

Frequently Asked Questions about Public Health and Unaccompanied Children

Background: When children are apprehended by immigration authorities are unaccompanied by a parent or guardian, they are placed in the care and custody of HHS. Typically, HHS then releases children to an appropriate sponsor – usually a parent, relative, or family friend – who can safely and appropriately care for them while their immigration cases proceed. The Administration for Children and Families Office of Refugee Resettlement (ORR) at HHS operates about 100 short-term shelters throughout the United States for unaccompanied children that care for the children until they are released to sponsors. Recently, because of a large increase in the number of unaccompanied children crossing the border, ORR has opened temporary shelters to meet the needs of this vulnerable population and has continued to expand permanent shelter capacity around the country.

1. How many temporary shelters are currently open?

As of July 29, 2014, three temporary shelters are open: Joint Base San Antonio-Lackland (Texas), Naval Base Ventura County-Port Hueneme (California) and Fort Sill (Oklahoma).

2. How do the ORR shelters affect our community?

The impact on the local community is minimal. Shelters are operated by non-profit organizations, generally as group homes. These shelters are consistently quiet and good neighbors in the communities where they are located.

ORR pays for and provides all services for the children while they are in care at a shelter. This includes providing food, clothing, education, medical screening, and any needed medical care to the children. Children spend fewer than 35 days on average at the shelters, typically do not attend local public schools, and do not integrate into the local community. They remain under staff supervision at all times.

3. Will I find out if a shelter is opening in my community?

For years, ORR-funded shelters for unaccompanied children have operated throughout the United States. These shelters are now in 14 states and federal officials are currently reviewing proposals from both new potential grantees and existing shelter providers to further expand our shelter capacity.

All shelters, except the three temporary shelters described above, are licensed by the state. Potential and existing grantees engage local communities and inform state licensing officials of intent to operate a program before a shelter is licensed and opened.

Separately, in order to enhance the capability to transition unaccompanied children from Customs and Border Patrol (CBP) to ORR, the federal government has undertaken efforts to identify potential locations for temporary shelters. Temporary facilities that have been identified for consideration are announced through a notification process to local community leaders, state officials and the Congressional delegation, as well as other stakeholders.

4. Do unaccompanied children pose a health risk to U.S. communities?

The Centers for Disease Control and Prevention (CDC) believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public.

Countries in Central America, where most of the unaccompanied children are from (Guatemala, El Salvador, and Honduras), have childhood vaccination programs, and most children have received some or all of their recommended childhood vaccines. However, they may not have received a few vaccines, such as chickenpox, influenza, and pneumococcal vaccines. As a precaution, ORR is providing vaccinations to all children who do not have documentation of previous valid doses of vaccine.

Children receive an initial screening for visible and obvious health issues (for example, lice, rashes, diarrhea, and cough) when they first arrive at CBP facilities. Onsite medical staff are available at CBP facilities to provide support, and referrals are made to a local emergency room for additional care, if needed. Children must be considered “fit to travel” before they are moved from the border patrol station to an ORR shelter.

Children receive additional, more thorough medical screening and vaccinations at ORR shelter facilities. If children are found to have certain communicable diseases (e.g., TB), they are separated from other children and treated as needed. The cost of medical care for the children while they are in ORR custody is fully paid by the federal government.

5. How and when are medical screenings conducted with the children?

For more information on ORR’s role in providing medical screening and care for unaccompanied children, please visit their webpage describing [Unaccompanied Children’s Services](#).

There are three places where unaccompanied children may be screened for health-related issues.

- When the children first arrive at the border, they are screened by CBP at border stations for visible health issues (for example, scabies, lice, rashes, diarrhea, and coughs), kept apart from other children if ill to prevent the spread of disease, and appropriately treated, if needed. Onsite medical staff are available to provide support, and referrals are made to a local emergency room for additional care, if needed.
- Children stay in a temporary or permanent ORR shelter until they can be released to a sponsor (usually a parent or other family member) while awaiting immigration proceedings. Upon arrival at permanent shelters, children receive comprehensive medical screenings, as well as vaccinations, if needed. Children placed into temporary shelters undergo full screening and immunizations prior to transfer into the temporary facility. Upon release from an ORR care provider, children and their sponsors receive copies of their medical and vaccination records and any test results.
- To assist in managing the large increase in unaccompanied children, CBP temporarily transferred some of the children apprehended at the border to a CBP processing center in Arizona. (As of July 20, children are no longer being sent to this center). Medical screenings at the center were conducted by HHS-deployed medical teams before children were sent to one of three temporary ORR shelters housed on military bases. The medical screening at the processing center included vaccinations as well as screening for TB, other medical concerns, and mental health issues. Children under 12 years of age and those found to have health related issues were sent to permanent ORR shelters (not the temporary shelters) that have the capacity to provide care and treatment as needed.

