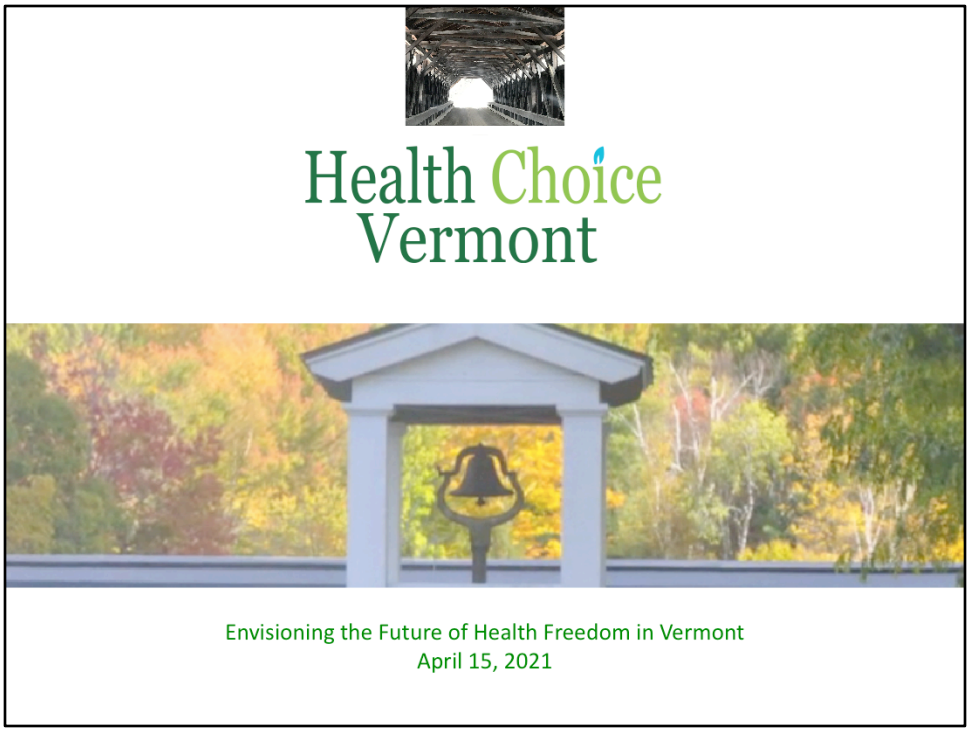


Good evening everyone – today is April 15th 2021 and welcome to: envisioning the future of health freedom in Vermont.

My name is Jennifer Stella and I will be moderating this evening's session. You may have noticed that our invited mentioned that we are building bridges not tunnels, and this is what we really must do at this time. We need to reach people in a way they can understand.

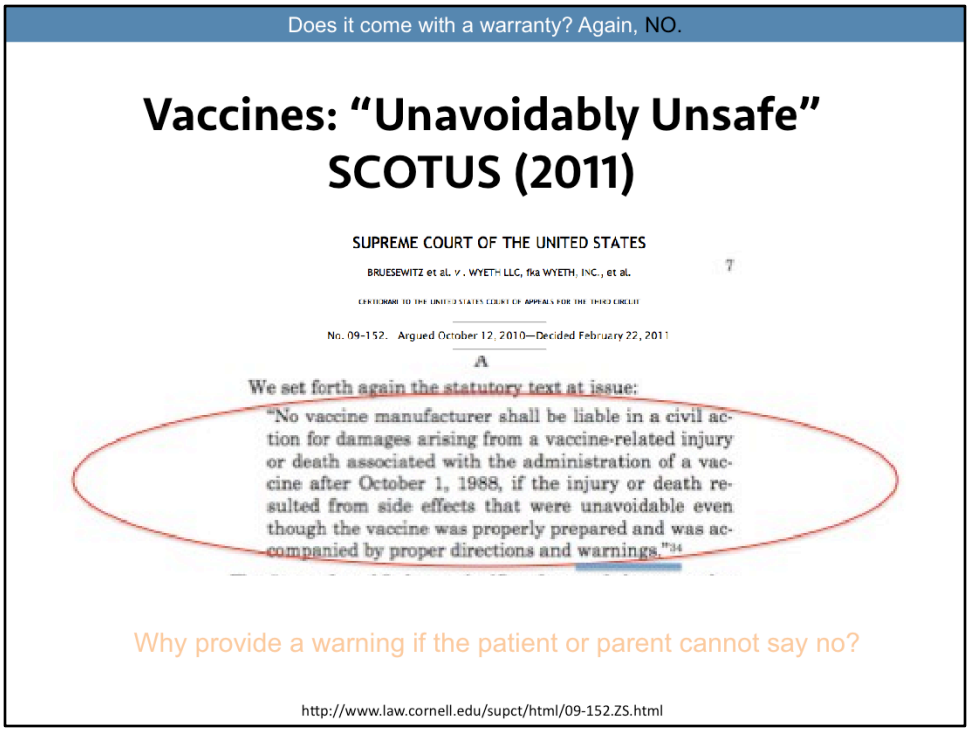
The challenges we face

The increasing hostility towards those who ask questions and seek true informed consent for medical care has triggered a biased and uneducated portrayal of those who support medical freedom. Censorship of the facts on social media, in the media, and in public are at an all time high.

All codes of medical ethics until this time have recognized the autonomy of the patient

and yet the current narrative is:

"I'm not willing to let unvaccinated people pose a risk to others as disease vectors"
– a prominent Vermont Senator to a constituent



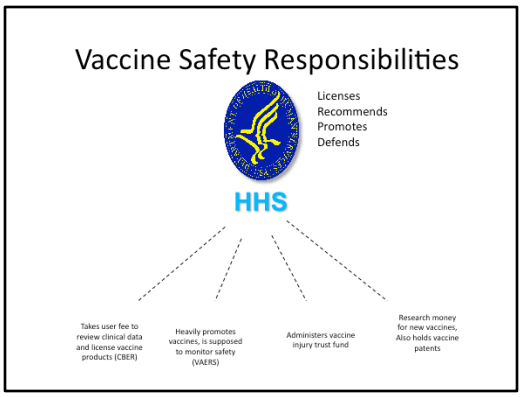
Manufacturers legal immunity is predicated on an adequate warning, andif you look in their package inserts you can see that they do provide warnings…
But these warnings are rarely conveyed to consumers (parents) by pediatricians.

Furthermore, giving a warning without a right to informed consent is meaningless. Thus mandatory injections without right to refuse is contrary to the US supreme court ruling and undermines the manufacturers basis for legal immunity from adverse effects.

