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Game on, Pathogens: Operationalizing HCID Preparedness Lessons for the 2026 FIFA World Cup

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Game on, Pathogens: Operationalizing HCID Preparedness Lessons for the 2026 FIFA World Cup

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Abstract

The 2026 FIFA World Cup, will draw massive international crowds and present unique public health challenges. High Consequence Infectious Diseases (HCIDs) – (e.g., Ebola Virus Disease) diseases with high mortality or outbreak potential – are of particular concern. Previous international sporting events show that while common travel-related illnesses (e.g., gastrointestinal infections or respiratory viruses) are more likely, the potential widespread disruption from an HCID requires vigilant preparedness. Past encounters with Ebola, COVID-19, and mpox underscore vulnerabilities, highlighting the importance of a robust HCID preparedness infrastructure. This paper distills lessons learned from two recent planning exercises both simulating an HCID outbreak during the World Cup. We provide an analysis of the HCID outbreak risks in the context of World Cup mass gatherings and NY/NJ's specific risk profile. Finally, we offer detailed recommendations for local healthcare systems and public health to mitigate the threat of HCIDs during the 2026 FIFA World Cup.

Keywords: special pathogens; ebola virus; FIFA; FIFA world cup; preparedness; high-consequence infectious disease; HCID; personal protective equiptment; PPE; NYC; mass gatherings

Background

Major international sporting events are mass gathering occasions that bring together hundreds of thousands of people from around the world. Such events inherently carry an increased risk of infectious disease transmission due to high crowd density, global travel, and the mingling of populations. While, most illnesses associated with mass gatherings have been relatively routine – travelers' diarrhea, foodborne infections, respiratory illnesses, or vector-borne diseases[1] - the potential for high-consequence infectious diseases (HCIDs) to emerge during such events, while low, is a serious concern. HCIDs, also referred to as Special Pathogens, are pathogens that cause severe disease with high fatality, few medical countermeasures, and can spread in the community or healthcare settings.[2] Examples include viral hemorrhagic fevers (VHFs) like Ebola Virus, highly pathogenic coronaviruses like Middle East Respiratory Syndrome (MERS), and other novel emerging viruses. While rarer than routine infections, their impact could spark an outbreak difficult to contain in a mass gathering scenario.

Historical experiences illustrate both the challenges and successes in managing infectious risks at large events. The 2010 Winter Olympics in Vancouver saw measles cases in international attendees.[3] In 2014, West Africa's Ebola outbreak raised alarms for the potential importation of Ebola cases during international events leading to vastly heightened global screening and preparedness efforts.[4] More recently, health experts attributed an international Champions League soccer match as

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a catalyst for early COVID-19 transmission.[5] The COVID-19 pandemic forced unprecedented postponements and modifications of mass gatherings (e.g., Tokyo 2020 Olympics held largely without spectators).[6] These examples underscore a key point: mass gatherings can amplify existing outbreaks or facilitate the introduction of pathogens, but proactive measures can dramatically mitigate these risks.

By 2025, public health authorities recognized that the World Cup 2026 represents a convergence of risk factors. High travel volumes and close crowd contact create a scenario where even a single imported HCID case could have outsized consequences. Preparedness thus must account for both routine health issues and worst-case scenarios involving rare but dangerous pathogens. This manuscript will discuss the HCID preparedness activities taken thus far, and provide recommendations for local healthcare facilities, particularly in the New York/New Jersey (NY/NJ) area, to prepare for HCID threats during the 2026 World Cup.

NY/NJ's Heightened Vulnerability: Lessons from Ebola, COVID-19, and Mpox

The New York City (NYC) metropolitan region is acutely aware of its vulnerability to emerging infectious diseases. As a global travel hub and densely populated urban center, NYC has repeatedly been at the forefront of infectious disease threats in the United States.