6. How does HHS ensure that children's medical needs are met before they are placed with a sponsor?

While in ORR custody, the children's health, educational and social service needs are provided for by ORR. All children that come into ORR care and custody are medically screened, vaccinated, and screened for behavioral health issues. Children with illnesses are treated while in ORR care and custody. ORR does not release any child to a sponsor if they have a medical condition that is a public health threat. During any point in the process, if a reportable disease, such as TB, is found during a child's medical screening, this would be reported to the state health department. This is a very rare circumstance.

7. What happens when a child leaves a shelter?

Most children remain in a shelter for less than 35 days and are released to appropriate sponsors, typically parents or other family members, who care for them while their immigration case is processed. Children are not released to a sponsor if they have a medical condition that is a public health threat. When a child is released to a sponsor, the child moves to the community in which the sponsor lives. They will not be released in the community where the shelter is located unless the sponsor lives in that community.

Upon release to the custody of a sponsor, unaccompanied children are generally ineligible for most public benefits, but could receive certain services such as charity care from medical providers. Because they are children, they typically attend public schools in the communities in which they reside after they are released to the care of a sponsor.

8. Once unaccompanied children are released to a parent or sponsor, where do they end up?

Between January 1 and July 7 of this year, we have released 30,340 children to sponsors, who care for them while their immigration case is processed. For state-by-state release data, please visit: <http://www.acf.hhs.gov/programs/orr/programs/ucs/state-by-state-uc-placed-sponsors>

9. Children released to sponsors may enroll in public school in their community. Will school officials have access to the children's immunization records?

When a child in ORR custody is released to a sponsor, the program requires grantees to provide the sponsor with a copy of the child's medical and immunization records compiled during their time in custody. Additionally, grantees follow state licensing requirements which may require further immunization record reporting.

The first page of the [Sponsor Handbook](#), which ORR grantees provide to sponsors in both English and Spanish as part of the placement process, outlines the sponsor's responsibilities regarding enrolling the child in school upon release. This information makes clear that a sponsor may be required to provide a series of documents, including immunization records, to the school upon enrollment, depending on the local school district's policies.

If a sponsor does not have a copy of the child's medical or immunization records, a new copy can be requested from ORR. Requesting parties seeking copies of an unaccompanied child's case files, specific information contained in a case file, or other confidential information pertaining to a child must make their request in writing to the ORR/DCS Division Director. This can be done via email – the request should be emailed to Requests.DUCS@acf.hhs.gov. Requesting parties also must file an Authorization for Release of Records form (ORR UAC/C-5) and include all supporting documentation as necessary.

10. What are the primary health issues affecting the children arriving at U.S. borders?

The majority of health issues being reported from DHS at the border stations are associated with the difficult journey or the crowded, unsanitary, and environmental conditions the children endured before they arrived. These illnesses include scabies, lice, rash illness, respiratory infections, and diarrhea. When children are referred to ORR, the program manages the medical screening and any data collected on illnesses from the unaccompanied children. CDC believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public.

- Cases of chickenpox have been identified (varicella vaccine is not routinely offered in Central America).
- During the screening conducted by ORR, a small number of cases of TB have been identified. Given that the children are from countries with higher rates of TB (about 25-60 cases of TB per 100,000 people) than the United States, public health officials would expect to find TB in some of these children. This is why TB screening is a part of ORR's routine medical screening process. Children found to have TB disease are separated from other children and appropriately treated until no longer infectious. Though the number of TB cases in the U.S. has decreased over the past two decades, almost all states have continued to report cases every year. There were 9,582 reported TB cases in the U.S. in 2013.
- Cases of seasonal influenza (H1N1 and flu B) also have been detected in some children arriving from Central America.
- In addition, several children have had severe respiratory illness. Some of these illnesses are due to influenza or pneumococcus infection. A CDC team is assessing the situation to determine the cause and extent of these illnesses and to recommend appropriate steps for preventing the spread of infection.