State tort law is preempted1 by National Childhood Vaccine Injury Act2 [42 U. S. C. §300aa–22(b)(1)], which states:

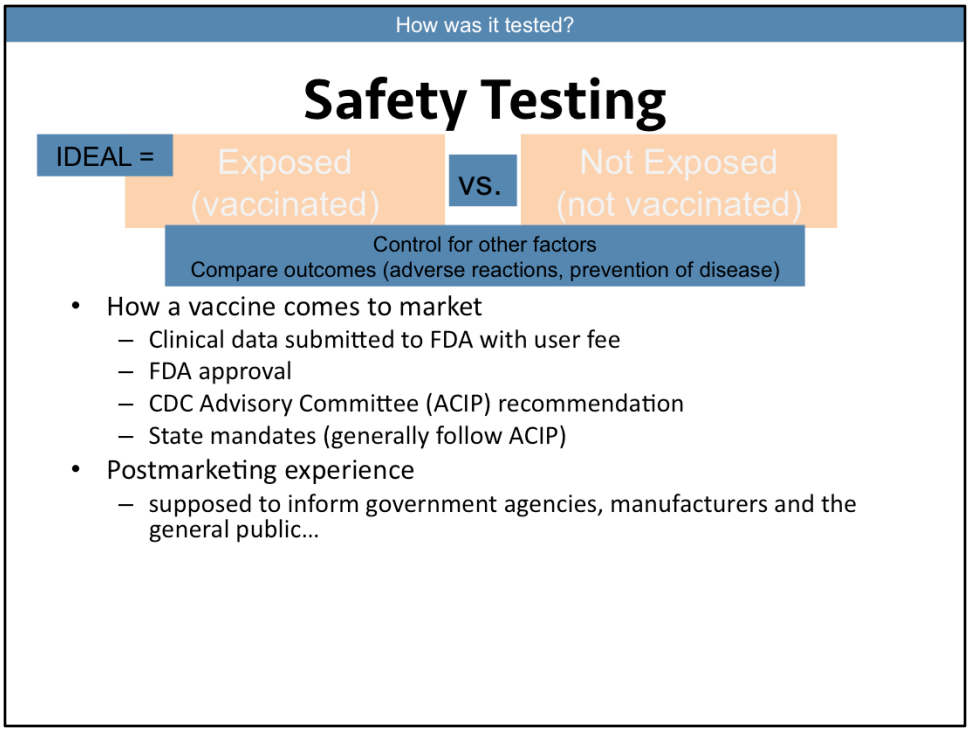
"no vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side-effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions 1 Bruesewitz v. Wyeth LLC https://www.supremecourt.gov/opinions/10pdf/09-152.pdf

2 National Childhood Vaccine Injury Act of 1986, 42 U.S.C. § 300aa-1 et seq., and Bruesewitz, supra http://www.uscfc.uscourts.gov/vaccine-program-readmore



When congress granted pharmaceutical companies immunity from liability for vaccine injuries they transferred all responsibility for vaccine safety to the United States Department of Health & Human Services (HHS) and its agencies, including the Food & Drug Administration (FDA), the Centers for Disease Control (CDC) and the National Institutes of Health (NIH).
This arrangement, along with school mandates, eliminated the normal market forces driving product safety (boycotts or lack of customers) and also (in states that did not offer free and respected "exemptions", has the potential to betray and violate the ethical doctrine of informed consent – where all patients, or parents, must be fully informed of the nature of the proposed procedure, the risks, and the alternatives – including doing nothing.

The 1986 Act transferred essentially all responsibility for vaccine safety from the pharmaceutical companies to the US Government agency, Health and Human Services (HHS). Twent years later, in 2006 a bi- partisan group of seven congressmen proposed a bill to create an entirely new government agency solely devoted to vaccine safety.
The primary sponsor of this bill explained the need for this bill as follows:
Federal agencies charged with overseeing vaccine safety research have failed. They have failed to provide sufficient resources for vaccine safety research. They have failed to fund extramural research. And, they have failed to free themselves from conflicts of interest that serve to undermine public confidence in the safety of vaccines. The American public deserves better and increasingly parents and the public at large are demanding better.
I'm a physician. ... When I first began working on this issue about seven years ago, I was shocked at the dearth of resources dedicated to vaccine safety research. ...
When I first tasked my staff with investigating this issue we got a lot of confused responses from federal agencies. The FDA told us to check in with the CDC, saying CDC did most of the vaccine safety research. The CDC referred us over to the NIH. Then, the NIH referred us back to the CDC. ...
Several issues relating to vaccine safety have persisted for years. The response from public health agencies has been largely defensive from the outset and the studies plagued by conflicts of interest. ...
Presently, vaccine safety research is an in-house function conducted predominantly by the CDC – the very agency that makes vaccine recommendations and promotes their uptake. This should not be.
This bill did not get out of committee, a fact which likely reflects the ratio of over 1,000 pharma lobbyists in Washington D.C. to virtually no vaccine safety lobbyists.
Many parents, doctors and scientists, as well as politicians, are legitimately concerned about the process whereby vaccines are licensed, recommended, promoted and defended by the same department. This is not because of any conspiracy, or belief in an insidious intent. Rather, the problem is with the structural conflicts and incentive scheme this system creates.



HHS, through the FDA, licenses all vaccines used by the American public.
All non-vaccine drugs licensed by the FDA undergo long-term multi-year double-blind safety studies during which the rate of adverse reactions in the group receiving the drug under review is compared to the rate of adverse reactions in a group receiving an inert placebo, such as a sugar pill or saline injection.
For example: Enbrel's pre-licensure trials followed subjects up to 80 months and controls received a saline injection. Lipitor's pre-licensure trials lasted a median of 4.8 years and controls received a sugar pill. Botox's pre-licensure trials lasted a median of 51 weeks and controls received a saline injection. And even with these long-term studies, drugs are still often recalled
While most drugs, like the ones above, are given to sick adults, pediatric vaccines are typically given universally to babies and toddlers. And while pharmaceutical companies remain liable for injuries caused by their non-vaccine drugs, they have no liability for injuries caused by their vaccines. One would therefore expect that pre-licensure safety testing for vaccines would be more rigorous than that conducted for drugs.
Unfortunately, unlike all non-vaccine drugs licensed by the FDA, vaccines are *not* required to undergo long-term double-blind inert-placebo controlled trials to assess safety. In fact, not a single one of the pre-FDA license clinical trials for vaccines given to babies and toddlers had a control group receiving an inert placebo. Further, most pediatric vaccines currently on the market have been approved based on studies with very short follow-up

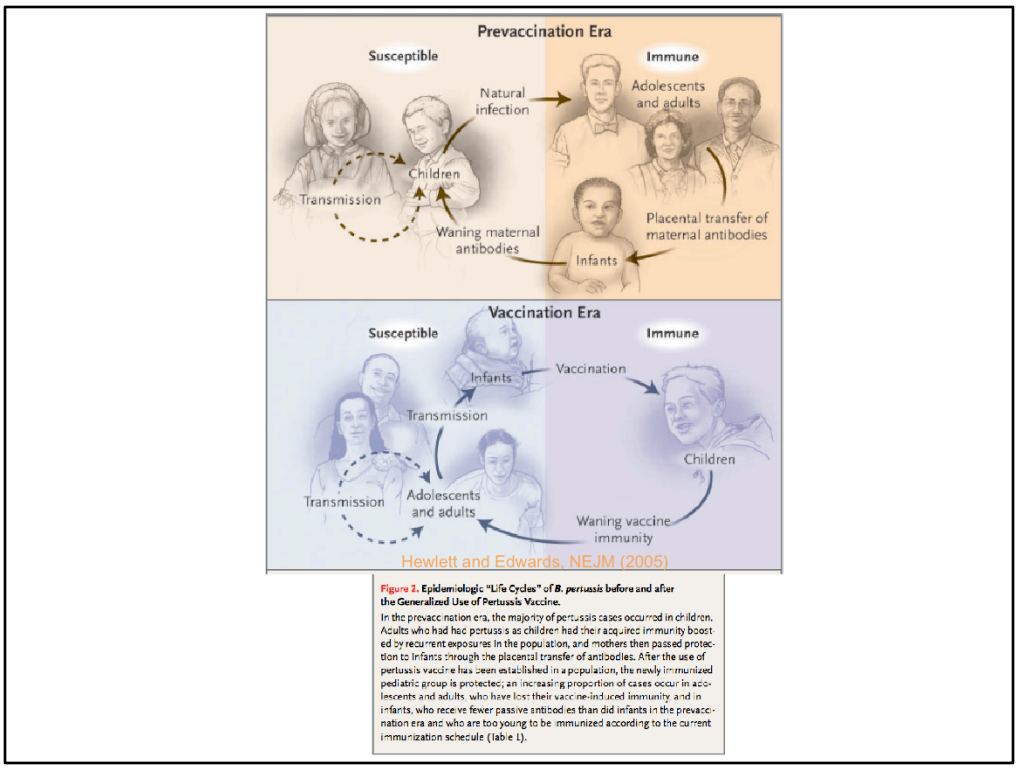


Figure 2. Epidemiologic "Life Cycles" of *B. pertussis* before and after the Generalized Use of Pertussis Vaccine.

