REVIEWER #1
Clearly the author is not knowledgeable in the fields of human or primate biology, evolutionary genetics, epidemiology of any kind, immunology or virology, or infectious disease transmission research (sexual or otherwise), or familiar with biomedical research evaluating outcomes and efficacy of disease screening, detection and treatment protocols. That is not necessarily a failing, as many very good articles have been written by social scientists, ethicists and those across public policy domains who have no biomedical or health science expertise. However, that also does not absolve authors from attempting to meet the standards of evidence demanded by scientific methods and objective reality.

The author references a few frequently cited articles by prominent HIV-AIDS researchers, only to dismiss them as racist stereotyping by the mainstream medical research establishment or "official" sources, but without actually addressing their content or methods – because these articles find empirical disparities in the proportion of African-Americans (or sub-Saharan Africans, or southern vs. northern Indians) who have either screened positive for HIV antigens, developed AIDS disease or died or its complications, across demographic population groups and within high risk social contexts (*e.g.,* prisons) and behavioral subgroups (*e.g.,* injection drug users).

In contrast, many of the sources cited by the author as "scientific evidence" to deny that HIV is an infectious disease that often is sexually transmitted have been thoroughly discredited (see especially the work of Bauer and his background). Others are third-hand, de-contextualized, and sometimes egregiously misrepresented, reports of studies and public policy news reports published in the popular press (see Fullilove, and reports on the role of prisons). The author ignores virtually all of the public health, epidemiological and biomedical research and published literature on the social and economic determinants of this extremely serious global and domestic health disparity affecting many African nations and population subgroups of African descent in the Americas.

I cannot emphasis how intellectually dishonest it is to dismiss what the author called mainstream and "official" biomedical and epidemiologic HIV-AIDS research as racist while prominently crediting articles by Henry Bauer, a retired professor of chemistry. Notably, Bauer during his tenure as professor at Virginia Polytechnic Institute & State University attacked affirmative action programs as promoting a lowering of academic standards, and the university's efforts to address issues of diversity, sexual assault and hate crimes as caving into "feminoid sexists calling men sexist" and "racist black fanatics calling others racist."[1] The author would have been more honest citing James Watson (whose "racial genetics" racism was soundly rejected by the biological sciences research community) or Charles Murray and the American Enterprise Institute's *Bell Curve* on "racial" genetics.

The author draws a convoluted inference that since HIV-AIDS is not an infectious disease, screening tests for HIV infection (HIV viral load and CD-4 lymphocyte cells counts notwithstanding) are racially biased in that they are more likely to be positive for African-Americans, based on genetic African descent. At one point the author states, "Disparities found in every economic and social group stem from something that is a direct expression of genetic characteristics just as are sickle-cell anemia, skin color, hair texture, and the like." Logically this is an argument for a genetic and population sub-group level basis for differences in susceptibility to HIV/AIDS - which would in fact deny the central role that the social

[1] Wikipedia has a brief biography and list of publications and statements for Bauer.

determinants of health have in producing population health inequities for those who are marginalized and at the bottom of the social hierarchy, both within the United States and globally.

> To be a poor man is hard, but to be a poor race in a land of dollars is the very bottom of hardships. (Du Bois, 1961)

There is a glaring omission of the role that the specific forms of economic and social oppression involving women play in creating and sustaining race and ethnicity-based disparities in both incidence rates and in mortality rates related to HIV/AIDS and their impact on both African and African-American women. Domestic abuse and violence, the sexual exploitation of women, and sex trade are not mentioned, and prostitution is mentioned only once, as a behavioral risk factor for men – not surprising, given the author's reliance on Bauer, who thought that sexual assault at Virginia Tech was not a serious problem on campus and did not merit special attention.

The author claims, by taking a statement out of context from a <u>2004</u> *Slate* blog op-ed piece, that " 'AIDS researchers don't have a solid explanation for why black women in America have such a shockingly high prevalence of HIV infection' (Cohen 2004)". This is false, both if one bothers to read all of the original Slate article, and also if one doesn't choose to ignore an enormous amount of epidemiologic, biomedical and public health and public policy research work done in the last five years.

In fact, Rucker Johnson and Steven Raphael from UC Berkeley's School of Public Policy have a nice piece on "The Effects of Male Incarceration Dynamics on AIDS Infection Rates Among African-American Women and Men". If not for the mass incarceration rates of black men, black women's rates of HIV infection would be similar to white women's rates. And, they are not the first researchers to note the genocidal impact of such massive disruption of social networks and family separations in African-American and African communities. Others have remarked on the similarities between conditions for African men who worked as miners under apartheid and African-American men in America's prisons.

The author is silent on the use of rape by HIV infected soldiers as a weapon of war in the Rwandan genocide – the work of activist Dr. Mardge Cohen and her organization WE-ACT in bringing HIV-AIDS treatment and political attention the thousands of Tutsi women who survived that horror but are now dying of AIDS would undermine the author's main arguments. Not coincidentally Dr. Cohen founded one of the first American women's HIV clinics, the Cook County Hospital's Women and Children with HIV Program – at one of the nation's largest public hospitals, serving a very low income and mostly African-American and Latino population. Even back in the early 90's, public health researchers there were investigating the links between higher African-American women's HIV-AIDS incidence, violence against women and poverty.

The author makes several false claims about human evolutionary genetics, such as, "Humans who migrated to other regions no longer needed such powerful immune systems. So people of relatively recent African ancestry command stronger immune reactions than do Asians, Caucasians, non-black Hispanics, or Native Americans, whose African ancestry is between 100,00 and 200,000 years in the past." -- truly curious in light of historic and biological records of devastating plagues which periodically have swept every continent and human civilization. What is true is that infectious diseases do erupt with lethal

ferocity and spread with epidemic swiftness in populations stressed by war, invasion and occupation, colonial or neo-colonial dispossession and the destruction of civil society, or forced migration – the Four Horsemen – War, Death, Famine and Plague. Unfortunately for African-Americans and Africans in these modern times, the tiny genetic variations associated with human population clusters are thoroughly confounded with social and political categories of ethnicity and "race". In the end, the author's call for a "non-racist interpretation of racial disparities in testing HIV positive" is racist at its heart, and has no scientific basis or evidence to support its illogical premises.

REVIEWER #2

This paper was reiterating race-based arguments that have long been discounted by the careful students of race and HIV/AIDS. The author creates a false dichotomy, "either accept that African heritage predisposes inevitably toward unbridled sexual activity and resort to illegal drugs; or one must accept that HIV-positive is not a contagious condition that reflects sexual transmission or sharing of infected needles." There are clearly other alternative explanations as to the high rates of HIV/AIDS.
I recommended that the article be rejected for these reasons. It is not well written, and the argument is weak.