**YouTube’s removal of a lecture on the effects of vaccines on mortality constitutes horrible censorship**

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<https://www.scientificfreedom.dk/news/>

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A week ago, YouTube removed a video of a lecture held at the [opening symposium](https://www.scientificfreedom.dk/lectures/) for the Institute for Scientific Freedom on 9 March 2019. This lecture was held by Professor Peter Aaby, one of the world’s top vaccine researchers. It is highly interesting and very important for everyone who wants to understand what vaccines do. I have therefore [uploaded the video](https://www.scientificfreedom.dk/lectures/) on the Institute’s homepage.

Aaby has published numerous papers in prestigious medical journals and his ground-breaking work was summarised in 2018 in a book celebrating the 40th anniversary for his studies in Guinea-Bissau.[[1]](#footnote-1) Aaby has shown, in many studies, that live vaccines, e.g. the measles vaccine, decrease mortality much more than can be explained by their specific effects against a particular microorganism whereas non-live vaccines increase total mortality.

All the lectures were filmed and [uploaded on YouTube](https://www.scientificfreedom.dk/lectures/). They are still there, apart from Aaby’s: . If you click on [the link](https://www.scientificfreedom.dk/lectures/) on the Institute’s homepage, this is what you get:

Text

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YouTube informed the filmmaker on 9 November:

Hi NORDICDOX,

We wanted to let you know our team reviewed your content, and we think it violates our medical misinformation policy. We know you may not have realized this was a violation of our policies, so we're not applying a strike to your channel. However, we have removed the following content from YouTube:

**Video**: [Most of you think we know what our vaccines are doing - we don't, Peter Aaby](https://www.youtube.com/watch?v=NPNHYAevTwg)

We realize this may be disappointing news, but it's our job to make sure that YouTube is a safe place for all. If you think we've made a mistake, you can appeal this decision - you'll find more details below.

**What our policy says**

YouTube doesn’t allow content that poses a serious risk of egregious harm by spreading medical misinformation about currently administered vaccines that are approved and confirmed to be safe and effective by local health authorities and by the World Health Organization (WHO). Learn more [here](https://support.google.com/youtube/answer/11161123).

[LEARN MORE](https://support.google.com/youtube/answer/9891785)

**What you can do next**

We want to help you keep your content on YouTube, so please:

• Review YouTube's [Community Guidelines](https://support.google.com/youtube/answer/9288567).

• Double check how your content may have violated our guidelines.

• Appeal here if you think we've made a mistake.

I got the missing video from the filmmaker and made a summary of it. Unfortunately, a complaint to YouTube is limited to 800 characters, so we sent this:

It is inappropriate that YouTube has removed this video. There is no misinformation whatsoever. Professor Peter Aaby is a top vaccine researcher. He talks about how live vaccines seem to decrease mortality much more than can be explained by their specific effects against a particular microorganism whereas non-live vaccines appear to increase total mortality. Aaby’s research has led to changes at the WHO, e.g. WHO recommended against a high-titre measles vaccine. He disagrees with WHO about the DTP vaccine, but Prof Peter Gøtzsche has reviewed the studies. Aaby is right, WHO is wrong. Historically, challenging authorities has been immensely beneficial for mankind and for making scientific progress. This is at the heart of science. I can send a full analysis of Aaby’s lecture.

The next day, YouTube informed the filmmaker that they had reviewed the content carefully and had confirmed that it violated their medical misinformation policy: “We know this is probably disappointing news, but it's our job to make sure that YouTube is a safe place for all.”

This is horrendous. What about making sure that vaccines are safe for all? Someone who is against scientific freedom must have seen the 2.5-year-old video and complained to YouTube, and YouTube automatically applied scientific censorship in a brain-dead fashion. It feels as if we are back to the Middle Ages where the King needed to approve all books before they were published.

Incidentally, I have written an [expert report](https://vaccinescience.org/expert-report-effect-of-dtp-vaccines-on-mortality-in-children-in-low-income-countries/) about the heart of the matter, the disagreement between Aaby and the WHO about the effect of the DTP vaccine on total mortality, and I have described this in my vaccine book:[[2]](#footnote-2)

I have studied in detail a WHO report from 2014 that seems to have been carried out in response to Aaby’s findings of increased mortality of the trivalent diphtheria, tetanus, and pertussis (DTP) vaccine in Guinea-Bissau.[[3]](#footnote-3) It assessed the effect of three vaccines on total mortality in infants and children: BCG, DTP, and measles.

