



FIFA World Cup

Select Priority Conditions

Disease Profiles

Overview



The purpose of this tool is to provide a concise working compilation of selected infectious-diseases associated with 2026 FIFA World Cup participating countries that have potential for spread in the Houston area and to help guide reporting to public health.

Call Immediately

- Diphtheria
- Measles
- Meningococcal Disease, invasive
- Viral Hemorrhagic Fevers, including Ebola

Within 1 Workday

- Hepatitis
- Mpox
- Pertussis
- Polio
- Tuberculosis

Within 1 Week

- Chagas
- Chikungunya
- Dengue
- Hantavirus
- Malaria
- Shigella
- Typhoid Fever
- West Nile Virus
- Zika

Please note that this is NOT a comprehensive list of reportable conditions. For a complete list of **Texas Notifiable Conditions** go to: <https://www.dshs.texas.gov/sites/default/files/IDCU/investigation/Reporting-forms/notifiable-conditions-2026-color.pdf>

CONSIDERATIONS:

- Low transmissibility
- Low risk of importation; mainly travelers
- Local transmission; vector presence
- Long latency with potential for chronic disease

FIFA-WC COUNTRIES: Argentina, Brazil, US

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **STANDARD**



CHAGAS

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Vector-borne via triatomine (“kissing”) bugs; infection occurs when contaminated feces enter skin or mucosa.

Contagiousness: No casual person-to-person spread. Possible spread via transfusion, transplant, and congenital transmission.

Population at risk: Travelers to and from endemic areas of Latin America, especially in rural settings.

Epidemiologic trends: Endemic in Latin America and parts of the southern US. Locally acquired cases reported in the southern US, including Texas.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation typically 1–2 weeks. No prodrome.

Rash and clinical course: Acute phase (8–10 weeks) often mild; symptoms may include fever, malaise, head and body aches, rash, GI symptoms, or eyelid swelling, with a prolonged asymptomatic phase that may progress to chronic disease.

Complications: Chronic disease may cause cardiomyopathy (heart failure, arrhythmias, sudden death) and GI disease (megaesophagus, megacolon).



PREVENTION & CONTROL STRATEGIES

Vaccination: No vaccine available. Prevention focuses on avoiding exposure to triatomine bugs.

Surveillance & outbreak response: Surveillance includes routine case reporting and screening of at-risk populations (individuals from endemic areas, blood/organ donors, pregnant women).

Treatment: Antiparasitic treatment with benznidazole or nifurtimox. Most effective when started early.

Mitigation: Vector control, personal protection (bite prevention), and community awareness.

CONSIDERATIONS:

- Moderate transmissibility
- Risk of importation
- Local transmission; vector presence
- Outdoor exposure and mass gathering

FIFA-WC COUNTRIES: Argentina, Congo DR, Curacao, Japan

CDC TRAVEL ADVISORY: LEVEL 2

- Outbreak in Mayotte, Suriname, Bolivia, Seychelles

TRANSMISSION PRECAUTIONS: STANDARD



CHIKUNGUNYA

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Bite of infected *Aedes* species mosquitoes. Vertical transmission may occur.

Contagiousness: A sick person transmits the virus to an uninfected mosquito (highest risk in the first week). After incubation in the mosquito (1-2 weeks), an infected mosquito transmits the virus to humans.

Population at risk: Newborns infected around the time of birth, older adults (≥ 65 years), and people with health conditions like diabetes or heart disease.

Epidemiologic trends: Endemic in many countries. Sporadic cases with limited local transmission have occurred in the US continental, including Texas.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: incubation period: 3–7 days (range 1–12 days). No prodrome; characterized by sudden onset of high fever and polyarthralgia.

Rash & clinical course: Fever (≤ 1 week), can be biphasic. Debilitating joint pain. Other symptoms: conjunctivitis, headache, myalgia, nausea, vomiting, or a rash (maculopapular) after fever onset. Joint pain can be disabling and may persist for months.

Complications: Hepatitis, myocarditis, neurologic disease, ocular disease, acute renal disease, and severe bullous skin lesions.



PREVENTION & CONTROL STRATEGIES

Vaccination: VIMKUNYA, approved for use in adults and adolescents aged ≥ 12 years.

Surveillance & outbreak response: Case and mosquito surveillance. Case investigations to determine if they are travel-associated or locally acquired to help guide response activities.

Treatment: Supportive care; managed for dengue until dengue has been ruled out.

Mitigation: Vector control, personal protection (bite prevention), and community awareness.

CONSIDERATIONS:

- Moderate transmissibility
- Risk of importation
- Local transmission; vector presence
- Outdoor exposure and mass gatherings

FIFA-WC COUNTRIES: Argentina, Cape Verde, Congo DR, Curacao, Japan, Portugal, Saudi Arabia

CDC TRAVEL ADVISORY: **LEVEL 1**

- Global

TRANSMISSION PRECAUTIONS: **STANDARD**



DENGUE

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Bite of infected *Aedes* species mosquitoes. Vertical transmission may occur.

