Ramirez, Angelica Public Comment #5

From: Aimee Smith <aimee.l.smith@att.net>
Sent: Tuesday, February 15, 2022 7:39 PM
To: Nelson, Bob; Hartmann, Joan; Williams, Das; Hart, Gregg; Lavagnino, Steve; Do-Reynoso, Van; Ansorg, Henning; sbcob
Subject: COVID mRNA and DNA injections are gene therapy

LATE DIST

Dear Board of Supervisors,

Dr. Henning Ansorg does not seem to be well informed when he claims that the available COVID injections are not gene therapy.

Gene therapy is not only the intentional modification of the hosts genome, it also includes displacing the host genome as is the case with the mRNA(Pfizer, Moderna) and viral vector DNA(J&J) COVID injections.

CEO of Bayer, the company that recently acquired Monsanto, is clear about it even if our own health officer is not yet up to speed.

"We are really taking that leap [to drive innovation] – us as a company, Bayer – in cell and gene therapies ... ultimately the mRNA vaccines are an example for that cell and gene therapy. I always like to say: if we had surveyed two years ago in the public – 'would you be willing to take a gene or cell therapy and inject it into your body?' – we probably would have had a 95% refusal rate," stated Oelrich.[1]

I suspect the CEO of Bayer is in a better position to know the meaning and use of the term gene therapy than our health officer. Also notice his glee at the effect of the pandemic getting this novel technology that his company profits from to be accepted without question.

But labeling aside, this is novel technology that is liability protected for the producers and has no long term safety record. It is unconscionable to pressure children with a very low death rate to take these risky treatments that do not stop transmission and have unknown effects on autoimmune disease, fertility and cancer, let alone rapidly waning efficacy.

I am truly appalled to see Dr. Do-Reynoso trying to "prove" that masking is effective by looking at aggregate county data at different times in the epidemic. At least once she did admit that it was not only the lifting of the masking policy but also the rise of the delta variant that gave rise to an increase in cases, but today she seems to have forgotten that there are multiple factors at play.

Please examine the following meta-analysis to at least understand some of the challenges we face trying to assess policy by looking at the aggregate data over time.

https://sites.krieger.jhu.edu/iae/files/2022/01/A-Literature-Review-and-Meta-Analysis-of-the-Effects-of-Lockdowns-on-COVID-19-Mortality.pdf

Should we be taking advice from anyone who claims they can look at these county plots and determine the effectiveness of an intervention such as masking? I do not feel comfortable doing so.

I am sure Dr. Do-Reynoso and Dr. Ansorg are aware that disease epidemics follow curves of increase followed by decline. And with the benefit of hindsight, certainly now know that there were waves for various variants regardless of the masking policy. Why are they trying to make a claim that is not founded in evidence? Do they think we are fools? What is this really about if not protecting health with policy based on solid evidence? Is this about facilitating a vaccine passport? Vaccine mandates that ignore the human right to bodily integrity?

It is also disconcerting that we hear nothing about addressing the harms of these policies. No curiosity on the part of the health officials or the board. My children are still exercising in masks. What is the long term health impact of that? I suspect no one knows yet. But whatever the impact, it is you who are responsible.

Lastly, the study that was cited for the Pfizer/BioNtech injection did reduce cases in the study group relative to controls, but deaths were not less. Further, the controls were unblinded so that we would never have the opportunity to examine longer term efficacy or long term health effects as the phase 3 trial requires.[2,3] A brand new technology with warp speed approval and early unblinding of controls is not the way to earn the trust of people who actually care about evidence and not just marketing claims.

There is also this troubling data from Scotland.[4] And there is much more concerning data being accumulated about adverse events and waning and negative efficacy.

Truth does take time to come out, but it usually outs. It is not wise to make policies that trample rights based on data from financially conflicted sources or tied to political agendas.

Sincerely,

Aimee Smith, PhD

[1] https://www.lifesitenews.com/news/bayer-executive-mrna-shots-are-gene-therapy-marketed-as-vaccines-to-gain-public-trust/

[2] https://www.canadiancovidcarealliance.org/wp-content/uploads/2021/12/The-COVID-19-Inoculations-More-Harm-Than-Good-REV-Dec-16-2021.pdf

[3] https://www.bmj.com/company/newsroom/covid-19-vaccine-trials-cannot-tell-us-if-they-will-save-lives/

[4] table 14 page 41 and figure 16 page 43

https://publichealthscotland.scot/media/11631/22-02-02-covid19-winter_publication_report.pdf

Table 14: PCR confirmed COVID-19 age-standardised case rate per 100,000 individu
average from 01 January 2022 to 28 January 2022.

	Unvaccinated			
Week	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals	No. tested positive by PCR
01 January - 07 January 2022	9,052	989,635	**924.48** (893.54 - 955.41)	3,037
08 January - 14 January 2022	3,686	981,074	**425.75** (402.08 - 449.42)	1,106
15 January - 21 January 2022	2,717	976,982	**305.01** (284.76 - 325.25)	784
22 January - 28 January 2022	2,332	970,430	**252.76** (235.76 - 269.76)	686
	2 Doses			
Week	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals	No. tested positive by PCR
01 January - 07 January 2022	34,356	1,123,613	**2,417.26** (2,382.49 - 2,452.03)	35,452
08 January - 14 January 2022	9,625	997,775	**887.21** (860.92 - 913.49)	13,952
15 January - 21 January 2022	6,071	933,147	**576.18** (556.06 - 596.30)	10,628
22 January - 28 January 2022	4,876	854,406	**515.70** (495.60 - 535.80)	10,885

Data in this table should not be used as a measure of vaccine effectiveness due to unaccounted for b
more information, please see the Interpretation of data and Vaccine effectiveness summary sections

Vaccination status is determined as at the date of PCR specimen date and population size by vaccine status are described according to
greyed-out section are considered preliminary and are subject to change as more data is updated. Age-standardised case rates are per
Population (see Appendix 6).

Figure 16: PCR confirmed COVID-19 age-standardised case rate per 100,000 individuals by vaccine status, seven-day rolling average from 10 May 2021 to 28 January 2022.