This is an informal compilation of HIFA messages exchanged up to 9 July 2026. For background on the project, see: www.hifa.org/gbs

CHIFA Spotlight: Group B Strep

Participants
Azanaw Muche, Ethiopia 1
Claire Oluwalana, Gambia 1
Dura Schlei, United States 1
Edamisan Ikuemonisan, Nigeria 1
Hajime Takeuuche, Japan 2
Julie Nyanchama Nyamao, Kenya 1
Katy Butler, United States 1
Kelli Smith, United States 5
Marti Perhach, United States 23
Mucheye Gizachew Beza, Ethiopia 4
Nehemiah Ndubi Okerio, Kenya 1
Neil PW (facilitator) 23
Rabia Khaji, Tanzania 1
Stephanie Lyons, UK 1

66 messages from 14 participants in Ethiopia, Gambia, Japan, Kenya, Nigeria, Tanzania, Uganda, United Kingdom, United States

Message 1: Announcement - Please distribute widely: CHIFA and HIFA Spotlight on Group B Streptococcus, 8-14 July 2026

24 June, 2026

Dear CHIFA colleagues,

A few weeks ago our sister forum HIFA (general health) announced a new service called HIFA Spotlights. We can now confirm our first Spotlight will be on Group B Streptococcus, a leading cause of serious infection in babies. As this is child health specific, the main discussion will be here on the CHIFA forum!

BELOW is all the information you need, or you can read online here:

https://www.hifa.org/news/chifa-and-hifa-spotlight-group-b-strep-8-14-ju...

If you are willing, PLEASE forward this message to any contacts and groups who may be interested, and encourage them to join CHIFA: www.hifa.org/joinchifa

We look forward to lively interaction worldwide on this important topic.

Many thanks and best wishes,

Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

HIFA Spotlight on Group B Strep, 8-14 July 2026

24 June, 2026

https://www.hifa.org/news/chifa-and-hifa-spotlight-group-b-strep-8-14-ju...

HIFA and CHIFA are delighted to announce our first Spotlight! We start with the topic of Group B Streptococcus, coinciding with Group B Strep Awareness Week (8–14 July 2026). The main discussion will take place on our global child health forum CHIFA. We shall also have discussion on our general forum HIFA-English. Join CHIFA (free!)

Group B Strep

Group B Strep (GBS) is a leading cause of serious infection in babies, causing 150,000 stillbirths and infant deaths each year. Many survivors have long-term disability.

'According to the WHO 2024 guideline, pregnant women should be offered universal antenatal screening for Group B Streptococcus around 35–37 weeks' gestation. WHO also recommends a risk-based alternative in settings where universal screening is not feasible. Those who test positive should receive intravenous antibiotics, such as penicillin or ampicillin, at least four hours before delivery to prevent passing GBS to their baby. This approach reduces the risk of newborn early-onset disease risk by about 80%.' WHO Fact Sheet

Empowering parents, health workers and policymakers to save lives and reduce suffering

All parents and all health workers need access to reliable healthcare information on how to prevent GBS disease and how to diagnose and treat the infection. All policymakers and public health professionals need accurate information to inform national screening policy.

Our discussion will look at:

1. What is your personal and professional experience of GBS disease? We would especially like to hear from you if, like Marti, Kelli and Kevin, your life has been impacted by GBS disease. Also we would like to hear your professional experience as a health worker, for example if you have been involved in the care of a mother and baby affected by GBS disease.

2. What is the situation in your country? Worldwide, GBS disease causes around 150,000 stillbirths and early infant deaths. The incidence is higher in North America, Europe, and Africa than in other regions. Some cases may not be recognised, especially in LMICs.

3. What can be done to reduce the burden of GBS disease? (with reference to the WHO guideline 2024)? In particular the guideline recommends universal screening of mothers at 35-37 weeks, but this is currently only a vailable in a few countries (eg US, Canada). What can be done to support countries to implement universal screening?

4. What do parents need to know about GBS disease? In your country? What do they know and how can this be improved?

5. What do health workers need to know about GBS disease? In your country? What do they know and how can this be improved?

6. What are the common myths about GBS disease? How can these be addressed?

We are grateful to Kelli and Kevin Smith who have kindly sponsored this Spotlight in honour of their daughter Finley Genevieve, facilitated by HIFA partner Group B Strep International.

Contact: Neil Pakenham-Walsh neil@hifa.org

See here for more information on Spotlights and how to propose your priority topic.

The main discussion will take place on our global child health forum CHIFA as well as our general forum HIFA.

All welcome!

Join CHIFA (free) www.hifa.org/joinchifa

We recommend the following to learn more about GBS disease:

1, WHO Fact Sheet

2. WHO Guideline

3. Group B Strep International resources

Introduction: Kelli Smith, United States (1) Group B Strep (1)

25 June, 2026

Hello,

My name is Kelli Smith, and I am a stay-at-home mother from the United States. I became an advocate for Group B Strep after our daughter, Finley Genevieve, passed away from Group B Strep in 2017, just 24 hours after she was born.

What began as a journey to understand what happened to our family has grown into a passion for education and advocacy. Through my work with Group B Strep International, I strive to raise awareness among parents, physicians, nurses, educators, and healthcare professionals about the importance of prevention, early recognition, and education.

I believe that every family deserves the chance to bring home a healthy baby, and I am committed to helping make that a reality through awareness, education, and advocacy.
Thank you,

Kelli

CHIFA profile: Kelli Smith is a stay-at-home mother based in the United States. kelliray13 AT gmail.com

Introduction: Kelli Smith, United States (3) Group B Strep (3)

25 June, 2026

Dear Kelli,

Welcome to CHIFA and thank you so much for your introductory message.

On behalf of CHIFA and HIFA I would also like to thank you and your husband Kevin for your generous sponsorship of this Spotlight on Group B Strep in honour of your daughter Finley Genevieve. I hope we shall have a rich and productive discussion. We shall be addressing a wide range of questions which everyone can review here: www.hifa.org/gbs

The 'official' period of our discussion is 8-14 July (coinciding with GBS Awareness Week). However, we welcome further messages on this topic at any time, starting today.

As CHIFA members our aim is to build a world where every parent, every health worker and every policymaker is empowered with reliable information to prevent, recognise and treat Group B Strep.

We also welcome those who have joined CHIFA recently including a few who have declared an interest in Group B Strep. We look forward to welcome further new CHIFA members onto our forum in the coming days. All: please forward this to anyone who may be interested to join us!

Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Introduction: Kelli Smith, United States (4) Group B Strep (4)

26 June, 2026

Dear Kelli

I am a vice chair of the Japan Child Meningitis Organisation (JaCMO).
Our organisation is a member of the Confederation of Meningitis Organisations (COMO).

It breaks my heart to hear that you lost your daughter to a GBS infection.
While the widespread use of Hib and paediatric pneumococcal vaccines in Japan has led to the near-eradication or drastic reduction of those serious infections, severe GBS infections remain a major problem.

We would like to solve this issue together.

Kind regards,
Hajime

CHIFA profile: Hajime Takeuchi is a professor at the Bukkyo University in Japan. Professional interests: child health, child poverty, child wellbeing. takechanespid@gmail.com He is a CHIFA Country Representative for Japan and a member of the CHIFA Steering Group (child health and rights) http://www.hifa.org/support/members/hajime takechanespid AT gmail.com

Introduction: Kelli Smith, United States (5) Group B Strep (5) GBS in Ethiopia

26 June, 2026

Hello,

I am Mucheye Gizachew from Ethiopia located in East Africa.

A 2020 study conducted in Ethiopia revealed that meningitis is one of the top ten causes of death among Ethiopian infants. Group B streptococcus (GBS) has emerged as a leading cause of meningitis in neonates and young infants, resulting in high mortality. Despite this, there is no report on GBS associated meningitis in Ethiopia where infant meningitis is common.

Hence, the aim of this study was to determine the proportion of GBS associated meningitis among Ethiopian infants. PCR was prospectively used to detect GBS in culture-negative cerebrospinal fluid (CSF) samples, which were collected from infants suspected of meningitis, at Tikur Anbessa specialized hospital, Ethiopia, over a one-year period. GBS was detected by PCR in 63.9% of culture-negative CSF samples. Out of the 46 GBS positive infants, 10.9% (n = 5) of them died. The late onset of GBS (LOGBS) disease was noted to have a poor outcome with 3 LOGBS out of 5 GBS positive samples collected from patients with the outcome of death. Considering the rate of GBS positivity (GBS vs. no GBS), the probable death was assumed (10.9% (5/46) vs. 3.8% (1/26)). PCR was advantageous in the identification of GBS in culture-negative CSF samples. GBS was detected in 64% of the CSF samples from infants with meningitis compared with zero-detection rate by culture

Enhanced identification of Group B streptococcus in infants with suspected meningitis in Ethiopia
Alene Geteneh et al
PLOS One, Published: November 19, 2020
https://doi.org/10.1371/journal.pone.0242628
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0242628

Best!

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Sincerely,

Mucheye Gizachew (BSc, MSc, PhD)
Head, Department of Medical Microbiology, SBMLS, CMHS, UoG
Associate Editor, Journal of Disability CBR & Inclusive Development
DAAD (Germany) In-Country Scholarship Fellow
Visiting Research Scholar at CDC, Atlanta, Georgia USA
Tele: +251-0581117678; Fax:+251-0581111479; P. O. Box: 196
Mobile: 251(0)910139535
Email: muchegiza@gmail.com (muchiye888@yahoo.com)
Official (Institution) email: mucheye. <mucheye.gizachew@uog.edu.et>
WWW.uog.edu.et <http://www.uog.edu.et/> <http://www.uog.edu.et/>

gizachew@uog.edu.et <mucheye.gizachew@uog.edu.et>*n*=1456; *h-index**=*21;
& *i10-inde**x*=27
LinkedIn: *https://www.linkedin.com/in/mucheye-gizachew-9a754b4a
<https://www.linkedin.com/public-profile/settings/>; **ORCID ID:*
https://orcid.org/ <https://orcid.org/0000-0002-3754-2618>
0000-0002-3754-2618
Research / Citation Metrics: *Citatio*00-0002-3754-2618
<https://orcid.org/0000-0002-3754-2618>
Scopus Author ID: 55123088900
<http://www.scopus.com/inward/authorDetails.url?authorID=55123088900&part...
Web of Science Researcher ID: MVU-5532-2025.

*ሥዓት** ጊዜን ያሳይሃል፡ ጊዜ ደግሞ ሰዎችን (ህዝብ)*

HIFA profile: Mucheye Gizachew Beza is an instructor, researcher and community service provider at the University of Gondar, Ethiopia. By profession, he is a Medical Microbiologist with academic backgrounds in Nursing and Biological Sciences. His professional and research interests focus on Group B Streptococcus (GBS), maternal and neonatal infectious disease prevention, antimicrobial resistance (AMR) focusing on One Health Approach, public health microbiology, biosafety and biosecurity, disease surveillance, and health education. He is particularly committed to advancing community awareness, strengthening public health interventions, and promoting evidence-based strategies to improve maternal and child health outcomes. His work aims to bridge research, education, and public health practice to address emerging infectious disease challenges and enhance healthcare quality and safety. Email address: muchegiza AT gmail.com

Group B Strep (3) Help us to publicise our first Spotlight!

28 June, 2026

Re: https://www.hifa.org/dgroups-rss/announcement-please-distribute-widely-c...

Dear HIFA and CHIFA colleagues,

I would like to ask for your help to invite new members to join our global child health forum CHIFA in readiness for our first HIFA Spotlight on the topic of Group B Strep disease. This starts officially on 8 July although some messages on the topic have already been exchanged: hifa.org/readchifa

Please forward this message to your contacts and encourage them to visit our dedicated landing page for more information: hifa.org/gbs

and to join CHIFA (free) at: hifa.org/joinchifa

If you are on LI, FB, X or IG, please like and repost our announcements:

LinkedIn: https://www.linkedin.com/feed/update/urn:li:activity:7475874996150534145/

Facebook: https://www.facebook.com/photo?fbid=1555328273295753&set=a.474329174729007

X: https://x.com/hifa_org/status/2070558901615939750

Instagram: https://www.instagram.com/p/DaAvZ_wieSf/?hl=en-gb

The more new members we can attract, the richer will be our discussion!

Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Group B Strep (4) Introduction: Dura Schlei, United States

29 June, 2026

Hello - my name is Dura Schlei and I'm a mom to three children - Spencer, Saylor, and Iris. In 2023, our daughter Saylor contracted late-onset Group B Strep Meningitis two weeks after she was born. Unfortunately, she ended up passing away almost a month later.

Happy to share my experience in the coming week.

Thank you for adding me to this community!

Regards,
Dura

CHIFA profile: Dura Schlei is Sr Manager HR, USA. duracannady@gmail.com

[*Note from CHIFA assistant moderator (NPW): Thank you and welcome to CHIFA, Dura. We are honoured to have you join our Spotlight discussion on Group B Strep and look forward to hearing your experience over the coming days. I would like to invite all CHIFA members to encourage others to join us for this important discussion. hifa.org/gbs hifa.org/joinchifa]

Group B Strep (5) Introduction: Julie Nyanchama Nyamao, Kenya - Kenya Medical Research Institute

2 July, 2026

My name is Julie Nyanchama Nyamao, I have been serving as a Senior Research Scientist at the Kenya Medical Research Institute (KEMRI), Centre for Global Health Research, in collaboration with the Liverpool School of Tropical Medicine. I lead the Maternal Immunization Readiness Network in Africa and Asia (MIRNA) study, and I am completing my PhD in Clinical Research, Maternal and Newborn Health at the University of Nairobi. I am also a certified midwife with over thirteen years of experience spanning clinical practice, research and health policy.

My area of interest lies in maternal immunization, with a particular focus on Group B Streptococcus (GBS) prevention and the translation of maternal vaccine evidence into national policy and health system readiness. I also consult for Kenya's Ministry of Health on the 100-Day Maternal and Newborn Health Rapid Results Initiative, working to reduce maternal and newborn mortality across the country's high-burden counties.

