U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS

FEMALE HEALTH SERVICES DIRECTIVE

IHSC Directive: 04-01
ERO Directive Number: 11772.2
Federal Enterprise Architecture Number: 306-112-002b
Effective Date: November 2, 2021
Technical Update: March 9, 2023

By Order of the Assistant Director
(b)(6),(b)(7)(C) DHSc, FACHE

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1. **PURPOSE:** This directive establishes policies and procedures for the delivery and administration of female health services.

2. **APPLICABILITY:** This directive applies to all U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) personnel, including but not limited to, U.S. Public Health Service (PHS) officers, civil service employees, and contract personnel. It applies to IHSC personnel supporting health care operations in ICE-owned and contracted detention facilities and to IHSC headquarters (HQ) staff.This directive applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of their employees supporting IHSC.

3. **AUTHORITIES AND REFERENCES**:

   3-1. Section 232 of the Immigration and Nationality Act, as amended, Title 8, U.S.Code, Section 1222 (8 U.S.C. § 1222), Detention of Aliens for Physical and Mental Examination.

   3-2. Section 322 of the Public Health Service Act, as amended, Title 42 U.S. Code, Section 249(a) (42 U.S.C. § 249(a), Medical Care and Treatment of Quarantined and Detained Persons.

   3-3. Title 42, U.S. Code, Section 252 (42 U.S.C. § 252), Medical Examination of Aliens.

   3-4. Title 8, Code of Federal Regulations, Part 232 (8 CFR § 232), Detention of Aliens for Physical and Mental Examination.

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3-5. Immigration and Customs Enforcement. (July 1, 2021). ICE Directive 11032.4, Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals.

4. POLICY: Female patients receive routine, age-appropriate, gynecological, and obstetrical health care assessments, treatment, and preventive female health services as medically appropriate.

5. RESPONSIBILITIES:

5-1. Health Services Administrator (HSA)

5-1.1 Ensures health services staff are trained initially and annually in appropriate screening and health care delivery for female patients.

5-1.2 Notifies the facility Enforcement and Removal Operations (ERO) field operations staff when health service staff identify a patient as pregnant, breastfeeding, postpartum or the patient pursues pregnancy termination.

5-1.3 Ensures pregnant patients have appropriate access to continued obstetric care, including timely appointments and transportation to and from provider appointments.

5-1.4 Maintains a supply of pregnancy test kits and emergency delivery kits for emergency birth in facilities housing females.

5-2. Clinical Director (CD)/Regional Clinical Director/Clinical Medical Authority (CMA) or designated physician.

5-2.1 Reviews all female health assessments and determines treatment frequency, priority, and content of appropriate female health care.

5-2.2 Establishes and reviews Clinical Practice Guidelines (CPG) annually.These guidelines provide clinicians with general information for the care and management of female patients.

5-2.3 Determines medical necessity and/or timing of all screenings, periodic health assessments, and other preventive services for female patients.

5-2.4 Ensures pregnant patients receive necessary and appropriate medical care while in custody.

5-2.5 Ensures a pregnant patient with a substance use disorder, whether suspected or diagnosed, receives appropriate screening at intake and other care intervals. The CD, CMA, or designated physician provides evaluation, treatment, monitoring, referral, and emergency care, including medication assisted treatment (MAT), if indicated.

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5-3. Physicians or Advanced Practice Providers (APP).

5-3.1 Perform all initial health assessments and periodic health assessments for female patients according to the CPGs and provide necessary medical support throughout pregnancy.

5-3.2 Refer pregnant patients who desire to maintain the pregnancy to a provider qualified for prenatal care and follow-up, and coordinate care with the obstetric provider throughout the pregnancy.

5-3.3 Ensure patients receive community resourced information about contraceptive methods, continuity of pregnancy care, and contraception upon release.

5-3.4 Provide patients with impartial advice and consultation about family planning and contraception upon request; where medically appropriate, prescribe and dispense medical contraception.

5-4. Physicians, APPs, Clinical Pharmacists.

5-4.1 Evaluate patients referred for consideration of emergency contraception (EC), determine whether EC is appropriate, and complete the EC consent form before ordering EC for the patient.

5-4.2 Prescribe EC and appropriate follow-up for those who desire to prevent pregnancy.

5-4.3 Refer to pregnancy termination services and appropriate follow-up for those who desire to terminate the pregnancy.

5-4.4 Ensure the patient completes the EC consent form before providing EC to the patient.

5-5. Nurses.

5-5.1 Perform pregnancy tests for female patients at intake and refer all pregnant patients to a physician or APP.

5-5.2 Refer female patients to a physician or APP for contraceptive initiation and emergency contraception.

5-5.3 Provide community-based resource information about contraceptive measures upon patient request.

