

Public Health Recommendations for Processing Families, Children and Adults Seeking Asylum or Other Protection at the Border

The United States has the ability to both safeguard public health in the midst of the COVID-19 response and safeguard the lives of children, families and adults seeking asylum and other humanitarian protection at the U.S. southern border, as public health experts have [repeatedly stressed](#) in letters urging revocation of policies that expel, block and turn back to danger children, families and adults seeking refuge. Not only have [public health experts](#) concluded that the March 2020 Centers for Disease Control and Prevention (CDC) [order](#) and its [extensions](#), which have been used to justify these policies, were specious from a public health perspective, but numerous [media reports](#) confirm that experts within CDC had [objected](#) to the order as [lacking](#) a public health basis and [not motivated](#) by public health concerns.¹ In early November 2020, a spokesperson for the Biden campaign told [CBS News](#) that a Biden Administration would “direct the CDC and [Department of Homeland Security] DHS to review this policy and make the appropriate changes to ensure that people have the ability to submit their asylum claims while ensuring that we are taking the appropriate COVID-19 safety precautions, as guided by the science and public health experts.”

The U.N. Refugee Agency (UNHCR) explained in its March 2020 legal [guidance](#) on the COVID-19 response that state entry measures should not prevent people from seeking asylum from persecution and that states may not deny entry to people at risk of refoulement. In November 2020, it [warned](#) that “measures restricting access to asylum must not be allowed to become entrenched under the guise of public health.” The public health consensus is clear: there is “[no public health rationale](#)” to bar or discriminate against asylum seekers or migrants based on immigration status. Moreover, various categories of travelers are currently allowed to arrive in the United States from international destinations, including at the southwest border,² and transmission of COVID-19 is already widespread within U.S. communities.

Instead of bans, expulsions and asylum denials, the Biden Administration should employ science-based public health measures at borders to protect the health of the American public, U.S. border officers, communities on both sides of the border and the lives of those seeking refuge, safety and freedom. We recommend effective, evidence-based public health measures, many of which are currently used in the United States and in connection to travel, to mitigate COVID-19 risks. These measures – outlined in greater detail below – include:

- Immediately strengthen public health decision-making, contingency planning for increases or shifts in arrivals, coordination (both internally and cross-border), and funding for public health authorities and humanitarian entities implementing public health safeguards, as well as strengthen public health surveillance³ at the border

¹ These policies, and their impact, are outlined in this [backgrounder](#). In late November 2020, a federal court [issued](#) a preliminary injunction blocking DHS from expelling unaccompanied children under the CDC order and finding that the government was not likely to prevail on its assertion that the U.S. public health laws cited as authority for the CDC order authorize expulsions.

² In addition to arrivals at U.S. airports, more than 40 million pedestrians, car, bus and train passengers, including U.S. citizens and various categories of persons deemed “essential,” entered the United States through the southern border between April and September 2020 according to the [Bureau of Transportation Statistics](#) (presumably including U.S. citizens and others deemed “[essential](#)”).

³ Public health surveillance is defined by CDC as “the ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice.”

and support improved public health capacity in Mexico by, among other steps, funding health, refugee aid, humanitarian and other agencies already working with asylum seekers and migrants there

- Use masks, social distancing, hand hygiene (including alcohol-based hand sanitizer and handwashing facilities), distancing demarcations and barriers at border posts and during processing
- Adapt border processing to minimize delays, avoid congregate situations, reduce density, and maximize ventilation, and use and repurpose areas appropriate for non-congregate processing, identifying larger locations with more appropriate layouts and conditions that can be used to scale up reception capacities should arrivals increase or shift
- Ramp up testing capacity, which should be conducted by CDC or the Department of Health and Human Services (HHS) and further enhanced via mobile medical/testing units, testing any person who has symptoms, has been exposed to a person with COVID-19, is referred to a congregate setting, or as required by any applicable (frequently-shifting) travel or after-travel guidance
- Expand quarantine capacity and isolation capacity through use of motels, mobile units or other individualized accommodations for people determined to be ill, or for those who need to quarantine due to symptoms, exposure, applicable travel or after-travel guidance, or inability to shelter at a home, ensuring that such capacities – which fall within the jurisdiction of CDC and/or local health authorities – are not conducted by Customs and Border Protection (CBP) or Immigration and Customs Enforcement (ICE), and that appropriate accommodations, supervision and support are in place for all children, including unaccompanied children, who are immediately transferred from CBP to Office of Refugee Resettlement (ORR) custody
- Ensure safety during transportation through use of masks, well-ventilated vehicles, larger capacity vehicles to allow sufficient distancing, and cleaning and disinfecting frequently-touched surfaces
- Employ safeguards at shelters or reception locations through measures including health screenings, masks, social distancing, reduced density, use of outdoor areas, ventilation, and testing, taking into account location layout, duration of stay and local requirements
- Do not hold families, adults or children in congregate detention, which presents a range of health risks; instead families and adults can shelter in place with their families or other community contacts in the United States (after any brief shelter or reception visit) through parole and proven case management alternatives to detention, while ensuring immediate transfer of unaccompanied children to HHS/ORR custody and their swift release to sponsors with use of safe travel precautions, and
- Provide health information and education appropriate for a person’s health literacy level and linguistic needs, including current information about after-travel precautions, which are subject to change

Many of the strategies identified in these recommendations can be scaled up or adjusted, if new arrivals increase or as needs shift among various border locations. While these recommendations focus on public health measures, various non-governmental organizations have issued recommendations on strategies to strengthen processing and prepare for potential shifts or increases in arrival numbers.⁴ U.S. authorities should consult with UNHCR, the U.N. Children’s Fund (UNICEF) and the various aid, medical and other humanitarian organizations already working with refugee and migrant populations on both sides of the border. As stressed below, contingency planning and coordination with local public health authorities, medical and refugee aid groups, shelters, and other organizations working with refugees on both sides of the border is critical, as is funding for public health measures and local health authorities, providers, shelters and others. In addition, as there are

⁴ Human Rights First, [“Walking the Walk: 2021 Blueprints for a Human Rights-Centered U.S. Foreign Policy, Chapter 3: Upholding Refugee Protection and Asylum at Home;”](#) International Rescue Committee, [“Safety for all: Responding to the humanitarian crisis in Central America, restoring the U.S. asylum system, and protecting the most vulnerable;”](#) Asylum Access & other organizations, [“Recommendations from Mexican Civil Society Organizations to the Biden-Harris Administration: Restitution and Support for Asylum Seekers Subjected to MPP.”](#)

significant variations among border locations – such as the physical design of ports of entry (POEs), security challenges due to threat levels on the Mexican side of the border, levels of COVID-19 transmission, shelter layouts and available local resources – specific steps require discussion and engagement with local health authorities, medical providers, shelters and refugee assistance organizations.

