating partner agencies. It examined transmission dynamics, surveillance, infection prevention and control (IPC), risk communication, and coordination.

The response, coordinated through the Public Health Emergency Operations Centre, involved targeted surveillance, case isolation, adapted IPC measures, and collaboration between health and correctional authorities. Despite challenges of congestion, delayed detection, and limited healthcare, transmission was interrupted.

This experience underscores the need to integrate prisons into national disease surveillance frameworks, strengthen prison health services, and address structural overcrowding. These lessons are relevant for policymakers and public health practitioners working to improve epidemic preparedness and response in correctional and other high-risk congregate settings.

Keywords: Mpox, Monkeypox, Correctional facility, Prison health, Outbreak response, Infection prevention and control, Nigeria

INTRODUCTION

Mpox is an emerging and re-emerging zoonotic disease of increasing global public health importance. The disease is caused by the monkeypox virus, a double-stranded DNA virus belonging to the genus *Orthopoxvirus*. Mpox shares clinical and epidemiological similarities with smallpox, though it is generally associated with lower case fatality rates and milder disease severity [1]. Following the global eradication of smallpox in 1980 and the subsequent discontinuation of routine smallpox vaccination, population-level immunity to orthopoxviruses has declined, creating favorable conditions for the resurgence of Mpox [2].

Since the early 2000s, Mpox outbreaks have been reported

with increasing frequency across Central and West Africa, with Nigeria experiencing a major resurgence beginning in 2017 after nearly four decades without confirmed cases [3]. Unlike earlier sporadic outbreaks, the 2017 Nigerian outbreak was characterized by sustained human-to-human transmission across multiple states, marking a shift in the disease's epidemiology and exposing weaknesses in national surveillance and outbreak preparedness systems [4].

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Correctional facilities represent a particularly vulnerable and often neglected setting in public health emergency planning. Chronic overcrowding, inadequate water, sanitation, and hygiene (WASH) infrastructure, limited healthcare capacity, and high prevalence of communicable diseases make prisons highly conducive to rapid disease transmission [5–7]. Outbreaks occurring within correctional facilities have implications that extend beyond incarcerated populations, affecting correctional staff, visitors, healthcare workers, and surrounding communities.

The occurrence of Mpox in a congested correctional facility in Rivers State during the 2017 outbreak presented a complex public health challenge. Effective containment required balancing outbreak control with security considerations, human rights concerns, and intersectoral coordination involving health, justice, and humanitarian actors. This chapter documents the management of that outbreak and distills lessons relevant for epidemic preparedness and response in high-risk congregate settings within resource-limited contexts.

EPIDEMIOLOGY OF MPOX

Etiology and virology

The monkeypox virus belongs to the family *Poxviridae* and genus *Orthopoxvirus*. Two major clades have been described: the Central African (Congo Basin) clade and the West African clade. The West African clade, responsible for outbreaks in Nigeria, is associated with lower mortality but retains substantial epidemic potential [8]. The virus is environmentally stable and can survive on contaminated surfaces, facilitating fomite transmission in overcrowded environments.

Transmission dynamics

Mpox transmission occurs through zoonotic spillovers from infected animals, primarily rodents and non-human primates, as well as through human-to-human transmission [3,9]. Human transmission occurs through direct contact with skin lesions, body fluids, and respiratory droplets during prolonged close contact, as well as through contaminated materials such as bedding and clothing. In congested correctional facilities where close physical contact is unavoidable, the risk of transmission is significantly amplified.

Clinical features

The incubation period for Mpox ranges from 5 to 21 days. The disease typically begins with a prodromal phase characterized by fever, headache, myalgia, and lymphadenopathy, followed by a centrifugal

vesiculopustular rash. Lymphadenopathy is a key distinguishing feature of Mpox compared with smallpox [10]. In resource-limited settings, Mpox may be misdiagnosed as varicella or other febrile rash illnesses, resulting in delayed isolation and ongoing transmission.