In October 2014, NYC saw one of the nation's few confirmed Ebola cases.[7] This case was a seminal moment for NYC's public health and healthcare systems. Thanks to drills and training preparing for Ebola patients in the months prior, NYC Health + Hospitals/Bellevue (Bellevue) successfully treated the patient with no secondary transmission. This demonstrated the value of advanced planning and training. In spring of 2020, NYC became the early U.S. epicenter of the COVID-19 pandemic with surges of critically ill patients. By March, 2023, NYC had over 45,000 COVID-19 deaths.[8] Limited surge capacity, supply chain dependence for personal protective equipment (PPE), and disparities in healthcare access became evident vulnerabilities. Yet it catalyzed improvements: hospital expanded Intensive Care Unit (ICU) capacity, public health enhanced surveillance, and healthcare and government officials strengthened communication pathways to better manage patient surges. In 2022, mpox (formally known as monkeypox) arrived in NYC amounting to over 3,800 cases by years end, demonstrating the region's susceptibility to previously rare diseases.[9] Mpox challenged public health with its unusual presentation and need for targeted outreach. NYC hospitals partnered with local and federal public health agencies to stand up clinics for testing, therapeutics, and vaccination – skills crucial in an HCID outbreak.[10,11] Notably, mpox highlighted the importance of communication with specific at-risk populations and combating stigma, considerations applicable in HCID scenarios.

NYC and New Jersey enter the World Cup preparedness phase, battle-tested by recent crises. Ebola taught the region how to handle one case of a deadly disease, COVID-19 how to cope with a pervasive pandemic, and mpox how to detect and contain outbreaks disproportionally affecting specific communities. These events have driven home the need for advanced planning, continuous training, and a well-coordinated regional response system. They also justify why the NYC/NJ area needs to take HCID risks seriously in 2026. Accordingly, local healthcare and public health authorities have been proactively leveraging national resources, especially the National Special Pathogen System of care (NSPS), to enhance readiness.

The National Special Pathogen System (NSPS)'s Role

To prepare for special pathogen threats nationwide, HHS established the NSPS. Evolving out of the Ebola response of 2014–2015 and the 2020 COVID-19 pandemic, the NSPS operates through a tiered framework of designated hospitals and partner institutions across four levels, each with increasing capabilities for handling patients suspected of or confirmed with HCID (Table 1).[12]

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Table 1. National Special Pathogen System of Care (NSPS) Level Designations.

NSPS Level	Designation Definition
Level 4 – Frontline Healthcare Facilities	All U.S. healthcare facilities (e.g., hospitals, clinics, urgent cares, etc.) that are not specifically designated as a higher level NSPS facility. Their role is to identify, isolate, and inform. Any hospital in the United States should be able to recognize a potential HCID case (based on symptoms and travel history), immediately isolate the patient with proper infection control, and inform public health authorities and the NSPS network for further guidance. Level 4 facilities are expected to initiate stabilizing care before transferring the patient to a higher-level center.
Level 3 – Assessment Hospitals	These are hospitals designated to evaluate and care for a case for up to 36 hours. They have basic isolation facilities and some on-site diagnostic capability. In Region 2, three hospitals have been designated as assessment centers where patients who screen positive for possible HCIDs can be safely managed while confirmatory testing and transport to a higher-level facility is arranged.
Level 2 – Special Pathogen Treatment Centers (SPTCs)	These centers host the enhanced clinical capability to manage HCID cases for the duration of illness. They have biocontainment units/high-level isolation units, trained personnel, and advanced diagnostics. These facilities work closely with the RESPTC/NSPS Level 1 and can either serve as overflow or initial receiving centers depending on circumstances. In January 2026, NETEC awarded 54 new NSPS level 2 facilities, including 10 in HHS Region 2 (New York, New Jersey, Puerto Rico, and the United States Virgin Islands). As these new centers complete their onboarding, they will grow the number of HLIU patient beds in the United States – meeting a critical need for the FIFA World Cup.
Level 1 – Regional Emerging Special Pathogen Treatment Centers (RESPTCs)	These are the regional hubs – thirteen across the U.S. – with the highest level of capability and resources for HCID care. A Level 1 RESPTC can provide definitive care for multiple VHF or novel respiratory patients through the duration of their illness, with advanced infrastructure, specialized infection control teams, and often research/clinical trial capabilities for special pathogens. Crucially, RESPTCs also serve a coordination role: they are funded to support training and preparedness outreach to other healthcare workers in their region. In HHS Region 2, NYC Health + Hospitals/Bellevue is the designated RESPTC. Bellevue, the oldest public hospital in America, has a distinguished history of managing infectious diseases – from the front lines of the 1918 Spanish flu to the 2014 Ebola case. As Region 2 RESPTC, Bellevue maintains a state-of-the-art HLIU and a highly trained staff for HCIDs, and it acts as a regional resource hub. It provides training materials, protocols, and expert guidance to other hospitals in New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands. Bellevue is also one of the three founding institutions leading NETEC (along with Emory University and University of Nebraska Medical Center), which reflects its central role in national special pathogens preparedness.