These recommendations include multiple levels of public health safeguards to be applied simultaneously. The current unavailability of particular measures should not be used as an excuse to turn away or ban people seeking protection. Instead, public health, humanitarian and health authorities should take steps to rapidly address any gaps and adjust practices to employ the range of other effective measures identified here.

Medical experts have long warned that detention of asylum seekers and migrants in congregate custody, jails and detention facilities has [negative health consequences](#), that asylum seekers and migrants [should be released](#) from such facilities given the dangers of COVID-19 spread there, and that [medical evidence](#) shows that alternatives to detention result in improved health outcomes. The [massive spread](#) of SARS-CoV-2 (the virus that causes COVID-19) in U.S. immigration detention facilities due to the lack of sufficient releases, confirms the urgent public health imperative to swiftly shift from mass migration detention to effective [community-based case management](#).

This is a dynamic situation. Public health measures will need to be reviewed and adjusted as the COVID-19 transmission context, asylum arrival levels, public health guidance, testing technology and capacity, availability of vaccines and therapeutics, and evidence and understanding of the disease change. As the science is rapidly evolving, we recommend following the best scientific guidance available at the time and ensuring that systems are in place to accommodate frequently updated guidance.

Evidence-based public health recommendations⁵ include:

Immediately strengthen public health planning, coordination (both internally and cross-border), funding and decision-making, as well as public health surveillance

Decisions relating to public health should be led by public health officials, without political interference or pressure to attempt to advance migration policy, asylum deterrence or other political objectives. Immediate planning and contingency planning by, coordination among, and sufficient funding for CDC, ORR, HHS Commissioned Corps of the United States Public Health Service (USPHS), shelters, local health authorities, refugee assistance organizations and other agencies will be critical to ensure implementation of public health measures. CDC and local public health authorities should collaborate to strengthen public health surveillance systems at the border. Humanitarian agencies and organizations should play a leading role in addressing responses to, and needs of, families, children and adults seeking humanitarian protection.

⁵ Numerous epidemiologists and other public health experts, including those with prior CDC experience, weighed into the development of these recommendations including experts with or contacted through: the Forced Migration and Health Program at Columbia University's Mailman School of Public Health; the Center for Humanitarian Health at Johns Hopkins Bloomberg School of Public Health; Physicians for Human Rights; and Doctors of the World; as well as Dr. Rebecca Cázares, Refugee Health Alliance; Dr. Joanne Csete, Columbia University Medical Center; Dr. Marie DeLuca, Columbia University Medical Center; Dr. Hope Ferdowsian, University of New Mexico School of Medicine; Dr. Rohini J. Haar, School of Public Health, U.C., Berkeley; Dr. Michele Heisler, School of Public Health, University of Michigan; Dr. Monik C. Jiménez, Harvard T.H. Chan, School of Public Health; Dr. S. Patrick Kachur, Columbia University Medical Center; Dr. Ling San Lau, Columbia University Mailman School of Public Health; Dr. Alan R. Lifson, School of Public Health, University of Minnesota; Dr. Joseph B. McCormick, University of Texas School of Public Health; Terry McGovern, Columbia University Medical Center and Columbia University Mailman School of Public Health; Dr. Ranit Mishori, Georgetown Medical Center; Lisa Mitchell-Bennett, University of Texas School of Public Health; Dr. Rachel Moresky, Columbia University Medical Center and Columbia University Mailman School of Public Health; Dr. Stephen Morse, Columbia University Medical Center; Dr. Kathleen Page, Johns Hopkins University; Dr. Rupa R. Patel, Washington University in St. Louis; Helen Perry, Global Response Management; Dr. Adam Richards, Community Partners International; Dr. Leslie F. Roberts, Columbia University Medical Center; Dr. Ana Cristina Sedas, Harvard Medical School; Dr. Ronald Waldman, George Washington University Milken Institute School of Public Health and Doctors of the World; Monette Zard, Columbia University Medical Center and Columbia University Mailman School of Public Health; and Dr. Amy Zeidan, Emory University School of Medicine.

Provide funding and resources to improve public health capacity in Mexico

The U.S. government and international community should swiftly increase support for medical, public health, shelter and refugee assistance organizations in Mexico to strengthen their capacity to safeguard asylum seekers and other migrants,⁶ their staff and broader communities from the spread of COVID-19. This includes support for staff training as well as enhancing efforts to educate asylum seekers on measures to avoid COVID-19 (and to not travel when ill), and to provide screening, testing, isolation and medical aid to people experiencing symptoms, recently exposed or who are ill. Strong support (including funding, supplies and technical expertise) for measures to combat COVID-19, and to provide free testing in refugee-hosting communities in Mexico, is imperative – not only for asylum seekers, but more broadly given cross-border travel as well as family and business connections between U.S. and Mexican communities. The United States should also collaborate with and fund international agencies, including UNICEF and UNHCR, and non-governmental organizations already working in Mexico.