In the prevaccination era, the majority of pertussis cases occurred in children. Adults who had had pertussis as children had their acquired immunity boosted by recurrent exposures in the population, and mothers then passed protection to infants through the placental transfer of antibodies. After the use of pertussis vaccine has been established in a population, the newly immunized pediatric group is protected; an increasing proportion of cases occur in adolescents and adults, who have lost their vaccine-induced immunity, and in infants, who receive fewer passive antibodies than did infants in the prevaccination era and who are too young to be immunized according to the current immunization schedule (Table 1).

This is from the New England Journal of Medicine – published in 2005.
It explains that In the so-called "prevaccination era", the majority of pertussis cases occurred in children.
Adults who had had pertussis as children had their acquired immunity boosted by recurrent exposures in the population, and mothers then passed protection to infants through the placental transfer of antibodies. After the use of pertussis vaccine has been established in a population, the newly immunized pediatric group is protected; an increasing proportion of cases occur in adolescents and adults, who have lost their vaccine-induced immunity, and in infants, who receive fewer passive antibodies than did infants in the prevaccination era …
In the pre-vaccination era close to 80% of cases occurred in children 5 years or younger and the shift in epidemiology is thought to be related to waning immunity in an immunized population. Since 1990, the incidence of pertussis among preschool-aged children has not changed, but the incidence among adolescents has increased in some areas (Clin Inf Dis 1999; 28:1230-7).
the vaccine era, naturally acquired disease usually provided comprehensive long-term immunity because natural immunity involves a more broad-spectrum response to the entirety of the bacteria and their toxins. Remember that being immune to any degree does not stop the bacteria from flying around and entering the air-way. When a naturally immune person reencounters whooping cough bacteria, the body will efficiently respond and clear them from the system. This is not necessarily true of vaccinated people.

Herd Immunity

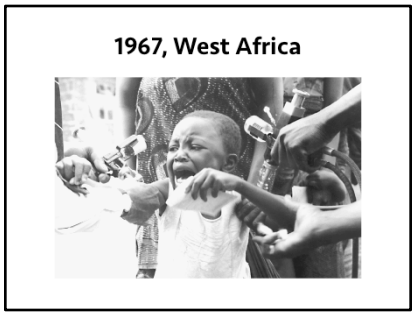
- 1909 Hamer
- 1923 Topley & Wilson
- 1933 Hedrich
  - measles in Baltimore 1900-1931; epidemics occurred when the natural immune population < 15 yrs old fell below 68%
- 1967 US Public Health Service prediction of elimination was based on this figure, neglecting the population > 15 yrs old
- 1971 Fox paper: "Herd immunity concept and relevance to public health immunization practices" in Am J Epidemiol

As part of work on germ theory, Hamer, in his 1906 paper, developed a quantitative argument, based on demographic data, in particular weekly births and recorded numbers of measles cases, to show that the periodicity of that disease was driven by the influx of susceptibles and their depletion

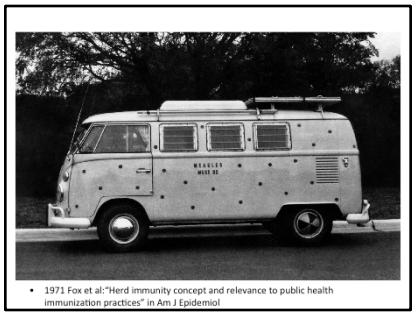
Herd immunity was actually first coined in the literature in 1923 by Topley and Wilson on experiments in experiments vaccinating lab mice.
They posed the question whether it is better that some individuals shall be highly resistent, and others fully susceptible, or that all shall possess some
Degree of immunity, even if this be of a lower grade.

In 1993 Hedrich published his work in studying measles epidemics in Baltimore from 1900-1931, which had age-specific notification requirements, and found that when the **natural** immune population < 15 yrs old fell below 68% this would start a new measles epidemic.

Until today, no disease has been studied more intensely with reference to herd immunity
than has measles due to Its frequency, its regular behavior, and the high quality of available data, and the discussion ever since 1967 of the possibility of eliminating measles both
nationally and internationally using vaccine.



Captured in 1967, this CDC image depicts a small West African child, who was in the process of simultaneously receiving his smallpox and measles vaccinations, during the West Africa Smallpox Eradication and Measles Control Program. The child was being vaccinated in both arms using a Hypospray Jet Gun. In 1980, the World Health Organization (WHO) declared the glbal eradication of smallpox, and recommended that all countries cease vaccination. https://phil.cdc.gov/Details.aspx?pid=1991



- 1971 Fox et al:"Herd immunity concept and relevance to public health immunization practices" in Am J Epidemiol

Before the measles vaccine became available in 1963, there were approximately 3 to 4 million cases, and an average of 450 deaths a year in the U.S., with epidemic cycles occurring every 2 to 3 years. More than half the population had measles by the time they were 6 years old, and 90 % had the disease by the time they were 15 years of age.

Things were about to change.

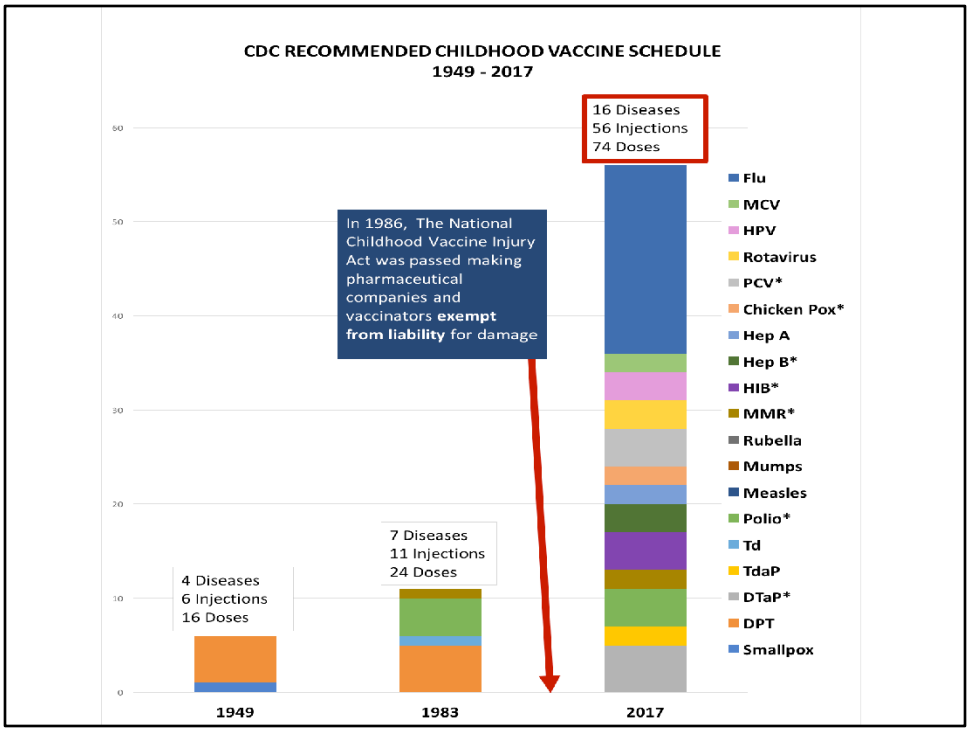
In 1967, the WHO had announced they would eradicate smallpox from the world in 10 years. And the US public health service had declared its intention to eradicate measles from the US within one year.