Contagiousness: A sick person transmits the virus to an uninfected mosquito (highest risk in the first week). After incubation in the mosquito (1-2 weeks), an infected mosquito transmits the virus to humans.

Population at risk: Pregnant people, children, adults over 65 years and people who had dengue before are at higher risk for serious illness.

Epidemiologic trends: Endemic in many countries. Sporadic outbreaks with limited local transmission have occurred in the US continental, including Texas.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 5–7 days (range 3–10 days). No prodrome. 3-phase clinical course: febrile, critical, and convalescent.

Rash & clinical course: Sudden onset of fever, severe frontal headache, pain behind the eyeball, and joint and muscle pain; many experience nausea and vomit. A rash may appear 3-5 days after fever onset. Most people recover within two weeks.

Complications: Increased vascular permeability may progress to severe disease and bleeding problems, known as dengue hemorrhagic fever (DHF). Patients should be monitored for signs of DHF.



PREVENTION & CONTROL STRATEGIES

Vaccination: Dengvaxia only recommended for children aged 9–16 years with laboratory-confirmed previous infection living in endemic areas in the US.

Surveillance & outbreak response: Case and mosquito surveillance. Case investigations to determine if they are travel-associated or locally acquired to help guide response activities.

Treatment: Treatment is supportive. Avoid NSAIDs and aspirin due to risk of bleeding. Hospitalization may be needed for severe cases.

Mitigation: Vector control, personal protection (bite prevention), and community awareness.

CONSIDERATIONS:

- Low-Moderate transmissibility
- Potential vaccination gaps
- Risk of importation and local transmission
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Uzbekistan

CDC TRAVEL ADVISORY: **LEVEL 2**

- Outbreak in several states in Nigeria and confirmed and suspect cases in the Kankan region of Guinea.

TRANSMISSION PRECAUTIONS: **DROPLET + CONTACT**



DIPHTHERIA

Report to Public Health: **Call Immediately**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Respiratory droplets or direct contact with infected skin lesions or wounds. Asymptomatic transmission may occur.

Contagiousness: Infected persons may shed bacteria for 2–4 weeks; with treatment, people are infectious for up to 4 days after antibiotic treatment.

Population at risk: Under or unvaccinated individuals, especially <15 years; those with waning immunity; close contacts and healthcare workers.

Epidemiologic trends: International outbreaks, with case resurgence tied to vaccination and surveillance gaps. Respiratory diphtheria is rare in the US.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Typically, 2–5 days (range 1–10 days); Prodromal phase: sore throat, low-grade fever, malaise, neck swelling within initial days.

Rash & clinical course: Respiratory form: pseudo membrane formation on tonsils/pharynx, “bull-neck” lymphadenopathy, hoarseness, stridor. Cutaneous form: non-healing ulcers with an ulcerative rash or scaling lesions, milder symptoms.

Complications: Severe: airway obstruction, myocarditis, polyneuropathy, kidney failure, bleeding disorders; mortality ~5–10%, up to 30% without treatment.



PREVENTION & CONTROL STRATEGIES

Vaccination: Diphtheria toxoid contained in Tdap, DTP, DTaP, DT or Td vaccines.

Surveillance & outbreak response: Real-time case reporting; contact tracing with symptom monitoring for high- and intermediate-risk exposures.

Treatment: Antitoxin (DAT): neutralizes circulating toxin; prompt administration is essential. Antibiotics: erythromycin or penicillin preferred; continue until two negative cultures 24 hours apart.

Mitigation: Immunizations during outbreaks. Droplet, contact and standard precautions until patient non-infectious; isolate cases and monitor contacts.

CONSIDERATIONS:

- Risk of importation
- Low-Moderate transmissibility
- High consequence / fatality rate
- Healthcare worker exposure risk

FIFA-WC COUNTRIES: Congo DR

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: AIRBORNE DROPLET CONTACT



EBOLA

Report to Public Health: **Call Immediately**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Direct contact with blood, body fluids or contaminated objects. Initial infection often stems from contact with infected wildlife.

Contagiousness: From symptom onset and entire duration of the illness. Postmortem remains are considered infectious.

Population at risk: Close contacts (e.g., household/caretakers, healthcare providers). Travelers to endemic areas.

Epidemiologic trends: Rare in the US; travel associated. High mortality rate (80-90 %).



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 8-10 days (range 2-21 days). No prodrome.

Rash & clinical course: Early “dry” symptoms include fever, aches, pains, and fatigue, with progression to “wet” symptoms including diarrhea, vomiting, and unexplained bleeding. Risk of transmission is highest during the “wet” stage of the illness.

Complications: Liver damage, kidney damage, shock, and central nervous system complications.



PREVENTION & CONTROL STRATEGIES

Vaccination: ERVEBO® for individuals aged ≥ 2 months (single dose) at potential risk of exposure.

Surveillance & outbreak response: Real-time case reporting; contact tracing with symptom monitoring for high- and intermediate-risk exposures.

Treatment: Two treatments are available to treat Ebola disease (species Orthoebolavirus zairensis only): Inmazeb™ and Ebanga™. Supportive care.

