



TRANSFORMATIVE HEALTH JUSTICE

16 February 2022

URGENT

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HPCSA President: Prof MS Nemutandani via Melissa de Graaff acting CEO: Registrar@hpcsa.co.za

The purpose of this communication is to deliver a critical letter by South African medical professionals regarding serious concerns about adverse effects from the C19 injection products, that are the motivation for discrimination, 'mandates' and harm.

While the contents are both substantiated and disturbing, THJ acknowledges confirmation from medical professionals that jab adverse effect reports to SAHPRA are not being communicated to the public. THJ is aware of adverse effects reported to www.SAVaers.co.za. You are welcome to view the growing public data download.

Despite the fact that experts and whistleblowers are speaking out about unsafe manufacturing and monitoring, fraudulent studies, product contamination, expired products, and court cases exposing that adverse effects data are ignored, the harm and risk to our nation is being suppressed by South African health stakeholders.

THJ draws your attention to the Understanding Vaccine Causation Conference convened by the World Council for Health, wherein legal, science, medical and data / advocacy experts presented credible and cogent information on how adverse effects are being proved. THJ also offer an opportunity to engage with said experts.

Given the effect on lives and livelihoods, South Africa expects ethical and transparent measures to be taken. Kindly respond in details to the letter below, and advise what action will be taken to alleviate pain and suffering, and by when. THJ looks forward to hearing from you by Wednesday 23 February 2022.

Shabnam Palesa Mohamed
Transformative Health Justice
Co-Founder and CEO

Email: info@THJ-Africa.org.za

Report negative jab effects: www.SAVAERS.co.za

View reports: www.SAVAERS.co.za



**CEO and Chairperson
South African Medical Association (SAMA)**

**CEO and Chairperson
Health Professions Council of South Africa (HPCSA)**

**CEO and Chairperson
South African Health Products Regulation Authority (SAHPRA)**

16 February 2022

Via: Transformative Health Justice / SA VAERS

Dear Colleagues

Urgent letter regarding Covid-19 response: physicians' expression of concern

We are writing to you to bring certain matters to your attention. These are matters of great concern to us, a group of physicians, on the front line.

We would like to raise the following points with you:

1. Observed post-vaccination adverse events
2. Blocking the spread of SARS COV2 as a reason to mandate vaccines
3. RCT data, serious illness, death and vaccine safety

1. Observed post-vaccination adverse events

Since the vaccine roll-out started, many of us have been caring for patients who have presented with new-onset of illness shortly after vaccination. The occurrences range from Bell's palsy, Herpes simplex virus outbreaks, Epstein-Barr virus reactivation to diabetogenic changes, hypertension, menstrual disruptions, and neurological manifestations (e.g., persistent paresthesia, Parkinson's disease, transient ischemic attacks, and Vaccine-induced Immune Thrombotic Thrombocytopenia (VIITP)). We also notice cardiovascular problems, for example deep vein thrombosis, myocarditis, myocardial infarcts, thrombophlebitis, cerebrovascular incidents, and pulmonary emboli commonly.

Most concerning are patients, who have established autoimmune disorders and are stable on treatment, who seem to deteriorate almost without exception in the months post vaccination. In many cases their therapies stop working. It takes months for them to get back to their pre-vaccination energy and pain levels if at all.

We don't know how to treat these patients because the pathogenesis of vaccine-induced injury has not been defined. This is distressing for us and our patients.

Many of these events are managed at a primary health care level and their frequency will not necessarily be noticed by epidemiologists or specialists who work in secondary and tertiary centres. Many of us have been in private practice for decades and we have never noticed such frequent events after administration of older well-known vaccines.

We also notice that our patients are not taken seriously by the medical system. When they attempt to report their adverse events or even when they seek medical treatment, they are often dismissed. Patients who are medically exempted from vaccination face discrimination in the workplace and on campuses. In addition, the adverse event reports filed to our local authorities are not reported to the public so there is essentially no awareness or transparency of this important issue.

2. Blocking the spread of SARS COV2 as a reason to mandate vaccines

The South African population is being educated that being vaccinated prevents the spread of SARS COV2. The evidence to the contrary by far outweighs this narrative. *The Lancet* recently published a piece on the reduced epidemiological relevance of the covid-vaccinated and concludes: *"Many decisionmakers assume that the vaccinated can be excluded as a source of transmission. It appears to be grossly negligent to ignore the vaccinated population as a possible and relevant source of transmission when deciding about public health control measures."*¹ The list of studies proving that vaccinated individuals are as infective as unvaccinated individuals is growing.