Both of these tasks were to be accomplished by the induction of herd immunity with vaccines.

By 1971, initial successes and failures were on the record.
Smallpox was rapidly disappearing from many countries as a result of simple increases in vaccine coverage, but it was lingering in some regions, in particular the Indian Subcontinent, despite apparently high coverage. In the United States, though the measles effort had succeeded in greatly reducing measles incidence, it was nowhere near eliminating transmission as the virus was found to persist in many cities and social groups throughout the country.

1971 Fox paper: “Herd immunity concept and relevance to public health immunization practices” in Am J Epidemiol

Fox and his colleagues set out to explain these events. They began by quoting a dictionary definition of herd immunity as "the resistance of a group to attack by a disease to which a large proportion of its members are immune, thus lessening the likelihood of a patient with a disease coming into contact with a susceptible individual” and they then set out to explore the quantitative implications of increasing the number or proportion of those with immunity within a population.” And thus began the eradication campaigns – using one MAJOR assumption, and that was: one live measles vaccine would protect for life, just as suffering a natural attack of the measles….



Since the liability shield came into effect in 1988, the childhood vaccination schedule has exploded.

Today's "pediatric schedule" is seven times the number of injections recommended in 1983, before industry was freed from liability for product harm.

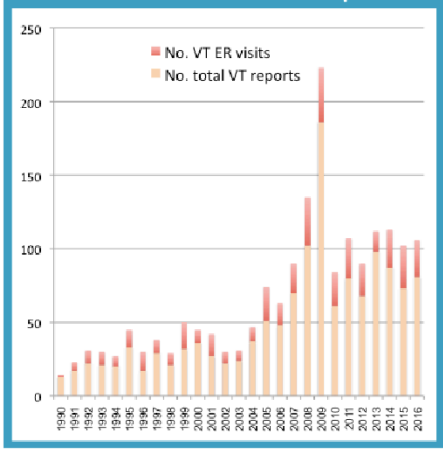
In 1983, the CDC's childhood vaccine schedule included 11 injections of 4 vaccines.

As of 2017, the CDC's childhood vaccine schedule includes 56 injections of 30 different vaccines.

The rapid growth of CDC's vaccine schedule is excepted to accelerate since there were 271 new vaccines under development in 2013 and far more currently under development. http:// www.phrma.org/press-release/medicines-in-developme nt-vaccines (listing 2,300 trials in search for "vaccines" between 2013 and 2017)

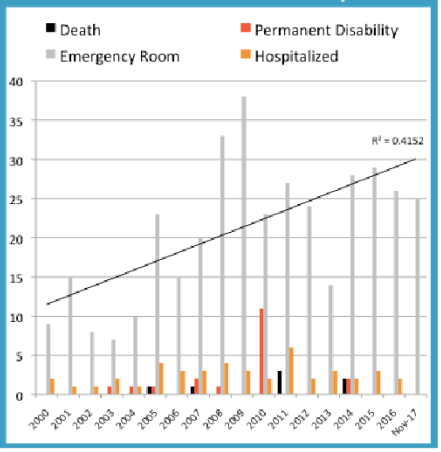
VAERS Reports Vermont, 1990-2016

Post-vaccination consumer reports



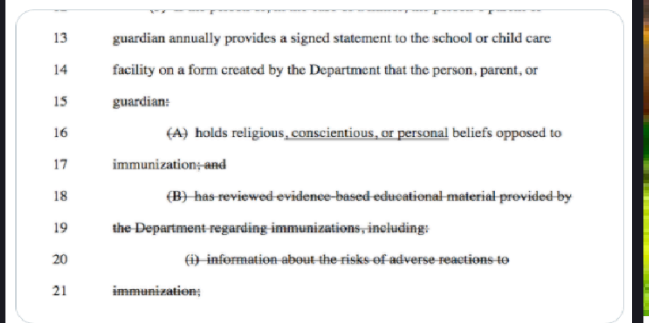
"Serious" VAERS Reports Vermont, 2000-2017 (Nov.)

Post-vaccination consumer reports



All Students including College:
The freedom to Remain in the "Control Group"

YES on Vermont H322: If passed, the bill would ensure that all parents retain decision-making authority for all vaccines for their minor children - daycare thru college. #education #health #parent #consent #schools #Vermont



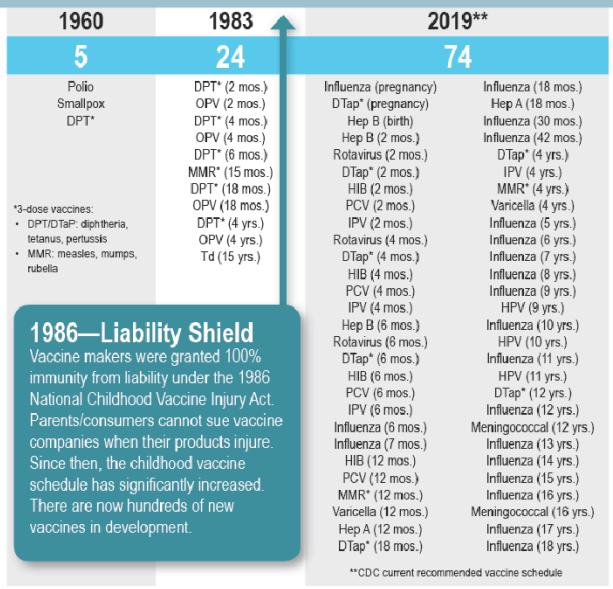
guardian annually provides a signed statement to the school or child care facility on a form created by the Department that the person, parent, or guardian:

(A) holds religious, conscientious, or personal beliefs opposed to immunization; ~~and~~

~~(B) has reviewed evidence-based educational material provided by the Department regarding immunizations, including:~~

~~(i) information about the risks of adverse reactions to immunization;~~

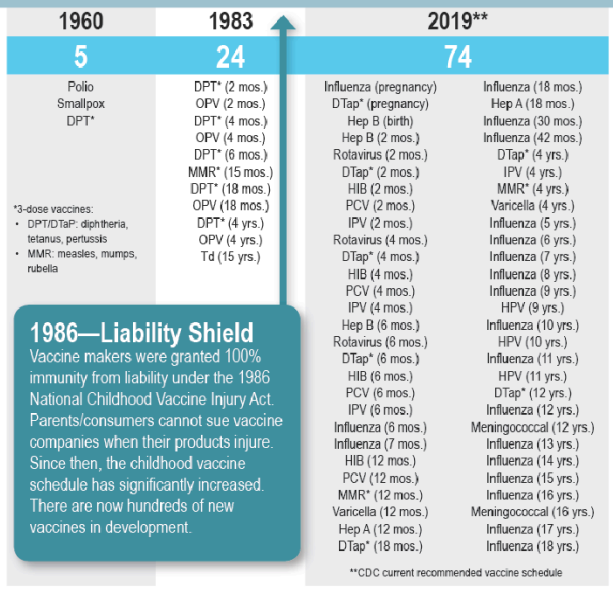
*Exemptions are required when opting out of even one dose of mandated school vaccines in Vermont.