Mitigation: Isolate patient. Implement standard, contact, and droplet precautions.

CONSIDERATIONS:

- Low transmissibility
- Low risk of importation; mainly travelers
- Severe illness / death potential
- Increase in spring and summer months

FIFA-WC COUNTRIES: Global spread

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **STANDARD**



HANTAVIRUS

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Virus spreads primarily via inhalation of aerosols contaminated with infected rodent urine, droppings, or saliva.

Contagiousness: Person-to-person spread is rare.

Population at risk: Mainly environmental exposures (e.g., occupational, household, recreational).

Epidemiologic trends: Different types exist worldwide. In the U.S., types causing hantavirus pulmonary syndrome (HPS) and hemorrhagic fever with renal syndrome (HFRS) are present.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 2-4 weeks (range: 9-33 days); febrile prodrome (3-6 days).

Rash & clinical course: Febrile illness with non-specific signs and symptoms including fever, chills, myalgia, headache, and gastrointestinal symptoms. May progress to an abrupt cardiopulmonary stage, 4-10 days after the initial phase of illness or HFRS within 1-2 weeks after exposure.

Complications: HPS: severe pulmonary disease with rapid progression to pulmonary edema and shock; HFRS: hypotension, renal failure, hemorrhage, shock.



PREVENTION & CONTROL STRATEGIES

Vaccination: No approved vaccines.

Surveillance & outbreak response: Case investigations, lab confirmation, contact tracing, environmental interventions.

Treatment: No specific treatment; supportive care. During cardiopulmonary stage, death may occur within 24-48 hours without adequate treatment.

Mitigation: Vector control, personal protection, and community education. Standard precautions and wet-clean to prevent aerosolization during cleanup.

CONSIDERATIONS:

- Moderate transmissibility
- Food-handler exposures can drive clusters
- Risk of importation and local transmission
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Global spread

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **STANDARD**



HEPATITIS A

Report to Public Health: **Within 1 Workday**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Fecal-oral route: Person to person or through contaminated food or water.

Contagiousness: Highest 1-2 weeks prior to symptom onset. In most cases, people are no longer infectious after the first week of jaundice (if present).

Population at risk: Close contacts, persons who inject drugs, those experiencing homelessness and men who have sex with men (MSM).

Epidemiologic trends: Sporadic outbreaks reported in different countries, including US, with low levels of transmission. Multinational outbreaks among MSM.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 28 days (range 15-50 days). No prodrome; acute onset.

Rash & clinical course: Infection can range from mild illness lasting 1–2 weeks to severely disabling disease lasting several months. Symptoms include abrupt onset of fever, malaise, anorexia, nausea, abdominal discomfort, jaundice, and dark urine. Most symptoms are gone within 2 months (but can last up to 6 months).

Complications: Fulminant hepatitis and liver failure, are rare but more common in older adults and people with underlying liver disease.



PREVENTION & CONTROL STRATEGIES

Vaccination: 2 single-antigen vaccines, Havrix (GlaxoSmithKline) and Vaqta (Merck), for people ≥ 1 year in a 2-dose series. A combined hepatitis A/B vaccine (Twinrix, GlaxoSmithKline) for people ≥ 18 years of age.

Surveillance & outbreak response: Prompt investigation of case reports and identification of close contacts for post-exposure prophylaxis (PEP).

Treatment: No specific treatment; supportive care.

Mitigation: PEP with immune globulin (IG) or vaccine administered within 2 weeks after exposure.

CONSIDERATIONS:

- Low transmissibility
- Risk of importation
- Local transmission; vector presence
- Outdoor exposure and mass gatherings

FIFA-WC COUNTRIES: Argentina, Congo DR, Saudi Arabia

CDC TRAVEL ADVISORY: **LEVEL 1**

- Outbreak in Ethiopia

TRANSMISSION PRECAUTIONS: **STANDARD**



MALARIA

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Bite of infective *Anopheles* mosquito species. Vertical transmission may occur.

Contagiousness: A sick person transmits the parasite to an uninfected mosquito. After incubation, the mosquito transmits it to people in its saliva.

Population at risk: People under 5 years of age, pregnant people, travelers to endemic regions, and people with HIV or AIDs.

Epidemiologic trends: Endemic in many parts of the world. Most cases are caused by *P. falciparum*. Cases in the US are usually travel related.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: typically, 1–4 weeks or as late as a year or more. No prodrome.

Clinical course: Illness ranges from mild to life threatening; symptoms often begin mildly and include fever, headache, vomiting, shaking chills, and other flu-like symptoms. Untreated, it can lead to jaundice, anemia, organ failure, and death.

Complications: Anemia, jaundice, kidney failure, seizures, circulatory collapse/shock, pulmonary edema, acute respiratory distress, acidosis, mental confusion, coma, and death.



PREVENTION & CONTROL STRATEGIES

Vaccination: No FDA approved vaccines in the US.

Surveillance & outbreak response: Case and mosquito surveillance. Case investigations to determine if they are travel-associated or locally acquired to help guide response activities.

