The money will be distributed among countries that are most at risk and that have poor infection surveillance systems and laboratory facilities in both animal and human health sectors. Almost half of the funds will be spent in East Asia and the Pacific and on core programmes in Africa. The planned intervention comprises reducing human exposure to the virus, strengthening the early warning system, rapid containment, capacity building, and coordination of research and development.

The outcomes of last week's conference in Beijing need cautious interpretation. Given the enormity of the problem, the pledges may well be honoured. The finance pledged is but a promise to deliver, however, and previous pledges for global emergencies remain unpaid. For instance, of the sums pledged in response to the tsunami disaster, $217m pledged by United States, $70m pledged by the European Commission, and $15m pledged by the United Kingdom remain unpaid.[4]

Investment in effective policies to control outbreaks and delay a pandemic would yield a manyfold rate of return. If this $2bn fund reduced the impact of the pandemic by a mere 1% it would yield a fourfold rate of return in the form of costs avoided. But property rights to the benefits are diffuse and thus underinvestment is likely. The economic problem is not merely one of raising funds: it also extends to their deployment.

Cash donations will have to be translated into real resources such as staff, laboratory facilities, and drugs, and the logistics of their deployment must be established. Many agencies are involved, each with its own chain of command, goals, and procedures. Gaps in the chain of governance may lead to delays in reporting or lack of diligence, with catastrophic consequences.

Human resources will be crucial in managing an epidemic. The human capital embodied in experts cannot be replicated quickly, yet the resilience of this expertise in a pandemic will be difficult to maintain given a predicted average incidence of infection of 25%. Recently a team from the UK was congratulated for its speedy response during the outbreak in Turkey. But even these people would be hard pressed if there was a rash of outbreaks in their region. There must be adequate "surge capacity" to cope with the volume of work. The ability to mobilise enough middle range scientists and laboratory assistants will be crucial, too—for example, by directing some of the pledged funding to the WHO programme for health security capacity development, which aims to improve competence in laboratory and epidemiological disciplines and to develop global surveillance.

Timely reporting of outbreaks of avian influenza is essential but difficult, given that domestic flocks represent the entire livelihood of many people and compensation is rarely available. Indonesia delayed a cull, although millions of chickens were infected, until they were sure that the H5N1 strain was involved.

Few decisions to report such outbreaks rely simply on scientific matters. Even infections that should be reported under International Health Regulations[5] have been kept secret to protect trade or tourism. Beijing, for example, experienced a 94% drop in the tourist trade in 2003 because of severe acute respiratory syndrome (SARS). But the public health benefit of early intervention is substantial. The cull of all the poultry in Hong Kong (estimated at 1.5 million birds) within three days in 1997 reduced opportunities for further direct transmission of bird flu to humans and may have averted a pandemic. It was such a rapid response to an outbreak that last week's pledging conference was intent on facilitating. More funds—not peanuts—will be required in the short and long term if rapid control is to be ensured.

Jennifer A Roberts *professor*

(j.roberts@lshtm.ac.uk)

Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London WC1E 7HT

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Sex workers to pay the price

UK plans to cut street prostitution will threaten sex workers' health

In 2004 the UK Home Office published a consultation paper on sex work, after a review of the Sex Offences Act (2003). The paper, *Paying the Price*,[1] was criticised by specialist services for giving less priority to the health of sex workers than before and for focusing too much on issues of criminal justice, and by health researchers for its unethical use of questionnaires and interviews. The resulting Home Office strategy[2] published last week aims to challenge the view that street prostitution is inevitable; achieve an overall reduction in street prostitution; improve the safety and quality of life of communities affected by prostitution, including those directly involved in street sex markets; and reduce all forms of commercial sexual exploitation.