Herewith a short summary of other relevant recent studies:

- Singanayagam and colleagues found that fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts.²
- A Vietnamese study³ showed that viral loads of breakthrough Delta variant infection cases in vaccinated nurses were 251 times higher than those of cases infected with prior strains during the early phase of the pandemic in 2020.
- Riemersma and colleagues showed there was no difference in viral loads when comparing unvaccinated individuals with those who have vaccine "breakthrough" infections and if vaccinated individuals become infected with the Delta variant, they may be sources of SARS COV 2 transmission to others that reveal the vaccines have very suboptimal efficacy.⁴
- Yahi, Chahinian and Fantini (2021) showed that in relation to the Delta variant, neutralizing antibodies could not neutralise the viral spike protein.⁵
- A Swedish study (a large retrospective study with 1,684,958 participants) is of interest and particularly concerning for it shows that while the vaccine provides temporary protection against infection, the effectiveness declines steadily and researchers report that "Vaccine effectiveness of BNT162b2 against infection waned progressively from 92% at day 15-30 to 47% at day 121-180, and from day 211 and onwards no effectiveness could be detected."⁶

Mandating the vaccines to stop the spread of the virus is clearly not a guaranteed solution. The reports that many of our universities and workplaces are doing exactly that is very concerning.

Choosing to vaccinate to prevent potential serious disease and death comes down to a risk versus benefit choice which is not the same for all patients.^{7,8} We will briefly elaborate.

3. RCT data, serious illness, death and vaccine safety

The gold standard for the efficacy of an intervention is the double-blind placebo-controlled trial. As you are aware, none of the current vaccines in use have completed phase three studies. The Pfizer and J&J vaccine was given emergency use approval on the strength of six months of data.^{9,10} For Pfizer, some study participants were only followed up for two months before publication of the six-month findings. With the unblinding and cross-over, only 7% of the placebo group made it to the six-month mark. To date, more patients have died in the intervention arm of this trial compared to placebo (i.e., all-cause mortality).^{11,12} As for prevention of serious illness and deaths, we are not able to draw any reasonable conclusions from this data as this study was not sufficiently powered for us to infer how well the vaccine prevents these outcomes.¹³ In the United States, more people died in 2021 of Covid-19 with vaccines than in 2020.¹⁴ Given the recent revelations around PCR testing inaccuracy, inconsistent data collection and how each country defines someone as “fully vaccinated,” this data is not conclusive enough to answer this question clearly. Authorizing mandates on observational data alone could be risky.

Additionally, a recent article in *The BMJ* has revealed events around data manipulation and fraud in the Pfizer study.¹⁵ The South African press did not report on this critical issue at all. Moreover, the FDA has recently released parts of documents submitted by Pfizer under a Freedom of Information request by a group of researchers in the United States (led by attorney Aaron Siri).¹² These documents reveal that Pfizer was aware of thousands of adverse events (about 50 000), of which nearly a third of the cases were fatal or had not recovered, within the first two months of the vaccine's release in the United States.¹² These revelations are of concern as they cast doubt on the reliability of the initial six months of data. To date, millions of adverse events reports have been registered within the United States VAERS system, the UK Yellow Card scheme, EudraVigilance and the WHO's VigiAccess system.

1. VAERS (US): <https://vaers.hhs.gov/reportevent.html>
2. Yellow Card system (UK): <https://coronavirus-yellowcard.mhra.gov.uk/>
3. EudraVigilance (EU): https://www.adrreports.eu/en/search_subst.html#
4. WHO (Global): <http://www.vigiaccess.org/>

You may also refer to **SA VAERS**, the independent vaccine reporting system in South Africa, run by Transformative Health Justice, a partner of the World Council for Health.

Many critics argue that the numbers in these databases don't prove causality. However, when one considers the size of the signal on VAERS, the often-fatal thrombogenic and immunogenic mechanisms of action of the spike protein, the external consistency of the signal in other surveillance systems and the ever expanding list of regulatory warnings for example, Guillain-Barre, myocarditis and VIITP that occur with a strong temporal association to inoculation, it is not unreasonable to argue that the Bradford Hill tenets of causality have been met.

The range of vaccine adverse event reports (both in the databases and peer reviewed literature) is wide, but we will briefly highlight some of our major concerns with respect to cardiovascular safety, especially in the young population, and vulnerable groups.