Treatment: Antimalarials; the treatment regimen depends on infecting plasmodium species, patient's clinical status, drug-resistance status, and previous use of antimalarials.

Mitigation: Chemoprophylaxis before travel, vector control and personal protection (bite prevention).

CONSIDERATIONS:

- Highly contagious
- Potential vaccination gaps
- Risk of importation and local transmission
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Global spread

CDC TRAVEL ADVISORY: **LEVEL 1**

TRANSMISSION PRECAUTIONS: **AIRBORNE**



MEASLES

Report to Public Health: **Call Immediately**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Inhalation of infectious droplets or contact with contaminated surfaces; virus can remain viable airborne for about 2 hours.

Contagiousness: 4 days before and after rash onset. Attack rates: >90% among susceptible close contacts. Ro: 12-18. Herd immunity requires >95%.

Population at risk: Infants <1 year, under or unvaccinated individuals, those with primary vaccine failure, and travelers to endemic regions.

Epidemiologic trends: Resurgences are ongoing due to waning immunity. Cases continue to rise globally.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 10–14 days post-exposure. Prodromal period lasts 4–7 days, with fever, cough, coryza, conjunctivitis, and Koplik spots.

Rash & clinical course: Rash appears 7–18 days after exposure, starting on face/neck and spreading downward, persisting for about 5–6 days.

Complications: Include ear infections, diarrhea with dehydration, pneumonia, blindness, and encephalitis. Particularly severe in children <5 and adults >30, pregnant women and people with compromised immune systems.



PREVENTION & CONTROL STRATEGIES

Vaccination: Two-dose MMR (measles-mumps-rubella) vaccination provides about 97% protection.

Surveillance & outbreak response: Real-time case reporting; contact tracing with symptom monitoring for high- and intermediate-risk exposures.

Treatment: No specific treatment; supportive care.

Mitigation: Isolation of infectious individuals. MMR vaccine within 72 hours or immunoglobulin for high-risk contacts. Patient placement: airborne infection isolation room (AIIR). Adhere to standard / airborne precautions.

CONSIDERATIONS:

- Low-Moderate transmissibility
- Risk of importation
- Local transmission group settings
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Congo DR, Germany, Netherlands, Portugal, Saudi Arabia, US

CDC TRAVEL ADVISORY: LEVEL 2

- Meningococcal Disease in the DR of Congo

TRANSMISSION PRECAUTIONS: DROPLET



MENINGOCOCCAL DISEASE

Report to Public Health: **Call Immediately**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Bacteria spread via respiratory / throat secretions; requires close lengthy contact.

Contagiousness: 7-10 days before symptom onset until 24 hours after treatment. Asymptomatic transmission may occur.

Population at risk: Infants <1 year; adolescents/young adults (16–23 years), e.g., college students and military recruits; older adults (≥65 years); household members.

Epidemiologic trends: US cases have increased since 2021, driven largely by serogroup Y.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: 3–4 days (range from 1–10 days). No prodrome; infants may show buccal signs, irritability, poor feeding, and bulging fontanelle.

Rash & clinical course: Meningitis: sudden onset of fever, headache and stiff neck, usually with nausea, vomiting, photophobia or altered mental status. Less likely: pneumonia, arthritis, otitis media, epiglottitis.

Complications: Meningococemia, characterized by abrupt onset of fever and a petechial or purpuric rash, often associated with hypotension, shock, acute adrenal hemorrhage and multiple organ failure.



PREVENTION & CONTROL STRATEGIES

Vaccination: MenACWY vaccines ((Menveo® and MenQuadfi®); MenB vaccines (Bexsero® and Trumenba®); MenABCWY vaccines (Penbraya™).

Surveillance & outbreak response: Real-time case reporting; contact tracing with symptom monitoring for high- and intermediate-risk exposures.

Treatment: Antibiotics (such as ceftriaxone, cefotaxime, penicillin) drops infectivity rapidly.

Mitigation: Isolation of infectious individuals. Chemoprophylaxis for close contacts. Standard and droplet precautions with thorough disinfection.

CONSIDERATIONS:

- Moderate transmissibility (sexual)
- Risk of importation (Clade I)
- Local transmission; network dependent
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Argentina, Congo DR, Germany, Netherlands, Portugal, Spain, Ghana, Japan, US

CDC TRAVEL ADVISORY: LEVEL 2

- Clade II in Ghana and Liberia

TRANSMISSION PRECAUTIONS: CONTACT



Monkeypox/MPOX

Report to Public Health: **Within 1 Workday**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Contact with lesions or fluids, prolonged respiratory exposure, contaminated objects, zoonotic contact and perinatal transmission.

Contagiousness: Until all scabs have shed and new skin has formed. Presymptomatic spread can occur.

Population at risk: Close contacts to infected persons or animals, and men who have sex with men.

Epidemiologic trends: Low-level ongoing Clade II transmission, with occasional Clade I cases (travel or community-linked). Spread predominantly human-to-human; with sexual contact as the main route.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 3–17 days (up to 21 days). Prodrome: fever, malaise, headache, myalgia, sore throat, lymphadenopathy, for 1–3 days.

