An urgent opportunity to ensure children's access to oral post-exposure prophylaxis trials for Bundibugyo virus disease

Lancet Child Adolesc Health 2026
Published Online
August 31, 2026
https://doi.org/10.1016/S2352-4642(26)00238-5

Children and pregnant women are known to be at high risk of death from Ebola virus disease.[1,2] In the current outbreak of Bundibugyo virus in the Democratic Republic of the Congo, the inequality in outcomes is particularly stark for children. As of Aug 4, 2026, of 1124 deaths among people with confirmed cases of Bundibugyo virus for whom age is reported, almost a third (357, 31·8%) were in children. The crude case fatality ratio (albeit likely underestimated) reached 61·7% (213 of 345 children) in those younger than 5 years compared with 28·9% (767 of 2654 adults) in adults, whereas data on pregnancy outcomes are not systematically reported.[3]

Extrapolating from Ebola virus disease outbreaks, household secondary attack rates after close contact with a primary case of Ebola might be high among young children and women of reproductive age (46% in children younger than 2 years and >50% in women older than 20 years).[4] Nevertheless, children and people who are pregnant or breastfeeding have often been excluded from early-phase trials of medical countermeasures such as vaccines, delaying access to potentially lifesaving preventive interventions. Therefore, these are the populations for whom evidence of effective, practical, and timely post-exposure prophylaxis (PEP) is urgently needed.

The EBO–PEP study,[5] which began on July 14, 2026, compares 10 days of daily oral obeldesivir with placebo as PEP in high-risk contacts of Bundibugyo virus, after a WHO-led expert consensus prioritised this antiviral on the basis of efficacy in non-human primates against Sudan virus and Marburg virus.[6] Currently, children weighing less than 30 kg (approximately those younger than 12 years) and people who are pregnant or breastfeeding are excluded from the study because of the lack of an available paediatric formulation, absence of published data supporting crushing or dissolution of adult tablets, and data on teratogenicity being unpublished. However, an opportunity to include children might exist because a paediatric obeldesivir formulation and dosing guidance, including for newborns, have been provided for previous studies on SARS-CoV-2 (NCT05996744) and respiratory syncytial virus (NCT06784973). Moreover, although safety might not be entirely equivalent, obeldesivir is a prodrug of the same active molecule (GS-441524) as remdesivir, for which paediatric safety data and US Food and Drug Administration approval extend to children and neonates weighing at least 1·5 kg, and for which benefit–risk recommendations already exist for treatment of SARS-CoV-2 infection in people who are pregnant or breastfeeding.[7]

In EBO-PEP, children and people who are pregnant or breastfeeding who would otherwise be eligible for the study are excluded from the primary randomisation and instead offered 10 days of intravenous remdesivir under a monitored compassionate-use subprotocol. The intention to offer PEP to excluded participants is commendable; nevertheless, this approach presents substantial implementation challenges, especially beyond a trial setting. Establishing and maintaining intravenous access for large numbers of non-hospitalised contacts for 10 consecutive days, particularly in young children, might exceed operational and human resource capacity in many outbreak contexts.[8] Ultimately, although it is currently the only available option, continued reliance on intravenous remdesivir alone without a clear pathway for inclusion in oral options might risk excluding many children and people who are pregnant or breastfeeding from both access to PEP options and participation in evidence generation.

Urgent actions are required from stakeholders supporting the development of preventive medical countermeasures. Gilead Sciences, the manufacturer of obeldesivir, has expressed willingness to reproduce its paediatric formulation. In the interim, pharmacokinetic studies on split, crushed, or dissolved adult tablets could be explored as a bridging option, although this option has its own challenges. Given the availability of paediatric dosing guidance in previous phase 2/3 trials, inclusion of children in a paediatric obeldesivir substudy should be feasible and urgently explored by sponsors and supported by donors. Unpublished data should also be made available to pregnant women and their clinicians to inform shared decision making about

the risks of Bundibugyo virus, fetal loss associated with Bundibugyo virus, and potential teratogenicity.[9] Alternative oral antivirals should be urgently explored through WHO-led Bundibugyo virus prioritisation processes[6] to ensure access for these groups.

In parallel, children and people who are pregnant or breastfeeding could be prioritised for access to monoclonal antibodies as PEP because they face higher mortality risk while remaining excluded from studies of alternatives. Monoclonal antibodies also offer the advantage of single-dose administration in outpatient populations, although access is currently a major challenge. MBP134 is a potential pan-ebolavirus therapeutic currently being assessed in the PARTNERS trial (ISRCTN30355388) for treatment of Bundibugyo virus, which includes children and pregnant women. In addition, maftivimab, the most potent neutralising component of REGN-EB3 (Inmazeb), which is already approved for PEP in newborns of mothers with confirmed Ebola virus disease, has shown broad in-vitro activity against Ebola virus, Sudan virus, and Bundibugyo virus.[6] Both MBP134 and maftivimab should be rapidly evaluated for their potential use as PEP for high-risk contacts, ideally within a framework capable of generating robust effectiveness evidence. Sponsors, regulators, and ethics committees should likewise support earlier inclusion of children and pregnant women in vaccine studies.