Vaccine-induced myocarditis is not mild. Unlike Covid-induced myocarditis, it is associated with persistently raised Troponin T levels and often requires hospital admission with months of follow-up.¹⁶ Sporting and recreational activities have to be ceased post-diagnosis for substantial periods of time. Various analyses have sought to understand the frequency of post-vaccination myocarditis. The risk is substantially large in young men under 30, with teenagers between 12- and 15 years being most affected. We would like to draw your attention to a new paper in the journal of the American Heart Association, *Circulation*, that studied the cardiac inflammation PULS score in circa 500 patients. A significant rise in inflammatory markers was associated with both mRNA inoculations. The PULS-score increased from 11% to 25%.¹⁷ Inflammatory changes persisted for on average 2,5 months post-vaccination. Not only is this significant in the development of cardiac disease, but also has implications for planned booster dosages. Asymptomatic cardiac damage and its implications needs to be considered. Young men (who are not at risk of dying of Covid-19 as a group) have a significantly increased incidence of myocarditis and pericarditis post-vaccination. This risk is especially increased with repeat doses.^{16,18-22} We believe, given the mounting data, that not enough quality data exists to stratify the risk for developing this condition. More prospective data is needed.

We want to express concern that pregnant women, children and patients with autoimmunity are being inoculated without adequate evidence of safety. *The New England Journal of Medicine* published one retrospective review that concluded that the vaccines were safe in pregnancy.²³ Unfortunately, the authors made a data interpretation error and omitted to identify that vaccination in the early trimesters were associated with a seven times increased risk for miscarriage. A correction was published, and the authors amended their recommendation on the safety of vaccination in pregnancy. However, the original article has been used to ratify vaccination in pregnancy and many clinicians were not made aware of the amended conclusion. The authors' amended statement was that not enough data exists to draw a definitive conclusion of vaccine safety in pregnancy. Two further articles have since warned of the adverse events in VAERS and V-Safe registries for pregnancy and the implications of fetal health and neonatal development.²⁴ While the outcomes of Covid-19 infection in pregnancy may be extremely serious, patients should be made aware of all the risks to make an informed decision.

Finally, are pregnant women's vaccination status being tracked against pregnancy outcome in South Africa?^{7,23,24}

Closing remarks and recommendations

Vaccine safety is a growing concern. Not all age groups are equally at risk of Covid-19 death and patients deserve to have their doctor help them weigh their choice. We advise that South Africa needs more transparent vaccination data tracking and reporting. The public needs to know that the authorities take these injuries seriously. Actions, such as notifying dates of vaccination on death certificates and conducting autopsies with histopathological sampling and analysis, are required to distinguish between vaccine-induced death or otherwise. SAHPRA needs to update the public on vaccine injury data regularly. Pharmaceutical companies need to vouch for the safety of their products. No medical treatment exists that has no side-effects. Doctors need to be sensitized that adverse events are happening, and these should be reported. Patients should not be required to prove what doctors and pharmaceutical companies aren't able to either. Excluding people from society based on their vaccination status is unethical, perhaps even medically indefensible.

Our liability as front-line clinicians in supporting mandatory vaccination remains unclear. We are concerned for the health of our patients. We are aware that arguing that we were just "following orders" by supporting a risky mandatory medical intervention, will not be accepted as a legal defense. It is our moral obligation, as physicians who have taken the Hippocratic oath, to raise these matters with you. Since SAMA, SAHPRA and the HPCSA advocate for and protects patients and physicians, we ask for your support in this matter.

Until these matters have been adequately investigated, our ongoing qualified support of mandates is not feasible. While these products may have a role to play in prevention of illness and deaths, we would argue that a medical intervention that comes with such risks belongs within the confines of the doctor-patient relationship and not in the hands of private industry and administrators.

If you are aware of data that we have not considered, please share it with us. We will gladly consider. Please acknowledge and respond to our letter within 7 days.

Your faithfully,

Frontline Physicians South Africa

	Title	Name and surname	Area of work	Highest qualification
1	Dr	EM Drewes	General practice	MMedFamMed
2	Dr	Leah Murray	General practice	MbChB
3	Dr	Jeanine Rossouw	General practice	MBChB
4	Dr	Louise Stopforth	General practice	MPhil SEM, MBChB
5	Dr	Nathi Mdladla	Specialist	FCA