Mpox in Nigeria

Nigeria's 2017 outbreak represented the largest documented Mpox outbreak in the country in over forty years [3,4]. Multiple states were affected, including Rivers State. The outbreak exposed gaps in laboratory diagnostic capacity, surveillance coverage, and preparedness for outbreaks in institutional and congregate settings.

CORRECTIONAL FACILITIES AS HIGH-RISK CONGREGATE SETTINGS

Correctional facilities are structurally predisposed to infectious disease outbreaks. Severe congestion limits physical distancing, while shared sleeping quarters, sanitation facilities, and recreational spaces facilitate close and repeated contact. In many low- and middle-income countries, prison health services are under-resourced and poorly integrated into national health systems [6,7].

Incarcerated populations often have a higher burden of underlying health conditions, including malnutrition, HIV infection, tuberculosis, and substance use disorders, which may increase susceptibility to infection and adverse outcomes [11]. Furthermore, stigma, fear of isolation, and limited access to healthcare may delay symptom reporting. The movement of staff and inmates between facilities and communities underscores the importance of addressing prison outbreaks as a public health priority rather than a purely custodial concern.

METHODS

Study design

A retrospective descriptive review of outbreak response activities was conducted, focusing on the Mpox outbreak in Rivers State between September 2017 and January 2018.

Data sources

Data were obtained from the Rivers State Ministry of Health, the Public Health Emergency Operations Centre (PHEOC), the Nigerian Correctional Service, and partner agencies, including the Nigeria Centre for Disease Control (NCDC) and the World Health Organization (WHO). Sources included case investigation forms, laboratory results, contact tracing records, situation reports, and coordination meeting minutes.

Case definitions and analysis

Suspected, probable, and confirmed cases were classified

using the NCDC and WHO case definitions. Descriptive analyses were performed to examine case distribution, transmission chains, response timelines, and outcomes, with a specific focus on the prison-associated cluster.

The authors have no formal affiliation with the World

Health Organization. WHO publications cited in this study were used solely as internationally recognized technical guidance documents that inform national outbreak response frameworks in Nigeria.

Table1. NCDC case definitions applied for Mpox outbreak investigation (Rivers State, 2017)

Case category	NCDC-aligned operational definition
Suspected case	An acute illness with fever ($\geq 38.3^{\circ}\text{C}$) and systemic symptoms such as intense headache, lymphadenopathy, back pain, myalgia, and asthenia, followed 1–3 days later by a progressively developing vesiculopustular rash that often begins on the face and spreads to the body, including the palms and soles.
Probable case	A case that meets the clinical case definition is not laboratory-confirmed but has an epidemiological link to a confirmed case (e.g., close proximity/shared space, or other defined exposure).
Confirmed case	A clinically compatible suspected/probable case that is laboratory confirmed (e.g., PCR, virus isolation, or IgM antibody positivity as indicated in the NCDC interim guidance).

RESULTS

Outbreak overview

Between September 2017 and January 2018, Rivers State investigated 98 suspected Mpox cases. Of these, 27 cases were laboratory-confirmed, four tested negative, and one case was lost to follow-up. The remaining suspected cases were epidemiologically investigated and monitored through the Integrated Disease Surveillance and Response (IDSR) system.

Epidemiological investigations identified a distinct institutional cluster of five confirmed cases linked to a congested correctional facility in Port Harcourt,

representing 18.5% (5/27) of all confirmed cases in the state during the outbreak period. This cluster constituted a clearly defined transmission event within the broader community outbreak.

The temporal sequence of case detection, laboratory confirmation, activation of response structures, and implementation of containment measures is illustrated in Figure 1. The overall distribution of suspected, confirmed, and prison-associated cases is summarized in Table 2, which highlights the correctional facility cluster's relative contribution to the total confirmed caseload in Rivers State. The epidemic curve of Mpox-confirmed cases in Rivers State is shown in Fig. 4.

