countries that can define their priorities convincingly (but do not have large populations of poor people), funding for corrupt and dictatorial governments that have little regard for their poorest citizens, and the enormous waste of the limited talents of many developing countries that have been spent on inventing new approaches to developing competitive proposals to satisfy yet another under-resourced aid bureaucracy with little chance of success.

That Périn and Attaran are urging a repeat of the failed design for the Global Fund that Attaran proposed in his and Sach's 2001 *Lancet* article[2] as the basis for allocating donor support for the health sector as a whole, is shameful. If there was ever a need for evidence-based thinking about international health policy to replace ideological befuddlement, Périn and Attaran have demonstrated it in their Viewpoint.

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1 Périn I, Attaran A. Trading ideology for dialogue: an opportunity to fix international aid for health? *Lancet* 2003; **361:** 1216–19.
2 Attaran A, Sachs J. Defining and refining international donor support for combating the AIDS pandemic. *Lancet* 2001; **357:** 57–61.

Sir—Ines Périn and Amir Attaran[1] want to replace ideology with dialogue in international medical aid. But by basing donor funding exclusively on a recipient country's proposals they assume that governments of such countries always act in the best interests of the populations they represent. However, in many countries people suffer exactly because of the negligence, corruption, and unfair policies of their governments.

Périn and Attaran suggest that submitted proposals should be assessed only if they are technically sound and fiscally accountable. This way of thinking presents exactly the same problems as the World Bank's conditional loans policies they criticise. The negative examples they cite represent countries where populations suffer because of irrational medical policies; precisely the reason why medical aid is so essential. The most acute needs are usually noted among populations under irresponsible governments.

Few will disagree that dialogue is necessary, but discussions need to involve more than assessment of recipient proposals. In Armenia, health professionals look with great pride at the Soviet health-care system. However, with a public health-care budget of about US$10 per person and real allocation often being only half of this amount,[2] a system that emphasises specialist centres, long multi-drug treatments, and frequent and long hospital stays cannot be maintained.[3]

An oversized and underpaid medical corps (a doctor's salary is about US$15–30 per month) requires under-the-table payments before any services are provided.[4] Protocols updated at central level do not easily lead to better quality of care, more user-friendly services, more respect of patients' rights, or more rational drug use, because the usual, donor-funded training courses are insufficient to change a 7-decades-old medical tradition.

Most health professionals would like to rebuild the old system, and requests to humanitarian organisations continue to focus on renovation of buildings and donation of drugs and equipment, with little concern for the actual accessibility, quality, and cost-efficiency of services provided. Armenia's recent HIV/AIDS proposal to the Global Fund for AIDS, Tuberculosis, and Malaria was fairly well written thanks to input from United Nations consultants. However, no proposal has yet been submitted for tuberculosis despite its being arguably a much bigger public-health problem; and care for sexually transmitted infections, a key issue in HIV prevention in this context, was largely neglected.

Périn and Attaran's model of dialogue is being tested in the Global Fund, but the application mechanism guarantees neither that proposals are made bottom-up, nor that priority problems are tackled.

What I understand by dialogue is an engagement in practical work alongside local counterparts to see if different approaches can work in practice, to understand the needs of the people, and to ensure that those most in need benefit from essential services.

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1 Périn I, Attaran A. Trading ideology for dialogue: an opportunity to fix international aid for health? *Lancet* 2003; **361:** 1216–19.
2 Mkrtchyan A. New tendencies in health care of Armenia (in Russian). Yerevan: Printing House Akop Meghapart, 2001.
3 Cassileth BR, Vlassov VV, Chapman CC. Health care, medical practice and medical ethics in Russia today. *JAMA* 1995; **273:** 1569–73.
4 Hovhannissyan S, Tragakes E, Lessof S, Aslanian H, Mkrtchyan A. Health care systems in transition: Armenia. *European Observatory on Health Care Systems* 2001. http://www.who.dk/document/e73698.pdf (accessed May 16, 2003).

Imatinib or transplant for chronic myeloid leukaemia?

Sir—In his account of the development of imatinib and its remarkable clinical efficacy in chronic myeloid leukaemia, Edward Sausville (April 26, p 1400)[1] alludes to the dilemma that faces newly diagnosed patients who in the pre-imatinib era would have been obvious candidates for early allogeneic stem-cell transplantation. We agree with his view that the long-term benefit of imatinib cannot yet be reliably assessed, but feel he has perhaps underemphasised the likelihood of cure in patients who, for long periods after transplant, have no evidence of residual disease even at the molecular level. Sausville draws attention to the fact that stem-cell transplants are hazardous, but omits mention of the fact that reduced intensity allografts are undoubtedly safer and could be as good as conventional transplants for treating the disease.[2,3]

The decision not to offer selected newly diagnosed patients the option of an allograft as primary treatment is probably simplistic. A good case can be made for identifying transplant candidates by combining the use of the Sokal or Hasford risk criteria to define a patient with standard or poor prognosis with non-transplant therapy with the Gratwohl score to identify a patient with a good chance of survival after transplant and consequently a reasonably good chance of cure.[4,5]

In the next few years, improved knowledge of overall survival data with imatinib, improved understanding of the effect on survival of complete cytogenetic responses to imatinib, and updated assessment of reduced intensity conditioning allografts should allow more definite recommendations. In the meantime, we believe that the younger patient who is not low-risk and who has an HLA-identical sibling or a molecularly HLA-matched unrelated donor should still be offered the choice of an initial trial of imatinib or an up-front transplant.

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1 Sausville EA. Imatinib for chronic myelogenous leukaemia: a 9 or 24 carat gold standard? *Lancet* 2003; **361:** 1400–01.
2 Or R, Shapira MY, Resnick I, et al. Nonmyeloablative allogeneic stem cell transplantation for the treatment of chronic myeloid leukemia in first chronic phase. *Blood* 2003; **101:** 441–45.