Unaccompanied Children, UC Care Providers, and Planning for the End of the COVID-19 Pandemic

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This document is adapted from a USCRI report on safe UC care during the pandemic that will be released in January 2021.

Since the outset of the pandemic, care providers have worked diligently to maintain the health and safety of the unaccompanied children (UCs) in their care. COVID-19 hit congregate-care facilities especially hard, which meant that staff had to adjust to changing practices around exposures and maintaining safety, emerging best-practices based on new information, new protocols, and new routines. UC care providers were largely successful in mitigating the worst of the pandemic, as confirmed by a recent report from the Office of Inspector General for the Department of Health and Human Services (HHS).

Although successful in mitigating the worst of the pandemic, the Office of Refugee Resettlement (ORR) system suffered from coordination challenges in the areas where care providers did not have much influence, as a prior brief discussed. Moving forward, HHS's own epidemiological experts—in the Division of Health for Unaccompanied Children (DHUC) and Commissioned Corps of the U.S. Public Health Service—must lead public-health efforts in a more robust, hands-on way. HHS must develop and implement policies that ensure availability, accessibility, and acceptability of COVID-19 vaccines for UCs and front-line staff at care providers.

At publication, two vaccines for COVID-19 have been approved for use in the United States, with a third close to approval in the UK and two other promising candidates in Europe. This brief gives recommendations for steps that UC care providers can take now to improve reception of the vaccines and to anticipate logistical speedbumps. The brief also gives recommendations for the much larger and more important steps ORR and HHS should take in planning, communication, and outreach as vaccination approaches. USCRI emphasizes that this brief is not comprehensive; instead, it presents a starting place and series of necessary but not sufficient steps.

Recommendations for UC Care Providers

To reiterate the introduction, the onus lies on ORR and HHS to lead planning for vaccination and the end of the pandemic. The federal government has access to resources, the ability to coordinate across many states and providers, and a messaging reach not available to individual UC care providers. The steps that UC care providers can take are comparatively modest. Still, UC care providers can act now to improve vaccine uptake, trust and morale, and logistical preparations for staff.

- **Ensure that UC provider staff are aware of how operations will change, and how operations will not change, post-vaccine.** Vaccinations will not mean an immediate return to normal (pre-coronavirus) operations within facilities. UC care providers should ensure that their staff realize that current measures are likely to remain in some form for an extended period. In the next few months, care-provider staff may be prioritized for vaccines under some states' immunization plans, but this will vary with each state. Similarly, 16-year-old and 17-year-old UCs may receive a vaccine but ORR has yet to provide guidance. Approval of a vaccine for use in children under the age of 16 remains distant. In the immediate term, the arrival of vaccines will not

eliminate the need for masking, physical distancing, testing, and other measures used to minimize COVID-19 risks.

- **Plan for logistical hurdles to staff vaccination now.** UC care providers should plan now for staff vaccination, with priority on staff who come into contact with UCs. In their plans, UC care providers should anticipate that not all prioritized staff will be on-site at once, due to shift work; that altered staff rotations may be necessary to ensure that minimum staffing needs are met at all times; and that some employees will need to take sick days when they experience expected side effects of vaccines, which include fatigue and fever. Care providers should ensure that plans are robust in the event that UC facilities are operating at close to capacity when vaccination occurs. For providers who operate facilities in multiple states, plans may differ because each state develops its own allocation and delivery plan for vaccine distribution.

- **Work to alleviate staff concerns before vaccines are rolled out in facilities.** UC care providers should anticipate that some staff will be uncomfortable with vaccines and that a few may resist vaccination. A recent survey showed that a significant minority of nurses was reluctant to being vaccinated, similar to informal data from certified nursing assistants in long-term care facilities and from firefighters. UC providers should recognize that building trust in the vaccine is a medium-term project, and that it requires trust from staff in care-provider leadership, who might appear distant to the concerns of staff who have daily contact with UCs. Further, UC care providers should be sensitive to reluctance to vaccination and lack of trust in medical experts among staff from historically marginalized populations, and should treat concerns as legitimate following a long history of medical racism. While each facility will be different and have different needs, leadership at UC care providers should strive to put trusted information in front of staff, keep staff apprised as information changes, and treat transparency as essential to building and maintaining trust.

Recommendations for ORR Planning

COVID-19 vaccines will neither distribute themselves nor administer themselves. The mass process of vaccination must be deliberate and managed process: if the federal government is laissez-faire, individuals with more social capital and less vulnerability will get the vaccine earlier, vulnerable people without health-care access who work in public-facing jobs will be vaccinated later, and more individuals will be infected and die than necessary. Among the risk groups to be prioritized are populations who have restricted access to health-care services—including both UCs after their release from ORR and their sponsors—individuals who work in congregate care facilities, and individuals who work among high-risk populations. Care provider staff fall into the latter two populations.

Epidemiologists at ORR and HHS must develop and distribute detailed procedures for vaccinations for care-provider staff and UCs in care-providers facilities as appropriate, as well as clear protocol for which individuals should be prioritized while there are more people who need immunization than available doses. Further, epidemiologists at HHS and ORR should develop procedures to assist sponsors and residents of sponsors' homes in accessing the vaccine because they are very likely to be members of high-risk populations.