11. What vaccines are provided to the children arriving at U.S. borders?

Children from Central America often participate in childhood vaccination programs, similar to those in the United States, and many will have received vaccines against vaccine-preventable diseases. However, a few vaccines are not offered, have not been available for very long, or are not widely used, such as chickenpox, influenza, and pneumococcal vaccines. To be cautious, ORR recommends children without vaccine documents receive vaccinations according to the Advisory Committee on Immunization Practices (ACIP) catch-up immunization schedule. Children are vaccinated with multiple vaccines before they are released from the ORR-funded program into a community. Typically, these include:

- Tdap or DTaP (tetanus, diphtheria, pertussis)
- MCV4 (meningococcal disease)
- MMR or MMRV (measles, mumps, rubella)
- Varicella (chickenpox)
- Influenza (routinely during flu season, and since July 11 in CBP processing centers and in the ORR temporary shelters)
- PCV13 (pneumococcal conjugate vaccine, since July 18)
- IPV (inactivated polio vaccine)
- Hepatitis A
- Hepatitis B

Unaccompanied children are eligible for vaccines through the Vaccines for Children Program (VCF), a federal program designed to ensure vaccination for children without insurance who are living in the

United States. When operational, the CBP processing centers and the temporary ORR shelters are considered Vaccine for Children sites, but they rely on the state health departments to order the vaccines needed for these facilities. As always, states are able to update their VFC estimates and/or request additional doses to support specific initiatives for VFC eligible children. The cost of these vaccines is fully paid by the federal government and the supply of these vaccines is sufficient to ensure that use of vaccine for this purpose will not diminish supply for other children.

For additional information about the VCF programs, see <http://www.cdc.gov/vaccines/programs/vfc/index.html>.

12. How and when are local health departments or hospitals called on to provide support for health issues?

Local health departments or hospitals may be asked to provide support for health issues at different points during a child's processing. When in ORR custody, the cost of this care is fully paid by the federal government.

- At the CBP border stations, onsite medical support is available to help address any immediate health needs found among the children. The CBP border stations may send an ill child to a local emergency room for care, if needed.
- Unaccompanied children are eligible for vaccines through the Vaccines for Children Program, a federal program designed to ensure vaccination for children without insurance who are living in the United States. The cost of these vaccines is fully paid by the federal government and the supply of these vaccines is sufficient to ensure that use of vaccine for this purpose will not diminish supply for other children.
- ORR shelters have long-standing relationships with local health departments or hospitals that help care for the children who have health-related issues that require treatment. ORR continues to work closely with these local health partners to provide care and treatment for the children as needed.
- During any point in the process, if a reportable disease, such as TB, is found during a child's medical screening, this would be reported to the state health department.

13. I heard the children have the flu. Should I be concerned?

CDC believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public. There have been some confirmed infections caused by seasonal influenza B and H1N1 viruses among the children arriving from Central America. These are common human seasonal flu viruses. No novel or variant ("swine flu") viruses have been detected. Flu is a common respiratory disease that can easily spread in settings like the shelters where the children are housed close to one another for extended periods. The best way to prevent the flu is through vaccination. However, flu spreads mostly through respiratory droplets and also can spread by touching infected surfaces, so staying away from people who are sick, covering coughs, frequent handwashing, and other everyday preventive actions can help prevent the spread of flu.

In Central America, the flu season has already started and CDC expects that flu activity will increase in these countries, probably peaking in late summer.

- Seasonal influenza A (H3N2) and influenza B viruses are the primary flu viruses circulating in Central America at this time.
- Although it has not been reported yet, CDC expects to see some children sick with H3N2 flu as well.

- Information about flu activity levels in the Southern Hemisphere is available through the [Pan American Health Organization](#).
- To help provide flu vaccines for the unaccompanied children in between U.S. flu seasons, approval was obtained from the U.S. Food and Drug Administration to use CDC's remaining supply of the 2013-14 flu vaccine until the 2014-15 vaccine is available.
- The protective effect of flu vaccination can take about 2 weeks to begin.