Rash & clinical course: Rash: 1-4 days after prodrome, painful lesions that progress over about 2-4 weeks. Generalized lesions but often concentrate in the anogenital area in recent outbreaks.

Complications: Secondary bacterial infections, sepsis, pneumonia, proctitis, myocarditis, ocular, neurologic, gastrointestinal issues. Severity associated with new / uncontrolled HIV infections.



PREVENTION & CONTROL STRATEGIES

Vaccination: JYNNEOS 2-dose or ACAM2000 1-dose. JYNNEOS effectiveness: one dose ≈36%, two doses ≈66% protection against medically attended mpox.

Surveillance & outbreak response: Real-time case reporting; contact tracing with symptom monitoring for high- and intermediate-risk exposures.

Treatment: Clinical management is supportive, with tecovirimat considered for severe or high-risk cases.

Mitigation: Isolation of infectious individuals. Vaccine for pre- and post-exposure. Standard and contact precautions with thorough disinfection.

CONSIDERATIONS:

- Highly contagious
- Potential vaccination gaps
- Risk of importation and local transmission
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Congo DR, Germany, Netherlands, US

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **DROPLET**



PERTUSSIS

Report to Public Health: **Within 1 Workday**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Person to person through direct contact with respiratory secretions.

Contagiousness: From onset of cold-like symptoms until 5 days after starting antibiotics or 21 days after cough onset without treatment.

Population at risk: Babies less than 1 year old are at greatest risk for getting whooping cough and having severe complications, including death.

Epidemiologic trends: Pertussis (whooping cough) is common in the United States, with increases in the number of cases usually occurring every few years.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: average of 7-10 days (range 4-21 days). Catarrhal stage: runny nose, sneezing, mild fever, and a slight cough that worsens over 1-2 weeks.

Rash & clinical course: Paroxysmal stage: coughing fits (paroxysms) that may cause a whoop, apnea, or vomiting (1-6 weeks). Convalescent stage: coughing gradually improves, may persist for weeks to months.

Complications: In infants, symptoms can include apnea, pneumonia, pulmonary hypertension, seizures, and encephalopathy.



PREVENTION & CONTROL STRATEGIES

Vaccination: DTaP and Tdap.

Surveillance & outbreak response: Prompt investigation of case reports and identification and evaluation of close contacts.

Treatment: Antibiotics within the first 1-2 weeks, before coughing paroxysms occur is most effective. Macrolides (i.e., azithromycin B, clarithromycin, and erythromycin); Trimethoprim-sulfamethoxazole.

Mitigation: Isolation of infectious individuals. Chemoprophylaxis for close contacts. Standard and droplet precautions with thorough disinfection.

CONSIDERATIONS:

- Highly contagious
- Potential vaccination gaps
- Risk of importation and local transmission
- International travelers should be vaccinated

FIFA-WC COUNTRIES: Global spread

CDC TRAVEL ADVISORY: LEVEL 2

TRANSMISSION PRECAUTIONS: CONTACT



POLIO

Report to Public Health: **Within 1 Workday**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Fecal-oral / oral routes (via water, food, surfaces, or respiratory droplets).

Contagiousness: Spread can occur immediately before and up to 2 weeks after symptoms appear. Asymptomatic transmission can occur.

Population at risk: Household contacts. Mainly affects children <5 years.

Epidemiologic trends: Wild poliovirus has been eliminated in many countries, including the US, but still circulates in some countries, where infections are most common during summer and autumn.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 7-14 days for paralytic cases (range of up to 35 days).

Rash & clinical course: Symptomatic infections may present with flu-like symptoms that can include sore throat, fever, tiredness, headache, or gastrointestinal symptoms; usually lasting 2 to 5 days.

Complications: Aseptic meningitis or acute asymmetric flaccid paralysis. Respiratory compromise due to diaphragmatic or bulbar paralysis. Permanent paralysis, deformities, post-polio syndrome later in life.



PREVENTION & CONTROL STRATEGIES

Vaccination: Inactivated Polio Vaccine (IPV): U.S. standard. Oral Polio Vaccine (OPV): Used globally.

Surveillance & outbreak response: Prompt investigation of case reports and identification of close contacts for vaccination status.

Treatment: No specific treatment; supportive care.

Mitigation: Enteric precautions: isolate cases for ~6 weeks or until two consecutive negative stool poliovirus tests. Standard and contact precautions.

CONSIDERATIONS:

- Low–Moderate transmissibility
- Local transmission; network dependent
- Food-handler exposures can drive clusters
- Resistance complicates therapy

FIFA-WC COUNTRIES: Cape Verde, Germany, Netherlands, US

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **STANDARD**



SHIGELLA

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Direct / indirect fecal–oral or sexual (oral–anal) contact. Asymptomatic transmission can occur (carriers).

Contagiousness: While bacteria are shed in stool. Shedding may last 1–4 weeks after onset of illness.

Population at risk: Household contacts, children <5 years, travelers, those experiencing homelessness, and men who have sex with men (MSM).