- **An ORR Plan that Ensures Vaccines for UCs and Care Providers.** Congregate-care facilities are widely recognized as locations of increased risk during a communicable disease public-health emergency. The National Academies of Sciences, Engineering, and Medicine have recommended that care workers be among the "jumpstart" phase of the first 5% of Americans to receive the vaccine, with the CDC's advisory board issuing similar recommendations. Likewise, the recent recommendation that 16-year-olds and 17-year-olds may receive the Pfizer vaccine must spur ORR's epidemiologists to develop a clear plan for immunization of older UCs. The initial outbreak of COVID-19 showed that states—which license and regulate ORR provider facilities—are limited in their abilities to command supplies of necessary materials such as PPE. But the federal government has a unique power to organize vaccine distribution and guarantee supply. ORR should immediately prepare a plan for getting the

vaccine to care-provider facilities. The plan should include contingencies for vaccine shortages, vaccine substitution, prioritization among facilities, clear special-handling procedures and/or planning to take staff and UCs to outside facilities, and should ensure that facilities have or can acquire any necessary infrastructure and materials as appropriate. For vaccines that require two doses, no child who has only received the first dose should be prevented from reunifying with family before the second dose is given. Instead, ORR might utilize and expand its case management capacity and expand Post-Release Services to assist children and their sponsors in accessing the second dose of the vaccine.

- An ORR Plan to Enable Vaccination Access for Sponsors, and Those Living in the Sponsor's Household. ORR should anticipate that a vaccine will become easily available long before mass immunization is accomplished. UCs' sponsors are disproportionately individuals at greater risk of COVID-19 infection and at greater risk of suffering adverse health consequences when they do. The ORR sponsor system presents an important opportunity and venue for accessing members of hard-to-reach populations for immunization. Having sponsors vaccinated would also keep UCs safe in their homes. ORR should ensure that sponsors and anyone who lives in the sponsor's or sponsors' household understands the importance and safety of the vaccine and information about how to access vaccinations.

Recommendations for ORR Communications and Outreach

HHS staff must provide the best available information on any and all vaccinations to those being vaccinated. Trust is a vital part of any immunization campaign, and historically immunization campaigns have failed when significant portions of the at-risk population mistrust the motives of the government, the individuals administering vaccines, or both. In a recent article published in *Nature*, the authors write that:

> "Introducing new vaccines into populations requires adequate time to train and prepare front-line health workers and vaccinators to be ready to manage public questions, and continuing dialogue between scientists and the public will be important to build confidence from the start, as well as to anticipate and manage adverse events."

In the above, a population includes those groups we might otherwise refer to as subpopulations. In other words, the training and preparations must attend to specific cultural histories and the experiences of marginalized groups. Trust-building and maintenance requires that ORR communicate facts about a vaccine—what a vaccine is, how this vaccine works, and why vaccination campaigns are important, among others—in addition to a mechanism for two-way communication when individuals require more attention to build trust.

- Advance Guidance on Vaccinations in ORR Facilities. ORR should prepare guidance for vaccinating care-provider staff and UCs, as necessary. At a general level, the procedures must explain who gets vaccines and the basis for making such a decision while vaccines are still scarce. The procedures must also be flexible enough that care providers are able to respond to changing situations in consultation with ORR. The guidance must be transparent about both the procedures and ORR's framework in which the procedures are situated. As part of the guidance, ORR must ensure that communication is two-way between ORR staff and care-provider staff. Proper management of a public-health crisis requires that front-line workers can contact public-health experts easily and non-confrontationally when guidance given is insufficient to situations on the ground.

- Consistent Updates to DHUC Guidance on the Vaccine. UC care providers are not epidemiologists but need to know that they are acting on up-to-date information. DHUC should provide regular guidance with best available information about vaccination and the vaccine or vaccines used in UC facilities. This guidance should be re-released on a regular and consistent basis, even when there are no changes, for the duration of the public-health emergency. The guidance should include information on how long a vaccination takes to become effective, how long vaccination lasts (if known), whether any populations are known for

whom the vaccination is less effective, common failure modes of delivery, situations that DHUC or other public-health experts are watching, and other practical information of use to care providers.

- **An Outreach and Communications Plan to Build Vaccine Trust.** Vaccination campaigns fail when vaccine confidence is low or when social trust is absent. ORR should prepare an outreach plan so that care-provider staff and UCs will willingly consent to vaccines and will show up at appointments to be vaccinated. For UCs and their households, this plan should include the production of culturally appropriate materials that explain what a vaccine is, how vaccines work, how the particular vaccine works, why vaccinations are important for individuals, and why vaccinations are important for populations, among others. The materials should be produced in languages that UCs and members of their household understand. Additionally, the outreach must plan for two-way communication between care-provider staff and those who might get the vaccine. HHS public-health experts should prepare outreach for the health workers who will be administering the vaccines—how to talk to people about vaccines, how to soothe anxieties around vaccination or injections (if an injection is required), and other key issues that can be anticipated in advance.