OHIO EDUCATION ASSOCIATION

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The OEA will lead the way for continuous improvement of public education while advocating for members and the learners they serve.

NEA Comments on the National Academy of Sciences' Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine
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My name is Scott DiMauro, I am a high school social studies teacher from Columbus, Ohio, and President of the Ohio Education Association, speaking on behalf of the National Education Association (NEA), the nation's largest professional employee organization committed to advancing the cause of public education. NEA's 3 million members work with students at every level of education—from pre-school to university graduate programs. NEA has affiliate organizations in every state and in more than 14,000 communities across the United States.

The NEA appreciates the work of this committee to develop this framework for vaccine allocation to assist policy makers in planning for equitable allocation of vaccines against SARS-CoV-2. The NEA welcomes this opportunity to present several comments today and will submit expanded written comments by Friday.

I would like to begin by noting that the National Education Association believes that vaccines are essential medical tools in preventing infectious diseases. Vaccines must be pervasive to be effective. We believe that vaccination guidelines from the American Academy of Pediatrics and Centers for Disease Control and Prevention should be followed by educators, parents and guardians, and students. State legislatures should establish clear guidelines for waivers that minimize the numbers of unvaccinated individuals to those necessary due to documented medical conditions.

With respect to the Discussion Draft of the Preliminary Framework for Equitable Allocation of a COVID-19 Vaccine, we strongly support the broadest description of school staff, which includes classroom teachers, paraeducators and other education support professionals, specialized instructional support personnel, librarians, administrators, and the faculty, staff, and other workers in institutions of higher education.

All staff who return to work in education worksites, including schools and campuses, are at higher risk of COVID-19 infection and must be protected from the virus with **non-pharmaceutical interventions before the vaccine is available. We agree wholeheartedly that it is important to include teachers and other school staff relatively early to facilitate the reopening of school buildings and to protect the most high-risk adults. We respectfully encourage you to broaden this crucial target by explicitly including faculty and all other workers in institutions of higher education. Indeed, as the discussion draft notes, many professors and other university employees are older or have underlying health**

conditions. We further urge you to include all education employees in Phase 1b, in recognition of the crucial role these institutions play and the underlying vulnerabilities of many of the employees who work in them. We strongly agree with the draft report's statement that exposures in school settings is very difficult to control, especially when providing care or education to young children.

We also support the draft's conclusion that school staff who are at higher risk because of age, crowded conditions inside facilities and other factors, should be vaccinated in Phase 1b. As noted above, we urge that all education employees be vaccinated in this phase.

We strongly support the continuation of these non-pharmaceutical interventions after vaccination of staff and students until there is clear scientific evidence that schools are no longer a source of virus transmission.

Nothing is more important than ensuring that we return to safe and equitable in-person instruction, and the work represented by the discussion draft is an important step in that direction. It is crucial for any vaccination plan to incorporate the voices of front-line workers, including educators, and we thank you giving us the opportunity to speak with you today. Thank you.

END OF COMMENTS

NASEM Draft language Line 1545:
Rationale
Across the nation, states and localities are placing a high priority on re-opening schools and expanding childcare programs to promote children's educational and social development and facilitate parents' employment. Exposure is very difficult to control in these institutions, especially those providing care or education to young children. All workers in these facilities are among those who need to be protected from the virus during Phase 2.

Due to the nature of their work, teachers and school staff who return to work in schools are at higher risk of COVID-19 infection and serve an important societal role in ensuring that students' educational needs are met. One could also argue that vaccinating teachers and school staff could help to reduce viral transmission, with these teachers and staff serving as connections between schools and broader society. Furthermore, the importance of re-opening schools, especially for elementary-aged children, cannot be understated. Reestablishing a sense of normalcy for students and their families through in-person education will help to achieve long-term health benefits for children and facilitate important social development for them as well. As some states and localities choose to begin reopening schools, it is also important to consider the direct impact of COVID-19 disease on teachers and staff. A recent study found that 39.8 percent of teachers had "definite" and 50.6 percent had "definite or possible" risk factors for severe COVID-19 disease (with similar results for other school staff), emphasizing the vaccine's potential importance in protecting teachers and promoting in-person education safely (Gaffney et al., 2020). Therefore, it is likely that teachers at highest risk would be vaccinated in Phase 1b.