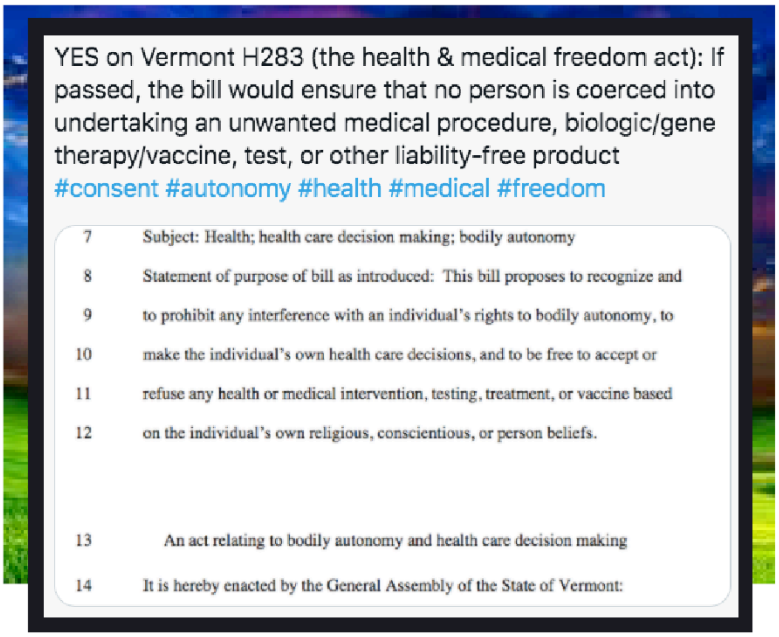
https://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_immunization.pdf


COVID-19 VACCINE MANUFACTURERS ARE EXEMPT FROM LIABILITY

*Exemptions are required when opting out of even one dose of mandated school vaccines in Vermont.



https://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_immunization.pdf


YES on Vermont H283 (the health & medical freedom act): If passed, the bill would ensure that no person is coerced into undertaking an unwanted medical procedure, biologic/gene therapy/vaccine, test, or other liability-free product #consent #autonomy #health #medical #freedom
Subject: Health; health care decision making; bodily autonomy
Statement of purpose of bill as introduced: This bill proposes to recognize and to prohibit any interference with an individual's rights to bodily autonomy, to make the individual's own health care decisions, and to be free to accept or refuse any health or medical intervention, testing, treatment, or vaccine based on the individual's own religious, conscientious, or person beliefs.
An act relating to bodily autonomy and health care decision making
It is hereby enacted by the General Assembly of the State of Vermont:

So you got the vaccine. Now what?

Over the last few months, members have asked many agency/health officials, elected representatives and senators: What should concerned individuals do, if they are sickened by a vaccine? What if a person believes that their health could be compromised, if they vaccinate (again)? While many have not responded, others have provided helpful information, which we summarize below.

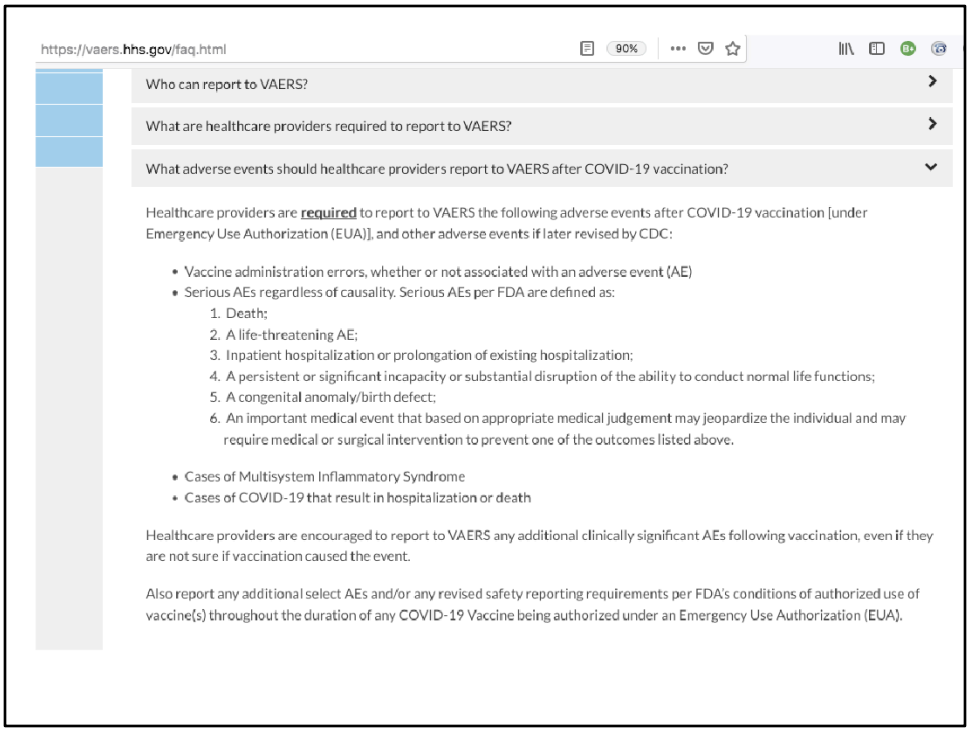
1) If you or a loved one felt sick after any vaccine dose, you should inform your doctor and report the symptoms to VAERS.

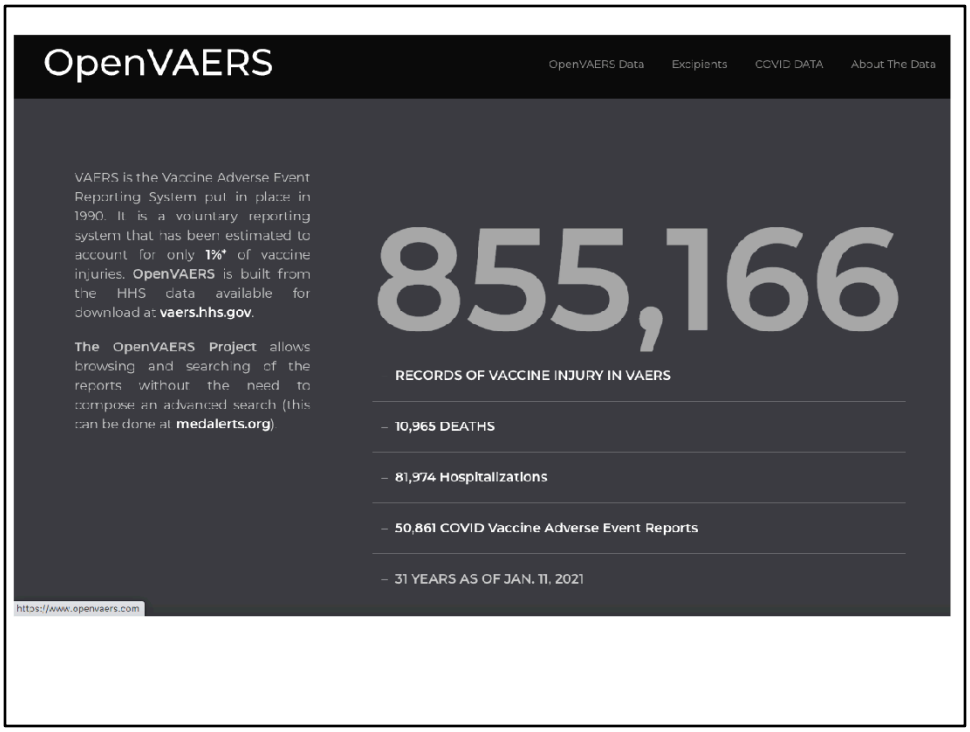
VAERS is the official U.S. government database that collects "post-market" vaccine symptoms to determine safety signals.