Note: An overview of each NSPS Level designation highlighting the clinical care capabilities expected at each level. Acronym: HCID- High-Consequence Infectious Disease; RESPTC- Regional Emerging Special Pathogen Treatment Center; NETEC- National Emerging Special Pathogen Treatment and Education Center; HHS- Health and Human Services; HLIU- High-Level Isolation Unit; FIFA- Fédération Internationale de Football Association; VHF- Viral Hemorrhagic Fever.

At the national level, the National Emerging Special Pathogens Training and Education Center (NETEC) underpins the NSPS. NETEC was originally established in 2015 as the National Ebola Training and Education Center, then expanded after the COVID-19 response to cover all special pathogens.[13] NETEC serves as the coordinating body for the NSPS and a knowledge hub for national special pathogen preparedness. It develops evidence-based guidelines, conducts trainings and webinars, assists in exercises, and provides tier-specific assessments and on-site technical assistance

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for healthcare facilities. During the World Cup 2026 preparedness efforts, NETEC plays a pivotal role in ensuring each region doesn't plan in isolation, but rather as part of a national system where resources can be brought to bear wherever needed.

The NSPS/NETEC structure is complemented by federal coordination through the U.S. HHS Administration for Strategic Preparedness and Response (ASPR). ASPR's regional teams collaborate with Regional Emerging Special Pathogen Treatment Centers (RESPTCs) and health departments to integrate HCID plans into broader emergency response frameworks. Additionally, the CDC brings pathogen testing, epidemiologists, and subject matter expertise to inform response operations. All these pieces together form a multilayered shield of defense against HCIDs during the World Cup. Every level, from community emergency rooms to the highest national authorities, has clearly defined roles in the event of an HCID case.

Case Study: NY/NJ 2026 World Cup Exercises and Key Findings

The U.S. health preparedness community has undertaken focused planning to address the unique challenges of the 2026 World Cup. The NY/NJ area, as the site of the final match and multiple high-profile games, participated in two major exercises to inform the region's readiness for HCID threats.

First, NETEC hosted a nationwide NSPS World Cup Tabletop Exercise (TTX) in January 2025, involving all 10 HHS regions, each RESPTC, federal partners (e.g., ASPR, CDC, etc.), and key local partners (e.g., departments of health, EMS, laboratories, etc.).[14] In this exercise, a suspected MERS case appears at a healthcare facility near a World Cup venue. The exercise objectives were to align on roles/responsibilities, communication processes, and coordination of operations across the NSPS when facing a special pathogen incident during a large event. Notably, this TTX emphasized inter-regional and federal coordination by having national partners participate in the regional discussions. Key findings from the TTX are highlighted in Table 2.

Table 2. Lessons Learned from the World Cup Table Top Exercise in January 2025.

Preparedness Measures	Description
Communication	Many regions identified communication pathways as a challenge: clarity was needed on how information flows from the frontline hospital up to city/state health departments, then to federal partners. It was recommended to refine protocols for situational reporting and emergency communication (e.g., establishing a single coordination center or incident command for a multi-state outbreak).
Emergency Medical Services (EMS) Coordination	Regions questioned how to handle cross-state patient transport, including jurisdictional issues, state credentialing, hand-off points, and what resources or training EMS crews would require for safely moving a contagious HCID patient. Action items included developing detailed transport Concept of Operations (CONOPs) – for example, deciding when to use specialized ambulances or vehicle isolation units, and ensuring caches of appropriate Personal Protective Equipment (PPE) and disinfection supplies are available for ambulance agencies.
Continued Exercises	Participants suggested more drills, including full-scale and scenario variations (e.g., a pediatric patient or multiple simultaneous patients, or a viral hemorrhagic fever scenario) to broaden readiness. This reflects a recognition that training must be ongoing; plans on paper need to be regularly tested with realistic scenarios.
Relationship Building	Building and sustaining relationships across agencies was highlighted as a strength to maintain. The exercise allowed peers across hospitals, public health, and emergency management to network and understand each other's roles. Going forward, keeping those channels open (through regular meetings or joint trainings) will strengthen regional resilience. One recommendation was to "socialize" the special pathogen response plans widely and ensure even institutions that were not in the core group are aware of how the system works, whom to call, and what their own responsibilities are.