Delayed inclusion in trials, absence of paediatric dosing guidance, and safety concerns are familiar barriers to access to medical countermeasures for children and people who are pregnant or breastfeeding. However, exclusion is not always the cautious choice, nor is it a neutral one. In the context of one of the world's deadliest infectious diseases, the question is not only whether it is ethical to include children and people who are pregnant or breastfeeding in research, but also whether it is ethical to exclude them. With urgent action and investment, we can do better.

PR and TRC declare funding from Gilead Sciences for a pediatric trial of remdesivir for respiratory syncytial virus treatment performed in Thailand in 2026. All other authors declare no competing interests. We thank Dr Armand Sprecher for expert technical feedback.

Neal Russell, Johanna Thomson, Matthew E Coldiron, Temmy Sunyoto, Tim R Cressey, Ali Judd, Pablo Rojo, Monica Rull, Daniela Garone, Bern-Thomas Nyang'wa
neal.russell@london.msf.org

Médecins Sans Frontières UK, London E1 8PR, UK (NR, MEC); Médecins Sans Frontières International, Paris, France (JT); LuxOR, Médecins Sans Frontières, Brussels, Belgium (TS); AMS-PHPT Research Collaboration, Faculty of Associated Medical Sciences, Chiang Mai University, Chiang Mai, Thailand (TRC); Penta Foundation, Padua, Italy (AJ); University College London, London, UK (AJ); Universidad Complutense de Madrid, Madrid, Spain (PR); Pediatric Infectious Diseases, Hospital Universitario 12 de Octubre, Madrid, Spain (PR); Innovation in Pediatric Global Infectious Diseases, Instituto de Investigación Hospital 12 de Octubre, Madrid, Spain (PR); Pediatric Clinical Trials Unit, Fundación para la Investigación Biomédica del Hospital 12 de Octubre, Madrid, Spain (PR); MSF Access, Médecins Sans Frontières, Geneva, Switzerland (MR); Médecins Sans Frontières International, Geneva, Switzerland (DG); Médecins Sans Frontières, Amsterdam, Netherlands (B-TN)

1 Kayem ND, Benson C, Aye CYL, et al. Ebola virus disease in pregnancy: a systematic review and meta-analysis. *Trans R Soc Trop Med Hyg* 2022; **116:** 509–22.
2 Dobbs KR, Lobb A, Dent AE. Ebola virus disease in children: epidemiology, pathogenesis, management, and prevention. *Pediatr Res* 2024; **95:** 488–95.
3 Institut National de Santé Publique. SitRep N°082/MVE B_04/08/2026. Institut National de Santé Publique. Aug 4, 2026. https://insp.cd/sitrep-n082-mve-b_04-08-2026/ (accessed Aug 6, 2026).
4 Bower H, Johnson S, Bangura MS, et al. Exposure-specific and age-specific attack rates for Ebola virus disease in Ebola-affected households, Sierra Leone. *Emerg Infect Dis* 2016; **22:** 1403–11.
5 ANRS Maladies infectieuses émergentes. The EBO-PEP project: a new strategy to prevent filovirus disease among high-risk contacts. ANRS Maladies infectieuses émergentes. July 3, 2036. https://anrs.fr/en/scientific-research/research-projects/the-ebo-pep-project-a-new-strategy-to-prevent-filovirus-disease-among-high-risk-contacts/ (accessed July 4, 2026).
6 WHO. WHO Technical Advisory Group on therapeutics prioritization for Bundibugyo virus disease: meeting report, 20 and 26 May 2026. World Health Organisation. May 28, 2026. https://www.who.int/publications/i/item/B09767 (accessed July 4, 2026).
7 US Centers for Disease Control and Prevention. Clinical considerations for special populations US Centres for Disease Control and Prevention. Feb 5, 2026. https://www.cdc.gov/covid/hcp/clinical-care/considerations-special-groups.html (accessed Aug 6, 2026).
8 Hoffmann Dahl E, Mbala P, Juchet S, et al. Improving Ebola virus disease outbreak control through targeted post-exposure prophylaxis. *Lancet Glob Health* 2024; **12:** e1730–36.
9 Schwartz L, Ahmed E, Palmero A, Ho CWL, Ravinetto R. Pregnancy as exclusion criterion in Ebola research: not again. *Lancet* 2026; **408:** 319–20.