I would welcome the opportunity to connect and explore areas of shared interest or potential collaboration. [*see note below]

Warm Regards

Julie Nyanchama Nyamao

CHIFA profile: Julie Nyanchama Nyamao is a Senior Research Scientist/Midwife at Kenya Medical Research Institute, Kenya. My professional interest lies in improving pregnancy outcomes and newborn survival through the prevention of Group B Streptococcus (GBS) disease. I am committed to generating and translating evidence on the burden of GBS into actionable policy, with the goal of driving government investment in maternal immunization as a cost-effective strategy for protecting newborns before they are born jnyanchama AT gmail.com

[*Note from CHIFA co-moderator (NPW): Welcome Julie and thank you for joining us for our upcoming discussion on Group B Strep: www.hifa.org/gbs Please invite your colleagues at KEMRI to do the same.]

Our CHIFA Spotlight on Group B Strep starts in 6 days! Three ways you can help

2 July, 2026

Dear CHIFA colleagues,

Our CHIFA Spotlight on Group B Strep starts in 6 days! hifa.org/gbs

Please help us to publicise. Here are three ways you can help:

1. Email this message to your contacts:

Subject: Group B Strep Awareness Week 8-14 July: Invitation to join a global conversation

Dear XXX

I am helping to publicise a special Spotlight discussion on Group B Strep on the CHIFA discussion forum.

CHIFA is a professional global forum with more than 3600 child health professionals in 140 countries worldwide. It works alongside HIFA (general health) in official relations with the World Health Organization, promoting the availability and use of reliable healthcare information.

Please join CHIFA today (free!): hifa.org/joinchifa

For more information on this discussion see: hifa.org/gbs

We look forward to welcome you!

PLEASE ALSO FORWARD THIS MESSAGE TO YOUR CONTACTS AND NETWORKS!!

Best wishes, YOURNAME

2. Print this A4 publicity poster and display it in your workplace:

https://www.hifa.org/sites/default/files/articles/Group%20B%20strep%20HI...

3. Like/comment/repost our publicity on social media

LinkedIn: https://www.linkedin.com/company/healthcare-information-for-all-hifa

Facebook: facebook.com/hifadotorg

Twitter/X: @hifa_org

Instagram: hifa_org

Thank you so much for your support, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Introduction: Azanaw Amare, Ethiopia

2 July, 2026

Hello, Dear Professors/Doctors,

I am Azanaw Amare Muche, Lecturer and Researcher at the University of Gondar. I have research and professional interests in antimicrobial resistance (AMR), molecular epidemiology, molecular virology, emerging viruses, genomic surveillance of bacterial pathogens, clinical microbiology, molecular diagnostics, hospital-acquired infections, One Health research, and infectious diseases. My interest centers on elucidating the mechanisms of emergence and transmission of bacterial pathogens and using molecular/genomic tools to support disease surveillance and public health interventions.

I am very excited to be on this mailing list and keen to learn from you all's expertise and experience, and I hope to engage with you, share experiences, and learn new things.

Looking forward to being a part of discussions and exploring collaborations on research and capacity-building projects!

Thanks for having me!

Best regards, Azanaw Amare Muche, Lecturer and Researcher, University of Gondar, Ethiopia
.....
With best regards!
Azanaw Amare: (BSc; MLS, MSc; Medical Microbiology)

Lecturer, Department of Medical Microbiology
College of Medicine and Health Sciences
The University of Gondar, P.o.box: 196
Gondar, Ethiopia.
Phone no:+25198439140

Institutional Email: Azanaw.Amare@uog.edu.et
ORCID: https://orcid.org/0000-0002-1098-6892

CHIFA profile: Azanaw Muche is a Lecturer and researcher at the University of Gondar, Ethiopia. Professional interests: AMR, Molecular Epidemiology, Genomic Surveillance of Bacterial Pathogens, clinical Microbiology, Molecular Diagnostics, Hospital-Acquired Infections, One Health Research, and Infectious Diseases. azanaw03 AT gmail.com

Group B Strep (6) Introduction: Azanaw Amare, Ethiopia (2)

2 July, 2026

[Re: https://www.hifa.org/dgroups-rss/introduction-azanaw-amare-ethiopia]

Dear Azanaw,

Thank you for your email and for being part of this important initiative [www.hifa.org/gbs], which aims to raise awareness about the public health importance of Group B Streptococcus (GBS), particularly its serious impact on neonates and young infants.

Best!
Mucheye

CHIFA profile: Mucheye Gizachew Beza is an instructor, researcher and community service provider at the University of Gondar, Ethiopia. By profession, he is a Medical Microbiologist with academic backgrounds in Nursing and Biological Sciences. His professional and research interests focus on Group B Streptococcus (GBS), maternal and neonatal infectious disease prevention, antimicrobial resistance (AMR) focusing on One Health Approach, public health microbiology, biosafety and biosecurity, disease surveillance, and health education. He is particularly committed to advancing community awareness, strengthening public health interventions, and promoting evidence-based strategies to improve maternal and child health outcomes. His work aims to bridge research, education, and public health practice to address emerging infectious disease challenges and enhance healthcare quality and safety. Email address: muchegiza AT gmail.com

Group B Strep (6) Personal and professional experience

5 July, 2026

Am DR NEHEMIAH NDUBI OKERIO born in 1976 in a very poor family background in Nyamira county Kenya. I am a pharmacologist MRI scan Technologist STD HIV-AIDS Cancer researcher. I have 30 years experience in humanitarian global health through management of African mobile clinics in sub Saharan East Africa fulfilling vision 2030. My eldest daughter gave birth to a grand son with Neonatal sepsis with uncontrollable rising temperature recently. GBS is real and we must struggle to create a permanent solution to prevent it.

My world class achievements please view
www.nyamiracountyadultassociation.org
www.doctorndubi.org

Former international general practitioner for www.bfsuma.com
WhatsApp number is
±254714989904

HIFA profile: Nehemiah Ndubi Okerio is a Pharmacologist; MRI scan Technologist and STD HIV-AIDS Cancer researcher in Kenya. www.nyamiracountyadultassociation.org Professional interests: Public Health. doctorndubi AT gmail.com

Group B Strep (7) Personal and professional experience (2)

6 July, 2026

Dear CHIFA colleagues,

Our first Spotlight starts officially in 2 days time: 8 July 2026!

The theme is Group B Streptococcus, a leading cause of serious infection in babies that causes 150,000 stillbirths and early infant deaths every year.

Here again is our landing page with further information:

https://www.hifa.org/news/chifa-and-hifa-spotlight-group-b-strep-8-14-ju...

What is YOUR personal and professional experience of GBS disease? We would especially like to hear from you if your life has been impacted by GBS disease. Also we would like to hear your professional experience as a health worker, for example if you have been involved in the care of a mother and baby affected by GBS disease.

Thank you to the following people who have already shared their experience: Kelli Smith (United States), Dura Schlei (US), Mucheye Gizachew Beza (Ethiopia), Haji8me Takiuche (Japan), Julie Nyanchama Nyamao (Kenya), and Nehemiah Ndubi Okerio (Kenya). You can review their messages on our RSS feed here: www.hifa.org/readchifa

Their personal and professional experience in this topic demonstrates how profoundly important it is, and how much of the morbidity and mortality from this disease is preventable if only every parent and every health worker had access to reliable information on prevention, diagnosis and treatment.

We look forward to lively interaction on this important topic.

If you are willing, PLEASE forward this message to your contacts and encourage them to join us here on CHIFA: www.hifa.org/joinchifa

Many thanks and best wishes,

Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Group B Strep (8) Group B Strep Awareness Week 8–14 July 2026

7 July, 2026

Hello,

I've enjoyed learning from the CHIFA and HIFA discussions for some years now, but just want to say as Group B Strep International's cofounder how honored we are to be a HIFA partner and for group B strep to be the featured topic for the very first CHIFA/HIFA spotlight. What a great way to kick off Group B Strep Awareness Week tomorrow!

Giving a special shoutout to our parent sponsors, Kelli and Kevin Smith, who are making this global discussion possible in honor of their daughter Finley Genevieve <https://www.groupbstrepinternational.org/finley-genevieve.html> and looking forward to all we will accomplish towards reducing the harm and heartache group B strep causes worldwide.

Sincerely,
Marti

(Ms.) Marti Perhach
Mother of Rose, stillborn due to GBS
CEO/Cofounder
Group B Strep International
+1 909 620-7214
marti.perhach@gbs-intl.org <mailto:marti.perhach@gbs-intl.org>
www.groupbstrepinternational.org <https://www.groupbstrepinternational.org/>

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

[*Note from CHIFA co-moderator (NPW): Thank you Marti and I am delighted to be part of this our first Spotlight, which is scheduled to coincide with Group B Strep Awareness Week 8–14 July 2026, starting tomorrow. All: Further information about this Spotlight, including six guiding questions, is available on our landing page at www.hifa.org/gbs Our first question is: What is your personal and professional experience of GBS disease? We would especially like to hear from you if, like Marti, Kelli and Kevin, your life has been impacted by GBS disease. Also we would like to hear your professional experience as a health worker, for example if you have been involved in the care of a mother and baby affected by GBS disease. To contribute, send email to: chifa@hifaforums.org Many thanks, Neil]

Group B Strep (9) Group B Strep in Japan

7 July, 2026

Dear GBS discussion members

In Japan, the Japan Society of Obstetrics and Gynaecology published the following guidelines in 2020. [*see note below]

GBS colonisation is confirmed using the following methods:
1) Perform GBS culture testing between 35 and 37 weeks of gestation.
2) Collect specimens from the vaginal introitus and the anus.

2. Administer intravenous antibiotics (such as penicillin) to the following pregnant women during vaginal delivery or after preterm premature rupture of membranes (PPROM) to prevent neonatal infection:
1) GBS identified (as per 1)
2) The previous infant had GBS infection

3) GBS detected in urine culture during the current pregnancy
4) GBS colonisation status unknown, with either ≥18 hours elapsed since membrane rupture or a fever of ≥38.0°C

(Sited in Japanese: https://minds.jcqhc.or.jp/common/summary/pdf/c00572.pdf)

A prospective study was conducted in selected prefectures of Japan over a 10-year period (January 2015–December 2024) involving pediatric patients aged from 0 days to under 15 years who developed invasive GBS infection. The incidence rates for early-onset disease (EOD; 0–6 days of age), late-onset disease (LOD; 7–89 days), and ultra-late-onset disease (ULOD; ≥90 days) were 0.02–0.04, 0.06–0.19, and 0.00–0.04, respectively. Regarding outcomes, 10 cases (2.8%) resulted in death, and 26 cases (7.3%) exhibited neurological sequelae. Maternal GBS screening was performed in 258 cases (73.5% of those with onset before 1 year of age), and 29.8% (77 cases) tested positive. Among mothers who tested positive, 76.6% (59 cases) had received prophylactic antimicrobials.

(Sited in Japanese: https://id-info.jihs.go.jp/surveillance/iasr/IASR/Vol46/547/547r06.html)

Kind regards,
Hajime

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A dream you dream alone is only a dream.
A dream you dream together is reality.

Prof. Hajime Takeuchi, MD (Paediatrician)
School of Social Welfare
Graduate School of Social Welfare
BUKKYO University
96, Kitahananobo-cho, Murasakino, Kita-ku, Kyoto 603-8301, Japan
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E-mail: takechanespid@gmail.com

CHIFA profile: Hajime Takeuchi is a professor at the Bukkyo University in Japan. Professional interests: child health, child poverty, child wellbeing. takechanespid@gmail.com He is a CHIFA Country Representative for Japan and a member of the CHIFA Steering Group (child health and rights) http://www.hifa.org/support/members/hajime takechanespid AT gmail.com

[*Note from CHIFA co-moderator (NPW): Thank you Hajime for relating the experience of Group B Strep in Japan. All: We welcome comparative experience from other countries, as well as any personal or professional experience you may like to share.]

Group B Strep (10) Finley Genevieve Smith

7 July, 2026

Good morning,

Below is our story about our daughter Finley Genevieve. We are so grateful to be a part of this international discussion/forum. We truly hope her story and many others educate and begin conversations that eventually may lead into change and a cure for group b strep.

In September 2017, our daughter, Finley Genevieve, died just 18 hours after she was born from early-onset Group B Streptococcal (GBS) disease.

Like many expectant mothers, I was screened for GBS at 36 weeks of pregnancy. My test result was negative, and I believed that meant my baby was protected. What I did not know was that GBS colonization can change between screening and delivery. I was induced at 39 weeks, and sometime during those three weeks, Finley became infected.

When she was born, she appeared healthy. There were no obvious signs that she was critically ill.

About eight hours after birth, she became unusually fussy. Her temperature was low, and her blood pressure was abnormal. She was taken from us for monitoring, and we were reassured that everything would likely be fine. As her condition changed, a respiratory therapist evaluated her and felt that her breathing difficulties could simply be part of a normal transition after birth. We now know these were early signs of invasive GBS disease.

When we saw Finley around noon, she was in an incubator connected to monitors measuring her temperature, blood pressure, and breathing. We were still being reassured. When she heard our voices, she opened her eyes, looked at us, and for a brief moment her vital signs seemed to stabilize. We held onto hope.

Less than two hours later, I held my daughter in my arms as she was baptized and took her final breath.

By then, the infection had spread throughout her tiny body. Although antibiotics had been ordered that morning, they were not administered until approximately three hours later. Tragically, by that point the disease had progressed beyond what medicine could reverse.

Finley's story is not shared to assign blame. It is shared because awareness saves lives.

A negative prenatal GBS screening result does not eliminate the possibility of early-onset GBS disease. Newborns can deteriorate with extraordinary speed, and subtle symptoms such as poor temperature regulation, respiratory changes, feeding difficulties, or unusual fussiness deserve urgent evaluation. Rapid recognition, timely assessment, and prompt treatment are critical.