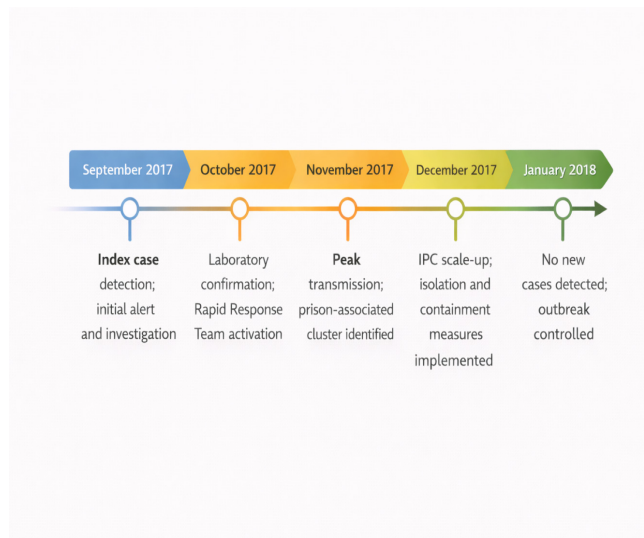


Fig1. Timeline of the Mpox outbreak and response activities in Rivers State, September 2017–January 2018.

Description: The figure depicts key milestones from initial alerts and laboratory confirmation through the activation of response mechanisms and the implementation of

control measures, demonstrating progressive escalation and subsequent containment of the outbreak.

Table2. *Distribution of suspected and confirmed Mpox cases in Rivers State, 2017–2018*

Case category	Number of cases	Percentage (%)
Suspected cases investigated	98	100
Laboratory-confirmed cases	27	27.6
Laboratory-negative cases	4	4.1
Lost to follow-up	1	1.0
Prison-associated confirmed cases	5	18.5*

*Percentage calculated as a proportion of laboratory-confirmed cases.

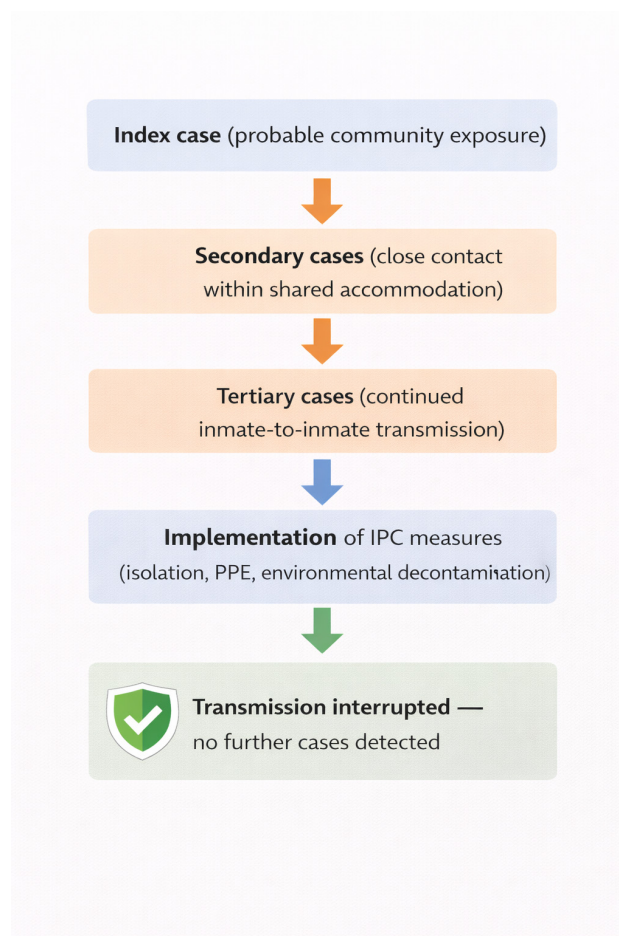
Transmission within the correctional facility

Epidemiological analysis demonstrated that transmission within the correctional facility originated from an index case with probable community exposure prior to incarceration. Following admission into custody, the index case transmitted infection to other inmates through close and prolonged contact in shared accommodation spaces.