I updated WHO’s literature searches and found two highly relevant studies where Aaby and colleagues had improved on their previous research in response to the criticisms raised in the WHO report.[[4]](#footnote-4) [[5]](#footnote-5) They found that the DTP vaccine doubled mortality, hazard ratio 2.14 (1.42 to 3.23), compared with DTP-unvaccinated children, confirming their previous findings. In one of their studies, which represents the best available evidence, they explained that the criticisms raised in the WHO report were either not relevant, or they had taken it into account. They found that all the documented biases in their observational study favoured the vaccinated group, i.e. they had likely underestimated the harmful effect of the DTP vaccine on mortality.

They also found that all studies of DTP that had analyzed existing data sets collected for other purposes suffered from substantial biases that led to underestimation of the harms of the vaccine. One such bias is frailty bias, where children with a poor prognosis generally tend to be vaccinated later or not at all. Another is survival bias. These studies have updated follow-up time for DTP-vaccinated children who survived whereas children who died without their vaccination status being documented were classified as "unvaccinated." Such procedures introduce substantial bias and give a misleadingly high mortality rate in the unvaccinated group that makes it difficult to find a possible increase in mortality with DTP.

I found major problems with the WHO report. Although it reported that most studies showed a deleterious effect of DTP, the authors concluded that the results were inconsistent because two studies showed a beneficial effect. However, some heterogeneity will always occur in observational studies, and these two studies did not find a *significantly* beneficial effect on mortality. Furthermore, it was obvious that they were so seriously biased that they should not have been taken into account.

The authors did not provide summary estimates because WHO’s working group had requested that meta-analyses not be done. This is an unacceptable interference with research by a body that includes people with numerous financial conflicts of interest in relation to vaccines. Furthermore, the reasons offered for not performing meta-analyses were invalid. It is difficult to understand why this highly unusual demand (which I have never seen elsewhere) was introduced unless one assumes that the WHO did not want to run a risk of receiving a systematic review that suggested that the DTP vaccine increases total mortality.

WHO’s experts who advised against using meta-analysis wrote, after having seen the WHO report, that the data suggested that both the BCG vaccine and the measles vaccine reduce all-cause mortality. I checked this claim by doing meta-analyses of the randomized trials that were included in the report, and I did not find significant reductions in mortality. Therefore, the experts could not conclude that these live attenuated vaccines reduce total mortality without including also the nonrandomized studies in their deliberations. In contrast, for the DTP vaccine they dismissed the nonrandomized studies. This is inconsistent and scientifically unacceptable, particularly considering that the results for the cohort studies for the BCG and the measles vaccines varied as much as those for the DTP vaccine.

I found many other serious problems with the WHO report. This is very surprising because two of the three authors of the WHO report are senior researchers in the Cochrane Collaboration. These two are the current editor-in-chief, Karla Soares-Weiser, and statistician Julian Higgins, who is editor of the 636-page *Cochrane Handbook*, which describes how to do reliable systematic reviews. These researchers even used vote counting in the WHO report (how many studies are for and how many against?), which is a method recommended against in the *Cochrane Handbook*.

A major problem with WHO is that the people who approved a vaccination program are also those who will consider whether there is reason to change their own recommendation. People are not likely to change their earlier decision, no matter how strong the evidence is that it was wrong.[[6]](#footnote-6) Not a single randomized trial has been carried out, but the DTP vaccine is nonetheless on the market and is widely used.

Aaby and colleagues have pointed out that WHO even uses the DTP vaccine as a marker for good coverage of vaccination in general. The WHO has operated with reaching a “milestone of 90% national coverage” with three doses of the vaccine in all countries by 2015.[[7]](#footnote-7) This should not happen. Program performance indicators should be those which are known to be positively associated with increased child survival.

In addition to all this, we now have the odd situation that the burden of proof has been reversed. WHO recommends the use of the DTP vaccine and seems to require very convincing evidence that it increases mortality before any action will possibly be taken.