Since losing Finley, my family has dedicated ourselves to raising awareness and advocating for better education about Group B Strep. If sharing her story helps even one healthcare professional recognize the warning signs sooner, encourages one parent to speak up when something doesn't seem right, or contributes to improving policies that protect newborns, then her life continues to make a difference.

From July 8 through July 14, we are honored to sponsor a global discussion on Group B Streptococcus through CHIFA/HIFA (Health Information For All). We hope healthcare professionals, researchers, policymakers, advocates, and families from around the world will join this important conversation as we work together toward a future where no family loses a child to a preventable or treatable infection.

Finley's life was only one day long, but her legacy is helping to create conversations that can save countless others.

Thank you,
Kelli Smith

CHIFA profile: Kelli Smith is a stay-at-home mother based in the United States. kelliray13 AT gmail.com

Group B Strep (11) Julia "Rose"

7 July, 2026

Hello,

I also would like to share my personal experience of why I became involved in the group B strep and wider perinatal health communities. I will be touching on many of the points in my story during the coming week's discussion.

My fourth child, Julia "Rose", was stillborn on July 1, 1998 just three days before her due date. After three healthy children I never imagined that this could happen, especially since this pregnancy had been the easiest one for me.

When I cultured positive for group B strep in early June, all four of my obstetricians made GBS seem as if it wasn't anything for me to worry about although they couldn't or wouldn't tell me much about it. (Women should have accurate information to know how to best protect their babies.) I had never heard of group B strep before and, since my baby books at home made no mention of it, I falsely assumed that the doctors must be right.

During the last two weeks in June, I was experiencing external vaginal burning. However, this did not raise any concerns with my OBs. (External vaginal burning can be a symptom of GBS colonization and can indicate high levels of GBS that can potentially harm the baby.) They just prescribed yeast infection medication without actually culturing me even though I complained at subsequent visits that I still had the same symptoms. (Yeast infection medication is not effective against group B strep which is a bacteria.) I again questioned one OB about why I wasn't receiving antibiotics for the GBS now. He said that I would receive IV antibiotics during labor and that it would instantly kill the GBS. (According to the Centers for Disease Control and Prevention (CDC), IV antibiotics generally take four hours prior to birth to be fully effective.)

I had my regular OB checkup at 4:45 PM the afternoon before I delivered Rose. I was so glad to hear her healthy heartbeat, but then the doctor examined me very forcefully to see if I was dilated. During all of my prenatal care, I had never had a doctor bear down on me like that for a cervical exam. Afterwards, the nurse handed me a mini-pad saying that I might bleed a bit. Over an hour later, I told my sister-in-law that I could still feel the forcefulness of his exam. (OB's can strip a woman's membranes during a cervical exam without her prior consent or knowledge of the risks even though the CDC clearly states that GBS can cross intact amniotic membranes. Just common sense indicates that even cervical exams can transport GBS closer to the baby. Studies have shown that the number of vaginal exams increase the rate of infection for the baby.)

The next morning I went into labor at 5:00 AM with contractions 10 minutes apart. (GBS positive women should go to the hospital when labor first starts so that they can start receiving IV antibiotics.) At 5:50 AM my contractions suddenly went to 1-3 minutes apart and I started retching and had the chills. My husband rushed me to our HMO-approved hospital through

heavy morning traffic even though there were other hospitals much closer. (Women should have alternate plans in the case of short labors or long distances to the hospital.)

I felt Rose kick me while I was waited in the nurses' station for a room; my request for IV antibiotics was in my hand. However, by the time I got into the labor and delivery room, there was no fetal heartbeat. My membranes were still intact and had to be ruptured before Rose was stillborn just 24 minutes after arriving at the hospital. The only nurse in the room issued a "code pink." She did the best she could until the resuscitation team arrived. At some point after that, one of my four OBs showed up; however, Rose could not be revived. (The OB should be called as soon as the woman goes into labor.)

Autopsy results showed chorioamnionitis (infected amniotic fluid) and pneumonia due to Group B strep. (Subsequent babies are more likely to be infected by GBS if previous siblings have had GBS disease.) However, four out of our five healthcare professionals advised us to not have an autopsy done as it would most likely not determine the cause of Rose's stillbirth. We decided to at least have a tissue sampling of Rose's heart and lungs cultured. Pathology testing of the placenta can sometimes indicate the cause of stillbirth; however, this was not routine nor suggested in a timely manner to us.)

My OB's did not give me accurate information as to how to help protect my baby from GBS nor any indication that losing my baby was even possible as a result of my being GBS positive.

Looking forward to empowering parents and healthcare workers through this global discussion.

Sincerely,
Marti

(Ms.) Marti Perhach
Mother of Rose, stillborn due to GBS
CEO/Cofounder
Group B Strep International
+1 909 620-7214
marti.perhach@gbs-intl.org <mailto:marti.perhach@gbs-intl.org>
www.groupbstrepinternational.org <https://www.groupbstrepinternational.org/>

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (12) Forum question to Group B Strep International

8 July, 2026

Hello,

Eight years ago, after losing my daughter Finley to Group B Strep just one day after she was born, I felt completely alone. I had never heard of Group B Strep before my pregnancy except that I was told I had tested negative at 36 weeks. I believed that meant my baby was safe.

After Finley died, I found Group B Strep International. It became more than an organization to me. It became a community that helped me understand what had happened and gave me a way to transform grief into advocacy.

As we begin this discussion for the HIFA community, I'd like to start with a question I think many parents would ask.

What is the one thing about Group B Strep that you wish every pregnant woman and every healthcare professional understood?

Thank you,
Kelli Smith

CHIFA profile: Kelli Smith is a stay-at-home mother based in the United States. kelliray13 AT gmail.com

Spotlight: Group B Strep (13) Group B Strep in Japan (2)

8 July, 2026

[Re: https://www.hifa.org/dgroups-rss/group-b-strep-9-group-b-strep-japan]

Thank you so much, Hajime, for sharing the Japanese GBS guidelines and the prospective study. Will link to them from our main website https://www.groupbstrepinternational.org/gbs-medical-articles-and-abstra...

I am glad to see that the prospective study included ultra-late-onset disease. Would you happen to know of any Japanese studies regarding GBS-caused stillbirths?

Best,
Marti

(Ms.) Marti Perhach
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CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (13) Group B Strep in Japan (2)

8 July, 2026

Dear Marti

I found another useful paper about GBS infections.

This is written in English. Group B Streptococcal Disease in Infants in Japan

DOI: 10.1097/INF.0000000000004144

However, I can not find the stillbirth rate caused by GBS infections. As a systematic review, this paper is useful. Maternal group B Streptococcus-related stillbirth: a systematic review.

DOI:10.1111/1471-0528.13527

Kind regards,
Hajime

CHIFA profile:
Hajime Takeuchi is a professor at the Bukkyo University in Japan. Professional interests: child health, child poverty, child wellbeing. takechanespid@gmail.com He is a CHIFA Country Representative for Japan and a member of the CHIFA Steering Group (child health and rights) http://www.hifa.org/support/members/hajime takechanespid AT gmail.com

Spotlight: Group B Strep (15) Group B Strep in Japan (4) What every pregnant woman and every healthcare professional should know

8 July, 2026

Dear Hajime,

Thank you so much for these papers. Noting that the first one includes the interesting point that GBS infection can be recurrent and that preterm birth and antenatal maternal GBS colonization were risk factors for recurrence of which parents should be aware.

As to the second, that's very clever that the authors include a sentence for a Tweetables abstract which I"ll note here "Systematic review finds Group B Streptococcus causes up to 12.1% of stillbirths, but more research is needed."

In regards to the question Kelli posed to the CHIFA forum, is there one thing about Group B Strep that you wish every pregnant woman and every healthcare professional understood?

Best,

Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (16) Forum question to Group B Strep International (2) Screening, diagnosis and treatment in LMICs

8 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-12-forum-questi...]

Hello Everyone,

One thing I really hope for, is that GBS screening will become widely available in LMIC settings, and immediate treatment/management options will also be available. Many women have still births or deliver babies with early onset neonatal sepsis, many usually ending up as early neonatal deaths. We do not always know the aetiology of these infections, as bacterial culture tools are not usually available (unfortunately I do not have figures). I have managed neonates with EONS – we do not always have a diagnosis; we can only make presumptive diagnoses.

I look forward to a time when we have these screening/diagnostic and treatment tools in LMICs. Still births/premature birth/ neonatal deaths are very traumatic experiences psychologically to families.

Thank you

Claire

CHIFA profile: Claire Oluwalana is a paediatrician with the Medical Research Council, Gambia. coluwalana AT mrc.gm

Spotlight: Group B Strep (17) Forum question to Group B Strep International (3) Parents need to be empowered by trained healthcare professionals

8 July, 2026

Kelli, thank you and your husband for being champions for advocacy in our Group B Strep International community. I had also believed that my baby was safe because, as I had tested positive, I was told that IV antibiotics during labor would kill the bacteria instantly. I had my test results in hand when I arrived at the hospital to make sure I got my IV antibiotics. However, Rose was stillborn, having passed away in utero just before I got into the delivery room.

The one thing about Group B Strep that I wish every pregnant woman and every healthcare professsional understood is that Group B Strep is not just an issue at birth for those who test positive. There is a whole spectrum of scenarios in which babies can become infected by GBS, ranging from miscarriages through ultra late-onset. Parents need to be empowered by their trained healthcare professionals with the knowledge they need to help protect their babies at all stages including recognizing the signs of infection and knowing how to respond.

Kelli, what is the one thing about Group B Strep that you wish every pregnant woman and every healthcare professional understood?

Best,

Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. www.groupbstrepinternational.org Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (18) Please help us to publicise our discussion and encourage new members to join us!

8 July, 2026

Our thanks to Marti, Kelli and all who have shared their experience on this important topic. The discussion has got off to a great start :-)

I also welcome several new members who have joined CHIFA in the past few days. We look forward to learn from your experience. Please send your thoughts to: chifa@hifaforums.org

Attracting more new members with an interest in Group B Strep will greatly help to strengthen the depth and breadth of this discussion further, so that we can raise awareness and understanding of this vital topic.

I would like to invite all CHIFA members to share the short URL of our landing page with your friends and colleagues: www.hifa.org/gbs

Our social media team has also prepared an A4 poster that you can attach to an email or print and display in your university or workplace:

https://www.hifa.org/sites/default/files/articles/Group%20B%20strep%20HI...

Thanks again and I look forward to continuing the discussion.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (19) Personal and professional experience (3)

8 July, 2026

Dear CHIFA colleagues,

The testimonies from Kelli (Finley Genevieve) and Marti (Julia “Rose”) bring a powerful human dimension to our discussion on Group B Strep. Their stories highlight similar themes: false reassurance from routine screening, subtle symptoms being overlooked, and missed opportunities for timely intervention. Both mothers describe receiving incomplete or inconsistent information about GBS risks, and both witnessed how quickly the disease can become fatal.

Moreover, both Marti and Kelli have channelled their grief into positive action and advocacy. After losing their daughters, they committed themselves to raising awareness, improving education, and helping other families and health workers recognise and respond to GBS risks more effectively. This is remarkable and inspirational.

Kelli says "Finley’s life was only one day long, but her legacy is helping to create conversations that can save countless others" and Marti ends her message "Looking forward to empowering parents and healthcare workers through this global discussion".

By bringing this topic to the attention of CHIFA members, representing child health professionals and others worldwide, I too look forward to this global conversation.

More info: www.hifa.org/gbs

To review messages sent on CHIFA: www.hifa.org/readchifa

Many thanks, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (20) What every pregnant woman and every healthcare professional should know (2) Response to Marti's question

8 July, 2026

In response to Marti's question, "Kelli, what is the one thing about Group B Strep that you wish every pregnant woman and every healthcare professional understood?"

I wish every pregnant woman and every healthcare professional understood that a negative Group B Strep screening test does not eliminate the risk of Group B Strep disease*.* GBS colonization can change after screening, and while current screening and intrapartum antibiotics have saved thousands of babies' lives, they do not prevent every case. Every newborn must still be carefully assessed, and any signs of illness should be treated with urgency because early-onset GBS disease can progress with remarkable speed.

Thank you,
Kelli Smith

Kelli Smith, MBA
434-466-7311

CHIFA profile: Kelli Smith is a stay-at-home mother based in the United States. kelliray13 AT gmail.com

Spotlight: Group B Strep (21) Screening, diagnosis and treatment in LMICs (2)

8 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-16-forum-questi...]

Thank you, Claire, for your insight on these issues in LMIC settings. What can you or others in this forum suggest as first steps to these screening/diagnostic and treatment tools becoming available in LMICs? Are there any LIMCs where such progress has been made?

Even in high-income countries, there is much room for improvement in determining the cause of stillbirths. I attended one of the IMPROVE workshops years ago and found it to be fascinating even as a parent for the compassionate investigative skills in their approach. https://www.stillbirthcre.org.au/researchers-clinicians/education-and-wo...

Best,

Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (21) What every pregnant woman and every healthcare professional should know (3) Screening for Group B Strep

9 July, 2026

[Re: Kelli Smith: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-20-what-every-p...]

These are such important points for everyone to know and understand, Kelli. Some other points regarding testing negative that others might not be aware of are:

Using antibiotics and/or vaginal medications may cause false negative test results. Sharing a reference to an article on this topic: Ostroff RM, Steaffans JW. Effect of specimen storage, antibiotics, and feminine hygiene products on the detection of group B Streptococcus by culture and the STREP B OIA test <https://pubmed.ncbi.nlm.nih.gov/8565413/>. Diagn Microbiol Infect Dis. 1995 Jul;22(3):253-9.

Also, that culture results are considered to be 95% to 98% accurate if done < 5 weeks before delivery, but after that the negative predictive value declines. Yancey MK, Schuchat A, Brown LK, Ventura VL, Markenson GR. The accuracy of late antenatal screening cultures in predicting genital group B streptococcal colonization at delivery. Obstet Gynecol 1996;88):811–5. Pregnant women who have tested negative should be aware that they can ask their healthcare providers about being tested again if they have not give birth within this window, and, of course, healthcare providers can initiate this conversation.