Require the use of masks

Asylum seekers and all others approaching U.S. ports of entry are – and must continue to be – [advised](#) to wear masks over the mouth and nose (excepting children under two years of age).⁷ CBP – including Border Patrol – staff should be specifically directed to wear masks on duty (to protect themselves, other staff and the public) and to provide masks to people who do not have them already. CBP can also add clear plastic or plexiglass barriers at interview locations. Interviewing officers can wear face shields as well as masks. The need for appropriate directives, training, supervision, and oversight to ensure that CBP staff wear masks (and comply with other public health measures such as social distancing) at all times during contact with other people is critical, given widespread community transmission of COVID-19 in the United States and reports that some border officers have not been [wearing](#) masks or not wearing them [properly](#).

Ensure social distancing in lines and during processing and take steps to reduce density

CBP and CDC should instruct CBP staff to facilitate social distancing to the extent possible in lines at ports of entry, during POE and Border Patrol processing, and as officers and agents conduct outdoor processing, using lines or other demarcations to set at least six-foot distances between people standing in lines or sitting during interviews. Agencies should identify steps to minimize time spent in areas where risks of COVID-19 exposure are higher (e.g., in spaces where distancing is challenging or indoor areas lacking ventilation). This includes steps to reduce processing time, as outlined below, and repurposing outdoor areas such as parking lots (weather depending) or other nearby facilities (such as adjacent facilities erected for Migrant Protection Protocols (MPP) hearings and/or other nearby locations), as well as identifying larger capacity reception locations to process increased arrivals, rather than holding families, children, and adults in congregate CBP custody at POEs or Border Patrol locations. With respect to indoor processing, in addition to distancing and minimizing processing time, ventilation (e.g., via open windows or [air filtration](#)) and measures to reduce density should be maximized.

Minimize border processing times and adapt processing to reduce COVID-19 transmission risks

Current evidence and [CDC guidance](#) indicate that the risk of COVID-19 transmission is higher when a person has close contact (within six feet) of an infected person and an increased duration of exposure,⁸ particularly in poorly ventilated or enclosed spaces. In addition to implementing social distancing and other measures outlined above,

⁶ While transmission of COVID-19 is widespread in Mexico, there are strategies that can be scaled up with additional support. Medical and refugee assistance organizations, shelters and others assisting asylum seekers in Mexico reported implementing public health [measures](#) - including social distancing, mask and hygiene kit distribution, testing, and the use of [temporary quarantine shelters](#) to ensure that deportees from the United States and other new arrivals do not transmit COVID-19 to people already staying in these locations. These measures [help protect](#) asylum seekers and have helped minimize the spread of COVID-19 in [shelters](#) and the tent [encampment of asylum seekers in Matamoros](#). Nearly all Mexican states [require](#) use of face coverings outside the home or, at a minimum, in public spaces like public transport. In addition, Mexican [authorities](#) advise travelers to wear masks and follow social distance measures.

⁷ CDC is studying the effectiveness of different mask materials and will continue to update its [guidance](#).

⁸ CDC considers [close contact](#) to be within six feet for a period of 15 minutes or more.

CBP – including Border Patrol – should adjust border processing protocols (adhering to U.S. refugee and anti-trafficking laws) to transit asylum seekers through POEs or other locations without delay, minimizing the time people spend there. Some suggestions include allocating sufficient officers,⁹ processing cases promptly (CBP was able to conduct processing within [two to four hours](#), even prior to COVID-19, so additional efficiencies could likely reduce that time significantly), coordinating and planning with shelters, attorneys, and refugee assistance organizations on both sides of the border, and in some cases – such as MPP cases which have already undergone CBP processing and are already in immigration court proceedings – swiftly transiting such people through POEs and potentially preparing paperwork in advance so asylum seekers can transit POEs without delays, as has already been done in some cases. In its recommendations relating to refugee reception and COVID-19, [UNHCR](#) recommends simplifying registration processes and focusing on collecting only essential data and identifying specific needs.

Ensure appropriate water, sanitation and hygiene (WASH) measures, including the provision of handwashing facilities and alcohol-based hand sanitizers

Border officers, asylum seekers and other people crossing at POEs or apprehended between ports should be advised to minimize physical contact and provided with and asked to use alcohol-based hand sanitizer (at least 60 percent alcohol, as per CDC) before and after exchanging documents, using fingerprint machinery, or touching other surfaces. CBP and Mexican counterparts should take steps to expand availability of hand-washing facilities at the border, which are often limited and lack soap, including by deploying portable washing stations.

Conduct health screening as appropriate and in accordance with local and public health guidance

Where there is already widespread community transmission (as is currently the case in U.S. communities), given limitations (including significant pre-symptomatic and asymptomatic transmission of SARS-CoV2) and challenges relating to such screenings, CDC has noted that health entry screening may not be the best use of limited resources at ports of entry.¹⁰ Depending on updated public health assessments, as well as logistical and security factors, and with proper resources, people crossing the border (including asylum seekers) could, in addition to being observed for symptoms, be asked (in writing and/or verbally) about symptoms and exposure to any contact with COVID-19. If necessary, they could be quickly afforded temperature checks, with such screenings conducted by screeners who are trained by medical professionals and independent of CBP. The conduct and degree of public health screening can be scaled up or down depending on current public health needs and assessments. Such screenings should moreover not be conducted in areas where people crossing the border will be in danger, as CDC has warned. People crossing the border at POEs, including asylum seekers, should be provided with linguistically-appropriate [health information](#) and education about COVID-19 (including information about how the disease is transmitted, disease symptoms, preventive measures and where to seek health information and healthcare services) and instructions relating to after-travel precautions. In addition, contact information can be requested in writing for risk assessment and [contact tracing purposes](#). The implementation of screenings after crossing the border (at or prior to entering a shelter or other reception location) is addressed below.

⁹ A report issued by the [DHS Office of Inspector General](#) found that CBP officers were instructed to de-prioritize asylum processing and turn asylum seekers away, and rather than allocating sufficient officers from CBP's [high level of staffing](#) to conduct this processing in a timely manner, some officers were directed to other functions.