Epidemiologic trends: Clusters of multidrug resistant (MDR) among MSM have been reported. In the US, MDR infections have been rising since 2016.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Usually 1–3 days (ranges 12 to 96 hours). No prodrome.

Rash & clinical course: Acute onset of diarrhea, moderate–high fever, abdominal pain, cramping, nausea, and tenesmus. Usually, symptoms resolve within 7 days without treatment. Diarrhea is often watery but may contain blood and mucus.

Complications: Pseudomembranous colitis, toxic megacolon, intestinal perforation, hemolysis, and hemolytic uremic syndrome. Infections can be severe, particularly in young children and the elderly.



PREVENTION & CONTROL STRATEGIES

Vaccination: No vaccine available.

Surveillance & outbreak response: Prompt investigation to identify to identify potential sources of infection.

Treatment: Antibiotics may be prescribed but susceptibility test may be needed to determine resistance.

Mitigation: Exclusion or isolation of symptomatic individuals. Use contact precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.

CONSIDERATIONS:

- Low–Moderate transmissibility
- Prolonged indoor exposure risk
- Multi / Extensively drug-resistant
- Resistance complicates therapy

FIFA-WC COUNTRIES: Global spread

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: AIRBORNE+CONTACT



TUBERCULOSIS

Report to Public Health: **Within 1 Workday**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Person to person through airborne droplets (can stay in the air several hours).

Contagiousness: Correlates with bacillary load and lung involvement. Effective treatment reduces contagiousness (2–3 weeks).

Population at risk: Close contacts, individuals in high-risk settings (shelters, prisons, healthcare), travelers to / residents of high-burden countries.

Epidemiologic trends: Worldwide endemicity but with wide variations by region and social context. Drug-resistant tuberculosis (TB) is an increasing concern.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 2-10 weeks, but time from infection to active disease can range from months to years (highest risk <2 years). Prodrome: fatigue, low-grade fever, night sweats, weight loss.

Rash & clinical course: Pulmonary: persistent cough (≥ 3 weeks), hemoptysis, chest pain. Extrapulmonary: may involve lymphadenopathy, spinal pain, renal or meningeal symptoms depending on site.

Complications: Respiratory failure, hemoptysis, meningitis, miliary TB, osteoarticular, or genitourinary involvement.



PREVENTION & CONTROL STRATEGIES

Vaccination: None currently available in the US.

Surveillance & outbreak response: Prompt investigation and contact tracing, screening of high-risk groups, treatment of latent TB.

Treatment: Drug-susceptible TB: four-drug regimen (rifampin, isoniazid, pyrazinamide, ethambutol) for 4 months (short-course) or 6 months standard.

Mitigation: Rapid detection and isolation, environmental controls, and personal protective equipment (N95 respirators). Follow airborne, contact and standard precautions.

CONSIDERATIONS:

- Risk of importation and local transmission
- Food- and water-borne transmission
- Shared environment exposures
- Increasing global antimicrobial resistance

FIFA-WC COUNTRIES: Argentina, Cape Verde, Congo DR, Curacao, Jordan, Saudi Arabia, Uzbekistan

CDC TRAVEL ADVISORY: **LEVEL 1**

- Outbreak of (XDR) typhoid fever in Pakistan

TRANSMISSION PRECAUTIONS: **STANDARD**



TYPHOID FEVER

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Fecal–oral transmission (food / water). Asymptomatic transmission can occur.

Contagiousness: Infectivity begins during late incubation and continues through acute illness; untreated individuals may shed for weeks.

Population at risk: Close contacts, travelers to endemic countries and those consuming high-risk foods (raw produce, unsafe water).

Epidemiologic trends: Sporadic travel-associated cases in the U.S.; local transmission is rare. Global increase in multi/extensively drug-resistant strains.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Usually 6–30 days; Gradual onset of fever, malaise, diffuse abdominal discomfort, headache, myalgias, and anorexia.

Rash & clinical course: Fever progression over several days to >102–104°F (39–40°C). Abdominal pain, constipation or diarrhea (children). Relative bradycardia and “Rose spots” may occur.

Complications: Intestinal hemorrhage or perforation, encephalopathy, hepatitis, cholecystitis, myocarditis, or sepsis. Chronic carriage, with persistence in the hepatobiliary system.



PREVENTION & CONTROL STRATEGIES

Vaccination: Vi capsular polysaccharide vaccine (ViCPS) (Typhim Vi) for intramuscular use; and live attenuated vaccine (Vivotif) for oral use.

Surveillance & outbreak response: Prompt case investigation and identification of close contacts.

Treatment: Antibiotic therapy tailored to susceptibility patterns, commonly azithromycin, ceftriaxone, or carbapenems for XDR strains.

Mitigation: For diapered or incontinent persons, use contact precautions, for the duration of illness or to control institutional outbreaks.

CONSIDERATIONS:

- Low-Moderate transmissibility
- High severity requiring immediate response
- Including Crimean-Congo, Lassa, Lujo, Marburg, and New World Arenaviruses

FIFA-WC COUNTRIES: Congo DR, Croatia, Portugal, Saudi Arabi, Uzbekistan

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: AIRBORNE DROPLET CONTACT



VIRAL HEMORRHAGIC FEVER

Report to Public Health: **Call Immediately**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Infected animals (Rodents, livestock) or arthropod (ticks, mosquitoes). Human-to-human, and laboratory exposures.