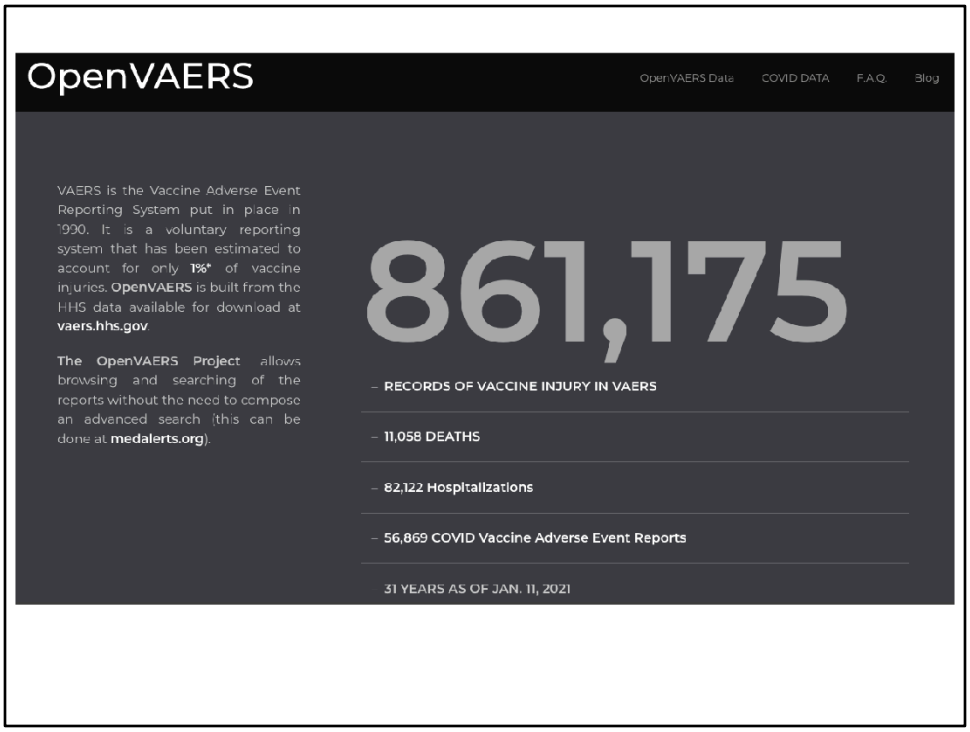
Since the COVID-19 products are brand new, your symptom reports are hugely important - both immediately and later on.

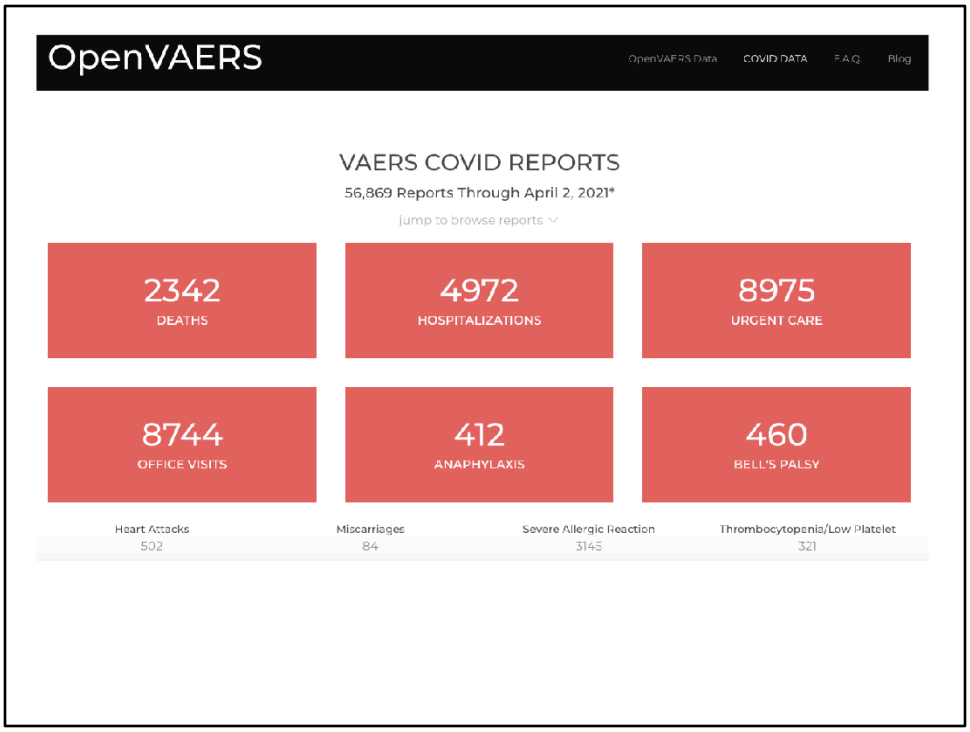
All post-vaccine symptoms should be noted in your health records. Careful documentation now, might save a life later.

There are common, uncommon, and unknown effects of these new vaccines. It is entirely up to you to insist that your symptoms get recorded into your medical records and into the official database, at: https://vaers.hhs.gov/.


https://vaers.hhs.gov/faq.html
90%
Who can report to VAERS?
What are healthcare providers required to report to VAERS?
What adverse events should healthcare providers report to VAERS after COVID-19 vaccination?
Healthcare providers are required to report to VAERS the following adverse events after COVID-19 vaccination [under Emergency Use Authorization (EUA)], and other adverse events if later revised by CDC:
• Vaccine administration errors, whether or not associated with an adverse event (AE)
• Serious AEs regardless of causality. Serious AEs per FDA are defined as:
1. Death;
2. A life-threatening AE;
3. Inpatient hospitalization or prolongation of existing hospitalization;
4. A persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions;
5. A congenital anomaly/birth defect;
6. An important medical event that based on appropriate medical judgement may jeopardize the individual and may require medical or surgical intervention to prevent one of the outcomes listed above.
• Cases of Multisystem Inflammatory Syndrome
• Cases of COVID-19 that result in hospitalization or death
Healthcare providers are encouraged to report to VAERS any additional clinically significant AEs following vaccination, even if they are not sure if vaccination caused the event.
Also report any additional select AEs and/or any revised safety reporting requirements per FDA's conditions of authorized use of vaccine(s) throughout the duration of any COVID-19 Vaccine being authorized under an Emergency Use Authorization (EUA).