¹⁰ CDC [port of entry guidance](#) indicates it would not be the best use of limited resources for authorities to conduct public health screenings for people crossing into areas after COVID-19 is already widely transmitted. The CDC guidance warns that screenings should not be conducted at POEs where safety and security of travelers and screeners cannot be assured or in areas vulnerable to violence. The U.S. has [ended](#) its “enhanced” screening at airports.

Immediately ramp up COVID-19 testing capacity¹¹

The U.S. government should immediately ramp up testing capacity and flexibility, including via the use of mobile testing units. Testing should be available for anyone who requires it, including people with symptoms or recent exposure, anyone who transits to congregate settings, and anyone advised to seek testing under current CDC guidance, including any applicable travel or after-travel guidance. Anyone identified at a POE or in CBP/Border Patrol custody as [needing testing](#) (e.g., due to symptoms of, or exposure to, COVID-19), should be referred to trained medical professionals for a COVID-19 test and appropriate follow-up.¹² Given the need for rapid results in border settings, at this time an [antigen test](#) that delivers results within five to 15 minutes is likely the best fit for initial use in these situations, though this type of test has [limitations](#) (while some rapid PCR tests can deliver results within 15 minutes, their cost and scalability currently present barriers). A positive antigen test is generally considered reliable when a person is symptomatic; however, a confirmatory PCR test will be required when an antigen test result is inconsistent with the clinical context, as detailed in [CDC Interim Guidance for Antigen Testing for SARS-CoV-2](#) (including [antigen test algorithms](#)) and [Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2](#).

As the science is rapidly evolving and as COVID-19 testing technology, accuracy, turnaround time, cost, throughput and scalability are expected to continually improve, we recommend following the best available scientific guidance on testing. Any person testing positive or exhibiting symptoms of COVID-19 should be directed to isolate, in accordance with [CDC recommendations](#), and as outlined below (with appropriate accommodations, support and supervision for children). Family members or companions traveling with that person should be referred to quarantine separately, with additional testing conducted subsequently. Any testing at POEs or for people in CBP/Border Patrol custody should be conducted by public health authorities or medical providers independent of CBP, such as CDC, CDC quarantine station staff, HHS Commissioned Corps of the USPHS, local health officials or medical professionals contracted by CDC or HHS, with federal funding support. CDC does not require blanket COVID-19 testing for all people arriving to the United States at the southern border, and asylum seekers should not be discriminated against, as noted above. However, to the extent that recent [CDC international travel guidance](#) recommending pre-travel testing is applicable to people crossing the southern border, CDC and HHS can facilitate rapid testing for asylum seekers at or just after arrival. A lack of available testing capacity is not (as claimed in the specious March 2020 [order](#)) a public health justification for turning away or denying protection to children and asylum seekers, and policies should include contingencies for anticipated intermittent periods of testing material shortages.

Post-arrival testing and other public health recommendations for unaccompanied children subsequently (and swiftly) transferred to HHS/ORR shelters and custody, as well as for asylum seekers visiting shelters or reception locations after crossing the border, are referenced below. As discussed, the use of congregate settings should be avoided where possible. Social distancing and use of outdoor areas should be maximized. However, to the extent that a location utilizes congregate settings, initial testing of all individuals, including those who are asymptomatic, would generally be advisable – depending on various factors including location layout, social distancing capacity, outdoor areas, length of stay (a few hours, overnight, or several days), COVID-19 prevalence in relevant communities at the time and the advice of local health authorities. CDC guidance, as noted below, does not require blanket testing of people entering humanitarian disaster shelters or homeless shelters but outlines

¹¹ While efforts should be made to strengthen testing capacity in Mexico, it would not be advisable, necessary or appropriate to require that all asylum seekers be subjected to blanket testing in Mexico. Medical and health groups working with migrants and asylum seekers in Mexico report a range of challenges, including lack of free testing, lack of public health services available to migrants and asylum seekers, restrictions on transporting testing equipment into Mexico, and substantial security risks in border areas where migrants are targeted for kidnappings, extortion and violence. Recent CDC [guidance](#) advises pre-departure testing for international travelers one to three days before departure; however, such guidance does not address security concerns and other challenges related to land border crossings - and as noted above, the U.S. can take steps to conduct rapid testing upon arrival.

¹² [CDC guidance](#) makes clear that people with symptoms of COVID-19 or people who have had [close contact](#) (within six feet for a total of 15 minutes or more) with someone with confirmed COVID-19 should be tested and advised to quarantine.

numerous safeguards relating to COVID-19. Regular consultation with, and the incorporation of guidance from, local public health authorities will be critical. Should time spent in locations with congregate settings extend beyond several days, additional testing will be necessary, as explained below, though immigration detention should *not* be used for the public health reasons referenced herein. Testing prior to (or at) referral to such shelters or other reception locations should be operated and overseen by CDC and/or HHS (in communication and collaboration with local health authorities, where such authorities have responsibilities), and be conducted by medical professionals associated with CDC or deployed by, and operating under the authority of, HHS – such as via the Commissioned Corps of the USPHS. Any testing decisions and actions must be directed, overseen and conducted by entities independent of CBP or ICE.

In addition, as noted in more detail below, CDC provides after-travel advice for travelers returning to the United States from Mexico. This advice regularly shifts depending on the public health situation. As of November 23, 2020, CDC advises travelers returning from Mexico to get tested three to five days after return (and to stay home for seven days, or 10 days if not tested). Should this guidance be applied to asylum seekers, they could either be tested upon reaching their destination homes (if they arrived at that home by day three) or could be tested at a reception or shelter location (if they are still present at such location three days after arrival from Mexico).

Refer ill people for treatment and isolation and expand capacity for safe quarantine/isolation

An asylum seeker or unaccompanied child who tests positive for COVID-19 should never be turned away from, or denied protection in the United States, but should instead be properly referred for medical care and isolation.