Severe congestion, limited ventilation, and delayed recognition of early symptoms contributed to secondary transmission, followed by a tertiary transmission event,

resulting in two generations of transmission within the facility. Contact tracing and case investigations delineated a clear transmission chain linking all five confirmed prison-associated cases.

Following the implementation of targeted infection prevention and control (IPC) measures, including isolation arrangements and reinforcement of standard precautions, no additional cases were detected among inmates or correctional staff. The structure and interruption of the transmission chain are illustrated in Figure 2.

**Fig2.** *Transmission chain of Mpox cases within the correctional facility in Rivers State.*

Description: Schematic representation of index, secondary, and tertiary Mpox cases within the correctional facility, indicating the point at which transmission was interrupted following IPC implementation.

Case management outcomes

All laboratory-confirmed Mpox cases were managed in accordance with national and WHO guidelines. Confirmed community cases were referred to designated isolation and treatment centres, including the University of Port Harcourt Teaching Hospital and the Infectious Disease Treatment Centre in Emohua.

Due to custodial and security considerations, the five confirmed cases in the correctional facility were managed in a designated isolation cell, with clinical oversight and

supportive care provided through collaboration between public health authorities and correctional health staff. Case management focused on symptomatic treatment, monitoring complications, and preventing onward transmission.

All confirmed cases recovered fully, and no fatalities were recorded during the outbreak period. Key response and case management interventions implemented during the prison outbreak are summarized in Table 3.

Table3. Key response and case management interventions during the prison-associated Mpox outbreak

Response domain	Key interventions implemented
Surveillance	Enhanced case finding and line-listing
Case management	Isolation, supportive care, clinical monitoring
Infection prevention and control	Designated isolation cell, PPE provision, environmental decontamination
Contact tracing	Identification and follow-up of inmate and staff contacts
Coordination	Multi-agency collaboration between health and correctional authorities
Risk communication	Health education for inmates and correctional staff

Characteristics of prison-associated Mpox cases

Further characterization of the prison-associated cases showed that all infections occurred among inmates in shared accommodation, underscoring the role of congestion and close contact in facilitating transmission. The outbreak was confined to inmates, with no confirmed infections among correctional staff.

Transmission was successfully interrupted after implementing IPC measures, and all affected individuals recovered without complications. A summary of the epidemiological characteristics of prison-associated Mpox cases is presented in Table 4. A graphical summary of the outbreak progression, response measures, and outcomes is presented in Figure 3.

Table4. Epidemiological characteristics of prison-associated Mpox cases in Rivers State, 2017

Characteristic	Description
Total confirmed prison cases	5
Likely source of infection	Community exposure (index case)
Transmission pattern	Person-to-person within facility
Number of transmission generations	Two
Primary exposure setting	Shared accommodation cells
Contributing factors	Severe congestion, delayed symptom recognition
Isolation location	Designated isolation cell within facility
Case fatality	0
Outbreak outcome	Transmission interrupted following IPC



Figure 3. Graphical summary of Mpox outbreak progression and response in a congested correctional facility.

Fig3. Graphical summary of Mpox outbreak progression and response in a congested correctional facility.

Description: Graphical overview summarizing outbreak response measures, and containment outcomes within the introduction, transmission dynamics, public health correctional facility.

Epidemic curve of confirmed Mpox cases in Rivers State, Nigeria, 2017 to 2018

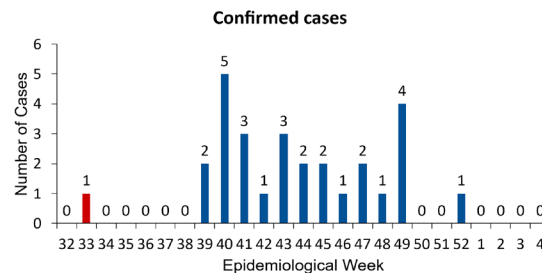


Fig4. Graphical summary of the Mpox outbreak. Epidemic curve of confirmed Mpox cases in Rivers State, Nigeria, 2017 to 2018.