Best!

Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (22) Group B Strep in Nigeria

9 July, 2026

1. Personal and Professional Experience with GBS Disease

Professionally, my engagement with GBS disease is from a health systems and economic perspective. The most pressing observation is the stark contrast between the availability of interventions and their implementation. Studies show that maternal GBS immunization could be a cost-effective intervention in Nigeria, with a cost-effectiveness ratio (about $320-$350 per DALY averted) similar to other recently introduced vaccines. However, this evidence is meaningless without robust surveillance to identify high-burden populations and the infrastructure to deliver the intervention. My work consistently highlights the disconnect between clinical evidence and systemic capability, a gap that defines the GBS challenge in Nigeria.

2. The Situation in Nigeria

The situation is one of a hidden epidemic with several key characteristics:

- Substantial but Unclear Burden: We know GBS colonization is common, affecting approximately 1 in 8 pregnant women, with higher rates in the South (13%) compared to the North (9%). Neonatal colonization is even higher at 16%, and the risk of invasive disease, though reported as 3%, is likely underreported.

- Data Gaps are the Norm: The lack of surveillance in 19 states is not just a data problem; it is a barrier to resource allocation, policy formulation, and evidence-based advocacy.

- Fragile Health System: Our antenatal care (ANC) coverage is inadequate. With only about 50% of pregnant women attending four or more ANC visits, the platform for delivering interventions like screening or vaccination is already compromised.

3. Reducing the Burden of GBS Disease: An Economist's View

From a health economics standpoint, reducing the GBS burden requires a multi-pronged, cost-effective strategy.

- Strengthen the Surveillance System: This is our most cost-effective initial investment. We cannot manage what we do not measure. We must expand surveillance to all 36 states, using standardized protocols to generate actionable data on incidence, serotypes (like V and II), and antimicrobial resistance. This data is the bedrock for policy.

- Invest in Prevention: The Case for Maternal Vaccination: Intrapartum antibiotic prophylaxis (IAP) is logistically challenging and expensive to implement at scale in Nigeria due to the need for universal screening and timely administration during labor. A maternal vaccine delivered during routine ANC visits is the most promising intervention. Economic modeling confirms that maternal GBS immunization would be a highly cost-effective intervention, potentially preventing one-third of GBS cases and deaths in Nigeria.

- Integrate with Existing Programs: Any new intervention must be integrated into existing maternal and child health platforms. This reduces costs and leverages existing community health structures for delivery and follow-up.

- Address the Treatment Gap: For neonates who develop invasive disease, access to quality care is limited. This includes strengthening neonatal intensive care units (NICUs) and ensuring access to essential antibiotics. The situation for Guillain-Barré Syndrome (GBS), a severe neurological condition that can follow infection and requires costly therapeutic plasma exchange (TPE), is a warning. The rarity of TPE use in Nigeria is a classic example of a severe access gap driven by cost and lack of expertise.

4. What Parents Need to Know and What is the Current Awareness

Parents need to know that GBS is a common bacterium that can be carried without any symptoms but poses a serious risk to newborns, causing sepsis, pneumonia, and meningitis.

The Current Situation: Awareness is critically low. A study on newborn screening, which can be a proxy for broader health awareness, found that 57.2% of caregivers were not aware of the screening tests available.

How to Improve:

- Community Health Education: Use existing platforms like antenatal and immunization clinics to educate pregnant women about GBS, its risks, and prevention strategies.

- Address Cultural Barriers: We must develop culturally sensitive messages in local languages to overcome potential fears and misconceptions. Overcoming these barriers is crucial for the success of any new health intervention.

- Empower with Simple Messages: A simple, clear message that GBS is a common, treatable

condition can be the most powerful tool. This is a significant improvement over the current situation where many mothers receive inadequate or no information.

5. What Health Workers Need to Know and What is the Current Awareness

Health workers are the frontline defense. They need to know the epidemiology of GBS in Nigeria, the risk factors for neonatal disease, and the protocols for prevention and treatment.

The Current Situation: While health workers typically have higher awareness than the public (e.g., 73.6% awareness for sickle cell screening), there is still a significant gap in clinical knowledge. Many healthcare workers have not been trained on GBS-specific protocols and may not be recommending preventive measures. The healthcare provider's awareness is crucial for successful vaccination.

How to Improve:

- Mandatory Continuing Education: Integrate GBS prevention and management into the mandatory continuing professional development (CPD) programs for doctors, nurses, and midwives.

- Simplify Clinical Guidelines: Develop and disseminate clear, concise, Nigeria-specific clinical guidelines on screening, IAP, and the management of neonatal sepsis.

- Champion a Culture of Inquiry: Health workers must be trained to ask about GBS and to advocate for surveillance and vaccination.

6. Common Myths about GBS Disease and How to Address Them

Myths, especially in the absence of clear information, can be dangerous.

Myth: It's a rare disease. Reality: Colonization is common (12-13%), but awareness of the condition is not.

Myth: There's nothing you can do. Reality: Interventions like IAP and future vaccines are highly effective.

Myth: It's a 'foreign' disease. Reality: GBS is a significant health problem in Nigeria, and our local serotypes (like V and II) are already being identified.

Myth: Vaccines are dangerous. Reality: The evidence for maternal GBS vaccines is positive, with mostly non-severe adverse events, and they are cost-effective.

How to Address Them:

- Data-Driven Advocacy: Use the meta-analysis data on prevalence to counter the rare disease myth.

- Leverage Trusted Voices: Engage religious and community leaders to deliver accurate messages.

- Utilize Mass Media: Launch public awareness campaigns on radio and TV, which have a wide reach in Nigeria.

- Evidence-Based Communication: Frame the vaccine discussion around its potential to prevent severe illness and death, emphasizing its cost-effectiveness and safety profile.

In conclusion, the battle against GBS in Nigeria is not just a clinical challenge; it is a systemic and economic one. Our path forward must begin with robust data, then proceed with wise investment in cost-effective preventive strategies like maternal vaccination, all while empowering both parents and health workers with the knowledge to act. The economic case is clear; the question is one of political will and health system strengthening.

--

Department of Agricultural Economics,

Faculty of Agriculture

Adekunle Ajasin University

PMB 001,

Akungba Akoko,

Ondo State, Nigeria

Source link:

https://hifaforums.org/_/yEMClrUl

Author:

edamisan.ikuemonisan@aaua.edu.ng

Spotlight: Group B Strep (23) Question for Marti - The limitations of screening

9 July, 2026

Good morning, this question is for Marti.

The limitations of screening

My 36-week GBS screening was negative, yet Finley developed early-onset GBS disease. Until she died, I had no idea that colonization can change between screening and delivery.

How often does this happen, and what should parents and clinicians understand about the limitations of current screening?

Kelli Smith

CHIFA profile: Kelli Smith is a stay-at-home mother based in the United States. kelliray13 AT gmail.com

Source link:

https://hifaforums.org/_/8V73cp3n

Author:

Kelli Smith, United States

Spotlight: Group B Strep (24) Day 2 update: Thank you to contributors and Guiding questions

9 July, 2026

Dear CHIFA colleagues,

Thank you all for your contributions to our global discussion on Group B Strep.

To date we have received 29 messages* on this topic from:

Azanaw Amare, Ethiopia

Claire Oluwalana, Gambia

Dura Shlei, United States

Edamisan Ikuemonisan, Nigeria

Hajime Takiuche, Japan (3)

Julie Nyanchama Nyamao, Kenya

Kelli Smith, United States (4)

Marti Perhach, United States (7)

Mucheye Gizachew Beza, Ethiopia (2)

Nehemiah Ndubi Okerio, Kenya

Neil (6)

*This includes 7 messages sent before the official start of the discussion.

Here again are the six guiding questions for our discussion:

1. What is your personal and professional experience of GBS disease? We would especially like to hear from you if, like Marti, Kelli and Kevin (below), your life has been impacted by GBS disease. Also we would like to hear your professional experience as a health worker, for example if you have been involved in the care of a mother and baby affected by GBS disease.

2. What is the situation in your country? Worldwide, GBS disease causes around 150,000 stillbirths and early infant deaths. The incidence is higher in North America, Europe, and Africa than in other regions. Some cases may not be recognised, especially in LMICs.

3. What can be done to reduce the burden of GBS disease? In particular the WHO guideline (2024) recommends universal screening of mothers at 35-37 weeks, but this is currently only

available in a few countries (eg US, Canada). What can be done to support countries to implement universal screening?

4. What do parents need to know about GBS disease? In your country? What do they know and how can this be improved?

5. What do health workers need to know about GBS disease? In your country? What do they know and how can this be improved?

6. What are the common myths about GBS disease? How can these be addressed?

We aim to address ALL the above topics over the coming 5 days. Please share your thoughts on any of the above (or indeed other issues relating to GBS) by email to: chifa@hifaforums.org

I shall now prepare a short summary of the discussion so far.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (25) Question for Marti - The limitations of screening (2)

9 July, 2026

Hi Kelli,

So many parents are blind-sided when they have tested negative for group B strep.

Here are two studies on how often colonization status can change between screening and delivery:

Virranniemi M, Raudaskoski T, Haapsamo M, et al. The effect of screening-to-labor interval on the sensitivity of late-pregnancy culture in the prediction of group B streptococcus colonization at labor: A prospective multicenter cohort study. Acta Obstet Gynecol Scand. 2019; 98: 494-499. https://doi.org/10.1111/aogs.13522

"Between late-pregnancy screening and labor, GBS colonization changed from negative to positive in 3.2% and from positive to negative in 2.5% of the women." (Note: this study was done in Finland)

Stephens K, Charnock-Jones D, Smith G
Group B Streptococcus and the risk of perinatal morbidity and mortality following term labor
American Journal of Obstetrics & Gynecology, 2023; 228, S1305-S1312

The authors note that 6% of GBS carriers at the time of delivery will remain undetected despite the culture being performed within 5 weeks of birth.

The older US CDC guidelines from 2010 (current guidelines are at acog.org/gbs <http://acog.org/gbs>) stated:

"Although maternal GBS colonization might increase clinical suspicion for early-onset GBS disease in an infant, in the era of universal screening, >60% of early-onset GBS cases have occurred among infants born to women who had a negative prenatal GBS culture screen (102,203,204). False-negative cases are not unexpected because culture at 35–37 weeks' gestation will fail to detect some women with intrapartum GBS colonization. As effective prevention strategies are increasingly implemented, a growing proportion of the remaining relatively low burden of disease will reflect inherent limitations in the strategies. Signs of sepsis in any newborn can be an indication of early-onset GBS disease, regardless of maternal colonization status." (Note the last sentence!!)

102. Van Dyke MK, Phares CR, Lynfield R, et al. Evaluation of universal antenatal screening for group B Streptococcus. N Engl J Med 2009;360:2626–36. 203. Pulver LS, Hopfenbeck MM, Young PC, Stoddard GJ, Korgenski K, Daly J, et al. Continued early onset group B streptococcal infections in the era of intrapartum prophylaxis. J Perinatol 2009;29:20–5. 204. Puopolo KM, Madoff LC, Eichenwald EC. Early-onset group B streptococcal disease in the era of maternal screening. Pediatrics 2005;115:1240–6. "

Perhaps those with clinical backgrounds or industry partners would like to comment on what should be understood about the limitations of current screening. Certainly, proper specimen collection is important. More on that topic soon!

Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (26) Dau 2 update: Summary - and a cautionary tale about AI

9 July, 2026

Dear CHIFA colleagues,

Here is a brief summary of the 25 messages so far. I decided to try using AI (Copilot) to help with this and have gone through the text output and made a few minor changes. Meanwhile, a cautionary tale: just half an hour ago I was talking to a friend who is a physiology lecturer at a medical school in England. He told me that the pass rate for medical students taking their first year exams had fallen substantially in 2026. This is also being seen nationally. He and others suspect that part of the reason may be AI. It seems that many students are now asking AI to produce summaries of lectures rather than working this through themselves. As a result, the students' lerning process is compromised, with poorer learning and poorer recall.

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CHIFA Digest – Short Summary: Spotlight on Group B Streptococcus (GBS)

(Messages up to 9 July 2026)

Our first CHIFA/HIFA Spotlight — timed with GBS Awareness Week (8–14 July 2026) — has generated powerful contributions from parents, clinicians, and researchers worldwide. The discussion highlights the global burden of GBS, the preventable nature of much GBS disease, and the critical need for reliable information for parents, health workers, and policymakers.

Key points from the discussion:

Personal testimonies from parents in the USA (Kelli Smith, Marti Perhach, Dura Schlei) describe the tragic loss of their babies to early- and late-onset GBS disease. Their stories emphasise how quickly GBS can progress and how gaps in awareness and clinical practice can lead to preventable harm.

The WHO 2024 guideline recommends universal antenatal screening and timely intrapartum antibiotics, reducing early-onset disease by ~80%. However, country experiences show wide variation in screening and diagnosis. We have heard from Ethiopia, Gambia, Japan, Kenya and Nigeria and look forward to hearing from other countries.

Contributors consistently highlighted low awareness among parents, inconsistent information for health workers, and the need for maternal vaccination, better surveillance, and improved stillbirth investigation.

All CHIFA members are encouraged to help publicise the Spotlight, invite colleagues to join CHIFA (free), and share the landing page: www.hifa.org/gbs.

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Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (27) Introduction: Elon Danziger (4) Recognition of early signs of GBS disease in babies

9 July, 2026

[Re: https://www.hifa.org/dgroups-rss/introduction-elon-danziger-global-strat...]

Dear Elon,

Just to comment on what you wrote in your response to David, I very much appreciate that NoviGuide encourages nurses to do frequent spot checks and rounds on babies, especially in case of any danger sign or risk factor.