6	Dr	Hannah Norton	General practice	MTechHomCumLaude(UJ)
7	Dr	Stephen Schmidt	Specialist	MMed (Int)
8	Dr	M L Mohlala	Specialist	Mb, ChB ; FRCS
9	Dr	Maré Olivier	General practice	MBChB
10	Dr	Rodger Pottie	Specialist	M.Med. (Plast & Recon)(Stell)
11	Dr	Lynette Pretorius	General practice	MBChB; BSc (Hons) Pharmacology
12	Dr	Shankara Chetty	General practice	MBBS
13	Dr	Gregory Tintinger	Specialist	MMed; PhD
14	Dr	Herman Edeling	Specialist	FCS (SA) (Neuro)
15	Dr	Tini De Boer	General practice	PhD medicine
16	Dr	M Bezuidenhout	General practice	MBChB
17	Dr	Ellapen V Rapiti	General practice	FCFP
18	Dr	Zandre Botha	Specialist	P. hD
19	None	Esté-Mari Radyn	General practice	B. Pharm
20	Dr	Hilda Landman	General practice	MB ChB
21	Dr	Susan Vosloo	Specialist	FCS(SA) M MED
22	Dr	Jyothi Sookram	General practice	Degree
23	Dr	Willie Marais	General practice	M. B.,Ch.B
24	Dr	Paolo Brogneri	General practice	BChD
25	Dr	Ami Muller	General practice	MBChB
26	Dr	Deon Kotze	General practice	MBChB
27	Dr	Frank Robert Muller	General practice	MMed Pharms
28	Dr	Nomangesi Ngcakani	Specialist	FCP(SA)
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30	Dr	Jurie Wynand Wessels	General practice	MBChB

31	Dr	Kerryn Mocke	General practice	Post graduate diploma
32	Dr	Petro Anker	Specialist	MBChB, FCA(SA)
33	Dr	Helen Muir	General practice	MBChB
34	Dr	Michelle Weyers	General practice	MBChB, MSc.Sportsmedicine
35	Dr	Anina van der Bijl	General practice	MBChB MBA
36	Dr	Chantél Blignaut	Specialist	MMed(Anaesthesiology)
37	Dr	Leon Coetzee	General practice	MBChB
38	Dr	Johan Ganzevoort	Specialist	MMed (Family Medicine)
39	Dr	Siobhan Dawson	Specialist	MBChB, MRCPsych
40	Dr	M Theologides	General practice	MSc
41	Dr	Elizabeth Schnabel	General practice	General Practitioner
42	Dr	Michaela Brandsch	General practice	M. Tech. Hom
43	Dr	Eseza Monica Okunga-Nambassi	General practice	MBChB; Diploma HIV Med
44	Dr	Engela Behrens	General practice	BChD (Pret) BSc Biochemistry (Hons) (Pret)
45	Dr	Koos Marais	General practice	BChD
46	Dr	Shawn Stewart	General practice	DSc
47	Dr	Colleen Bland	General practice	M.Tech Hom
48	Dr	Eve Samson	Specialist	Fcorl
49	Dr	Naseeba Kathrada	General practice	MBChB
50	Dr	Sohail Bayat	General practice	MBChB
51	Dr	Aysha Osman	Specialist	FCA
52	Dr	Aadilah Domingo	General practice	Diploma in Anaesthesia
53	Dr	Mahomed Jeewa	General practice	M.B.,Ch.B. (Natal)
54	Dr	Tracey Brandt	General practice	MBBCh

55	Dr	Muniera Ahmed	General practice	MBChB
56	Dr	Hassen Dhooma	General practice	MBChB
57	Dr	Fathima Motala	General practice	General practitioner
58	Dr	Nicola Scholfield	General practice	MBBCh
59	Dr	Teresa Swart	General practice	MBChB MPhil
60	Dr	Alta Louw	General practice	MBChb
61	Dr	Charlene Muller	General practice	BChD
62	Dr	Mohsin Moola	General practice	MBChB, MICGP
63	Dr	Stephen Schmidt	Specialist	MMed (Int)
64	Dr	Maré Olivier	General practice	MBChB
65	Dr	Jolanda Niemann	General practice	MBChB
66	Dr	Alwyn Jacobus Carstens	Specialist	M.Med Rad
67	Dr	Michael williams	General practice	MBChB
68	Dr	Hilda Landman	General practice	MB ChB
69	Dr	Maria Olivier	General practice	MBChB
70	Dr	Ursula Ingrid Paul	General practice	MBBCh
71	Dr	Rodger Pottie	Specialist	M.Med.(Plast&Recon) Stellenbosch
72	Dr	Marna Turner	General practice	MBChB
73	Dr	Janet Giddy	General practice	MFamMed, MPH
74	Dr	Rafiq Harneker	General practice	MBChB
75	Dr	Jolanda Niemann	General practice	Tertiary
76	Dr	Teresa Swart	General practice	MBChB MPhil

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