5-5.4 Administer EC, per clinical practice guidelines, to patients who desire to terminate a pregnancy.

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5-6. Pharmacists.

5-6.1 Procure and stock prenatal vitamins, EC, and other necessary female health care medications at the IHSC-staffed medical clinic and after-hours cabinet, per the IHSC formulary.

5-6.2 Inform qualified health care professionals (QHCP) of the process to procure EC from off-site pharmacies, if needed.

6. PROCEDURES: Refer to the IHSC Clinical Practice Guidelines (CPGs) for pregnancy, pregnancy termination, and EC.

6-1. Health Assessment. The female initial health history and examination shall include the following:

6-1.1 Pregnancy testing for female patients ages 10-56 and documented results.

6-1.2 Breastfeeding status.

6-1.3 Contraception use.

6-1.4 Reproductive history that includes number of pregnancies, number of live births, number of spontaneous or elective pregnancy terminations,and pregnancy complications.

6-1.5 Menstrual cycle.

6-1.6 History of gynecological problems.

6-1.7 Gynecological surgical or procedural history.

6-1.8 Family history of breast, gynecological, and female organ, or genital problems.

6-2. Pregnancy Status Communication. Upon receipt of a positive pregnancy result:

6-2.1 The QHCP must:

6-2.1.a Generate a Special Needs Form 819 with recommendations for appropriate accommodation,

6-2.1.b Complete the Medical/Psychiatric Alert Form834;

6-2.1.c Place a pregnant global alert on the patient's electronic health record (eCW).

6-2.2 The HSA, or designee, must:

6-2.2.a Track all pregnant, postpartum, and breast-feeding patients through the Enterprise Business Optimizer

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(eBO) Reports 1157 "Pregnant Patients Current" and 1158 "Pregnant Patients Historical."

6-2.2.b Send a copy of the Special Needs Form 819 and the Medical/Psychiatric Alert Form 834 to the facility administrator;

6-2.2.c Add newly identified pregnant breastfeeding and postpartum patients to the IHSC Pregnancy Status Database;

6-2.2.d Track the term of pregnancy, with status updates regarding apatient's pregnancy, in the IHSC Pregnancy Status Database; and

6-2.2.e Coordinate with the facility administrator to ensure each pregnant patient is housed appropriately.

6-3. Pregnancy. The QHCP documents the clinical finding; documents the desire of the pregnant patient regarding her pregnancy – whether she elects to keep the child, use adoptive services, or terminate the pregnancy – in the electronic health record (eCW), and provides and documents counseling and assistance in accordance with the pregnant patient's decision.

6-3.1 Within two business days of a physical examination, the physician or APP refers a pregnant patient to a provider qualified to provide prenatal care, including medical examinations, prenatal laboratory testing, and diagnostic tests, comprehensive counseling, administration of vaccines, postpartum follow-up, and lactation services.

6-3.2 The physician or APP generates the orders and treatment plans, documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions; coordinates specialty care for patients with a high-risk obstetric specialist, when indicated; and provides and documents postpartum care.

6-3.3 The physician or APP refers all chemically dependent pregnant patients to an obstetrician or another appropriate provider capable of addressing these needs immediately.

6-3.4 Health service staff must transfer pregnant patients to the proper facility and community resources when a physician or APP refers patients for health needs beyond what the facility or local community can provide.

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6-3.5 Termination of Pregnancy. The physician or APP refers pregnant patients who desire to terminate the pregnancy to a qualified provider to ensure access to pregnancy termination services within two business days of a health encounter. The physician or APP transfers pregnant patients to the proper facility and community services for continuity of care.

6-3.6 ICE assumes responsibility for the cost of pregnancy termination if continued detention is necessary and appropriate, if carrying a fetus to term would endanger the life of the mother, or when the pregnancy resulted from rape or incest.

6-3.7 Clinical staff inform ICE stakeholders about the patient's transportation needs for medical appointments, and religious and social services counseling related to the patient's decision to terminate a pregnancy.

6-4. **Contraception**: QHCPs within their scope of practice provide patients with impartial advice and consultation about family planning and contraception. QHCPs prescribe and dispense medical contraception after a negative pregnancy test, when medically appropriate and requested by the patient.

6-5. **Emergency Contraception (EC):** Patients have access to emergency contraception at intake.

6-5.1 Clinicians refer a patient who reports unprotected sexual contact within the past five days to a physician or APP.

6-5.2 A behavioral health provider or an emergency department may provide further evaluation to assist in determining the appropriateness of EC as outlined in the IHSC Clinical Practice Guidelines.