OpenVAERS
OpenVAERS Data
Excipients
COVID DATA
About The Data
VAERS is the Vaccine Adverse Event Reporting System put in place in 1990. It is a voluntary reporting system that has been estimated to account for only 1%* of vaccine injuries. OpenVAERS is built from the HHS data available for download at vaers.hhs.gov.
The OpenVAERS Project allows browsing and searching of the reports without the need to compose an advanced search (this can be done at medalerts.org).
855,166
RECORDS OF VACCINE INJURY IN VAERS
– 10,965 DEATHS
– 81,974 Hospitalizations
– 50,861 COVID Vaccine Adverse Event Reports
– 31 YEARS AS OF JAN. 11, 2021
https://www.openvaers.com


OpenVAERS
OpenVAERS Data
COVID DATA
F.A.Q.
Blog
VAERS is the Vaccine Adverse Event Reporting System put in place in 1990. It is a voluntary reporting system that has been estimated to account for only 1%* of vaccine injuries. OpenVAERS is built from the HHS data available for download at vaers.hhs.gov.
The OpenVAERS Project allows browsing and searching of the reports without the need to compose an advanced search (this can be done at medalerts.org).
861,175
– RECORDS OF VACCINE INJURY IN VAERS
– 11,058 DEATHS
– 82,122 Hospitalizations
– 56,869 COVID Vaccine Adverse Event Reports
31 YEARS AS OF JAN. 11, 2021


OpenVAERS
OpenVAERS Data
COVID DATA
F.A.Q.
Blog
VAERS COVID REPORTS
56,869 Reports Through April 2, 2021*
Jump to browse reports
2342
DEATHS
4972
HOSPITALIZATIONS
8975
URGENT CARE
8744
OFFICE VISITS
412
ANAPHYLAXIS
460
BELL'S PALSY
Heart Attacks
502
Miscarriages
84
Severe Allergic Reaction
3145
Thrombocytopenia/Low Platelet
321

Phase 3 Follow-up

Data from Phase 3 studies should include a median follow-up duration of at least 2 months after completion of the full vaccination regimen to provide adequate information to assess a vaccine's benefit-risk profile. From a safety perspective, a 2-month median follow-up following completion of the full vaccination regimen will allow identification of potential adverse events that were not apparent in the immediate postvaccination period. Adverse events considered plausibly linked to vaccination generally start within 6 weeks of vaccine receipt.[7] From the perspective of vaccine efficacy, a 2-month median follow-up is the shortest follow-up period to achieve some confidence that any protection against COVID-19 is likely to be more than short-lived. The EUA request should include a plan for active follow-up for safety (including deaths, hospitalizations, and other serious or clinically significant adverse events) among individuals administered the vaccine under an EUA in order to inform ongoing benefit-risk determinations to support continuation of the EUA.

2.7 Continuation of Clinical Trials Following Issuance of an EUA for a COVID-19 Vaccine

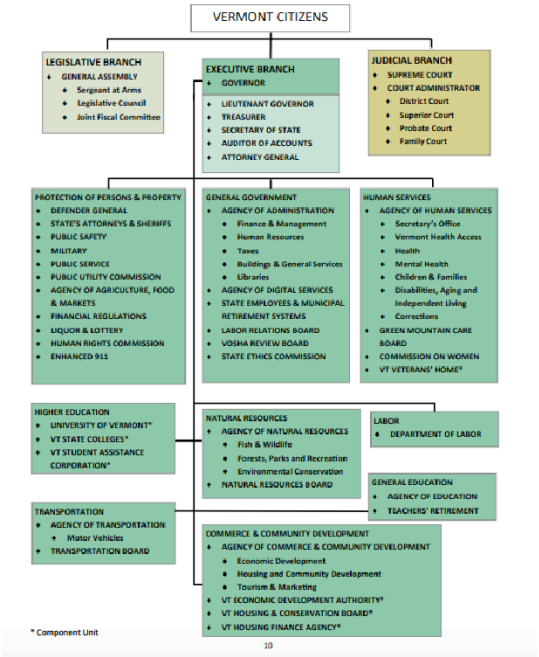
FDA does not consider availability of a COVID-19 vaccine under EUA, in and of itself, as grounds for immediately stopping blinded follow-up in an ongoing clinical trial or grounds for offering vaccine to all placebo recipients. To minimize the risk that use of an unapproved vaccine under EUA will interfere with long-term assessment of safety and efficacy in ongoing trials, it is critical to continue to gather data about the vaccine even after it is made available under EUA. An EUA request should therefore include strategies that will be implemented to ensure that ongoing clinical trials of the vaccine are able to assess long-term safety and efficacy (including evaluating for vaccine-associated enhanced respiratory disease and decreased effectiveness as immunity wanes over time) in sufficient numbers of participants to support vaccine licensure. These strategies should address how ongoing trial(s) will handle requests for unblinding and crossover of placebo recipients to receive vaccine in the trial and loss of follow-up information for study participants who choose to withdraw from the study in order to receive the vaccine under an EUA.

Page 11 https://www.fda.gov/media/146217/download

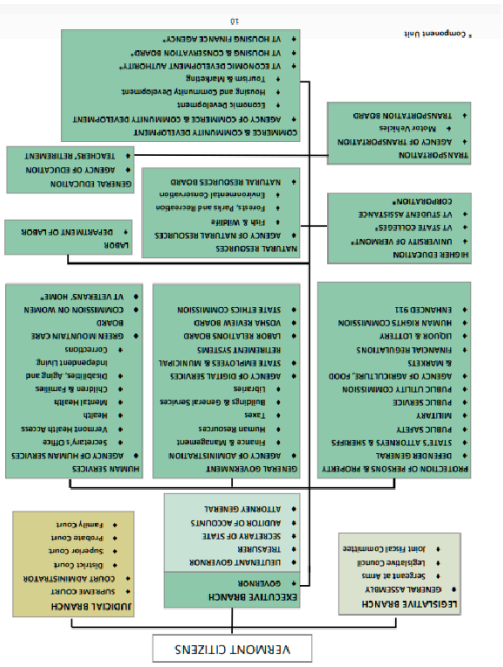
H323: “the VAERS Bill”

- THIRD time introduced (2017/2018, 2019/2020 > 2021/2022)
- Simply asks for a report(!) of VAERS data so the Legislature can see for themselves, how many consumers are reporting product injuries…
- If you have a story to tell, we need to talk
- Collecting 3 minute video testimonials (if you want to help with this project please get in touch)
- 15 second moment of silence for all those injured in the name of “public health”

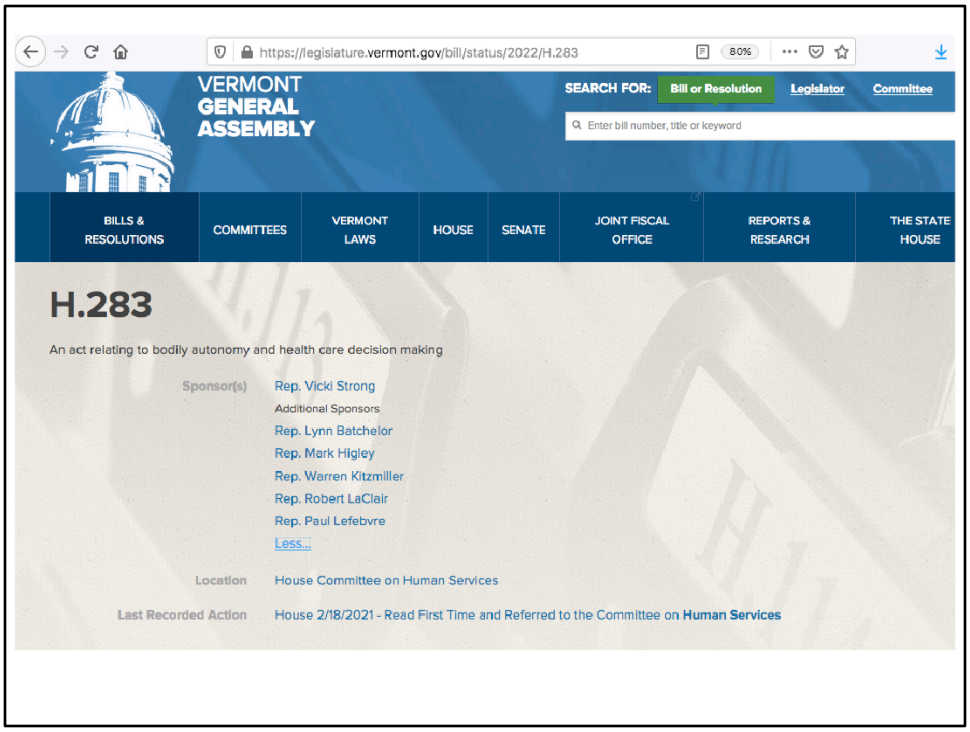

Health Freedom
As Americans
We know what Freedom is.
But…
What is health?
What are the terms
of the social contract
that **you** are willing to live by?



