

in the two arms. Nevertheless, the effect of autologous myoblasts and fibroblasts is highly unlikely to be related only to any drawbacks in the study.

The results of Strasser and colleagues' study are impressive, both in terms of efficacy and tolerability of the new procedure. Further re-evaluation at longer follow-up is needed, and multi-institutional studies are highly recommended. If the data are confirmed, this approach is likely to cause a substantial change in the treatment of female stress urinary incontinence, and could become one of the most important innovations in urology since the development of extracorporeal shockwave lithotripsy for urinary stone treatment and tension-free vaginal tape for stress urinary incontinence. Moreover, Strasser's study encourages new trials to examine whether the injection of fibroblasts in urethral submucosa is necessary, and to address the role of autologous cell implantation in patients with stress urinary incontinence due to concomitant urethral hypermobility and intrinsic sphincter deficiency, who are likely to benefit from such a surgical approach, alone or in combination with the traditional midurethra tension-free vaginal slings, or in patients with mixed urinary incontinence.

\*Giacomo Novara, Walter Artibani

Department of Oncological and Surgical Sciences, Urology Clinic, University of Padua, Padua, Italy (GA, WA); and IRCCS Istituto Oncologico Veneto, 35128 Padua, Italy (GN)  
giacomonovara@libero.it

We declare that we have no conflict of interest.

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## Comprehensive response to rape needed in conflict settings

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Mass rape and sexual torture of women and girls by men in conflict areas is one of the most gruesome legacies of the 20th century. Nowhere has this been more evident than in the Democratic Republic of the Congo, where thousands have been gang raped with such violence as to cause vaginal fistulae.<sup>1</sup> War is also usually associated with great upheaval of populations, and many women and girls are forced to have sex in return for safe passage, food, shelter, and other resources.<sup>2</sup> Peacekeepers and aid workers are among the exploiters.<sup>1</sup> Refugee camps are often unsafe, and rape occurs.<sup>3</sup> Furthermore, large-scale movements of people provide opportunities for new consensual sexual encounters with concomitant spread of sexually transmitted infections. War in Africa is generally assumed to be one of the factors fuelling the HIV epidemic.

In today's *Lancet*, Paul Spiegel and colleagues draw together a substantial amount of data for prevalence of HIV infection in conflict and refugee settings to empirically test the assumption about HIV spread in conflict areas.<sup>4</sup>

Their conclusion that there are insufficient data to support assertions that conflict and forced displacement increase HIV prevalence challenges the conventional wisdom. Any review of secondary data leaves unanswered questions: what the prevalence of HIV infection in displaced populations would have been if there had not been conflict and displacement is unknown. Antenatal surveillance estimates of HIV infection are inevitably more likely to be available for long-term refugee populations. The prevalence of HIV infection in people who spend little time in camps, or those who are internally displaced and do not enter a camp, is unavailable, as are data for prevalence in men in these settings. Furthermore, some of the assessments referenced by Spiegel were made several years after the conflict, and the lower than expected prevalence of HIV infection could have reflected an effect of conflict on disease progression and death. Nonetheless, the large number of countries from which data are available, and the fact that there are other countries—including Angola and Mozambique—that have much the same patterns as

those in Spiegel's review, affirms the general validity of Spiegel's argument.

Spiegel and colleagues' conclusions are a salient reminder of the value of interrogating assumptions about the HIV epidemic that are often taken as common knowledge. They remind us of the need for nuance in our understanding of the dynamics of sexual behaviour and HIV transmission. To become locked into a discourse that enumerates spiralling sexual risk, without consideration of the dynamics of conflict that might reduce consensual sexual activity, is easy. Many areas of conflict have night-time curfews or other restrictions on movement, which greatly reduce exposure of the civilian population to the contexts in which they could encounter new sexual partners and engage in risky activity after an evening's drinking. Conflict and displacement often splits families, and refugee settings may have disproportionate numbers of women and girls, which could have a net effect of reducing sexual activity. Spiegel explains why widespread brutal rape may not translate into an increased prevalence of HIV infection at a population level. Another critical factor is that many of the men who rape are young, live in rural settings, and would tend to have a low prevalence of HIV infection.

The international community is increasingly recognising the need to provide care for victims after rape in settings of conflict and displacement, and to plan to prevent rape.<sup>5</sup> Spiegel and co-workers findings provide a further reminder of the need for rape services to be situated within comprehensive sexual and reproductive health-care services, rather than overly emphasising prevention of HIV infection. These services are notoriously deficient in refugee settings.<sup>1</sup> Health services after rape need to be responsive to the needs of survivors, which inevitably encompass prevention, or termination, of pregnancy; treatment for sexually transmitted infections; psychological support; and treatment for injuries, including reconstructive surgery. Even the guidelines for gender-based violence in humanitarian settings<sup>5</sup> fall short of advocating for a comprehensive rights-based package of care for women after rape, because they fail to address the need for the provision of safe abortion.

What is the effect of conflict in the long term? Experiences in South Africa and Mozambique suggest that there could be substantial risks of HIV spread during the phase of reconstruction after conflict, because usual

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sexual activity is resumed in a context of economic recovery, infrastructure development, and renewed population mobility. After conflict might also be a time of particular further vulnerability to sexual and intimate partner violence.<sup>1,6</sup> The long-term effect of conflict on children is rarely discussed. Various forms of exposure to trauma in childhood might result in increased use of violence, including sexual violence, in later years as well as sexual risk-taking.<sup>7</sup> This exposure is a long-term potential effect of conflict on violence and HIV, and one that has yet to take its rightful place as a priority for research and intervention.

*Rachel Jewkes*

Gender and Health Research Unit, Medical Research Council, Pretoria 0001, South Africa  
rjewkes@mrc.ac.za

I declare that I have no conflict of interest

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