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Christopher J L Murray and colleagues[1] report on the dramatically high burden of antimicrobial resistance (AMR) worldwide, particularly in low-income and middle-income countries. The authors also emphasise the insufficient data on the prevalence of bacterial infections and AMR in low-resource settings. Although the figures presented are striking, they do not sufficiently depict the suffering of patients living in these locations and the frustration of clinicians unable to treat an infection that is typically easily curable elsewhere. As clinicians working in eastern Democratic Republic of the Congo, our fear is the imminent unavailability of active antibiotics.

See **Online** for appendix

Among the interventions commonly proposed to contain AMR, laboratory diagnosis is regularly depicted as a crucial but difficult-to-implement part of the solution. We do not share this fatalistic vision, and instead believe that Mini-Lab ,[2] which we consider to be one of the most emblematic examples of reverse innovation, could be the way forward.[3,4] This self-contained, quality-assured, stand-alone clinical bacteriology laboratory, which was initially developed by Médecins Sans Frontières to facilitate sepsis diagnosis in its fields of intervention, allows for the expansion of bacteriology testing to district hospitals. Because the Mini-Lab is based on unexpensive technologies,[5] it could make bacteriology tests affordable for patients. Along with individual care, the Mini-Lab could also contribute to AMR surveillance in rural areas and, ultimately, to the elaboration of antibiotic guidelines based on local epidemiological data.[6]

For more about **Mini-Lab** see https://fondation.msf.fr/en/projects/mini-lab

We ask public health authorities and international partners (eg, The Africa Centres for Disease Control and Prevention or the Foundation for Innovative New Diagnostics) to actively promote the evaluation of such small-scale laboratories in other low-resource settings. Such equitable access to laboratory diagnosis will make targeted antibiotic treatments at the district hospital level possible and will strengthen population confidence in the African health system. If action is not taken now, we will soon be back in the darkness of the pre-antibiotic era, with its health insecurity and social unrest.

We declare no competing interests.

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Christopher J L Murray and colleagues[1] evidence the global burden of antimicrobial resistance (AMR), which disproportionally affects low-income and middle-income countries (LMICs).

The strategic empowerment of pharmacy professionals (pharmacists and pharmacy technicians) in anti-microbial stewardship (AMS) remains an under-recognised and under-utilised AMR solution for LMICs. In particular, pharmacists across all sectors possess the capability (specialist knowledge of medicines), opportunity (contact with prescribers and patients), and motivation (professional commitment to the rational use of medicines) to promote AMS (appendix).[2–5] These professionals are, therefore, uniquely positioned to drive urgently required behaviour change in infection prevention and control practices and appropriate antimicrobial use.

Good practice examples by pharmacy professionals include, but are not limited to, optimising treatment of infections through good prescribing practices, educating health-care workers and patients on AMR and AMS, managing antimicrobial agents, surveilling antimicrobial use and consumption, administering and promoting vaccines,