If an arriving person tests positive for SARS-CoV-2 and does not require hospitalization, CDC should work with local health authorities, HHS's Commissioned Corps of the USPHS, shelters, state refugee health programs and/or humanitarian assistance organizations (which should be provided necessary resources), to provide access to facilities like unused dorm rooms, motel rooms or other structures with individual rooms that allow such people to isolate and to allow people who were exposed to an ill person (but tested negative) to quarantine for the requisite period¹³ and undergo additional testing, depending on exposure date. This approach could be scaled up as needed, and gaps could be addressed through mobile and/or rapidly erected individualized housing units.¹⁴

Neither CBP nor ICE should conduct isolation or quarantine. The legal authority to quarantine people entering at POEs falls within CDC's jurisdiction. Access to communication with, and support of, medical care, humanitarian and legal organizations, family and others, must be assured during this time. Unaccompanied children should be, as noted, immediately transferred to HHS custody; and any quarantine or isolation of children must be implemented in appropriate accommodations with support and supervision. In principle, children should not be separated from the custody of their parents. Appropriate accommodations to allow quarantine or isolation without separating a family, as well as other public health measures, should be employed. A person determined to be ill with COVID-19 and in need of hospitalization should be referred to a hospital for medical care. Given the generally [younger ages](#) of most asylum seekers and limited spread in shelters and encampments, this population is unlikely to present a significant strain on local hospital capacities; however, local hospital capacity should be supported and contingencies planned for. Local health authorities, shelters and refugee assistance organizations (with funding support) should plan for, and be prepared to scale up isolation and quarantine capacity, if needed. However, mass quarantine requirements for travelers and other people arriving at borders would raise a range of concerns and are not required from a public health perspective. Moreover, as noted below, travelers are advised

¹³ The CDC has updated its [quarantine guidance](#), as of December 2, 2020, to give the option of quarantine periods of 10 days, or 7 days after receiving a negative test result, as alternatives to the 14-day quarantine period, subject to guidance from local public health authorities. Such guidance is frequently updated, so systems should be in place to accommodate frequently updated guidance.

¹⁴ Mobile trailers have been deployed to scale up quarantine and isolation capacity. For example, LA county used [mobile recreational vehicles](#) for quarantine purposes and the state of California procured [1,309 mobile trailers](#) for isolation capacity (for uses including referrals from homeless shelters). Trailers have also been used for temporary housing after hurricanes, and some universities quickly scaled up modular units for isolation as well.

to shelter at home (for the requisite number of days, depending on their location and applicable guidance at the time) and to take other after-travel steps upon reaching their home or other destination location.

Employ measures appropriate for children (including unaccompanied children) and families

Screenings for unaccompanied children under U.S. anti-trafficking and refugee [law](#)¹⁵ [should](#) occur using the public health safeguards outlined here. As necessary, accommodations should be made for all children based on the age, developmental stage and best interests of the child. Unaccompanied children should be immediately transferred to ORR custody, using the public health safeguards for transportation outlined below, and released to sponsors without delay, ensuring use of appropriate public health and child protection measures in transport. HHS guidance on the screening, testing, care and release of unaccompanied children should be updated whenever CDC guidance changes, and should be provided promptly to all care providers with appropriate training. Officials should use age-appropriate and linguistically appropriate communication to conduct health screenings, discuss the risks of COVID-19 and advise on any specific safety measures. Children who are identified as needing additional medical care should be immediately referred for evaluation and treatment. Any use of quarantine or isolation must include proper accommodation, support and supervision for children, including access to legal service providers, child advocates, mental health service and recreational access.

Procedures, policies and decisions relating to unaccompanied children and asylum seekers should also be reviewed by CDC epidemiologists and public-health experts, HHS's Administration for Children and Families (ACF), and people with pediatric medical training and expertise, including pediatricians, child psychologists, the American Academy of Pediatrics (AAP) and experts on the needs of migrant and refugee children. Precautions relating to the testing of children are referenced below in the "shelters" discussion. AAP [recommends](#) that the processing of children and families should occur in a humanitarian and child-friendly manner, not take place in CBP centers (the conditions of which are not consistent with APP recommendations for the appropriate care and treatment of children), and that HHS should be put in charge of overseeing the treatment of such children and families. AAP has long [recommended](#) that pediatric medical expertise should be available on site in CBP locations or other sites where children are in government custody, advised CBP and DHS to increase medical staffing accordingly, and called for required medical screening of all children less than 18 years old by a medical professional with pediatric training.¹⁶

Deploy safe processing measures in Border Patrol custody

Public health measures that Border Patrol should use are outlined throughout these recommendations, including:

- use of masks by agents (including when with other agents) and provision of masks to any person apprehended who does not have a mask¹⁷
- provision and use of alcohol-based hand sanitizer before and after exchanging documents, using fingerprint machinery or touching surfaces
- facilitation of at least six-foot distancing during processing

¹⁵ U.S. anti-trafficking [law](#) requires that children be screened to determine if they meet the criteria to be designated as an unaccompanied child, a designation that is critical for them to access protections from return to trafficking or other harms. U.S. law and treaties also bar the return of people to countries where they face [persecution](#) or [torture](#) and require access to asylum adjudications or [screenings](#) for humanitarian protection for people who fear return to their countries.

¹⁶ KIND has [recommended](#) DHS fulfill Congress's directive to hire licensed child welfare professionals at southern border facilities (to conduct required screening and processes for unaccompanied and accompanied children, including to identify protection needs and supervise their care), maximize placement of unaccompanied children in smaller-scale facilities, transitional foster care, and long-term foster care, prioritize family and community-based care broadly, in service of the best interests of the child, and cautioned that "influx" facilities only be used in extraordinary circumstances involving an unanticipated increase in unaccompanied children.

¹⁷ A [recent report](#) indicated that the Border Patrol held children in its custody for days without providing a new mask each day. Children and asylum seekers should be swiftly transferred from CBP to shelters and reception locations. Should this recommendation not be followed (which would present public health concerns), officers must provide clean, new masks each day and follow other public health measures.