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Protocol and Plan Development	The need to review and refine existing plans was evident. Regions realized that some protocols were not uniformly understood. The after-action report (AAR) advised updating regional and local emergency operations plans and clinical guidelines to incorporate the World Cup exercise lessons learned.

Note: Key findings from the World Cup Table Top Exercise (TTX) that took place in January 2025. The TTX highlighted areas of strength while also identifying the existing preparedness gaps. These lessons were used to help prepare Region 2 for the Full-Scale Tranquil Passport Exercise in June 2025. Acronym: HCID- High-Consequence Infectious Disease.

Five months after the TTX, HHS ASPR-led the 2025 Tranquil Passport Full-Scale Exercise (FSE) in June, 2025.[15] In the scenario, Americans contracted a fictitious "Disease X" from a Toronto World Cup watch party, leading to a cluster of infected U.S. citizens that needed repatriation. The FSE orchestrated a multi-state, multi-agency response to this crisis: from initial case recognition in Canada, to international notification, to deploying specialized biocontainment transport to bring the Americans home for treatment, and finally activating five High-Level Isolation Units (HLIUs) across the East Coast, including the RESPTC at Bellevue. Real federal assets were utilized or simulated, such as ASPR's Portable Biocontainment Unit (PBCU), for ground transport.[16] The objectives included validating safe patient transport without contaminating vehicles or personnel, effective coordination between local hospitals up to federal agencies, and seamlessly intaking patient into the HLIUs. Early insights from the exercise indicated generally successful patient movements and strong collaboration, while highlighting needed improvements – clarifying inter-state EMS handoff procedures and ensuring all partners know the communication chain for an incident spanning multiple jurisdictions. The FSE also reinforced the importance of protecting first responders while caring for HCID patients. This FSE stress-tested the NSPS in a realistic World Cup emergency, providing invaluable data for after-action analysis. In May 2026, NETEC will lead another World Cup HCID preparations TTX with key partners.

Overall, these exercises demonstrate that the NSPS and Region 2 partners are on the right track for World Cup preparedness, while also identifying specific improvements before summer 2026.

Recommendations for Local Healthcare Systems

Hosting the World Cup finals presents a complex but manageable challenge for NY/NJ's health sector, provided that robust preparedness steps are in place. The following recommendations are directed at healthcare facilities in the region but also applicable across the country, emphasizing practical measures to prevent and respond to a potential HCID incident. These recommendations align with national guidance and exercise lessons, and they are grouped by phase (pre-event, during the event, and post-event), acknowledging that preparedness is a continuum. Table 3 summarizes key actions for healthcare facilities.

Table 3. Key Preparedness Actions for Healthcare Systems (NYC/NJ Region).

Action Area	Preparedness Measures for Health Facilities
Surveillance & Screening	Implement travel history screening for all febrile/acute illness patients during World Cup period; set alerts in EHR for "FIFA World Cup" exposure. Monitor syndromic surveillance reports from public health for clusters. Train triage staff to flag *any* patient with international travel or event attendance and relevant symptoms.
Infection Control & Training	Conduct refresher training on donning/doffing PPE for HCIDs; drill isolation procedures before the event. Ensure appropriate PPE (impermeable suits, N95/PAPRs, etc.) is stockpiled and easily accessible. Verify that airborne isolation rooms or high-level isolation units are functional and staff are familiar with protocols (e.g., waste management, sample handling).
Communication Protocols	Re-confirm internal call tree: who contacts infection control, hospital leadership, and how (especially after-hours). Post clear guidance in EDs: "Suspect HCID? Isolate patient and call

