

Commentary

Ebola virus disease and the 2026 FIFA World Cup mass gatherings: implications for global health security

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Received: 23 June 2026

Accepted: 04 August 2026

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ABSTRACT

The 2026 Fédération Internationale de Football Association (FIFA) World Cup kicked off on June 11, 2026 in Mexico with the first opening match. It is unarguably the largest football event in the history of FIFA-organized tournaments, with three nations United States of America, Canada, and Mexico jointly hosting a 48-nation tournament featuring 104 matches. In contrast, previous tournaments, such as the 2022 event in Qatar, were limited to 32 participating countries and a single host nation. The number of participating countries from Africa was raised from five to nine with the epicentre of the current Ebola virus disease (EVD) outbreak, DR Congo (DRC) one of the participating countries having qualified through the intercontinental play off. Equally important is the fact that it is the longest running World Cup event lasting 39 days compared to 32 days previously.

Keywords: FIFA, Ebola virus disease, Global health security

INTRODUCTION

Ebola virus disease (EVD) is a highly virulent zoonotic single-stranded negative sense ribonucleic acid (RNA) viral haemorrhagic fever in humans and other primates, caused by four of the six known strains.^{1,2} The incubation period varies between 2 and 21 days. It was first identified in 1976 during outbreaks in the then Zaire (now DRC) and Sudan. It is transmitted via direct contact with blood or other body fluids, contaminated objects and infected animals such as fruit bats, monkeys, chimpanzees and antelopes. It is a highly virulent virus with mortality as high as 60-90% in some instances. Death is often due to hypovolaemic shock, typically occurring between the 6th and 16th day of symptoms.²

The epicenter of the current Ebola virus outbreak is the DRC with spread to adjacent Uganda.³ The current outbreak is caused by the Bundibugyo strain of Ebola virus which was first discovered in 2007 in the Bundibugyo district of Uganda. While it is a less virulent strain with case fatality rate (CFR) of 30-50%, what makes it worrisome is that it is a very uncommon strain for which there is currently no approved vaccine or specific antiviral treatment.³ Differences in their viral properties are determined by variations in their genetic and molecular structures; the RNA sequences differ by roughly 30-40% while there are also significant differences in their surface glycoprotein configuration. These contribute to differences in antigenicity, immune recognition and vaccine effectiveness. These contribute to

differences in antigenicity, immune recognition and vaccine effectiveness.⁴

CURRENT STATUS OF EBOLA VIRUS OUTBREAK, CHALLENGES AND CONSTRAINTS

The current outbreak is considered the third largest Ebola outbreak ever recorded and the largest ever accounted for by the Bundibugyo strain. As of June 22, 2026, 1,003 confirmed cases and 254 deaths (CFR=25.3%) have been reported in DRC in a little over thirty days.³ The outbreak is concentrated in the Eastern provinces of Ituri, Northern and Southern Kivu of DRC. In the meantime, Uganda has reported 19 confirmed cases and 2 deaths (CFR=10.5%) in the districts of Kampala and Wakiso, mostly linked to importation from DRC although some local transmission occurred.³

On May 17, 2026, the WHO declared the current outbreak a Public Health Emergency of International Concern (PHEIC) for a number of reasons- Rapidly increasing number of cases, Cross-border spread, high risk of further international transmission, lack of licensed countermeasures such as vaccines and specific therapy for the Bundibugyo strain, a combination of ongoing conflicts, population movement and limitation in healthcare access (vi) need for coordinated international response.⁵ On June 5, 2026, WHO and Africa Centre for Disease Control (CDC) launched a six-month Continental Preparedness and Response Plan between June and November 2026 with a bid to coordinate responses across Africa and mobilize approximately 518 million USD to support affected and at-risk countries.⁶ In June 2026, the Federal Government of Nigeria announced a 10 billion Naira Ebola Emergency Preparedness Fund to strengthen the Nigeria CDC, improve surveillance and outbreak preparedness and, support rapid response systems.⁷ These efforts have yielded immediate significant containment of the outbreak as the rise in cases have been limited to DRC with no other African country currently affected by the outbreak while suspected cases have been investigated in Brazil and Italy with all coming out as negative.⁸ Additionally, Public Health experts currently hold the view that the risk of widespread transmission during the World Cup is low to minimal, basing their assessment on the fact that Ebola virus is not airborne unlike COVID-19 and other viruses associated with pandemics. It does not spread through casual contact such as travelling on the same bus, in the same plane or standing side by side on the stands and, moreover, the host nations have been taking preventive measures since May 2026 which have proven successful to date.⁹⁻¹¹