This is problematic. I consider Aaby’s findings much more convincing than those in the WHO report, and we base our decisions on the best available evidence. This evidence tells us that the DTP vaccine likely increases total mortality in low-income countries. I therefore believe no one should be offered this vaccine without full informed consent that includes information that the vaccine is likely to increase total mortality. Furthermore, we need to do trials, e.g. where one of the groups receive a live vaccine shortly afterward.

YouTube’s censorship in this case is of the worst kind. If we are not allowed to challenge authorities, we have created a world we do not want to live in. The essence of science is to challenge the findings of others, and this is exactly what Aaby has done based on good science done by himself and others. But it gets worse. YouTube’s [Vaccine Misinformation Policy](https://support.google.com/youtube/answer/11161123) states:

Don’t post content on YouTube if it includes harmful misinformation about currently approved and administered vaccines on any of the following:

* **Vaccine safety:** content alleging that vaccines cause chronic side effects, outside of rare side effects that are recognized by health authorities
* **Efficacy of vaccines:** content claiming that vaccines do not reduce transmission or contraction of disease
* **Ingredients in vaccines:** content misrepresenting the substances contained in vaccines

Thus, we are only allowed to post material about harms of vaccines that have been “recognized by health authorities.” This provision is detrimental to the public. The authorities, e.g. drug agencies, are very slow in acknowledging even serious harms of vaccines and other drugs,[[8]](#footnote-8) for example that people become dependent on depression pills and that they double the risk of suicide, both in children and adults.[[9]](#footnote-9)

Furthermore, who decides if material about vaccines is misinformation and on what basis? Who should judge who is right in a scientific dispute? Some high priest of science, or what? YouTube does not allow content claiming that vaccines do not reduce transmission or contraction of disease. But this is an essential problem with several vaccines, and it is being lively debated right now to what extent the COVID-19 vaccines can prevent infection or transmission.

YouTube provides some examples of what they do not allow:

* Claims that vaccines cause chronic side effects such as:
  + Cancer
  + Diabetes
  + Other chronic side effects
* Claims that vaccines do not reduce risk of contracting illness
* Claims that vaccines contain substances that are not on the vaccine ingredient list, such as biological matter from fetuses (e.g. fetal tissue, fetal cell lines) or animal byproducts
* Claims that vaccines contain substances or devices meant to track or identify those who’ve received them
* Claims that vaccines alter a person’s genetic makeup
* Claims that the MMR vaccine causes autism
* Claims that vaccines are part of a depopulation agenda
* Claims that the flu vaccine causes chronic side effects such as infertility
* Claims that the HPV vaccine causes chronic side effects such as paralysis”

We are not allowed to claim that flu vaccines can cause permanent harm. But this is not a claim, it is a fact. The Pandemrix vaccine caused narcolepsy, which is a serious and irreversible disease, in people with certain tissue types.[[10]](#footnote-10) Moreover, there are many examples that vaccines have killed people, which is worse than getting permanently harmed (see footnote 10 below).

We are not allowed to claim that the HPV vaccines cause “chronic side effects.” But this is not a claim, it is a fact. The European Medicines Agency (EMA) published a 40-page report in November 2015 concluding that there are no serious neurological harms of the HPV vaccines. However, EMA did a very poor job where they, among other things, trusted what the companies reported to them even though they already knew that the companies had concealed serious neurological adverse events earlier.[[11]](#footnote-11) Against all odds, as other vaccines were used in the control groups in all trials but a few small ones, my research group found that the HPV vaccines increased serious nervous system disorders significantly: 72 vs. 46 patients, risk ratio 1.49 (1.02 to 2.16; p = 0.04).[[12]](#footnote-12)

YouTube explains that it “may allow content that violates the misinformation policies noted on this page if that content includes additional context in the video, audio, title, or description.”

Aaby does not provide any misinformation about vaccines. His statements are backed up by solid science and there are references to this science on his slides (see my summary just below).

I shall not comment on YouTube’s [COVID-19 Medical Misinformation Policy](COVID-19%20medical%20misinformation%20policy). I shall only say that the detailed guidance over four pages is utterly absurd, and that judges would disagree wildly if they were asked to assess the same video.

**My summary of Aaby’s 25 minute lecture**

00:57 “No routine vaccine was tested for overall effect on mortality in randomised trials before being introduced.”