Group B strep is the HIFA/CHIFA Spotlight topic this week and all too often we at Group B Strep International hear from parents where the signs and risk factors were overlooked.

Best,
Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. www.groupbstrepinternational.org Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (27) Group B Strep in Nigeria (2) Personal and professional experience (4)

9 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-22-group-b-stre...]

Dear Dr. Ikuemonisan,

Thank you for your comprehensive assessment of the current GBS situation in Nigeria and what needs to be done to improve care. Very insightful and inspirational!

Would you happen to know of any parents who might be willing to share their GBS story publicly? I know they can be sometimes difficult to identify in settings where the cause of the infection in individual cases may not be known.

Sincerely,
Marti

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Spotlight: Group B Strep (29) Results for Development (2) Meeting information needs for national policymaking

10 July, 2026

Dear CHIFA colleagues,

This morning I opened a discussion here on CHIFA on how organisations can better coordinate to meet the information needs of policymakers. This was in relation to a new toolbkit from the US-based NGO 'Results for Development', on the topic of early childhood development.

The questions I raised could equally be applied to Group B Strep disease (or indeed any health topic).

The World Health Organization issued a GBS guideline in 2024:

'According to the WHO 2024 guideline, pregnant women should be offered universal antenatal screening for Group B Streptococcus around 35–37 weeks' gestation. WHO also recommends a risk-based alternative in settings where universal screening is not feasible. Those who test positive should receive intravenous antibiotics, such as penicillin or ampicillin, at least four hours before delivery to prevent passing GBS to their baby. This approach reduces the risk of newborn early-onset disease risk by about 80%.'

https://www.who.int/news-room/fact-sheets/detail/group-b-streptococcus-(gbs)

The guideline is available here: https://www.who.int/publications/i/item/9789240099128

However, as we have seen in the first 2 days of our Spotlight on GBS, country experiences show wide variation in screening. We have heard from Ethiopia, Gambia, Japan, Kenya and Nigeria and look forward to hearing from other countries.

The Group B Strep International links to guidelines from Australia, Canada, New Zealand and the United States. https://www.groupbstrepinternational.org/gbs-organizations--guidelines-w...

Perhaps it could be useful to build a comprehensive table of countries, whether they have a national guideline, and whether the guideline recommends universal screening, risk-based screening or another approach.

It would also be interesting to track how this table changes over time.

We would expect the WHO global guideline to encourage many countries to consider adoption of universal screening. Perhaps some of the people in our current CHIFA discussion will be personally involved in this deliberation.

The above also raises the wider question of the capacity of national policymakers and public health leaders in each country to assess the global GBS guideline and whether and how this may be adapted and adopted for national policy. This in turn requires synthesis of global evidence (which has already been done by WHO) with local evidence (including evidence not only from research but also from civil society: https://www.hifa.org/projects/support-systems-how-can-decision-making-pr...).

This global-local synthesis is clearly a weak spot in the global evidence ecosystem. More could be done to support countries to adapt and use guidelines.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (30) Meeting information needs for national policymaking (2)

10 July, 2026

Dear CHIFA colleagues,

WHO global guideline development is now rigorous and systematic, and is one of the most important functions of the Organization. It hasn't always been this way. Right up to the 1990s, guidelines were produced by 'experts' sitting around a table. Thanks to the work of the Cochrane Collaboration and other organisations, WHO started experimenting with more structured reviews. The watershed moment was 2007, when WHO created the Guidelines Review Committee, which completely reformed their overall approach. Core elements include:

- Mandatory systematic reviews for all recommendations.

- Use of GRADE (Grading of Recommendations, Assessment, Development and Evaluation).

- Requirement for Guideline Development Groups (GDGs) with diverse expertise and conflict-of-

interest management.

- Standardized templates, decision tables, and peer review.

- Public posting of guidelines and evidence profiles.

The rigour of WHO guideline development is a huge advance in the strengthening of the global evidence ecosystem https://www.hifa.org/about-hifa#ecosystem

But there are clearly challenges on how national policymakers and public health professionals can use, adapt and adopt this guidance, and thereby develop national policy that reflects national evidence and realities.

A further recent innovation from WHO is their 2023 publication 'Strengthening countries' capacities to adopt and adapt evidence-based guidelines: a handbook for guideline contextualization'

https://iris.who.int/server/api/core/bitstreams/63282011-3089-4189-b09d-...

A key challenge is: how to improve not only the rigour, but the usability and adaptability of WHO guidelines.

One way to approach this is to ask national policymakers whether the content or presentation of global guidelines could be improved to make them more readily usable at country level.

Coming back specifically to national policymaking on GBS, has anyone had experience of this? If you know others who could help with this, please forward this message and invite them to join us: www.hifa.org/gbs & www.hifa.org/joinchifa

I also invite people to review the current WHO global GBS guideline itself: https://www.who.int/publications/i/item/9789240099128

One of the key recommendations is that: 'Women should be provided with evidence-based, up-to-date information on the prevention of early onset GBS disease in newborns and the maternal screening offered in their setting before being offered screening. The information should facilitate an understanding of the purpose of screening, the procedure involved in obtaining swabs in their setting and the potential implications of a positive result including subsequent intrapartum antibiotic prophylaxis. Women should give consent for the procedure and be able to refuse without mistreatment.'

It is encouraging that WHO guidelines are not only rigorous but also increasingly cognisant of the importance of meeting information needs.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (31) Meeting information needs for national policymaking (3)

10 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-29-results-deve...]

Very interesting questions you raise, Neil. Thank you for bringing up the comprehensive table of countries' approaches to GBS screening. We (Group B Strep International) have compiled our own internal table based off of this supplemental review which can be found at https://drive.google.com/file/d/1D-bhH46AjA-ijNSOCqXgyUnhHMZVkVOQ/ for this article: [*see note below]

Le Doare K, O'Driscoll M, Turner K, Seedat F, Russell NJ, Seale AC, Heath PT, Lawn JE, Baker CJ, Bartlett L, Cutland C, Gravett MG, Ip M, Madhi SA, Rubens CE, Saha SK, Schrag S, Sobanjo-Ter Meulen A, Vekemans J, Kampmann B; GBS Intrapartum Antibiotic Investigator Group. Intrapartum Antibiotic Chemoprophylaxis Policies for the Prevention of Group B Streptococcal Disease Worldwide: Systematic Review. Clin Infect Dis. 2017 Nov 6;65(suppl_2):S143-S151. doi: 10.1093/cid/cix654. PMID: 29117324; PMCID: PMC5850619.

Will check further on making our internal table available for others to update and contribute to.

Best,
Marti

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[*Note from HIFA moderator (NPW): Thanks Marti, I have put in a request to view/edit this google doc and look forward to see how it can be developed further]

Spotlight: Group B Strep (32) Meeting information needs for national policymaking (4) Screening to prevent GBS disease

10 July, 2026

Dear Marti and all,

'According to the WHO 2024 guideline, pregnant women should be offered universal antenatal screening for Group B Streptococcus around 35–37 weeks' gestation. WHO also recommends a risk-based alternative in settings where universal screening is not feasible. Those who test positive should receive intravenous antibiotics, such as penicillin or ampicillin, at least four hours before delivery to prevent passing GBS to their baby. This approach reduces the risk of newborn early-onset disease risk by about 80%.' WHO Fact Sheet

Yet there is marked variation between countries. The United States and some other countries have adopted universal screening for all pregnant women. Whereas the UK (below) and others have not.

The issue is not straightforward. For example, as Kelli has eloquently said: "I wish every pregnant woman and every healthcare professional understood that a negative Group B Strep screening test does not eliminate the risk of Group B Strep disease. GBS colonization can change after screening, and while current screening and intrapartum antibiotics have saved thousands of babies' lives, they do not prevent every case. Every newborn must still be carefully assessed, and any signs of illness should be treated with urgency because early-onset GBS disease can progress with remarkable speed."

The decision to adopt universal screening versus 'a risk-based alternative' may be complex. The typical 'risk-based alternative' is to offer intrapartum antibiotic prophylaxis when one or more risk factors are present.

https://iris.who.int/server/api/core/bitstreams/10edd56e-eb79-4782-83a2-...

In contrast to the United States, the United Kingdom does not currently have universal screening for GBS.

The National Health Service patient-facing website says:

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Group B strep is a type of bacteria called streptococcal bacteria. It's very common in both men and women and usually lives in the bottom (rectum) or vagina.

Group B strep is normally harmless and most people will not realise they have it...

Group B strep is common in pregnancy and rarely causes any problems.

It's not routinely tested for, but may be found during tests carried out for another reason, such as a urine test or vaginal swab...

Routine testing is not currently recommended and tests are rarely done on the NHS. This is because group B strep is very common and testing cannot predict whether a baby will get an infection. You can pay for a test privately...

==

The NHS site does not give full information on the risk-based approach to prevention of GBS either.

The WHO guidance appears to recommend universal screening where this is feasible, and a risk-based approach where it is not. But the NHS guidance does not seem to align with WHO guidance and probably needs to be reviewed, or at least explained better.

One factor in NHS decisions is the input from NICE, the National Institute for Health and Care Excellence, which 'helps practitioners and commissioners get the best care to people, fast, while ensuring value for the taxpayer'.

I checked the NICE website and it says:

"Guidelines from the Royal College of Obstetricians and Gynaecology and The National Screening Committee do not currently recommend routine screening for GBS at any stage during pregnancy. Additionally, NICE does not currently recommend selective testing for women considered to be at increased risk of GBS."

https://www.nice.org.uk/advice/mib28/resources/xpert-gbs-test-for-the-in....

Would anyone on CHIFA have time to look into this NICE/NHS decision process a little closer on our behalf? Even better, does anyone know someone who has participated in the process? If so, please invite them to join us: www.hifa.org/joinchifa

Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (33) Personal and professional experience (4) GBS in Ethiopia (2)

11 July, 2026

Dear all,

Thank you very much for organizing this remarkable week, which has brought global attention to Group B Streptococcus (GBS).

1. My personal and professional experience with Group B Streptococcus (GBS) disease

As a medical microbiologist, educator, and researcher, I have observed that GBS is an important but neglected cause of neonatal sepsis in Ethiopia. Limited awareness, weak laboratory capacity, and the absence of routine screening and national guidelines result in missed opportunities for prevention.

Improvement strategies: Increase awareness, strengthen laboratory capacity, and introduce national GBS screening and prevention guidelines.

2. What is the situation of GBS in Ethiopia?

The burden of GBS in Ethiopia is likely underestimated due to limited surveillance and diagnostic services. Routine antenatal screening is unavailable, neonatal infections are rarely confirmed microbiologically, and national data on GBS and antimicrobial resistance are scarce. For instance, a 2020 Ethiopian study demonstrated the significant public health burden of GBS: 5 of 46 (10.9%) GBS-positive infants died, with most deaths occurring in late-onset GBS disease (LOGBS). PCR also detected GBS in 64% of culture-negative cerebrospinal fluid samples, highlighting the need for improved diagnostics and prevention strategies.

Suggested solution: Establish national surveillance, improve laboratory diagnosis, and integrate GBS screening into existing antenatal care would be cost-effective.

3. How can we reduce the burden of GBS disease?

Reducing GBS requires collaboration among governments, healthcare providers, researchers, and communities. Priorities include public awareness, routine maternal screening where feasible, timely intrapartum antibiotic prophylaxis (IAP), improved surveillance, health worker training, and support for maternal GBS vaccine introduction when available.

Strategies: Develop a national GBS prevention program through multisectoral collaboration.

4. What do parents need to know about GBS?

Parents should know that GBS is a common bacterium carried by many healthy women without symptoms. It can be transmitted during childbirth and cause severe infections in newborns, but early detection and treatment can save lives.

Mechanisms for improvement: Educate families during antenatal and post-natal care about GBS, its warning signs, and when to seek immediate medical attention.

5. What do healthcare workers need to know about GBS?

Healthcare workers should recognize GBS as a major cause of neonatal infection as they are the frontlines in the healthcare systems. Maternal screening, timely intrapartum antibiotics for eligible mothers, accurate diagnosis, and proper reporting are essential for preventing early-onset disease.

Suggested strategies: Incorporate GBS prevention, diagnosis, and management into routine healthcare worker training and clinical guidelines as it is done for HIV, TB, malaria, etc.

6. What are the common myths about GBS?

Common myths include that GBS is a sexually transmitted infection, affects only unhygienic women, or can be prevented by hygiene alone. However, GBS commonly colonizes healthy women, is often asymptomatic, and requires evidence-based prevention strategies.

Mechanism of improvement: Conduct public education campaigns to correct misconceptions and promote evidence-based GBS prevention.

Best!

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Sincerely,

Mucheye Gizachew (BSc, MSc, PhD)
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Associate Editor, Journal of Disability CBR & Inclusive Development
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gizachew@uog.edu.etn=1456; h-index=21; & i10-index=27
LinkedIn: https://www.linkedin.com/in/mucheye-gizachew-9a754b4a; ORCID
ID:https://orcid.org/0000-0002-3754-2618
Research / Citation Metrics: Citatio00-0002-3754-2618
Scopus Author ID: 55123088900
Web of Science Researcher ID: MVU-5532-2025.

HIFA profile: Mucheye Gizachew Beza is an instructor, researcher and community service provider at the University of Gondar, Ethiopia. By profession, he is a Medical Microbiologist with academic backgrounds in Nursing and Biological Sciences. His professional and research

interests focus on Group B Streptococcus (GBS), maternal and neonatal infectious disease prevention, antimicrobial resistance (AMR) focusing on One Health Approach, public health microbiology, biosafety and biosecurity, disease surveillance, and health education. He is particularly committed to advancing community awareness, strengthening public health interventions, and promoting evidence-based strategies to improve maternal and child health outcomes. His work aims to bridge research, education, and public health practice to address emerging infectious disease challenges and enhance healthcare quality and safety. Email address: muchegiza AT gmail.com

Spotlight: Group B Strep (34) The limitations of screening (3)

11 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-25-question-mar...]