Contagiousness: Variable. Depends on the pathogen and illness stage. Direct contact with infectious body fluids. No airborne spread known at this time.

Population at risk: Travelers to endemic areas. Direct contacts of a confirmed cases. Laboratory personal.

Epidemiologic trends: Highly unlikely in U.S. but frequently outside of the U.S. Traveler monitoring recommended for 21 days after exposure risk travel.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Depends on the pathogen.

Rash & clinical course: Fever, severe headache, muscle pain, vomiting, diarrhea, abdominal pain, pharyngitis, chest pain, proteinuria (high protein urine). Maculopapular rash on trunk of body. Fine desquamation (peeling skin) 3-4 days after rash onset.

Complications: Hemorrhage, shock, multi-organ failure, high case fatality depending on etiology.



PREVENTION & CONTROL STRATEGIES

Vaccination: No universal vaccine available.

Surveillance & outbreak response: Real-time case reporting; contact tracing with symptom monitoring for high- and intermediate-risk exposures.

Treatment: No specific treatment; supportive care.

Mitigation: Isolate patient. Implement standard, contact, and droplet precautions.

CONSIDERATIONS:

- Low transmissibility
- Risk of importation
- Local transmission; vector presence
- Outdoor exposure and mass gatherings

FIFA-WC COUNTRIES: Global spread

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **STANDARD**



WEST NILE VIRUS

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Bite of infected *Culex* species mosquitoes. Vertical transmission may occur. Laboratory exposures and blood/organ recipients.

Contagiousness: Uninfected mosquitoes feed on infected birds. After incubation in mosquito, an infected mosquito may transmit the virus to humans.

Population at risk: People in endemic areas, especially outdoor workers.

Epidemiologic trends: Leading cause of mosquito-borne disease in the contiguous US. Transmission is highest in summer and early fall (94%).



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 2-6 days (range: 2-14 days). No prodromal stage. An estimated 80% of human infections are subclinical or asymptomatic.

Rash & clinical course: Non-neuroinvasive disease: fever, fatigue, headache, myalgia, arthralgia, transient maculopapular rash, or GI symptoms.

Complications: Neuroinvasive disease: meningitis, encephalitis, or acute flaccid myelitis. Risk is higher among older and immunocompromised individuals.



PREVENTION & CONTROL STRATEGIES

Vaccination: No vaccine available.

Surveillance & outbreak response: Case and mosquito surveillance. Case investigations to determine if they are travel-associated or locally acquired to help guide response activities.

Treatment: No specific treatment; supportive care.

Mitigation: Vector control, personal protection (bite prevention), and community awareness.

CONSIDERATIONS:

- Low-Moderate transmissibility
- Risk of importation
- Local transmission; vector presence
- Outdoor exposure and mass gatherings

FIFA-WC COUNTRIES: Argentina, Cape Verde, Curacao, Portugal

CDC TRAVEL ADVISORY: None currently

TRANSMISSION PRECAUTIONS: **STANDARD**



ZIKA

Report to Public Health: **Within 1 Week**

Report confirmed and suspected cases to the Houston Health Department at (832) 393-5080, Harris County Public Health at (832) 927-7575 or (713) 755-5050 or contact your local health department.



TRANSMISSION & EPIDEMIOLOGIC PATTERNS

Mode of transmission: Bite of infected Aedes species mosquitoes. Vertical /sexual transmission may occur.

Contagiousness: A sick person transmits the virus to an uninfected mosquito (highest risk in the first week). After incubation in mosquito (1-2 weeks), an infected mosquito transmits the virus to humans.

Population at risk: Pregnant people; infection increases risk for birth defects and miscarriage.

Epidemiologic trends: Endemic in many countries, with sporadic outbreaks. Limited local transmission have occurred in the US, including Texas.



CLINICAL PRESENTATION & COMPLICATIONS

Incubation & prodrome: Incubation: 3 to 14 days. No prodromal stage.

Rash & clinical course: Most infections are asymptomatic or result in mild illness with fever (acute onset), rash (maculopapular), conjunctivitis, muscle /joint pain, malaise and headache (2–7 days).

Complications: Congenital Zika Syndrome (microcephaly, limb contractures, high muscle tone, eye abnormalities and hearing loss), pregnancy complications (fetal loss, stillbirth and preterm birth), Guillain-Barré Syndrome, Neuropathy, Myelitis.



PREVENTION & CONTROL STRATEGIES

Vaccination: No vaccine available.

Surveillance & outbreak response: Case and mosquito surveillance. Case investigations to determine if they are travel-associated or locally acquired to help guide response activities.

Treatment: No specific treatment; supportive care.

Mitigation: Vector control, personal protection (including safe sex practices to reduce sexual transmission), and community awareness.