2:44 Aaby explains how mortality from measles dropped dramatically by 85% in children under 5 in Guinea-Bissau when his group started to vaccinate against measles, which was a defining moment for him. Five studies in Africa all showed more than a 50% reduction in mortality by comparing the year before with the year after the introduction of the measles vaccine. According to WHO, the measles vaccine reduces total mortality by 10-15%, which is more than you would expect based on its effect on measles only.

3:45 Aaby did a randomised trial in Africa where children in one arm were vaccinated early in life, with a higher measles vaccine dose than usual. Something very strange happened. For boys, there was no difference in total mortality. Girls had a two-fold higher mortality if they got the new measles vaccine.

5:20 Aaby wrote to WHO and asked them to check what had happened when others had used the new vaccine. “I got a letter back saying, thank you for your interest, but we know you have small numbers.”

But Aaby had many deaths in his study. The problem was that he had not planned a subgroup analysis beforehand, looking at boys and girls separately. Aaby argued that he looked at the data and that they did not make sense to him.

WHO didn’t do anything initially, but Aaby convinced WHO that they should have an expert panel look at the data. The experts decided: “This is not plausible. There is no biological explanation. So, it can’t be true.” Secondly, it had not been planned. Aaby: “You cannot plan to kill children.”

6:45 “Luckily, one of the members of the panel was an American from Johns Hopkins. He went back to Haiti where he used the vaccine, and he found the same thing.”

Later, Canadians in Sudan found the same. “So, just one year later, the WHO withdrew the vaccine. There was no real explanation … they made no attempt to understand what had happened.“

7:40 “The meta-analysis of the African studies showed that the mortality between 4 months and 5 years of age … was a 33% increase, all of it being female increase in mortality. Just in Africa, that would have meant at least half a million additional female deaths per year. So, we are talking about big numbers if we play with the immune system.”

8:15 Aaby’s data showed that the mortality in African children who had received the BCG vaccine (Bacillus Calmette-Guérin, against tuberculosis) was only half of that in unvaccinated children. Immunologists said that this was because the best children got vaccinated, i.e. a selection bias. But you should not pay attention to this. If this was correct, children who got two vaccines should also have lower mortality, but those who also got the DTP vaccine had a mortality very similar to the unvaccinated children. The BCG vaccine reduces mortality by 45% whereas DTP, the most commonly used vaccine in the world, increases mortality by 84%. I sent these data to the WHO four years ago, but nothing happened. When BMJ accepted the paper, they got a bit nervous, so we were called to a meeting in Geneva, and I invited them to come to Bissau to check our data. They sent a mission of three people to Bissau. And then they sponsored other sites to see if they could find the same.

10.10 “I clearly had the feeling that they were going to come after me. That’s the kind of feeling you get if you come up with something that is unpleasant to those who hold power.”

Aaby then looked at his data when they introduced DTP in Guinea-Bissau in 1984. The unvaccinated children had been travelling or were sick and had lower nutritional status (which Aaby’s team had measured on everyone). However, mortality was two times higher for those who had received the vaccine over the next 6 months.

11:50 Aaby had made three studies and they show the same even though it is the worst children who do not get vaccinated. This is clearly worse for girls than for boys. There is no selection bias as regards vaccination of girls and boys, but 16 studies (from Africa, India and Bangladesh) show together a 50% higher mortality for girls than for boys. Before the introduction of the vaccines, mortality was slightly lower in girls. It is also unnatural in the sense that after the measles vaccine, mortality is lower in girls than in boys.

13:25 This seems to be negative boosting. DTP1 gives 20% higher mortality, but with DTP2, it is 70% higher mortality for the girls than for the boys. DTP3 is the vaccine we use to monitor the vaccination program in low-income countries.

14:00 That vaccine is actually killing children.

15:00 No DTP vaccine after high-titre measles vaccine (in 5 African countries): no difference in mortality between girls and boys. If the DTP vaccine is given, there is a two-fold higher mortality for the girls. This explains the increased mortality with the high-titre measles vaccine (published in 2003 in Lancet).

In 2004, the WHO presented the results of their sponsored studies. They did not show “any negative effect of DTP vaccination and no difference was found between males and females. The committee (the Global Advisory Committee on Vaccine Safety) concluded that the evidence is sufficient to reject the hypothesis for an increased non-specific mortality following vaccination, and that the effect seen in Guinea-Bissau was probably explained by a confounding factor in the dataset (Weekly Epidemiological Record 2004). Aaby’s comment on his slide: no information on which factor – and there were several other data sets.