https://finance.vermont.gov/sites/finance/files/documents/Rpts_Pubs/CAFR/VT_2020_CAFR_FINAL_INTRO.pdf



https://finance.vermont.gov/sites/finance/files/documents/Rpts_Pubs/CAFR/VT_2020_CAFR_FINAL_INTRO.pdf


https://legislature.vermont.gov/bill/status/2022/H.283
80%
VERMONT
GENERAL
ASSEMBLY
SEARCH FOR:
Bill or Resolution
Legislator
Committee
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H.283
An act relating to bodily autonomy and health care decision making
Sponsor(s)
Rep. Vicki Strong
Additional Sponsors
Rep. Lynn Batchelor
Rep. Mark Higley
Rep. Warren Kitzmiller
Rep. Robert LaClair
Rep. Paul Lefebvre
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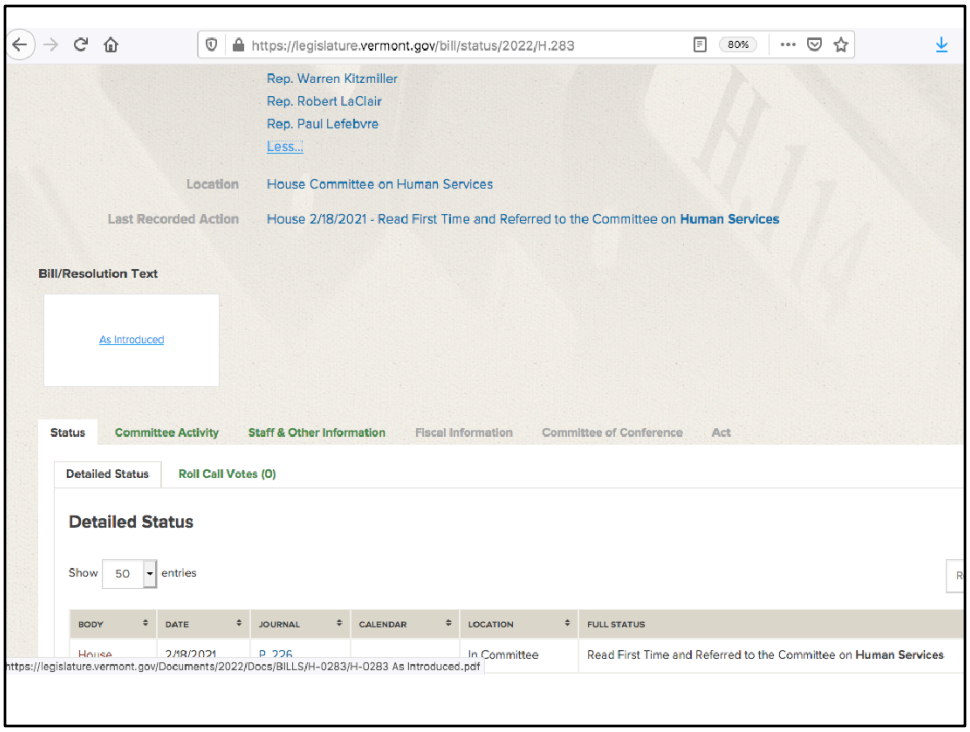
Location
House Committee on Human Services
Last Recorded Action
House 2/18/2021 - Read First Time and Referred to the Committee on Human Services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Rep. Warren Kitzmiller
Rep. Robert LaClair
Rep. Paul Lefebvre
Less...
Location
House Committee on Human Services
Last Recorded Action
House 2/18/2021 - Read First Time and Referred to the Committee on Human Services
Bill/Resolution Text
As Introduced
Status
Committee Activity
Staff & Other Information
Fiscal Information
Committee of Conference
Act
Detailed Status
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Detailed Status
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House
2/18/2021
P. 226
In Committee
Read First Time and Referred to the Committee on Human Services
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H.283

Introduced by Representatives Strong of Albany, Batchelor of Derby, Higley of Lowell, Kitzmiller of Montpelier, LaClair of Barre Town, and Lefebvre of Newark

Referred to Committee on

Date:

Subject: Health; health care decision making; bodily autonomy

Statement of purpose of bill as introduced: This bill proposes to recognize and to prohibit any interference with an individual's rights to bodily autonomy, to make the individual's own health care decisions, and to be free to accept or refuse any health or medical intervention, testing, treatment, or vaccine based on the individual's own religious, conscientious, or person beliefs.

HEALTH CARE DECISION MAKING

§ 251. STATEMENT OF POLICY

The State of Vermont recognizes the rights of each individual to bodily autonomy, to make the individual's own health care decisions, and to be free to

VT LEG #353234 v.1

accept or refuse any health or medical intervention, testing, treatment, or vaccine based on the individual's own religious, conscientious, or personal beliefs.

§ 252. COERCION AND INTERFERENCE PROHIBITED

(a)(1) Notwithstanding any provision of law to the contrary, the State of Vermont; its agencies, subdivisions, instrumentalities, and designees; and all other employers, businesses, nonprofit organizations, institutions, facilities, schools, churches and other places of worship, travel carriers, licensing authorities, and other individuals and public and private and entities shall not deny, restrict, infringe upon, or impose conditions on an individual's rights to bodily autonomy, to make the individual's own health care decisions, and to be free to accept or refuse any health or medical intervention, testing, treatment, or vaccine based on the individual's own religious, conscientious, or personal beliefs.

(2) The prohibitions set forth in subdivision (1) of this subsection include not denying, restricting, infringing upon, or imposing conditions on an individual's employment, travel, education, child care, religion, benefits, insurance, or participation in sports, camps, or other recreation based in whole or in part on the exercise of an individual's right to refuse any medical intervention, testing, treatment, or vaccine based on the individual's own religious, conscientious, or personal beliefs.

VT LEG #353234 v.1

(b) Notwithstanding any provision of statute or rule to the contrary, including a statute or rule addressing an outbreak, epidemic, or potential outbreak or epidemic of a contagious, infectious, or communicable disease, and notwithstanding any statute, rule, order, or directive that may be adopted or promulgated in response to an emergency, including a national security emergency, statewide emergency, local emergency, public health emergency, or peacetime emergency, each individual shall retain the rights to bodily autonomy, to make the individual's own health care decisions, and to be free to accept or refuse any health or medical intervention, testing, treatment, or vaccine based on the individual's own religious, conscientious, or personal beliefs.

§ 253. ENFORCEMENT

Any individual who suffers damage, loss, or injury as a result of any conduct prohibited by section 252 of this chapter may bring an action in Superior Court against the individual or entity that engaged in the conduct for injunctive relief, compensatory and punitive damages, costs and reasonable attorney's fees, and other appropriate relief.

Sec. 2. EFFECTIVE DATE

This act shall take effect on passage.

Focus on Solutions

- Engagement at all levels
- Grassroots efforts to build bridges and win hearts and minds
- PASS PROTECTIVE LEGISLATION!
- OPEN PUBLIC HEARING
- Control group:
  - High schools, colleges, health care, insurance, businesses – what is our own vision, how can we support each other?

In an age of deceit, telling the truth is a revolutionary act.