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The strategy looks to the controversial Swedish model that criminalises men who pay for sex, and uses police photographs of sex acts and possession of condoms as evidence of sex work. This discourages sex workers from using condoms and introduces tension and potentially violence between them and clients. The Home Office proposes a range of approaches for a variety of sex markets, based on the sex of workers and the locations

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where sex workers and clients meet. But the strategy does not explicitly tackle health and human rights and will not, therefore, tackle genuine areas of vulnerability and exploitation. Currently, children are sexually abused, people are trafficked and enslaved, and vulnerable individuals, including those with drug dependency or mental health conditions, are coerced and controlled, often by organised criminal gangs. Neither adult sex workers nor clients dare to report these abuses for fear of exposing their own involvement in sex work.

The proposed strategy rejects calls to license premises which comply with ordinary requirements of workplace legislation on health, safety, and labour. A licensing system could ensure that children were not employed, employees were not in possession of drugs, and foreign nationals had work permits.

Instead the strategy focuses on disrupting street sex markets. Kerb crawling will be policed in established red light areas despite strong evidence that this will simply displace sex work to other locations and increase the prevalence of acquisitive crime.[3] This will also reduce sex workers' negotiating powers, make it harder for them to find clients, increase their time on the streets, and force them to solicit more directly—increasing the risk of causing offence or distress to people not looking for paid sex. These conditions are directly linked to increased violence, pressure to abandon safer sex practices, and increased public disorder, including vigilante attacks.[4]

Sex workers are now uncertain about their legal status and are unsure whether the new Home Office strategy has become law. Outreach services and health researchers have noted increased fears among sex workers regarding the safety and confidentiality of such services.

Specialist healthcare services in red light areas face an uncertain future. Outreach work, provision of condoms, needle exchange schemes, and primary care for a population rarely registered with a general practitioner could be compromised if the strategy is enforced and sex workers become reluctant to seek help. Without access to specialist fast track services for sexual health, sex workers may face delays in receiving treatment for sexually transmitted infections, which could have profound consequences both for sex workers and the wider population.

The recent increase in sexually transmitted infections in the general population in the United Kingdom contrasts with a reduced prevalence in female sex workers.[5] And the prevalence of HIV infection in sex workers, mainly associated with injecting drug use, remains low—between 0% and 3.5%.[5] Sex workers have a responsible approach to managing the risk of sexually transmitted infections, with a high prevalence of condom use for commercial vaginal sex (98%). The Home Office strategy shows inadequate understanding of risk, and the proposed changes could increase negative health outcomes, while limiting patients' access.

Multiagency work by healthcare professionals, police, social services, and sex workers will be disrupted if red light areas are phased out as the strategists intend. This will increase the risks to sex workers, 87 of whom have been murdered in the United Kingdom since 1990.[6] Collaborative working gives sex workers the support to report violent clients and other predators who aim to coerce and control them. The lack of detail in the strategy about implementing the new approaches, especially regarding indoor sex work, leaves most of the sex workers we have spoken to feeling uneasy that they will have to wait and see how the strategy affects their access to health care and their contact with the criminal justice system.

Petra Boynton *non-clinical lecturer in healthcare research*

(p.boynton@pcps.ucl.ac.uk)

University College London

Linda Cusick *reader in substance use*

(linda.cusick@paisley.ac.uk)

Institute for Applied Social and Health Research, University of Paisley

Competing interests: LC is the academic representative on the board of the UK Network of Sex Work Projects.

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Oxygen treatment at home

Will be better organised from 1 February in England and Wales

In England and Wales (but not in Scotland) prescriptions for oxygen concentrators have until now been written by the general practitioner, usually after assessment of patients and recommendation by respiratory specialists. Concentrators are then installed in patients' homes by companies that have regional NHS contracts. Patients using oxygen cylinders rather than concentrators receive supplies from local pharmacies after prescription by their general practitioners. From next week (1 February 2006) new arrangements will apply in England and Wales.

There will be three important improvements: all forms of home oxygen treatment will now be provided by a single supplier in each region of England and Wales after receipt of a home oxygen order form specifying the details of usage, such as flow rate and expected hours of use; ambulatory oxygen—including that supplied as liquid—will be generally available for the first time; and specialists based in hospitals will be able to order home oxygen directly. Indeed, respiratory medicine and paediatric teams will probably become the main prescribers of long

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