Hi, I just want to follow up on the specimen collection topic mentioned in my previous response to Kelli and how that might impact a mom's GBS status.

In looking at the American Society for Microbiology's Guidelines for the Detection and Identification of Group B Streptococcus (which can be downloaded at https://asm.org/guideline/guidelines-for-the-detection-and-identificatio...), their recommendations under Specimen, Storage, Collection and Transport are:

- Use a single swab to obtain a screening specimen first from the lower vagina and then from the rectum without use of a speculum.

- Collect vaginal-rectal specimens using a flocked swab and place in a liquid-based transport medium such as Amies transport media.

- Transport vaginal-rectal specimens to the testing laboratory within 24 hours.

There is detailed info as to why flocked swabs are preferable to traditional fiber wrapped swabs and what to if a specimen culture is delayed beyond 24 hours after collection as that may yield false negatives.

Best,
Marti

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Spotlight: Group B Strep (35) Meeting information needs for national policymaking (5) Group B Strep policies

11 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-31-meeting-info...]

In case you are unable to open the link for the supplemental review I included in my previous response, please scroll down to the end of the systematic review at https://academic.oup.com/cid/article/65/suppl_2/S143/4589585 and click on Supplement material 1 to open that link. If you happen to notice that any of the guidelines (referenced on page 10) have updates, please let us know.

Best!
Marti

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Spotlight: Group B Strep (36) Should there be informed consent before fetal membrane "sweeping" (also known as "stripping") ?

11 July, 2026

Dear colleagues,

I would like to add a second thing to my first answer to Kelli's question, "What is the one thing about Group B Strep that you wish every pregnant woman and every healthcare professional understood?" I would also like it to be known and understood that GBS can cross intact membranes. In regards to this, I would like to pose the question, "Should there be informed consent before fetal membrane "sweeping" (also known as "stripping")?

We have a collection of information available on this topic at https://www.groupbstrepinternational.org/prenatal-onset.html#membranestr... . Would be glad for you to share your perspective on this for the forum.

Best!
Marti

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Spotlight: Group B Strep (37) Reflections on our discussion so far

11 July, 2026

What a great discussion we are having! I have especially valued the exchanges between Marti and Kelli, and the valued contributions from many contributors worldwide.

This discussion is highly significant for CHIFA and HIFA not only because it is our first Spotlight (www.hifa.org/spotlights) and not only because this is such an important topic, but also because it is the first time we have had a sponsored discussion that has been led by people with lived experience. Marti and Kelli (and Dura) have generously shared their personal experience of loss due to GBS disease. This adds a powerful and human dimension to our exploration of this topic.

We have already touched on many of the six guiding questions for our discussion [www.hifa.org/gbs]:

1. WHAT IS YOUR PERSONAL AND PROFESSIONAL EXPERIENCE OF GBS DISEASE?

We warmly welcome further sharing of personal experience and also professional experience of GBS disease. We would especially like to hear from you if, like Marti, Kelli, and Dura, your life has been impacted by GBS disease. Also we would like to hear your professional experience as a health worker, for example if you have been involved in the care of a mother and baby affected by GBS disease.

2. WHAT IS THE SITUATION IN YOUR COUNTRY?

We have heard already from several countries: Canada, Ethiopia, Gambia, Japan, Kenya, Nigeria, United States. We look forward to hear more from these countries, and from other countries too.

3. WHAT CAN BE DONE TO REDUCE THE BURDEN OF GBS DISEASE?

We have noted that the WHO guideline (2024) recommends universal screening of mothers at 35-37 weeks, but this is currently only available in a few countries (eg US, Canada). What can be done to support countries to implement universal screening?

Some countries (such as the UK) have a risk-based approach whereby GBS screening is limited to women considered at high risk. To what extent does this approach protect women as compared with universal screening?

We have seen that early signs of illness in the newborn can be overlooked and that severe illness can develop with frightening speed. What can be done to recognise these symptoms earlier so that there is a higher chance of successful treatment?

4. WHAT DO PARENTS NEED TO KNOW ABOUT GBS DISEASE?

5. WHAT DO HEALTH WORKERS NEED TO KNOW ABOUT GBS DISEASE?

Kelli addressed 4 and 5 eloquently in just a few words: "I wish every pregnant woman and every healthcare professional understood that a negative Group B Strep screening test does not eliminate the risk of Group B Strep disease*.* GBS colonization can change after screening, and while current screening and intrapartum antibiotics have saved thousands of babies' lives, they do not prevent every case. Every newborn must still be carefully assessed, and any signs of illness should be treated with urgency because early-onset GBS disease can progress with remarkable speed."

Marti has enriched our conversation with her expertise on GBS gained though her leadership of our partner organisation Group B Strep International https://www.groupbstrepinternational.org/ I encourage you to explore their website.

6. WHAT ARE THE COMMON MYTHS ABOUT GBS DISEASE?

A few messages have touched on myths. We would welcome more on this topic. Can you help identify common myths about GBS, why and how they arise, and how they might be addressed?

Thank you again to everyone who has contributed to this discussion, and everyone who has been following it. We are now on day 4 of our 7-day conversation and I look forward to many more stimulating contributions.

Please send your thoughts by email to: chifa@hifaforums.org

You can review all messages here: www.hifa.org/readchifa

Thank you and best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (38) Chronic GBS vaginitis and/or urinary tract infections

12 July, 2026

Thank you, Neil and team, for coordinating this discussion!

I'd like to ask both the CHIFA and HIFA forums for any resources they might know of for women, pregnant and non-pregnant, who suffer from chronic GBS vaginitis and/or urinary tract infections caused by GBS. We at Group B Strep International hear constantly from women who are plagued with persistent symptoms despite taking antibiotics and are trying alternative treatments that may not nessarily by safe or effective.

Sincerely,
Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. www.groupbstrepinternational.org Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (38) USA GBS Protocols

13 July, 2026

Hi. To whom it may concern,

I was hoping to share my son's story. Please note that we are in the USA and these are the current standards.

I was GBS+ with our Elliott. I was tested and positive at 36 weeks and didn't get antibiotics when I found out because I was supposed to be having a c-section. I didn't get antibiotics when I was in labor at 37 weeks because my labor was "quick" and there "was no time." And c-section did not occur.

Sweet E was born on 2/7/23 at 5:19am. Hour 29 (2/8/23) was our game changer and symptoms of illness began. That's when lab work and treatment also began. Because that's what the current protocols require.

Current protocols (set as a "standard" across the nation) are to monitor a baby of an untreated mother for 72 hours with an increase in vital sign monitoring and for other signs and symptoms. He received abx for 1 month. But they didn't help. His post abx MRI showed extensive global encephalomalacia.

Due to me not getting the antibiotics in labor, and the current protocols, Elliott is 1 in 8 survivors with significant disabilities.

Did you know that GBS (Group B Strep) is the leading cause of meningitis and sepsis in newborns?

Did you know that the current protocol is to only monitor post delivery for signs/symptoms of meningitis?

Did you know that 1 in 8 survivors are to have significant disabilities?

Did you know that July is GBS Awareness Month?

Our Elliott is ONE in EIGHT.

Let's have this discussion. Let's bring awareness. What can we do different so we can minimize this disease?

Thank you so much for your time.
Katy Butler

CHIFA profile: Katy B is a SAHM with GBS international, USA. mktgarland AT gmail.com

Spotlight: Group B Strep (39) USA GBS Protocols (2) Long-term disability in survivors of GBS

13 July, 2026

Dear Katy and CHIFA colleagues,

Thank you so much for sharing your personal story of your son Elliott.

"Did you know that GBS (Group B Strep) is the leading cause of meningitis and sepsis in newborns?

Did you know that the current protocol is to only monitor post delivery for signs/symptoms of meningitis?

Did you know that 1 in 8 survivors are to have significant disabilities?"

The WHO fact sheeet on Group B STrep notes:

'Some babies who survive a serious GBS infection can have long-term health problems. About 20–30% of babies who survive GBS meningitis may have lasting problems such as hearing loss, seizures, or delays in learning to move, speak, or think. Some may also develop cerebral palsy, which affects movement and muscle control. Babies who survive GBS sepsis can also sometimes have developmental problems, though this is less common than after meningitis. Most babies recover fully, but some, especially after severe infection, may need ongoing follow-up care.'

An Australian study notes that 'Little is known about the long-term risk of death and hospitalisation after group B streptococcal (GBS) infection during infancy... Despite reductions in the overall rates of GBS infection (especially of early onset), the burden of disease remains high. Preterm infants are at high risk of death from GBS infection and all survivors continue to be at risk of death and health problems, including chronic conditions such as cerebral palsy and epilepsy.' Yeo KT, Lahra M, Bajuk B, et al. Long-term outcomes after group B streptococcus infection: a cohort study. Archives of Disease in Childhood 2019;104:172-178. https://adc.bmj.com/content/104/2/172.long [restricted access]

A Norweggian study found that 'Of GBS infection survivors, 20.7% were diagnosed with neurodevelopmental disorders (NDDs)... Infants with GBS meningitis were more often diagnosed with NDDs... The burden of invasive GBS infection during infancy is considerable and continues to affect children beyond infancy. These findings emphasize the need for new preventive strategies for disease reduction, and the need for survivors to be directly included into early detection pathways to access early intervention if required.' Mynarek M, Vik T, Andersen GL, Brigtsen AK, Hollung SJ, Larose TL, et al. Mortality and neurodevelopmental outcome after invasive group B streptococcal infection in infants. Dev Med Child Neurol. 2024; 66: 125–133. https://doi.org/10.1111/dmcn.15643 [open access]

A systematic review (2017) notes 'GBS meningitis is an important risk factor for moderate to severe NDI, affecting around 1 in 5 survivors. However, data are limited, and we were unable to estimate NDI after GBS sepsis.' Kohli-Lynch M et al. Neurodevelopmental Impairment in Children After Group B Streptococcal Disease Worldwide: Systematic Review and Meta-analyses. Clin Infect Dis. 2017 Nov 6;65(suppl_2):S190-S199. doi: 10.1093/cid/cix663. PMID: 29117331; PMCID: PMC5848372.

"Let's have this discussion. Let's bring awareness. What can we do different so we can minimize this disease?"

The WHO website notes: 'In 2020, Member States committed to implementing the Defeating meningitis by 2030 global road map. The roadmap focuses on eliminating the main causes of acute bacterial meningitis – including GBS, including through prevention, treatment and further research.' 'The road map on defeating meningitis sets out a plan to tackle the main causes of acute bacterial meningitis: Neisseria meningitidis ((Nm), meningococcus), Streptococcus pneumoniae ((Spn), pneumococcus), Haemophilus influenzae (Hi) and Streptococcus agalactiae (group B Streptococcus (GBS)).' It can be downloaded here: https://iris.who.int/server/api/core/bitstreams/64850fcf-300f-4b54-b234-...

I see that Marti was consulted in the development of this roadmap. Marti, please can you let us know about your role and the process? Are you happy with the final roadmap? Skimming the report, it seemed to me that it was addressing all causes collectively, with little specific content

on Group B Strep. This may well reflect common factors. In addition, the roadmap is about meninigitis in all age groups. Did it adequately address perinatal infections?

Also, what progress has been made on the recommendations of the roadmap? Has there been a significant increase in political and financial support for meningitis in general, and for Group B Strep in particular?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (40) Long-term disability in survivors of GBS (2) Quality of care

13 July, 2026

Looking at the WHO roadmap (which deals with bacterial meningitis collectively in children and adults, and with different pathogens) Isee

EXTRACTS

Strategic Goal 6: Improve diagnosis of meningitis at all levels of care:

Develop and disseminate regionally specific policies on testing requirements and tools for each level of the health system, according to the required decisionmaking (for example, for immediate clinical management, epidemic response, antimicrobial resistance)...

Establish appropriate training and supervision of health workers at each level of care for timely identification, diagnosis, referral and treatment of meningitis in all age groups. [curiously this was the last ecommended activity - I would have put it at the top, together with meeting the information needs of parents]

Strategic Goal 8: Develop and implement a contextspecific policy to identify mothers who are GBS carriers, and for diagnosis of infant GBS infection, particularly for lowresource settings [indeed this was probably the basis for the later WHO guidance on screening that we have discussed]

COMMENT (NPW): I get the impression that specific guidance related to Group B Strep and periinatal infections is perhaps missing in this roadmap? Is there a need for the derivation of a specific roadmap for Group B Strep, which would buildon the collective roadmap?

On the issue of 'Improve diagnosis of [Group B Strep] meningitis at all levels of care' we need to know a lot more about this. What is the current level of care for mothers and infants in relation to Group B Strep? What do health workers know about its prevention and treatment? Are they able to adequately and reliably identify early signs of sepsis and meningitis in infants? Is appropriate treatment initiated without delay. Do health workers have access to diagnostic support? In general, are health workers empowered by the health system with their basic SEISMIC needs? www.hifa.org/needs

I invite your comments on quality of care available in different settings.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (41) What every pregnant woman and every healthcare professional should know (4)

13 July, 2026

What does every parent need to know about group B Strep? What are the three most important things?

Thanks to this discussion, I have learned three things:

1) GBS is common and usually harmless in adults, but it can be life-threatening for newborns. Around 10–30% of pregnant women carry GBS without symptoms. It is part of the normal gut/vaginal microbiome and usually causes no problems for the mother. But for babies, GBS can cause sepsis, pneumonia, and meningitis, especially in the first week of life.

2) Most early-onset GBS infections can be prevented with antibiotics during labour. If a mother carries GBS, IV antibiotics given at least 4 hours before birth reduce the risk of early-onset disease by about 80%. This is why knowing your GBS status and receiving timely treatment during labour is important. Howevr, in many countries (eg UK), universal screening is not done - only 'high-risk' mothers are screened. (I haven't yet learned whether this high-risk approach is adequate.)