CDC also has recommended that staff working closely with the children remain up-to-date on their seasonal flu vaccination. This is consistent with longstanding CDC recommendations for flu vaccination.

14. I heard the children have lice and scabies. Should I be concerned?

CDC believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public. CBP has been reporting head lice and scabies in some unaccompanied children during the visual screening at border stations. Any child found to have lice or scabies is treated right away, before going to a shelter. Scabies and lice are easily treated, and CBP has been treating both when they are identified.

Important things to know about scabies and head lice:

- Scabies is an infestation of the skin by the human itch mite and is easily treatable.
- Head lice are insects that live on the human scalp and also easily treatable.
- Scabies and head lice are found worldwide and affect people of all races and social classes.
- Both can spread rapidly in crowded conditions where close body and skin contact is frequent. Institutions such as nursing homes, extended-care facilities, and prisons are often sites of scabies outbreaks. In the United States, head lice are most common among pre-school children attending child care, elementary schoolchildren, and households of infested children. Children living in shelters very close to one another can easily transmit scabies and lice to each other.

CDC is providing training tools to CBP to help officers and agents more easily recognize scabies and lice when the children first arrive at border stations.

15. I heard the children have pneumonia and pneumococcal disease. Should I be concerned?

CDC believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public. Pneumonia and pneumococcal disease have been found in some of the children in the shelters, and CDC is currently investigating these clusters of cases. CDC recently issued interim guidance to ORR recommending that all unaccompanied children receive a single dose of pneumococcal conjugate vaccine (PCV13).

Pneumonia is an infection of the lungs that can be caused by viruses, bacteria, and fungi. Pneumonia can often be prevented with vaccines and by following good hygiene practices, such as washing your hands regularly and disinfecting frequently touched surfaces. Pneumonia can usually be treated with antibiotics for bacterial pneumonia or antiviral drugs for viral pneumonia (such as Tamiflu).

Pneumococcal disease is an infection caused by a common bacteria known as *Streptococcus pneumoniae*, and sometimes referred to as pneumococcal bacteria. Pneumococcal bacteria can cause many types of illnesses, including ear infections, pneumonia, meningitis, and bloodstream infections. Pneumococcal disease spreads when people who have pneumococcal bacteria in their nose and throat cough or sneeze. Pneumococcal infections can be a serious complication of flu infections. Flu infections can make people more likely to develop bacterial pneumonia.

Pneumococcal vaccines can prevent pneumococcal disease caused by the serotypes (“strains”) included in the vaccines. PCV13 (a vaccine with 13 different pneumococcal strains) provides children high levels of protection against invasive pneumococcal disease. And it also prevents those children from spreading pneumococcal bacteria to adults. In the United States, CDC recommends that children and adults receive pneumococcal vaccines.

Although vaccines to protect against pneumococcal disease have been part of routine immunization in Central America for several years, many of the older children arriving in the United States may not have been vaccinated for pneumococcal disease in their home countries.

Vaccinating enough children with PCV13 can protect the larger community or population against the 13 strains of pneumococcal bacteria included in the vaccine. This is known as herd immunity. Unaccompanied children who are released to family members or foster families will have low risk of disease because of the herd immunity provided by the U.S. vaccination program. Through their routine immunizations, children in those families will be protected against the strains of pneumococcal bacteria included in PCV13.

16. I heard the children have tuberculosis. Should I be concerned?

CDC believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public. During the screening conducted by ORR, a small number of cases of TB disease have been identified. Given that the children are from countries with higher rates of TB than the United States, finding TB disease in some children would be expected. This is why TB screening is a part of ORR’s routine medical screening process. Children found to have TB disease are sent to shelters that have the capacity to care for them. They are separated from other children and appropriately treated until they are no longer considered to be infectious. The appropriate state and local health departments are notified. Once a child is no longer considered infectious, she or he may be released to a sponsor, and will be referred to health departments to continue their TB treatment. The health department monitoring care in the shelter’s community will transfer the case to the local health department in the sponsor’s community (as is done when anyone in the U.S. who is being treated for TB moves). Though the number of TB cases in the U.S. has decreased over the past two decades, almost all states have continued to report cases every year. There were 9,582 reported TB cases in the U.S. in 2013.