- health screenings conducted by medical professionals¹⁸ independent of CBP, such as professionals deployed by HHS through the Commissioned Corps of the USPHS, which should include observation for symptoms, inquiry of symptoms and a recent history of exposure to anyone with COVID-19 and conducting temperature checks as needed (including to help detect other illness or high fevers, particularly for children)
- immediate transfer of unaccompanied children from CBP custody to HHS/ORR custody; minimizing delays in, and enhancing efficiency in, processing time to significantly reduce time in custody
- avoiding congregate detention and minimizing time in high-density settings or areas where distancing is challenging
- conducting outdoor field processing (weather depending), repurposing or enhancing (via individual units, maximized outdoor areas and ventilation) other nearby humanitarian reception locations to conduct rapid non-congregate processing rather than holding families, children, and adults in Border Patrol locations with conditions that are typically congregate¹⁹ and otherwise deficient from a health perspective
- promptly processing asylum seekers without delays so they can transit to reception locations, shelters or home destinations
- in transport, use of masks and well-ventilated, larger vehicles with distancing between seats (as outlined below) and allocation of sufficient additional vehicles and officers to transport
- referral of any person identified as in need of testing due to symptoms of, or exposure to COVID-19, to CDC, HHS/USPHS, local health authorities or independent medical professionals for a test, and
- for any person then in need of either isolation or quarantine, coordinating with CDC, local health authorities, shelters or refugee assistance organizations, to arrange safe transport to such accommodations, while using public health measures and not taking children from their parent's custody

Use case management alternatives, not detention

Families with children and adults seeking asylum or other protection should not be held in detention or other congregate settings by CBP or ICE but should instead be released to join their families or other contacts in the United States through parole or community-based case management alternatives to detention. [Medical evidence](#) demonstrates that alternatives to detention result in improved health outcomes. Moreover, an estimated [92 percent](#) of people in MPP already have family in the United States. For the remaining small percentage (who are not planning to join family or friends and are in need of a destination location), shelters, refugee aid or case management programs could potentially help identify an appropriate destination, with necessary funding. Before travel, asylum seekers should be reminded about public health measures to use both when traveling (by bus or air) and after reaching their destinations – including the need to wear masks, socially distance, wash hands frequently and take any after-travel steps (below). Case management programs can be scaled up or down in response to increases or decreases in arrivals. The policy of holding asylum seekers and migrants in jails and detention facilities has long raised public health concerns. Asylum seekers, including many traumatized from harms that pushed them to flee, often [suffer from high levels](#) of PTSD and depression [in U.S. detention](#). [AAP](#) has warned that detention harms the health and development of children. In early 2020, the repeated recommendations of leading public [health experts and former DHS officials](#) that immigrants and asylum seekers be released from administrative detention given the danger COVID-19 would spread in these facilities²⁰ were not

¹⁸ Congress has in the past provided CBP with funding for medical professionals, but the U.S. Government Accountability Office [reported](#) that the funds were used to purchase all-terrain vehicles and for K9 dogs.

¹⁹ The recent [report](#) noted above, which revealed that the Border Patrol is holding children in Border Patrol stations for extended periods of time in congregate locations with deficient conditions, is a reminder that steps must be taken immediately to adjust the type of space CBP uses and to swiftly transfer children to ORR custody.

²⁰ See also, William D. Lopez et al., "[Preventing the Spread of COVID-19 in Immigration Detention Centers Requires the Release of Detainees](#)," American Journal of Public Health.

followed. Failure to follow these recommendations resulted in a [massive spread](#) of SARS-CoV-2 in U.S. immigration detention facilities, confirming the imperative to swiftly shift from a reliance on congregate detention to the use of case management.²¹

Ensure safety measures are adopted during transport

As U.S. agencies transport asylum seekers and children to HHS facilities, local shelters or other (non-detention) reception locations, and as Border Patrol transports people from the field, officers or other people conducting such transport should use larger vehicles to enable social distancing. They should leave sufficient empty seats (at least six feet of space between people), clean vehicles frequently (routinely cleaning and disinfecting frequently touched surfaces, including door handles), leave some windows open to increase ventilation, and require all officers and migrants to wear masks (except children under two years of age). Sufficient numbers of well-ventilated and larger capacity vehicles and staff to drive them should be identified and allocated. In selecting new reception locations or making transport decisions, steps should be taken to minimize transportation distances, taking into account the person's specific needs and circumstances. While trips should be kept brief, and HHS locations and reception areas located nearby, to the extent longer trips are necessary additional safeguards should be implemented, such as minimizing passenger numbers in vehicles. In addition, safeguards for travel (by air, train or bus) should be employed for any unaccompanied children traveling between facilities or to reunify with family. Children and receiving family members should be provided with PPE and information tailored to their language and literacy.

Coordinate with shelters and reception locations

As these recommendations focus on the initial crossing of the border, and necessary public health measures may vary for different states, locations and types of facilities, this document does not delve into the details of specific public health measures that should be implemented in different shelters or reception locations within the United States. CDC, ACF, HHS and Commissioned Corps of the USPHS, local health authorities as applicable, shelters and other refugee assistance agencies should meet, plan and coordinate on the implementation and logistics of public health measures in relevant sites. As they plan locations, spaces and activities, they should endeavor to maximize social distancing and ventilation; minimize time in indoor areas or in areas where distancing is challenging; and prioritize non-congregate housing.²² If scale-up is necessary and arrivals increase or shift in location, reception locations should be designed to reduce density and maximize social distancing, use of outdoor settings, and ventilation.²³

HHS/ORR shelters housing children after immediate transfer from CBP custody must implement any HHS/ORR, CDC and/or other applicable measures applicable to shelters housing children. HHS/ORR guidance on the screening, testing, quarantine, care and release of unaccompanied children should be updated whenever CDC guidance changes, and should be provided promptly to all care providers with appropriate training. For instance, any ORR requirements on quarantine should be reviewed to assess whether quarantine times can be reduced for children given recent shifts in CDC guidance. Similarly, recommendations on testing should be reviewed and updated as CDC guidance shifts. Critical steps include the provision of sufficient PPE – including masks suitable for children, implementation of initial health screening and temperature checks for arrivals at shelters, and referral of any staff member or children with symptoms or exposure for COVID-19 testing. To the extent children are entering congregate settings in shelters where they will be held for weeks or longer, testing of all children entering such a facility is advisable, and testing should be conducted in accordance with any ORR requirements. Many

²¹ While detention is not recommended, if asylum seekers are housed in congregate settings, screening and frequent testing would be advisable, as well as implementation of other public health measures.