3) Parents must know the warning signs of GBS infection in babies up to 3 months old. Symptoms can appear at birth or weeks later. Seek urgent medical care if a baby shows:

poor feeding or vomiting

fever or very low temperature

lethargy, irritability, or unusual sleepiness

breathing problems (grunting, fast breathing, working hard to breathe)

pale, blue, or blotchy skin

bulging soft spot (late-onset meningitis)

Every baby must be monitored closely in the neonatal period. Clinicians should start empirical antibiotics before test results are available, because newborn infections can progress very quickly. Penicillin or ampicillin is typically used first, often in combination with gentamicin.

Group B Strep International provides a wide range of leaflets: https://www.groupbstrepinternational.org

Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (42) What every pregnant woman and every healthcare professional should know (5) A question for Marti re screening

13 July, 2026

Hi Marti, Thanks on behalf of CHIFA for all your contributions to this discussion through your leadership of Group B Strep International.

I was reviewing previous messages and I wanted to ask if we could review a meesage you sent previously:

https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-21-what-every-p...

In it, you said:

"Also, that culture results are considered to be 95% to 98% accurate if done < 5 weeks before delivery, but after that the negative predictive value declines."

This seems to imply that, in a term (40 week) pregnancy, the culture results are 95% to 98% accurate if done between 35 and 40 weeks. We might expect the accuracy of the test to be better at, say, 49 weeks rather than 45 weeks. Or is that not the case?

Also, 'after that the negative predictive value declines', this seems to suggest that the accuracy reduces during the period between 35 and 40 weeks, so that it is less at 37 weeks as compared with 35 weeks.

Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (43) What every health worker should know

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13 July, 2026

What does every health worker need to know about group B Strep?

They should of course know what every mother knows and more besides.

We haven't pinned down what every mother should know, but I proposed three things in my previous message:

1) GBS is common and usually harmless in adults, but it can be life-threatening for newborns. Around 10–30% of pregnant women carry GBS without symptoms. It is part of the normal gut/vaginal microbiome and usually causes no problems for the mother. But for babies, GBS can cause sepsis, pneumonia, and meningitis, especially in the first week of life.

2) Most early-onset GBS infections can be prevented with antibiotics during labour. If a mother carries GBS, IV antibiotics given at least 4 hours before birth reduce the risk of early-onset disease by about 80%. This is why knowing your GBS status and receiving timely treatment during labour is important. However, in many countries (eg UK), universal screening is not done - only 'high-risk' mothers are screened. (I haven't yet learned whether this high-risk approach is adequate.)

3) Parents must know the warning signs of GBS infection in babies up to 3 months old.

What should every health worker know, in addition to the above. From our discussion I understand that:

Every health worker who cares for women in pregnancy, including primary health workers, midwives, obstatricians, should be aware of their national policy for screening (does every country have a policy?) and implement this. If the national policy is universal screening, every health worker should be aware and offer this to the mother. If the national policy is risk-based screening, every health worker should be aware of and be able to identify risk factors in every pregnant woman and offer screening accordingly.

Every health worker who attends a delivery should be aware of the GBS status of the mother (where available) and should be aware that procedures such as sweeping/stripping the membranes can increase risk of GBS transmission to the baby.

Every health worker should be alert to the warning signs of GBS in babies, and act with urgency if these signs present. This applies to all nurses and midwives working in the hospital or clinic where the baby was born, and all health workers who attend the infant in the following days and weeks. Additional guidance is needed for women and health workers in low-income countries where home birth is more common and often unattended by a health professional.

GBS needs to be included in all pre-service and in-service training. Evidence-informed guidance is needed in appropriate language, format and technical level for different cadres of health worker.

What guidance is available in your country?

What else should every health worker know?

Best wishes, Neil

CHIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA

is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (44) USA GBS Protocols (3) Parent stories

14 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-38-usa-gbs-prot...]

Many thanks to Katy for sharing her and Sweet E's group B strep experience and her advocacy to bring about change!

What can we do differently to minimize GBS disease in their and other situations?

We at Group B Strep International need your help to identify gaps in care and communication surrounding GBS disease. We are asking mothers who conceived on or after January 1, 2003, whether they have had a baby infected by GBS or not, to share their experience.

We would be grateful if you would share the link https://www.groupbstrepinternational.org/waves.html with your contacts and social media. Healthcare professionals, please share this opportunity with your patients to help inform care for future generations. All eligible mothers, including those of you who are healthcare professionals, please share your experience and perspective to help make a difference for other families.

Sincerely,
Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. www.groupbstrepinternational.org Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (45) What every health worker should know (2) Community health workers

14 July, 2026

Dear Neil and colleagues,

Thank you for an excellent series of discussions. Reading the contributions, I have been reflecting on the issue from the perspective of community health systems in low- and middle-income countries.

One important lesson is that preventing deaths from Group B Streptococcus (GBS) does not begin in the labour ward — it begins in the community.

Imagine two mothers.

The first delivers in a well-equipped hospital where her GBS status is known, antibiotics are available, and the baby is closely monitored. If the baby develops poor feeding or breathing difficulties, clinicians act immediately.

The second delivers in a rural setting where GBS screening is unavailable, the nearest health facility is several hours away, and the family believes that a sleepy baby is simply "resting after

birth." By the time the baby develops grunting, poor feeding, or hypothermia, valuable hours have been lost.

The bacterium may be the same, but the outcome is determined by the health system surrounding the mother and newborn.

This discussion therefore reminds us that improving GBS outcomes requires more than clinical protocols. We also need strong antenatal counselling, birth preparedness, effective referral systems, postnatal home visits, and community education so that parents recognize newborn danger signs and seek care immediately.

In many countries, community health workers are the first contact for mothers after delivery. They may not diagnose GBS, but they can save lives by identifying newborn danger signs early, encouraging prompt referral, supporting follow-up after discharge, and reinforcing messages given during antenatal care. Integrating GBS awareness into existing maternal and newborn health programmes may therefore be a practical and cost-effective approach, particularly where universal screening is not yet feasible.

Another point that has received less attention is the long-term journey of survivors. Several colleagues have highlighted neurodevelopmental impairment following invasive GBS disease. This means that our responsibility should not end when the infection is treated successfully. Babies recovering from GBS meningitis or severe sepsis should, where possible, receive developmental follow-up, hearing assessments, vision screening, and family support so that disabilities are identified early and appropriate interventions can begin. Survival alone is not enough; every child deserves the opportunity to reach their full developmental potential.

Finally, I believe one message could resonate widely with both health professionals and parents:

"A newborn cannot tell us they have sepsis. They only change their behaviour. When a newborn suddenly feeds poorly, becomes unusually sleepy, struggles to breathe, or feels too hot or too cold, every hour matters. Treat these changes as a medical emergency, not as something to wait and see."

This simple message is relevant not only for GBS but for neonatal sepsis more broadly, regardless of the underlying pathogen.

Thank you all for this valuable discussion. It highlights that reducing newborn deaths from GBS will require collaboration between families, communities, frontline health workers, hospitals, researchers, and policymakers.

Best wishes,

Rabia

Ms. Rabia A. Khaji
Public Health Expert | TB, HIV, Malaria, SRH | M&E | Operational research | Consultant | Board Member | Gender & Community Systems | Mentor
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CHIFA profile: Rabia Abeid Khaji is the Head of Monitoring and Evaluation and TB Portfolio at SHDEPHA+ in Tanzania. Her professional work is fundamentally centered on overcoming barriers to health information access, particularly for healthcare professionals and vulnerable communities in low-resource settings. Her experience includes: - Gender and Equity Focus: She recently led a comprehensive TB gender assessment for Tanzania and contributed to the national TB Gender Operational Plan, directly engaging with the challenges of equitable access to health information and publishing. - Community-Led Monitoring: She developed frameworks for Community-Led Monitoring (CLM) of TB services, empowering communities to identify and report service gaps—a process that deeply resonates with understanding end-user needs in the evidence ecosystem. - Research and Advocacy: She co-authored published operational research on TB and has extensive experience presenting findings at international conferences, such as the Union World Conference on Lung Health, International Aids Society etc. I understand the critical importance of disseminating research findings effectively to impact policy and practice. - Stakeholder Engagement: She serves on the boards of the Tanzania STOP TB Partnership and the Tanzania TB Community Network (TTCN), and is a member of the SMART4TB Afro Community Advisory Board. These roles require constant collaboration with diverse stakeholders, from policymakers to community health workers.

Spotlight: Group B Strep (46) WHO Defeating Meningitis by 2030 Global Road Map (1) International Symposium on Streptococcus Agalactiae Disease

14 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-39-usa-gbs-prot...]

Dear Neil and CHIFA colleagues,

In regards to the questions posed, my role in the Defeating Meningitis by 2030 Global Road Map was minimal through a web-based consultation at one point in its development. I defer to others who were involved to comment on the process and am grateful to them for developing this very important road map.

I am always glad to have group B strep included in collective efforts and in regards to this call for action, it strengthens the awareness for the need for a maternal GBS vaccine which is in development through several independent efforts. To my knowledge, two are in late-stages of clinical development.

The biennial International Symposium on Streptococcus Agalactiae Disease (ISSAD) https://issad.org/ focuses on perinatal group B strep (common name for Streptococcus agalactiae) infections with many common participants from the road map efforts so from my perspective, there's a good balance with the road map's broader scope.

Perhaps other CHIFA colleagues who are more in-the-know can comment on progress for the road map recommendations as well as political and financial support for meningitis in general and GBS in particular.

Best!
Marti

CHIFA profile: Marti Perhach is CEO/Cofounder of Group B Strep International, United States. Professional interests: Group B strep disease research and prevention, prenatal infection, One Health. www.groupbstrepinternational.org Email address: marti.perhach AT gbs-intl.org

Spotlight: Group B Strep (47) What are the common myths about GBS disease?

14 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-39-usa-gbs-prot...]

These are two common perinatal misconceptions that are applicable to group B strep disease.

FICTION
Babies move less as they grow closer to term.

FACT
While the type of fetal movements may change in the third trimester, there is no evidence to support that the number of fetal movements decrease because "there is less room for your baby to move."

Clinical practice guideline for the management of women who report decreased fetal movements <https://sanda.psanz.com.au/assets/Uploads/DFM-Clinical-Practice-Guidelin....
Brisbane, July 2010.

FICTION
Autopsies never find a cause.

FACT
"A reasonable cause of death was identified in 99/124 pregnancies (79.84%)." (4) "Systematic review finds GBS causes up to 12.1% of stillbirths...", (2) Please be aware that besides full autopsies, there are other pathology testing options which may provide answers.
Bonetti, L.R., Ferrari, P., Trani, N. et al. The role of fetal autopsy and placental examination in the causes of fetal death: a retrospective study of 132 cases of stillbirths. Arch Gynecol Obstet 283, 231–241 (2011).

Nan C, Dangor Z, Cutland CL, Edwards MS, Madhi SA, Cunnington MC. Maternal group B Streptococcus-related stillbirth: a systematic review. BJOG 2015; 122: 1437–1445.

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Spotlight: Group B Strep (48) A question for Marti re screening (2)

14 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-42-what-every-p...]

Hi, Neil,

In regards to your post, "This seems to imply that, in a term (40 week) pregnancy, the culture results are 95% to 98% accurate if done between 35 and 40 weeks. We might expect the accuracy of the test to be better at, say, 49 weeks rather than 45 weeks. Or is that not the case?,"

I think you mean 39 weeks rather than 35 weeks, but here's what one of the sources referenced in the acog.org/gbs <http://acog.org/gbs> guidelines states: "Test performance was similar from 1–5 weeks before delivery, but declined when 6 or more weeks had elapsed between the antenatal culture and delivery." MARKENSON, G., VENTURA, V., BROWN, L., SCHUCHAT, A., & YANCEY, M. (1996). The Accuracy of Late Antenatal Screening Cultures in Predicting Genital Group B Streptococcal Colonization at Delivery. Obstetrics & Gynecology, 88(5), 811–815.

However, from my GBS parent perspective, having a highly accurate rapid test available that could be performed at the start of labor would be an ideal adjunct scenario for those who test negative (to my understanding, there are several highly accurate rapid tests in development)... or, better yet, a maternal GBS vaccine being available could alleviate the need for testing.

Best,
Marti

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Spotlight: Group B Strep (49) A question for Marti re screening (3)

14 July, 2026

Many thanks for your latest post Marti (#48), this clarifies. I think I misinterpreted your original statement ""... 95% to 98% accurate if done < 5 weeks before delivery, but after that the negative predictive value declines." I interpreted the words 'after that' to mean the period after '5 weeks before delivery' (eg 35-40). Your response clarifies that you meant that the negative predictive value decreases when the test is done earlier ie more than 5 weeks before delivery.

My understanding of "negative predictive value" means how reliable a negative test result is — in other words, if your test says you don't have GBS today, how likely is that to be true.". At the time of screening at around 35-37 weeks, the negative predictive value is very high, around 95-98%. However, if a mother has a negative screening test, this may be accurate to tell her if she has colonisation with GBS at that time, but the mother may yet become colonised later in pregnancy.

So perhaps we need two separate terms: one to describe the point accuracy of the test (negative predictive value) and one to describe the risk of colonisation in the final weeks of pregnancy after a (true) negative screening.

The message to the mother might be something like: "GBS is a normal bacterium that can come and go, so a woman who tests negative at 35 weeks might become positive later on. The screening test is at least 95% accurate but it only tells us what's happening on the day it's done.

It can't predict what happens in later weeks. About X% of women with negative screening result subsequently become colonised by GBS in later weeks." Do we have an estimate for X?

As you say, a rapid test at the start of labour would be very helpful, especially if the results could be obtained within minutes. It may not provide adequate time for IV antibiotics for those 10-20% of labours that last less than 4 hours. But a positive result would be a signal to monitor very carefully the newborn infant.

If I have misunderstood or misrepresented anything in the above, please let us know!

Thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Group B Strep (50) Community health workers (2) Late-onset Group B Strep

14 July, 2026

Dear Rabia and colleagues,

Thank you for this thoughtful summary. I particularly agree with the point that our responsibility should not end once the infection has been treated successfully.