DISCUSSION: PUBLIC HEALTH EMERGENCY RESPONSE

Emergency Operations Centre activation

Following confirmation of Mpox cases in Rivers State, the Rivers State Public Health Emergency Operations Centre (PHEOC) was promptly activated to provide overall coordination and strategic leadership for the outbreak response. Activation of the PHEOC enabled the establishment of an incident management system that brought together key response pillars, including surveillance, case management, infection prevention and control (IPC), risk communication and community engagement, logistics, and partner coordination [12,13]. Daily situation reviews and coordination meetings facilitated timely information sharing, rapid decision-making, and alignment of response activities between the health sector and correctional authorities. This centralized coordination structure was particularly critical in addressing the operational complexities of responding to an outbreak within a custodial setting.

Infection prevention and control measures

Infection prevention and control measures were adapted to the constraints of the correctional environment to limit further transmission. An isolation cell was established within the facility to temporarily separate suspected cases pending referral or confirmation. Personal protective equipment, including gloves, masks, and protective clothing, was provided to prison healthcare workers and staff involved in case management and

environmental cleaning. Environmental decontamination of shared spaces, sleeping areas, and sanitary facilities was conducted using approved disinfectants. In addition, targeted training sessions were organized for prison healthcare staff and selected correctional officers on Mpox recognition, standard and transmission-based precautions, safe handling of linens and waste, and appropriate use of personal protective equipment. These measures were instrumental in interrupting transmission within the facility.

Risk communication

Risk communication activities were implemented to address fear, misinformation, and stigma associated with Mpox among inmates, correctional staff, and surrounding communities. Health education sessions within the facility emphasized early symptom recognition, prompt reporting of illness, and adherence to IPC measures. Messaging was designed to be culturally appropriate and sensitive to the custodial context to encourage cooperation and reduce resistance to isolation measures.

Coordination

Coordination among the Rivers State Ministry of Health, the Nigeria Centre for Disease Control (NCDC), the World Health Organization (WHO), and Médecins Sans Frontières ensured technical guidance, logistical support, and consistency of public messaging. This multi-agency collaboration strengthened trust, improved compliance with control measures, and contributed significantly to the successful containment of the outbreak.

Response outcomes

The coordinated public health emergency response resulted in the timely containment of Mpox transmission within the correctional facility and prevented further spread to staff and surrounding communities. Activation of the PHEOC enabled rapid case identification, isolation, and referral, while implementation of context-specific IPC measures reduced ongoing exposure in a highly congested environment. Enhanced surveillance and targeted contact tracing facilitated early detection of secondary and tertiary cases, allowing prompt interruption of transmission chains. Risk communication efforts improved symptom reporting and compliance with control measures among inmates and correctional staff. Collectively, these interventions stabilized the outbreak and set the stage for the descriptive epidemiological findings presented in the Results section.

CHALLENGES AND SYSTEMIC GAPS

The management of the Mpox outbreak in a congested correctional facility in Rivers State was constrained by structural, operational, and systemic weaknesses, many of which have been explicitly highlighted in WHO prison-health guidance and the Integrated Disease Surveillance and Response (IDSR) technical framework [16–20].

- **Severe congestion and infrastructure limitations** significantly undermined outbreak control. WHO prison-health guidance identifies overcrowding, poor ventilation, and inadequate living conditions as major drivers of communicable disease transmission in custodial settings and emphasizes that these conditions limit the feasibility of isolation and physical distancing measures [16,17,27].
- **Delayed case detection and reporting** were influenced by limited access to healthcare, low awareness of Mpox among inmates and custodial staff, and fear of stigmatization. Prison guidance emphasizes early detection through routine surveillance and prompt reporting of priority syndrome processes, which are weakened when prison health services are poorly integrated into national surveillance systems [20,22].
- **Contact tracing capacity was constrained** by shared accommodation, frequent inmate mixing, incomplete movement records, and restricted access for public health teams. WHO guidance for congregate settings notes that prisons require adapted contact-tracing approaches because standard community-based methods are difficult to implement in custodial environments [19,28]. IDSR further underscores the importance of complete case investigation and timely

follow-up of contacts for effective outbreak control [20].