²² CDC has for instance recommended public health measures for humanitarian disaster [shelters](#), homeless [shelters](#) as well as [shared living locations](#).

²³ In connection with [humanitarian disaster shelters](#), CDC has recommended that the use of dormitories, hotels and small shelters (fewer than 50 residents) be prioritized rather than larger shelters, and that large congregate shelters should be a last resort.

such shelters – which are housing children for many days, several weeks or more – have been conducting such testing as well as quarantine. Various factors may impact assessments of the need for entry testing, including the COVID-19 transmission context, the layout of the facility, length of stay, age range of children and corresponding ability/inability to socially distance, and the requirements of ORR and relevant public health authorities. Any use of quarantine or isolation should ensure appropriate accommodation, supervision and structure for children, and should not limit outdoor recreation for children (with precautions), access to mental health care, or legal services of child advocates.

HHS should receive and provide ORR shelters with funds for testing unaccompanied children upon transfer to HHS/ORR custody, as well as regularly updated guidance from CDC regarding timing of testing, follow-up testing and standardization of testing. CDC advises that repeat [antigen testing](#) may allow early identification of SARS-CoV-2 infection and prevention of transmission in high-risk [congregate settings](#), but emphasizes the limitations of this type of test, including a lower sensitivity. Confirmatory PCR tests will be required in specific circumstances, which have been [outlined in CDC guidance](#). However, it is important to note that data supporting the use of antigen tests for screening asymptomatic people as well as children generally is currently lacking. Further, any testing procedures involving children should be designed to avoid unnecessary testing and to minimize any associated distress and discomfort (e.g., prioritize recommended sample collection methods that are non-invasive or minimally invasive, such as nasal swabs or saliva). Any recommendation to conduct testing for children sent to ORR shelters does not constitute a public health justification for turning away children seeking protection, including if such testing is not available.²⁴ HHS shelters should endeavor to release children to sponsors as quickly as possible, using public health and child protection measures, including in connection with travel.

With respect to families and adults transiting from CBP ports of entry or Border Patrol custody to local shelters or other reception locations, including any larger reception locations scaled up to accommodate increased arrivals, such people should, upon or just prior to entering such locations, be given basic public health screenings. Screenings should include inquiries about any symptoms or exposure to people with COVID-19 and observation for symptoms and temperature checks. These people should also be given reminders to wear masks, socially distance (to the extent possible) and wash hands frequently. Moreover, at shelters and other reception locations, humanitarian workers should use the public [health safeguards recommended](#) by CDC and by local health authorities for people in the United States and at such facilities, including with respect to the use of masks, social distancing, safe transportation, ventilation, disinfecting of rooms and dining areas, and availability of washing facilities and hand sanitizer.

In addition to testing for any person who exhibits or reports symptoms or reports recent exposure to someone with COVID-19, CDC, HHS and local public health authorities should work with local shelters and refugee aid organizations to assess whether there is a need for routine testing on arrival for all people presenting to a shelter or reception location. Such locations should work to avoid use of congregate settings and maximize social distancing and use of outdoor areas. To the extent a location utilizes congregate areas or settings, initial testing will be advisable – depending on various factors including length of visit (a few hours, overnight, or several days), location layout, social distancing capacity, use of outdoor areas, COVID-19 prevalence in relevant communities at the time, and the advice of local health authorities. For instance, an asylum seeker who will be present for only two hours at an outdoor reception location where distancing is possible may not require initial testing from a public health perspective. However, an asylum seeker spending three days at a facility with congregate housing or limited distancing should be tested on arrival if possible. CDC guidance does not currently require blanket testing

²⁴ The American Academy of Pediatrics has, in its [recommendations](#) to a Biden administration, recommended that ORR increase its permanent bed capacity in smaller settings so children are not placed in large, congregate or unlicensed, “influx” facilities; that children never be separated from their parents unless a competent family court makes that determination; that children should not be kept in hotels (as ICE had done in connection with expulsions under the CDC order); that family detention be ended, as well as the use of electronic monitoring devices on parents; that community-based case management be used for children and families; and that every effort be made to reunify all children in ORR custody with sponsors as quickly and as safely as possible.

of people entering humanitarian disaster shelters but does outline potential testing guidance for homeless shelters.²⁵ Regular consultation with, and the incorporation of guidance from, CDC, HHS, ACF, and local public health authorities will be critical. The absence of sufficient numbers of tests is not a justification for expelling or denying entry to asylum seekers.

CDC after-travel guidance for travelers returning from Mexico recently shifted, from encouraging people to consider testing after they reach their homes to now (as of November 23, 2020) advising testing three to five days after arriving back, along with advising travelers to generally stay home for seven days upon returning home (see below). Such guidance shifts regularly as situations evolve. Asylum seekers who transit from the POE or border to their home destinations quickly should be advised to follow these instructions upon reaching their destination. Asylum seekers who stay at border shelters for three days or more should receive any recommended follow-up testing at such locations (currently, three to five days after arriving from Mexico), and then once they travel on to their destinations, follow any other relevant travel guidance.

Any people identified, via screening and testing, as having COVID-19 or its symptoms should be referred to isolate, and those exposed to a person with COVID-19, to quarantine, in a motel or similar location with individual rooms as noted above. The capacity of shelters, local authorities and/or other local humanitarian entities to facilitate such isolation and quarantine capacity should be supported through sufficient resources and increased via mobile units if necessary. Staff at shelters or other reception locations should advise asylum seekers of any travel requirements for continued transit on to their destination locations. Some states may, for example, require testing before travel to those destinations.

