Medical Laboratory Services in Africa Deserve More

To the Editor—The recent review by Petti et al. [1] and the editorial commentary by Bates and Maitland [2] are timely contributions to the literature about the situation regarding inadequate medical laboratory services in Africa, as well as some of reasons behind this situation. The suggestions by Petti and colleagues about how laboratory services may be improved are thought provoking, but evidence from Africa about where implementation of programs has achieved success is difficult to come by. The authors refer several times to situations in which laboratory services continue to be less than acceptable. Interestingly, the British government allocated £950,000 to Malawi in 1998 to improve medical laboratory services [3]. This amount of money is equivalent to 40% of Malawi’s gross national budget for the 2005–2006 financial year. Obviously, if the finances necessary to improve laboratory services require such amounts of money, Malawi may not be able to commit the necessary resources to the improvement of laboratory services.

We agree with Petti et al. [1] that over-reliance on empirical treatment and management of syndromes have contributed to the relegation of laboratory services in many African countries. In Malawi, for instance, syndromic management of sexually transmitted infections, presumptive treatment of malaria in pregnant women, and initial treatment of all cases of fever as if they were due to malaria are the national standards of practice [4]. We suggest that all presumptive and empirical treatment measures be considered temporary and that etiologic diagnosis and treatment be the gold standard. Unfortunately, it is not uncommon for paying clients to access private antennal clinics and to be provided with presumptive antimarial therapy as a matter of routine when laboratory investigations could have been conducted first.

The lack of continued medical and professional development as a requirement for reregistration of health professionals in some of the developing nations impedes progress in laboratory services [5]. We also suggest that, if some physicians trained in laboratory medicine and pursued that as a profession, changes may occur. The usual practice, however, is for technician-level staff to take charge, but in many cases, these leaders cannot stand up effectively enough to influence the medical establishment. The training and recruitment of biomedical technicians for the maintenance and repair of laboratory equipment should also be a matter of priority.

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The “Achilles Heel” of Global Efforts to Combat Infectious Diseases

To the Editor—In the 1 February 2006 issue of Clinical Infectious Diseases, a timely article by Petti et al. [1] on the need for increased investment in laboratory services in Africa was accompanied by an excellent editorial commentary by Bates and Maitland, who called for “laboratories and their advocates…to be given a much louder voice on the international health care stage” [2, p. 384]. Many have become concerned that laboratory services are the “Achilles heel” in global efforts to combat HIV infection, tuberculosis, and malaria and the antimicrobial resistance that accompanies them.

On 9–10 May 2005, the American Society of Microbiology (ASM) held a meeting of experts from the United States and other countries to engage in a thoughtful discussion about laboratory infrastructure needs in underresourced countries to support infectious disease prevention and control programs. The meeting focused on (1) the need to increase the awareness of the importance of laboratories to the success of public health programs in underresourced countries and (2) ways to build on existing or planned programs that require a good laboratory system for a program’s success.