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	XYZ number immediately." Establish liaison with regional public health – e.g., assign a point person to join daily World Cup health briefings. Test emergency communication tools (satellite phones, radios, or backup systems) in case conventional lines are overwhelmed.
EMS/Transport Coordination	Coordinate with EMS for HCID patient transfer. Pre-arrange for specialized transport units or designated ambulances on standby. For inter-facility transfers, ensure transfer agreements and legal paperwork (consents, EMS waivers) are prepared in advance. Have a protocol for notifying the receiving facility (e.g., Bellevue) well ahead so they can activate their HCID team and prepare isolation room before patient arrival.
Healthcare Capacity & Staffing	Assess and augment staffing: designate an HCID team for each shift (could be drawn from ICU or ID nurses) that would focus solely on the isolated patient, to avoid mixing with general patient care. Plan for staff surge. Cross-train additional staff now (for redundancy). Ensure mental health support is available for staff, recognizing that dealing with a disease like Ebola can be stressful; resilience plans (rotating staff, counseling) should be part of the preparedness.
Public Communication & Education	Prepare signage in facilities (in multiple languages common to visitors) about respiratory etiquette and asking patients to report travel. If possible, have materials ready to hand out to patients: e.g., "If you've been to a World Cup event and feel ill, please inform the nurse/doctor." Coordinate messaging with public health so that hospital public affairs teams know how to handle media inquiries in an HCID event – ideally funneling to the health department's unified message. Take precautions to protect patient privacy.

A summary of core actions hospitals and healthcare facilities should undertake to be ready for a potential HCID case during the World Cup. These measures span improved surveillance, rigorous training and protocols, interagency coordination (especially for communication and transport), surge capacity planning, and patient/public communication. They derive from exercise lessons and established best practices in special pathogen preparedness. Acronyms: EHR- Electronic Health Record; FIFA- Fédération Internationale de Football Association; PPE- Personal Protective Equipment; HCID- High-Consequence Infectious Disease; PAPR- Powered Air-Purifying Respirator; ED- Emergency Department; ICU- Intensive Care Unit; ID- Infectious Disease.

Pre-Event Preparedness (Now until early 2026):

Enhance Surveillance and Screening:

Hospitals should institute or reinforce surveillance systems to flag patients with potential HCID symptoms. All points-of-entry to a healthcare facility must routinely ask patients with compatible symptoms about travel history and World Cup event attendance. Specific travel screening questionnaires covering countries with ongoing outbreaks or anyone coming from World Cup venues can be implemented at triage. Likewise, maintain an up-to-date list of global infectious disease alerts and ensure this information is rapidly shared with frontline providers, like the Region 2 RESPTC's monthly travel screening list.[17] As part of surveillance, local public and state labs in the region should be ready to perform rapid rule-out tests and coordinate confirmatory testing for rare pathogens via CDC's Laboratory Response Network. Healthcare facilities can conduct drills simulating the arrival of an HCID patient at their hospital, testing staff's ability to isolate and notify infection control. In late 2025, the Region 2 RESPTC partnered with the NYC Department of Health and Mental Hygiene (NYCDOHMH) to offer free mystery patient drills to healthcare facilities throughout the region.

Refine HCID Emergency Plans and Protocols:

Hospitals should review their infectious disease emergency operations plan including protocols for isolation, internal notification, and external notification. Once a suspected HCID is identified, the hospital should know how to isolate them and inform their local public health authority. The Region 2 HCID Patient Transport Concept of Operations (CONOPs) – outlining the plans, roles, responsibilities, and communication channels for transport an HCID patient within HHS Region 2

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– should be disseminated and practiced.[18] Just-in-time training (JiTT) materials should be prepared to rapidly train or refresh staff on infection prevention and control measures.

Strengthen Communication Channels:

It is vital to establish robust communication pathways both within and between institutions. Internally, hospitals should test their incident command system (ICS) activation for an infectious disease scenario. Interagency drills should be conducted so all relevant partners (e.g., health departments, RESPTC, CDC, EMS, laboratory, etc.) are looped into a coordinated call or virtual room for a suspected patient, similar to the ASPR Tranquil Passport FSE from June 2025.