- **Inadequate healthcare infrastructure and IPC capacity** further limited the effectiveness of the response. WHO emphasizes that functional IPC programmes—including trained personnel, adequate PPE, WASH facilities, and standardized procedures—are essential to prevent amplification of outbreaks, particularly in high-risk settings such as prisons [24–26]. These components were insufficiently developed within the correctional facility.
- **Security-related operational restrictions** affected the implementation of the outbreak response. WHO prison-health guidance recognizes that custodial security requirements can conflict with public health operations and recommends formalized coordination mechanisms between health and justice sectors to balance security with timely health interventions [16,18].
- **Weak integration of prison health into national surveillance and preparedness systems** represented a major systemic gap. Both the WHO and IDSR frameworks emphasize that prison health services should be embedded within national health systems to ensure timely surveillance, reporting, and coordinated emergency response [16,20–22].

LESSONS LEARNED AND POLICY IMPLICATIONS

The Mpox outbreak in a congested correctional facility in Rivers State underscored critical lessons for epidemic preparedness and response in custodial settings. Foremost among these is the need to fully integrate correctional facilities into national disease surveillance and emergency preparedness frameworks, including the Integrated Disease Surveillance and Response (IDSR) system. The delayed detection and initial response observed during the outbreak illustrate the consequences of treating prison health as peripheral to mainstream public health systems rather than as an integral component of national health security [6].

A key lesson was the importance of dedicated, context-specific infection prevention and control (IPC) strategies for correctional environments. Standard IPC guidelines designed for hospitals or community settings must be adapted to address the realities of congestion, restricted movement, and shared infrastructure in prisons. Establishing designated isolation spaces, strengthening WASH infrastructure, ensuring consistent access to personal protective equipment, and building IPC competencies among prison healthcare workers and custodial staff

are essential to reducing outbreak amplification in such settings [14].

The outbreak also highlighted the value of routine health screening and syndromic surveillance within correctional facilities. Regular screening of inmates at entry and during incarceration can facilitate early detection of priority infectious diseases and reduce delays in outbreak recognition. Embedding these screening activities within routine prison health services and linking them to state and national surveillance reporting mechanisms would strengthen early warning systems and improve response timeliness [6].

Furthermore, the response revealed long-standing deficiencies in prison health service capacity, including a limited healthcare workforce, inadequate diagnostic capabilities, and weak referral systems. Strengthening prison health services through improved staffing, training, infrastructure investment, and formal integration with public health emergency response structures is essential to achieving care equivalence and improving outbreak outcomes among incarcerated populations [14,15].

Finally, the outbreak reinforced the critical role of structural and policy interventions to reduce congestion in correctional facilities. Overcrowding not only undermines basic human rights but also drives the transmission of infectious diseases. Policies that promote alternatives to incarceration, expedited case processing, and improved prison infrastructure are therefore not only justice-sector reforms but also essential public health interventions [15].

Collectively, these lessons emphasize that effective prevention and control of infectious disease outbreaks in correctional facilities require intersectoral collaboration, sustained political commitment, and deliberate policy action. Integrating prison health into national surveillance systems, strengthening IPC and healthcare capacity, and addressing structural drivers such as congestion are indispensable steps toward building resilient health systems that protect both incarcerated populations and the wider community.

CONCLUSION

The Mpox outbreak in a congested correctional facility in Rivers State illustrates the intersection of public health, human rights, and health system resilience. Strengthening prison health systems and embedding epidemic preparedness within correctional structures are critical for protecting both incarcerated populations and the wider community.

Conflict of Interest

The authors declare no conflict of interest.

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