Advise asylum seekers of after-travel measures for use upon reaching their destinations

Asylum seekers should be advised to adhere to any applicable after-travel precautions, which may evolve given shifts in the COVID-19 transmission context and other developments.²⁶ Recent [CDC guidance](#) recommends testing three to five days after arrival at destination and a stay-at-home (or hotel stay) period of 7 days, or 10 days without testing, for international air travelers and “others with higher risk of exposure.” CDC currently describes travelers with “higher risk of exposure” to include people arriving from countries with Level 2, Level 3, and Level 4 Travel Health Notices, which, at the time of writing, includes [Mexico](#). The guidance however, which focuses on air travel, does not address specifically whether it applies to people crossing in or arriving at the U.S. southwest border. People are also advised to follow state and local recommendations related to travel, and to avoid being around people who are at increased risk of severe illness for 14 days. Information about any required or advisable after-travel measures should be provided verbally as well as in writing in Spanish (and other languages, as appropriate) to asylum seekers at ports of entry or in Border Patrol custody. This information should be provided again by shelters, case management and/or other people assisting them after crossing into the United States. Infographics may also be helpful to assist with any literacy gaps. Information should also be provided about

²⁵ CDC guidance for [humanitarian disaster shelters](#) currently provides that “[i]f testing for COVID-19 is available, shelter staff, volunteers, and residents should be tested in accordance with state and local health department guidelines.” In connection with [congregate homeless shelters](#) (which are different from short-term refugee receiving shelters in some ways), current CDC guidance states that “[i]f there is [moderate or substantial](#) transmission in the community, [initial and regular facility-wide testing](#) may be considered as approaches to limit the virus’s spread in homeless shelters” and “in areas where community transmission is substantial, health departments may consider coordinating with partners to offer facility-wide screening testing for all clients, volunteers, and staff in all sites at least once.” The guidance also states that “[i]t is unknown if entry testing for homeless service sites and encampments provides any additional reduction in person-to-person transmission of the virus beyond what would be expected with implementation of other infection preventive measures (e.g., social distancing, cloth face covering, hand washing, enhanced cleaning and disinfection).” The CDC also provides guidance for prioritizing testing locations based on various factors if resources are limited.

²⁶ For example, prior to November 23, 2020 (when Mexico had a [Level 3 Travel Health Notice](#)), people arriving from Mexico were advised to “take extra precautions . . . to protect others for 14 days after you arrive,” specifically to “stay home as much as possible,” avoid people at higher risk for severe illness from COVID-19, and consider getting tested for COVID-19 (though people crossing the southern border do not appear to have been informed of this guidance, and such guidance would likely be unworkable for those who cross the border regularly). As noted above, the CDC issued new [guidance](#) on December 12, 2020 for international air travelers or others with higher risk of exposure.

locations that provide free testing for non-citizens in destination locations, as well as any relevant recommendations relating to travel between U.S. states.

Guarantee non-discriminatory vaccine access

Any COVID-19 vaccine, as well as influenza vaccine,²⁷ recommended for the U.S. population should be made available to asylum seekers, refugees and migrants on a non-discriminatory basis and in line with the November 16, 2020 [WHO Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines](#). This guidance includes public health recommendations for a “humanitarian buffer” to ensure that sufficient supplies of vaccine are available for vulnerable populations, including refugees and asylum seekers, in humanitarian and emergency situations. As the International Organization for Migration’s Director General Antonio Vitorino has stated, access to vaccines for refugees and asylum seekers is vital for this population’s safety and for the wellbeing of host communities. Access to and distribution of vaccines for refugees and migrants must be [equitable and nondiscriminatory](#). Vaccines should be provided without charge. They should also be administered with voluntary informed consent and by medical professionals independent of CBP or ICE. The United States should support efforts, if and as needed, to help make vaccines available to asylum seekers in Mexico and the communities that host them. The lack of vaccines or sufficient available vaccines is *not* a public health justification for expelling or denying access to asylum seekers and children, and vaccines are [generally not recommended](#) at border crossings.

Scale measures - up and down - as needed

Many of the measures outlined above – including health screenings, case management, testing, quarantine and isolation capacity, and reception locations - can be adapted or scaled up, if and as arrival numbers increase, decrease or shift along the border. For instance, the identification and use of motels or other facilities with individual rooms – including temporary or mobile facilities – can be scaled up and scaled down with planning and funding, as can case management programs with appropriate support, as former ICE officials, service providers, and other experts have [confirmed](#). In addition, flexible tools such as [mobile](#) medical or [testing](#) capacities and portable handwashing stations, could be deployed to enhance capacity at various locations along the border, as needs shift. HHS, DHS and civil society and refugee assistance organizations should work together to identify reception locations²⁸ capable of accommodating larger numbers of people, employing the public health safeguards outlined above, should arrivals increase or shift locations. Most critically, contingency planning and funding, including for local health authorities and entities, will be crucial.

As noted above, the COVID-19 pandemic is a dynamic situation and the public health guidance will need to be reviewed and adjusted – guided by the best available scientific evidence – as the transmission context, arrival levels, quarantine guidance, testing technology and capacity, availability of vaccines and therapeutics, and evidence and understanding of the disease change. Above all, as UNHCR confirmed in its March 2020 [legal guidance](#), state entry measures should not prevent people from seeking asylum from persecution and may not deny entry to people at risk of refoulement. These recommendations demonstrate that it is possible for the U.S. to honor its legal obligations to asylum seekers while also upholding sound, science-based public health principles and practices to manage the pandemic.

²⁷ An [April 2020 paper](#) reported that at least three children who crossed the U.S. southern border and were in CBP custody “died with laboratory-confirmed influenza infection as a contributing factor” in the previous year.

²⁸ The AAP has [recommended](#) ORR increase its permanent bed capacity in smaller settings so that children are not placed in large, congregate or unlicensed, “influx” facilities. KIND has [cautioned](#) that, if considered, “influx” facilities only be used in extraordinary circumstances and provided specific recommendations on placement limitations, expert input, design and administration.