Regardless, it is worthy to note that the ongoing 2026 FIFA World Cup may pose potentially serious challenge to healthcare workers in their efforts to stem the global spread of the Ebola virus infection as millions of fans, hundreds of players, officials, and the media (some of whom may harbour subclinical infections) who are travelling across the borders of three host countries may

serve as hosts for the virus. Health authorities like WHO are concerned that the outbreak may in reality have already circulated undetected for weeks or months (before the first case was confirmed on 15th May 2026), raising concerns about the possibility of subclinical cases being present in the World Cup host nations. Epidemiological model traced the earliest spill over to January-February 2026; investigations eventually traced the earliest known suspected case to a healthcare worker who developed symptoms on 24th May 2026 and later died.¹²

Factors that could remotely trigger transmission and/or spread of the virus during the tournament include- possible contact with hospitalized subclinical cases that fall ill during the World Cup within the extended duration of the newly-formatted tournament. Large volume of international travel; the 2026 World Cup currently has about 5 million ticket sales and still counting. Low speed of detection and isolation of the Bundibugyo strain due to late development and limited availability of point-of-care testing kits for the virus.¹³ Dismissive attitude from lethargic societies who have grown wary of outbreaks announcement and suspicious of vaccine uptake. Reduced quality of healthcare response. This is especially critical in developing countries such as Nigeria and other African countries which have experienced attrition in their number due to the “JAPA” syndrome (brain drain) among other reasons.¹⁴

In terms of healthcare workforce and readiness, the three host nations are bedevilled by challenges that are capable of reducing their capacity for early containment and treatment of cases should it arise. These challenges include inconsistent coordination between the Federal and States during fast moving outbreaks, loss of experienced public health staff post-COVID-19, burnout and funding instability in state and local health departments, limited rural hospital surge capacity and uneven public trust.¹⁵⁻¹⁷ The declaration of Ebola by WHO as a PHEIC did galvanize significant early regional actions in countries that share border with DRC and the three host nations of the 2026 FIFA World Cup but global responses have so far been suboptimal at best with health systems of most nations playing catch up.¹⁸ This is evidenced by persistent funding gaps, operational challenges, and continued expansion of the outbreak with only a little above 50 nations across the globe showing serious commitment so far.¹⁸

RECOMMENDATIONS

To forestall global spread during the on-going FIFA World Cup, we hereby suggest the following: system strengthening for early detection of suspected cases and isolation in the host nations; foreign nationals presenting with flu-like illnesses to health facilities should be flagged while supply of POC testing kits to cities in the host nations should be prioritized. For events with such as the World Cup with mammoth crowds, this should include thermal scanners at entrances and hallways to

detect spectators with fever. Since FIFA has access to phone numbers and e-mails of every spectator, public enlightenment on symptomatology of Ebola and what to do in case anyone develops fever should be sent periodically to every spectator, including players and officials; this should include emergency call lines and how to get to the nearest POC test centre, the big jumbotron screens in stadiums can be deployed for public actions against Ebola using carefully crafted graphics and messaging; where possible, WHO and FIFA can collaborate with sponsors to also employ the use of the pitch-side perimeter advertising boards for added effect. COVID-19 and the Tokyo 2020/Qatar 2022 events have already showed how to successfully use strict "player bubbles," fast testing methods, and phone apps to track who might have been exposed to a virus. Other traditional steps include fast tracking emergency funding for provision of adequate personal protective equipment and infrastructure, putting retired healthcare workers on standby in case of surges, further tightening border control and containment and securing public/community trust.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Akinbodewa AA, Ariyo OE, Ogundele OA, Akinbodewa OM. Ebola virus disease and the 2026 FIFA World Cup mass gatherings: implications for global health security. *Int J Community Med Public Health* 2026;13:5515-8.