CDC Travel Health Notices



CDC uses Travel Health Notices to inform travelers about global health risks during outbreaks, special events or gatherings, and natural disasters, and to provide advice about protective actions travelers can take to prevent infection or adverse health effects.

Level 4: Avoid all travel

Avoid travel to this destination unless traveling for humanitarian aid or emergency response; there is an extreme health risk for travelers and no available precautions.

Level 3: Reconsider nonessential travel

Reconsider nonessential travel to this destination. The outbreak or event poses risk to travelers because limited precautions are available.

Level 2: Practice enhanced precautions

Practice enhanced precautions for this destination. The Travel Health Notice describes additional precautions or defines a specific population at risk.

Level 1: Practice usual precautions

Practice usual precautions for this destination, as described in the Travel Health Notice and/or on the [destination page](#).

Why to report?



Who do I call to report a disease of concern?

Health care providers can report by calling the public health agency or local health department in their jurisdiction. See *Reporting Contacts* table for a list of public health jurisdictions in the greater Houston area.

Why report to public health authorities?

Reporting helps health departments take key actions, such as facilitating non-commercial testing, providing post-exposure prophylaxis (PEP), conducting contact tracing, and other important actions to protect the community and limit disease spread.

Suspected and confirmed cases of notifiable conditions in Texas should be reported to public health agencies, as set out in the Texas [Health & Safety Code, Chapters 81, 84, and 87](#) and [Chapter 97, Title 25, Texas Administrative Code](#).

The list of notifiable conditions is set by the Texas Department of State Health Services and can be accessed directly [here](#). In addition, any outbreaks, exotic or newly recognized diseases, or unusual group expressions of disease should be reported to public health agencies. The condition you are managing may pose a significant risk to the community.

Where should I call to report a suspected or confirmed case?

Report to the corresponding public health jurisdiction, based on the patient's address or hospital location. For Houston Health Department you can call 832-393-5080 and select the option for the epidemiologist on call. For Harris County you can call (713) 439-6000 or (713) 755-5050. However, there is no wrong entry in public health; we will help you get there. Public health works together!

What if I can't reach the health department?

If you are unable to connect with a live person, we may be responding to another report; leave your name, contact information, and the reason for your call and someone will reach back out to you. Do not put protected health information in a voicemail.

Do we need to have a final lab result to report?

No. Report when there's suspicion or differential diagnosis (e.g., measles, meningococcal disease, etc.) for immediate public health action. This includes reporting before receipt of lab results or confirmation of diagnosis.

What information do we need to report to the health department?

At minimum report on patient demographics (e.g., name, date of birth, sex, race, ethnicity, phone number and residential address), medical records number, language of preference, travel history, vaccine history. Additional information may be required for public health action. As a trusted partner, let the patient or patient family know that local health authorities may be reaching out for follow up.

How does it work?



PUBLIC HEALTH AND CLINICIANS Partners for Healthier People and Communities



Different roles. Shared goals. Better health for all.

Public Health Reporting Contacts



Public Health Jurisdiction	Telephone	After Hours	Fax	Website
Houston Health Department (HHD)	(832) 393-5080	(832) 393-5080	(832) 393-5232	www.houstontx.gov/health/index.html
Harris County Public Health (HCPH)	(832) 927-7575	(713) 755-5050	(713) 439-6306	http://publichealth.harriscountytexas.gov/
Brazoria County Health Department	(979) 864-1166	(979) 583-1979	(979) 864-3694	https://www.brazoriacountytx.gov/departments/health-department/infectious-diseases
Chambers County Health Department	(409) 267-2731	(409) 267-9862	(409) 267-4276	www.ccph.org
Fort Bend County Health and Human Services	(346) 481-6500	(832)-612-7761	(832) 471-1817	https://www.fbchhs.org/
Galveston County Health District	(409) 938-2208	(409) 220-1523	(409) 938-2399	www.gchd.org
Montgomery County Public Health Department	(936) 523-5026	(888) 825-9754	(936) 539-9272	https://mcphd-tx.org
Texas Department of State Health Services (Region 6/5 South)	(713) 767-3000	(800) 270-3128	(713) 767-3006	www.dshs.state.tx.us/region6-5/default.shtm

HHD / HCPH Resources



HHD FIFA World Cup 2026
Webpage

[fifa26 | Houston Health
Department](#)

Houston Area Health Alert
Network (HAN)

Scan QR Code to subscribe



Additional Resources



<https://www.dshs.texas.gov/diseases-conditions>

<https://www.dshs.texas.gov/notifiable-conditions>

<https://www.houstonhealth.org/services/data-reporting/disease-reporting>

<https://www.cdc.gov/yellow-book/hcp/travel-associated-infections-diseases/index.html>

<https://www.cdc.gov/surv-manual/site.html#php>

<https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html>

<https://wwwnc.cdc.gov/travel>

<https://wwwnc.cdc.gov/travel/notices>

<https://wwwnc.cdc.gov/travel/destinations/list>

<https://www.cdc.gov/yellow-book/hcp/preparing-international-travelers/travel-medicine-resources-for-healthcare-professionals.html>

<https://travel.state.gov/en/international-travel/travel-advisories.html>