EMS and Transport Logistics:

Well before the event, NETEC and the RESPTCs should engage with their regional EMS providers to discuss HCID patient movement plans. This includes which equipment will be used for transport – e.g., isolation transport units or plastic drapes in ambulances – and how to source them. Training and exercises for EMS crews on donning PPE, transporting an HCID patient, and decontaminating vehicles post-transport are essential. Jurisdictional coordination must be addressed: a patient might need transport from New Jersey to New York (or vice versa). Transportation plans should account for contingencies like multiple symptomatic patients or the need for air transport. Every EMS agency should know what to do and who to call if they get called for a possible HCID patient.

Capacity Building and Supplies:

Hospitals, especially NSPS Level 1 and Level 2 hospitals, should assess their HCID surge capacity. This means ensuring that HLIUs are functional, equipment and PPE is available, and staff are fit-tested and PPE trained. Hospitals might also identify secondary units, like a backup ICU area that can be converted for isolation. Stockpiling critical supplies is prudent – PPE, point of care testing capabilities, staffing redundancy, and medical countermeasures. Health Care Coalitions can assist by coordinating resource inventories and facilitating sharing agreements. Additionally, plans for staff augmentation should be developed. A single HCID patient requires a large team on rotating shifts, so hospitals must be ready to pull in extra nurses, laboratorians, and other specialists. Training more staff in advance can create a larger pool to draw from. Finally, ensure mental health professionals are on-site to support healthcare staff.

Community and Traveler Engagement:

Public health departments may leverage the pre-event period to engage with communities and travelers. For instance, issuing travel advisories or health guidance for visitors coming to the World Cup: encouraging them to stay up-to-date on routine vaccines, practice good hygiene, and seek medical advice when ill. Consider setting up information booths or distributing multilingual flyers in airports, fan zones, and hotels about accessing healthcare if needed. This pre-event health promotion can reduce the burden of common illnesses and, perhaps, catch an HCID case sooner.

During the World Cup Event (June–July 2026):

Heightened Clinical Vigilance:

During the weeks of the tournament, all frontline providers must be on high alert for potential HCID cases. Hospitals should consider implementing preparedness efforts to remind staff to follow identify, isolate, and inform protocols. Keep outbreak lists updated and immediately communicate emerging outbreaks to clinical staff. Triggers for suspicion should be slightly broadened during this time: for example, an atypical pneumonia in a World Cup attendee might warrant testing for MERS or other pathogens not typically top of differential. Hospitals might cohort any undiagnosed febrile patients away from general waiting areas as a precaution. A regional on-call infectious disease physician can be a resource for frontline physicians deciding if a patient needs HCID work-up. Essentially, a culture of "when in doubt, isolate and call for help" should be fostered.

Real-time Coordination and Information Sharing:

Health care facilities should work with public health authorities to maintain real-time situational awareness. Emergency Operations Center (EOC) may be activated specifically for World Cup health issues, and this should include the entire spectrum from public health to health care

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delivery. EOCs are staffed by a multi-agency team that monitors hospital reports, syndromic surveillance signals, and international inputs, and can rapidly respond to suspected cases... RESPTCs should deepen their collaboration and participating in their local EOCs as if an HCID case is confirmed, this coordination group would oversee the response alongside the incident command at the involved hospital, mobilizing resources (e.g., testing, transport, etc.) and harmonizing communications. Coordinated public messaging should be developed while maintaining patient privacy.

Infection Control and Safety Measures:

Hospitals should implement universal good practices such as reinforcing hand hygiene, cough etiquette, and mask recommendations in clinical settings when respiratory virus cases increase. In venues and crowded settings, measures such as improving ventilation where feasible and ensure availability of hand sanitization stations can reduce transmission. If COVID-19 or influenza surges, authorities may even contemplate testing or masking campaigns for general mitigation – this also may reduce transmission of HCIDs that spread by respiratory route. Additionally, healthcare workers with an unprotected exposure to a suspected or confirmed HCID should be monitored for the onset of symptoms.

EMS/Transport on Standby:

EMS units equipped for biocontainment transport should be on heightened alert and possibly staged strategically during big match days. Similarly, NSPS facilities might keep an HLIU bed or two free (or have a plan to rapidly clear one). If a 911 call comes in about a sick World Cup visitor with concerning HCID symptoms, dispatchers should alert supervisory staff and direct the patient to a pre-identified assessment hospital rather than any local hospital. These nuances can be the difference between a controlled response and a chaotic one.