Estimated Group Size Across the United States, there are 8,605,000 teachers and staff at elementary and secondary schools; there are also approximately 463,000 people who provide child care services (BLS, 2019).

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Phases	Population Group	Criterion 1: Risk of Acquiring Infection	Criterion 2: Risk of Severe Morbidity and Mortality	Criterion 3: Risk of Negative Societal Impact	Criterion 4: Risk of Transmitting Infection to Others	Mitigating Factors for Consideration
1a	High risk workers in health care facilities	H	M	H	H	High risk of acquiring infection due to no choice in setting but may have access to personal protective equipment. Essential to protecting the health care system.
1a	First responders	H	M	H	H	High risk of acquiring infection due to no choice in setting but may have access to personal protective equipment. Essential to protecting the health care system.
1b	People with significant comorbid conditions	M	H	M	L	High risk of severe morbidity and mortality, but may be able to social distance and isolate.
1b	Older adults in congregate or overcrowded settings	H	H	L	L	High risk of acquiring infection due to lack of choice in setting.
2	Critical risk workers (part 1)	H	M	H	M	High risk of acquiring infection due to no choice in setting, but may have access to personal protective equipment.
2	Teachers and school staff	H	M	H	H	High risk of loss to an essential service, but there are alternative choices such as online schooling (lower grades should be given priority).

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Social, Economic, and Legal Contexts

The social, economic, and legal contexts will affect vaccine distribution and uptake. For example, if some health insurers, care providers, or employers fail to cover the full vaccine administration cost, the allocation framework is unchanged, but the federal government or states should make efforts to provide funds to cover the cost of vaccine administration (and other vaccination costs) for low-income individuals. Once vaccine availability has increased sufficiently and vaccine safety in younger groups has been assessed, children will be offered a COVID-19 vaccine (Mello et al., 2020). Historically, the most effective way to ensure broad uptake of vaccine in children is through mandates that condition school attendance on evidence of vaccination or an accepted reason for exemption, such as a medical contraindication. There will certainly be wide variation among states and even within states regarding such mandates, particularly with respect to whether nonmedical exemptions will be allowed. To ensure an orderly return to schools, states may benefit from having their mandates clarified by attorneys general issuing interpretations of existing authorities and their departments and agencies issue interpretative guidance, or by considering ways to tighten existing law regarding exemptions. Despite the allocation framework, it is possible that some school districts may be tempted to mandate vaccination of schoolchildren immediately, as a means of moving more quickly toward re-opening schools. At a state level, this would allocate the vaccine in a manner different from the committee's proposed allocation framework (i.e., by prioritizing schoolchildren). Another possibility is that some employers would require employees to be vaccinated or to have some evidence of prior infection (on

the employer's assumption that this confers immunity) (Phelan, 2020). If a state is not allocating vaccine supplies in accordance with the recommended phases, this would divert vaccine supplies toward many who are not in the higher risk categories described in Phases 1 and 2. If large employers acquire doses of the vaccine, as has happened in the past with 2009 H1N1 vaccines, this could limit supplies available to state and local health departments. Although there is precedent for employers requiring vaccination, subject to some limitations based on union agreements or religious exemptions, (e.g., many hospitals and nursing homes require employees to be vaccinated against the flu) a number of concerns arise when vaccine supply is limited, as it will be with COVID-19 vaccine(s). If employers require vaccination, the allocation framework would be unchanged, but pressure would certainly be brought to bear on health care providers by people needing to maintain their employment, regardless of whether they are at high risk of infection. Such a requirement could change rates of vaccine uptake, and would pose a dilemma for those individuals for whom the vaccine is medically contraindicated—either take the vaccine or lose employment—and would be a possible violation of the Americans with Disabilities Act (Yang et al., 2020). Mandated vaccination could also violate Title VII of the Civil Rights Act of 1964 if there is a religious exemption or could violate collective bargaining rights (in unionized workplaces). Additionally, it is important to note that the equitable allocation scheme will fail if a separate private vaccine market emerges for those who can pay the most. SLTT authorities should not waiver from their adherence to the proposed equitable allocation scheme to satisfy the demands of private employers or institutions that are seeking or requiring vaccination of all workers.