I am a Lecturer in Health Psychology at the University of Manchester (UK), and over the past few years I have had the privilege of interviewing parents and caregivers whose infants experienced late-onset Group B Strep infection. One consistent message from these conversations is that the impact of late-onset GBS extends far beyond the acute illness itself.

Families described feeling profoundly unprepared for their infant's sudden deterioration, often because they had never been informed that late-onset GBS could occur after leaving maternity services or what symptoms should prompt urgent medical assessment. Parents also described uncertainty surrounding diagnosis, prognosis and longer-term consequences, and many continued to experience significant psychological distress months or even years after the infection, including after infants had made a full physical recovery.

These experiences reinforce the importance of viewing GBS as more than an acute infectious disease. Alongside efforts to improve prevention, early recognition and treatment, we also need clear, family-centred communication throughout pregnancy, acute care and discharge, together with ongoing psychological and practical support that reflects families' changing needs over time. This includes support for fathers, wider caregivers and future pregnancies, which are often overlooked.

Our qualitative study is under review, and I hope it will contribute further evidence to these important discussions once published.

Thank you again for facilitating such a valuable conversation.

Best wishes,
Stephanie Lyons

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NIHR Research<https://www.nihr.ac.uk/explore-nihr/support/research-support-service/> Support Service<https://www.nihr.ac.uk/explore-nihr/support/research-support-service/> I Twitter: @NIHR_RSS<https://twitter.com/NIHR_RSS>

CHIFA profile: Stephanie Lyons is a Lecturer in Health Psychology at the University of Manchester, England. Professional interests: Supporting families to understand the risks and signs of GBS infections, to seek medical support appropriately when needed, and to recover after GBS infections. stephanie.lyons AT manchester.ac.uk

Spotlight: Group B Strep (51) What are the common myths about GBS disease? (2)

14 July, 2026

Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-47-what-are-com...

Dear CHIFA colleagues,

Marti notes two myths associatd with GBS disease: Babies move less as they grow closer to term; and Autopsies never find a cause.

These are two of the eight myths listed on the Group B Strep International website: https://www.groupbstrepinternational.org/gbs-myths.html

At the top of the page: 'Knowledge is power – that's why knowing the facts about group B strep (GBS) is so important. We aim to clarify some common misconceptions surrounding GBS, providing accurate information based on current medical understanding and guidelines. By addressing these misconceptions head-on, we hope to empower individuals with the knowledge needed to make informed decisions about their health and the health of their babies. There are many misconceptions surrounding GBS, so let's separate the facts from the fiction!'

Below are the other six myths on the GBSI website, with a comment from me. I invite your comments on any of these.

1. FICTION: GBS is only a concern at birth.

FACT: Group B Strep is not only a concern at birth. It is also a concern during pregnancy and early infancy. During pregnancy, GBS can infect babies in the womb and potentially cause miscarriage or stillbirth. According to the US Centers for Disease Control and Prevention (CDC) and several studies, GBS can cross intact membranes. (1) GBS can also cause preterm labor

and preterm premature rupture of membranes. (See video presentation by Dr. David M. Aronoff.) Babies can be miscarried, stillborn, born premature or be very sick at or soon after birth due to GBS infection that began prior to birth. After a baby is born, they are still susceptible to GBS up to several months of age due to their underdeveloped immune systems and can be infected by sources other than their mother.

2. FICTION: IV antibiotics aren't worth it.

FACT: IV antibiotics for GBS-positive pregnant women during labor are crucial to help protect newborns from early-onset GBS disease, based on robust evidence demonstrating significant reductions in neonatal morbidity and mortality associated with GBS infections. Early-onset GBS disease in newborns can be severe, causing conditions such as sepsis, pneumonia, and meningitis within the first week of life. Studies have shown that administering antibiotics during labor to GBS-positive women reduces the incidence of early-onset GBS disease in newborns by over 80%. Antibiotics are most effective when administered intravenously during labor because they help reduce the bacterial load in the birth canal at the time of delivery, minimizing the chances of transmission to the newborn during passage through the birth canal.

3. FICTION: GBS only affects pregnant women.

FACT: While GBS is commonly associated with pregnancy, it can also affect non-pregnant adults. According to the CDC, most cases of GBS disease in adults are among those who have other medical conditions. Learn more about GBS in nonpregnant adults.

4. FICTION: GBS stillbirths are "rare" or "very rare."

FACT: Until recently there has not been surveillance data to determine how often GBS stillbirths actually occur, pathology testing is not always done, and fetal death records are seldom updated with the final diagnosis. It is currently estimated that 46,000 babies are stillborn due to GBS each year worldwide.

5. FICTION: All babies born to GBS positive mothers will be infected.

FACT: Maternal GBS colonization does not guarantee that the baby will be infected. With proper screening and administration of antibiotics during labor (if indicated), the risk of transmission to the baby can be significantly reduced.

6. FICTION: Natural remedies can eliminate GBS.

FACT: Natural remedies such as garlic or tea tree oil have not been proven to prevent your baby from becoming infected. Some alternative treatments are unsafe. Yogurt and probiotics are known to have health benefits, but the exact impact on GBS colonization is not yet known.

Do any of the above myths resonate with your experience? Any comments or observations?

COMMENTS (NPW):

Myth 2 is clearly important if held by the mother or health worker. Is there a significant problem whereby mothers refuse antibiotic treatment during labour, even if they are GBS positive?

Myth 6 is also important if held by the mother or health worker (or complementary healer). The

idea that “natural remedies can eliminate GBS” is one of the most harmful myths in circulation. The short answer: no natural remedy has ever been shown to eradicate GBS carriage or prevent GBS disease in newborns. This myth creates dangerous false reassurance and can delay proven, life-saving care. Looking into this, I see that myth 6 is related to myth 2. Parents who seek 'natural' treatments are at risk of being falsely reassured and may be more likely to refuse antibiotics during labour. The complementary and wellness industry thrives on a powerful mix of commercial incentives, social-media misinformation, and public misunderstanding of health science — and this is exactly why myths like “natural remedies can eliminate GBS” spread so easily.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (53) What are the common myths about GBS disease? (3) How to address misinformation

14 July, 2026

Here are two more myths

Myth: “GBS is a sexually transmitted infection.”

Fact: It is not an STI; it is a common bacterium carried naturally by 20–40% of adults.

Myth: “GBS is associated with poor hygiene.”

Fact: GBS carriage is a normal biological variation, not a hygiene issue.

GBS is part of the natural bacterial flora in many people. It is not picked up from dirt, unclean environments, or inadequate washing. It is not a sign of neglect, poor self-care, or unsafe living conditions.

GBS carriage fluctuates over time — people can test positive one month and negative the next — because of normal microbiome changes, not hygiene.

These two myths are especially harmful because they stigmatize parents, especially mothers, by implying blame where none exists. It can make families feel guilty or responsible for something that is purely biological and out of their control. These myths are partly a result of people's ignorance. But they are also propagated deliberately by elements of the wellness industry and by individual social media influencers.

We invite comments and suggestions on how these myths (and those on the GBSI website) can be addressed.

Most of the global efforts around misinformation have been dominated by arguments for debunking and prebunking, and there has been some effort to help ensure that reliable information is more visible (especially the work of WHO with Google and others).

These are all important (especially, in my view, the latter). But we have also noted here on HIFA that both reliable healthcare information and misinformation arise as a consequence of a functioning (or failing) global evidence ecosystem. This is why HIFA's central purpose is to strengthen the global evidence ecosystem: www.hifa.org/ecosystem

Universal access to reliable healthcare information and protection from misinformation can only be achieved by strengthening the global evidence ecosystem. There are no shortcuts.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (54) What are the common myths about GBS disease? (4)

14 July, 2026

Thank you for bringing up these myths, Neil. I concur fully about the stigma they can cause for parents.

I'd like to comment in regards to the first myth that, while GBS is naturally found in the digestive and lower reproductive tracts of both men and women, parents should be aware that bacteria can be passed between sexual partners, including through oral contact. We include this information in our
brochure https://www.groupbstrepinternational.org/uploads/9/9/9/4/99946050/gbs_br... so that parents can be empowered to make informed choices, such as after testing negative, a new partner, etc. This also brings to mind the question, "Would it be best to avoid kissing young babies on their lips?"

Sincerely,
Marti

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Spotlight: Group B Strep (55) A question for Marti re screening (4)

14 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-49-question-mar...]

Thank you for asking for clarification, Neil. Apologies for the confusing wording. To clarify, copying what the CDC Nov. 19, 2010 MMWR "Prevention of Perinatal Group B Streptococcal Disease, Revised Guidelines from CDC, 2010" states under Specimen Collection and Processing for GBS Screening | Timing of Screening":

"Because GBS colonization status can change over the course of a pregnancy, the timing of specimen collection for determination of colonization status is important. Because colonization can be transient, colonization early in pregnancy is not predictive of early-onset GBS disease (44). Late third trimester colonization status has been used as a proxy for intrapartum colonization (140). The negative predictive value of GBS cultures performed ≤5 weeks before delivery is 95%–98%; however, the clinical utility decreases when a prenatal culture is performed more than 5 weeks before delivery because the negative predictive value declines (37)."

The US obstetrical guidelines for GBS have since been updated at acog.org/gbs <http://acog.org/gbs> where they require permission to post excerpts, but their similar wording is under Timing and Procedure for Preterm Culture-Based Screening.

I defer to others in this forum to expound on the meaning of "negative predictive value" but, to my understanding in regards to your proposed message to the mother, yes, the screening test as you note only tells with certainly (assuming no false negatives, etc.) what's happening when it was performed, but is still predictive according to studies that have been done.

I suggest this version as a message (similar to what we have in our brochure), "GBS is a normal bacterium that can come and go, so a woman who tests negative might become positive later on. If you test negative, ask your provider about being tested again if you have not given birth within five weeks. Regardless of your GBS status, make sure you and everyone who takes care of your baby know the signs of GBS infection in babies and how to respond."

In regards to "Do we have an estimate for X?" perhaps others here will know of studies with those estimates they could post.

Best,
Marti

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Spotlight: Group B Strep (56) Honored for Group B Strep to be in the HIFA/CHIFA Spotlight

14 July, 2026

Thank you everyone for following our global discussion on group B strep this past week! We so appreciate hearing the perspectives of those who posted and would especially like to thank Neil and his team for coordinating this first Spotlight. Thank you, Neil, for moderating the posts and your insightful comments!

Also, giving a special shoutout to our parent sponsors, Kelli and Kevin Smith, who sponsored this global discussion in honor of their daughter Finley Genevieve to make a difference for families worldwide!

Looking forward to continuing conversations on group B strep and would like to share some resources to help us all further group B strep disease awareness and prevention year-round:

- GBS Awareness Materials: https://www.groupbstrepinternational.org/downloadable-gbs-awareness-mate...

- Take (if eligible) and share our WAVES Study to help identify gaps in care and communication regarding GBS disease in babies: https://www.groupbstrepinternational.org/waves.html

- To connect with fellow researchers, healthcare professionals, & professional health advocates focused on GBS research and disease prevention, join us at: https://www.gbsresearchconnect.org/

I am so impressed with all the good work HIFA.org has done to promote universal access to reliable healthcare information. I hope this discussion will inspire us all to empower parents, healthcare workers and policymakers in all resource settings with the information and tools they need to reduce the suffering caused by group B strep disease worldwide.

Best and many thanks!
Marti

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Spotlight: Group B Strep (57) Honored for Group B Strep to be in the HIFA/CHIFA Spotlight (2)

14 July, 2026

Thank you so much for your warm feedback, Marti. And again, thank you to Kelli and Kevin Smith for your sponsorship.

This is the last official day of our first Spotlight. However, we welcome further messages on this topic in the coming days and we shall include them in our summary.

I hope everyone will agree this first Spotlight has been a success. Marti, Kelli, Mucheye, Edem and I shall review the discussion and prepare a summary. In the meantime we welcome comments from CHIFA memmbers. What worked well for you and what might we do better next time?

I look forward to future Spotlights on other topics. This is an affordable way to put *your* priority topic at the centre of the global health community. For one focused week, we mobilise the HIFA forums to generate insights, visibility, and engagement around the issue you care about most. See: www.hifa.org/spotlights

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA

is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Group B Strep (58) Informed consent: a topic for a future Spotlight?

15 July, 2026

[Re: https://www.hifa.org/dgroups-rss/spotlight-group-b-strep-55-should-there...]

Neil, I think this would be an excellent topic for a future Spotlight. It could also address which risks and potential benefits should be included in informed consent as well as the patient-friendly terminology needed for it to be clear and understandable.

[www.hifa.org/spotlights]

Best,

Marti

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Spotlight: Group B Strep (59) Honored for Group B Strep to be in the HIFA/CHIFA Spotlight (3)

15 July, 2026

Hello Neil and all others,

Thank you for your hard work. It has been a privilege to contribute to this first CHIFA Spotlight. I sincerely appreciate the efforts of Neil, Marti, Kelli, Kevin Smith, Edem, and everyone involved in making this discussion a success. I look forward to working with the team on the summary and to future Spotlights that continue to promote collaborative learning and global child health.

Best!

Mucheye

HIFA profile: Mucheye Gizachew Beza is an instructor, researcher and community service provider at the University of Gondar, Ethiopia. By profession, he is a Medical Microbiologist with academic backgrounds in Nursing and Biological Sciences. His professional and research interests focus on Group B Streptococcus (GBS), maternal and neonatal infectious disease prevention, antimicrobial resistance (AMR) focusing on One Health Approach, public health microbiology, biosafety and biosecurity, disease surveillance, and health education. He is particularly committed to advancing community awareness, strengthening public health interventions, and promoting evidence-based strategies to improve maternal and child health outcomes. His work aims to bridge research, education, and public health practice to address emerging infectious disease challenges and enhance healthcare quality and safety. Email address: muchegiza AT gmail.com