Children found to have latent TB infection (LTBI) receive treatment if they will be in custody with ORR long enough to complete their treatment. When a child who has been diagnosed with LTBI but not given LTBI treatment is released to a sponsor, the sponsor is notified and the child is referred to the health department in the sponsor’s community for LTBI follow-up. ORR sends a routine notification to the health department in the receiving state, which allows for the possibility of follow-up. ORR is not requesting disposition reports for the children who are referred in this way.

Important things to know about TB:

- TB is caused by a bacterium called *Mycobacterium tuberculosis* that is spread through airborne droplets. These usually attack the lungs but can attack any part of the body, such as the kidney, spine, and brain.
- There are two forms of TB: latent TB infection and TB disease.
 - People with latent TB infection don’t feel sick, don’t have symptoms, and can’t spread TB bacteria to others.
 - A minority of people with latent TB infection can go on to develop TB disease if they do not take preventive therapy. People with TB disease feel sick, have signs and symptoms, and may spread TB bacteria to others.

- TB disease can almost always be treated and cured with medicine.
- Treatment for latent TB infection or TB disease can be arranged by officials at health departments in most U.S. jurisdictions.
- For the unaccompanied children, TB is diagnosed by conducting a TB skin test, known as a PPD, a chest X-ray or a blood test.
 - BCG (or bacille Calmette-Guerin) is a vaccine for TB that is often given to infants and small children in other countries (such as Guatemala) where TB is common. Children who were vaccinated with BCG may have a positive reaction to a TB skin test. This reaction may be due to infection with the TB bacteria. However, in some people, BCG vaccination may cause a positive skin test when they are not infected with TB bacteria.

17. I heard media reports about infectious diseases like multidrug-resistant TB, dengue, and Ebola among unaccompanied children. Should I be concerned?

CDC believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public. There have been incorrect reports and rumors about some unaccompanied children being diagnosed with various infectious diseases, including the following:

- Multidrug-resistant TB: Multidrug-resistant TB is a form of TB that cannot be treated with drugs (e.g., isoniazid and rifampin) that are typically used to treat TB. HHS has received no reports of multidrug-resistant TB among unaccompanied children.
- “Swine” flu: The 2009 flu pandemic was caused by an H1N1 flu virus partially of swine origin that initially was called “swine flu” in the lay media. However, H1N1 is a human virus that now circulates during flu season all over the world. The few cases of flu that have been diagnosed among unaccompanied children are caused by common seasonal flu viruses, not some kind of unusual virus.
- Dengue: Dengue is a viral disease that is spread by mosquitoes; it cannot be spread from person to person. HHS has received no reports of dengue among unaccompanied children.
- Ebola: Ebola is a severe viral disease that occurs in humans and nonhuman primates (such as monkeys, gorillas, and chimpanzees). Ebola disease in humans has never been reported outside of Africa. HHS has received no reports of Ebola among unaccompanied children.

18. What is CDC’s role in the federal response to the unaccompanied children arriving at the U.S.-Mexico border?

CDC is supporting the efforts of the lead agencies involved in this humanitarian response, including various components of the Department of Homeland Security (DHS) and the Administration on Children and Families (ACF) within the Department of Health and Human Services (HHS). CDC is supporting these agencies in several ways:

- CDC has been called on to provide consultation on medical screening, disease surveillance, and outbreak response planning, tuberculosis (TB) screening, shelter facility environmental assessments, medical records development, vaccinations, and communications.
- CDC activated its Emergency Operations Center on June 24, 2014, to coordinate and track CDC activities supporting the broader federal response.
- In early June, CDC provided public health recommendations to other components of HHS in the following areas:
 - Safe, secure, and appropriate shelter for unaccompanied children
 - Adequate water, sanitation, and hygiene

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- Outbreak prevention, detection, and control
 - Medical screening, treatment, and prevention (vaccination, TB screening, portable medical records)
- CDC is conducting a public health investigation of clusters of pneumonia and influenza among some unaccompanied children in several locations.
- Commissioned Corps officers from multiple federal agencies, including CDC, serve on other response teams. HHS has deployed response teams, including those that conducted health screening and vaccinations at certain CBP facilities.

CDC remains ready and available to provide public health assistance as requested by the lead agencies in this response.