How could there be confounding when it was the worst children that were not vaccinated?

16:50 To back up their point, WHO got a very esteemed group of very well-known professors from the London School (of Tropical Medicine and Hygiene) to form a task force on the effect of routine infant vaccination on child survival. But this task force was only about the DTP issue. The report is not published, the data they analysed are not there, but the conclusion is on the Internet:

“The task force is unanimous that the totality of the evidence provided in the papers reviewed does not suggest a deleterious effect of DPT vaccination; on the contrary, they provide substantial evidence against such an effect. Furthermore, with the exception of the studies from Guinea Bissau, there was little evidence of a differential effect between boys and girls.”

The WHO studies were from Bangladesh, India, Burkina Faso, Senegal, Ghana, and Papua New Guinea.

17:50 We had actually predicted this when we had the discussions about the vaccines. In 2001, we said that the WHO sponsored studies would produce survival bias. Survival bias is when your information is better for those who survived and that happened very easily. I will give you a simple example. You see two children and come back 6 months later; one has survived and was vaccinated 3 months ago. The other child died, and we don’t know anything; the parents threw the card away, and the child will be declared unvaccinated. But no information is not unvaccinated.

It took us several further years to convince the people from the London School that there was a problem with survival bias. They eventually wrote an editorial. The Global Advisory Task Force accepted this and then the Global Advisory Committee on Vaccine Safety said that they would watch out for potential deleterious effects of the vaccine.

19:30 In 2014, WHO made their own review. We had produced an update saying that there are non-specific effects of vaccines. The WHO review included 10 of the 16 studies with data on DTP. They found that the DTP vaccine was associated with a 38% higher mortality. But what they said was that “the findings were inconsistent, with a majority of studies indicating a detrimental effect of DTP, and two studies indicating a beneficial effect.” However, those two studies have major survival bias. So, in spite of previous discussions, they had included the studies with survival bias. If you exclude the two studies with survival bias, what comes out is a two-fold higher mortality with the DTP vaccines. So, the findings were not inconsistent; the methodologies have been inconsistent.

If you take all the studies in the review, you will see a very clear pattern. All of the DTP effects are above 1, and all of the effects of the live measles and the BCG vaccines are well below 1 in terms of effect on survival. The measles and the BCG vaccines are associated with a 45% lower mortality and DTP is clearly associated with a higher mortality.

21:10 Most of you have not been trained in this. Immunology has been developing in the last 5-10 years. We forgot about the innate immune system; that’s the first line of defence. It is not about T-cells and B-cells, it’s about the innate immune system, which is changed when you get these vaccines. So, you can induce enhanced performance by a live vaccine, but you can also induce tolerance with an inactivated vaccine.

22:10 GSK has developed a malaria vaccine. It didn’t really matter for the boys, but for the girls, there was a two-fold higher mortality in spite of protecting against malaria. We are currently testing this vaccine in Africa, in three countries with 720,000 children, so if there is anything to their own data, we are going to kill between 2,000 and 5,000 girls unnecessarily.

I have tried to give you an overview of 40 years of work, but there is good news and bad news. The good news is that every time we introduced a live vaccine, measles, BCG, and measles again - and what has happened in the last 20 years is not appreciated; the information is nowhere - we don’t know why mortality has dropped 70%. We campaigned about the measles and the oral polio vaccine (also a live vaccine). Whenever we had these campaigns, the mortality dropped. So, you have to untrain everything you learned at the university. It is not about specific diseases; it’s how you train the immune system. And these live vaccines apparently train the system beneficially. But the negative part is that when we introduced DTP or DTP booster, mortality went up. When we introduced hepatitis B, which is also an inactivated vaccine, the same thing happened. WHO has said that they will recommend further research on non-specific effects, but they also said they cannot study DTP. So, the committee the WHO has formed has said that it cannot study DTP.

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12. Jørgensen L, Gøtzsche PC, Jefferson T. Index of the human papillomavirus (HPV) vaccine industry clinical study programmes and non-industry funded studies: a necessary basis to address reporting bias in a systematic review. Syst Rev 2018;7:8. [↑](#footnote-ref-12)