Public Communication and Risk Messaging:

Throughout the event, health authorities should actively communicate with the public and stakeholders. Daily or weekly briefings to share updates on health issues, remind visitors about preventive measures, and combat misinformation. Social media monitoring can catch early case rumors so officials can quickly investigate and address them. Should an HCID case be confirmed, a joint press conference with city and state health leaders, and possibly federal partners, would help deliver a calm, unified message. Messages should emphasize the capability of NSPS and the local treatment center to treat the patient. Be prepared to counter any xenophobia or stigma that might arise. Finally, take all precautions to protect the patient's privacy. Hospitals and EMS agencies may consider using privacy screens during the patient hand-off to prevent media access.

Post-Event (After the World Cup and beyond):

Post-Travel Surveillance and Medical Follow-up:

Many World Cup attendees will depart NYC/NJ and travel back home. Healthcare providers should remain vigilant in the weeks following the event for patients who present with illnesses linked to World Cup travel. For example, a resident with international friends visiting for the final might come in with an illness – a detailed travel and exposure history can reveal if they were at any event venues or had close contact with international visitors. Public health departments may coordinate with the CDC's Division of Global Migration and Quarantine to notify other jurisdictions if a World Cup traveler is diagnosed after returning home. Conversely, NYC/NJ should be prepared to receive notifications from elsewhere (e.g., if a case of Lassa fever is diagnosed in another country in a person who had been in NYC for the World Cup). Enhancing global surveillance data sharing for a few weeks post-event is a worthwhile step.

Evaluation and After-Action Review:

The conclusion of the World Cup is not the end of the effort. All involved entities should convene for an after-action review (AAR) to evaluate what worked well and what could be improved. If no HCID events occurred, learning can be drawn from near-misses or the general healthcare strain during the event. If an incident did occur, examining the response in detail (timelines, bottlenecks,

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outcomes) will be crucial for future planning. It's recommended to capture data such as time to identification and isolation, lab turnaround times, and communication effectiveness. This AAR process should produce a report with recommendations to further bolster the NSPS and regional response plans.

Sustaining Preparedness Investments:

Finally, one overarching recommendation is to use the momentum from World Cup preparations to institutionalize lasting improvements. This might involve securing ongoing funding for special pathogens programs (e.g., maintaining the Region 2 RESPTC capabilities), continuing joint trainings between healthcare and public safety agencies, and keeping the public engaged in preparedness. The World Cup is a fixed-time event, but the threat of pandemics or emerging infections is continuous. In 2028, the Summer Olympics will be hosted in Los Angeles, California; however, multiple men's and women's group stage and knockout soccer matches will be held in Queens, NY, presenting another opportunity for international travelers visiting the NY/NJ region.[19] By treating the World Cup as a catalyst, NYC/NJ can leave a legacy of a stronger, more connected health system. As the Region 2 RESPTC website aptly notes, "The nation needs a system that prevents information siloes, shares resources, and invests in enhanced clinical care capabilities" for special pathogens. The efforts put forth for 2026 should advance that vision.

Conclusion

The 2026 FIFA World Cup will be a momentous occasion for the NY/NJ region, and with thorough preparation, it can be a safe one. Historical precedent suggests that while mass gatherings pose epidemiologic risks, strong preparedness and early interventions mitigate those risks. NYC/NJ's experiences with Ebola, COVID-19, and mpox have reinforced that our health systems must expect the unexpected and respond decisively.

Thanks to the evolution of the NSPS and NETEC's leadership, the nation is better positioned to handle an HCID threat than ever before. Bellevue's RESPTC and its partner hospitals stand as a testament to lessons learned and investments made in special pathogen readiness. The World Cup TTX and Tranquil Passport FSE tested the multi-layered, practiced response that brought together local ingenuity and national support. By enhancing surveillance, perfecting communication pathways, drilling transport and treatment procedures, and educating both healthcare workers and the public, we can significantly mitigate the impact of any infectious disease incident. The World Cup provides an impetus to close remaining gaps in our infectious disease preparedness so fans can enjoy the World Cup festivities with the confidence that behind the scenes, a vigilant public health and healthcare system is guarding their health and ready for whatever challenge might emerge.

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