6-5.3 Medical staff must not provide EC if the patient:

6-5.3.a Has a positive urine pregnancy test;

6-5.3.b Refuses to sign the IHSC Medical Consent Form (IHSC Form 793) or electronic equivalent;

6-5.3.c Refuses to sign the IHSC Emergency Oral Contraception Consent Form 925;

6-5.3.d Is a juvenile and has contra indications to receiving over the counter EC or cannot independently consent to receive contraceptive care;

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6-5.3.e Appears mentally impaired or under the influence of an intoxicating substance; or

6-5.3.f Provides inconsistent or confusing responses, appears under duress or is unable to communicate effectively.

6-6. Special Management Unit (SMU) Housing. The facility administrator, in consultation with the CMA, reviews and decides SMU placement initially and every 48 hours. The facility administrator may not place female patients who are pregnant, post-partum, or breastfeeding, or have recently miscarried, terminated pregnancy, or experienced any other complications related to childbirth, into a SMU.

6-7. Restraints during pregnancy. The general prohibition on restraints applies to all pregnant women in ICE custody, whether during transport, in a detention facility, or at an outside medical facility.

6-7.1 Health service staff must not restrain a patient during pregnancy or post-delivery recuperation except for extraordinary circumstances that render restraints absolutely necessary, as directed by the on-site or off-site medical authority.

6-7.2 Health service staff must not use restraints, unless one or more of the following applies:

6-7.2.a Physicians and APPs direct the use of restraints for medical reasons;

6-7.2.b Reasonable grounds exist to believe the patient presents an immediate and serious threat of hurting herself, staff, or others; or

6-7.2.c Reasonable grounds exist to believe the patient presents in immediate and credible risk of escape that health service staff cannot minimize through any other method.

6-7.3 Restraints are never permitted on women in active labor or delivery.

6-7.4 Physicians and APPs determine the safest restraint method and duration using the least restrictive restraints necessary, limited to handcuffs in the front for pregnant or post-partum patients.

6-7.4.a In extraordinary circumstances when restraints are necessary, health service staff shall not restrain a pregnant patient in a face-down position with four-point restraints, on her back, or in a restraint belt that constricts the area of the pregnancy.

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6-7.4.b Health service staff must make all attempts to place the patient on her left side if she is immobilized.

6-7.5 Health service staff must document approval of and guidance for the use of restraints.

6-8. Travel During Pregnancy.

6-8.1 Ground travel for removal or transfers for all pregnant patients requires medical case review and approval by the CD/RCD and/or an OB/GYN.

6-8.2 Air travel for removal or transfers:

6-8.2.a Air travel for all pregnant patients up to and including the 26th week (26 weeks and 6 days) requires medical case review and approval by the CD/RCD and/or an OB/GYN for domestic and international flights.

6-8.2.b Air travel for all pregnant patients in the 27th week up to and including the 35th week (35 weeks and 6 days) requires medical case review and approval by an OB/GYN for domestic and international flights.

6-8.2.c IHSC does not recommend air travel for any pregnant patient at 36 weeks (36 weeks through term).

7. HISTORICAL NOTES: This directive replaces the April 12, 2022 Technical Update of the 04-01, *Female Health Services*.

7-1. Summary of Changes:

7-1.1 Added clarification for transferring patients to appropriate community services when indicated.

7-1.2 Replaced “coordinated” to “inform” ICE stakeholders for pregnant patients’ transportation needs.

7-1.3 Changed "detainee” to “patient” where appropriate.

7-1.4 Added definition for ICE Stakeholders.

7-1.5 Removed inapplicable legal reference.

8. DEFINITIONS: See definitions for this policy in the IHSC Glossary located in the IHSC Policy Library. The following definitions apply for purposes of this directive:

8-1. Breastfeeding – Also known as nursing, is the process of feeding human breast milk to an infant, either directly from the breast or by expressing (pumping out) the milk from the breast and administering by bottle.

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8-2. Emergency Contraception – Also known as postcoital contraception and the morning-after pill, refers to oral contraceptives and the copper intrauterine device (IUD) that a patient can use after unprotected sexual intercourse to prevent a possible pregnancy.

8-3. ICE Stakeholders - Includes U.S. Immigration and Customs Enforcement (ICE)/Enforcement and Removal Operations (ERO)/Field Office Director (FOD) and/or Facility Administrator and custody officials Field Office Director, Assistant Field Officer Director, Officer in Charge, Custody.

8-4. Medication-assisted treatment (MAT) – One of the modalities for the treatment of individuals with opioid use disorder to sustain recovery and prevent overdose.

8-5. Prenatal care – Health care for the pregnant female, including prenatal laboratory and diagnostic tests and orders and treatment plans that document levels of activity, nutrition, medication, housing, and safety precautions.

8-6. Substance use disorder - Occurs when the recurrent use of alcohol or drugs cause significant impairment.

9. APPLICABLE STANDARDS:

9-1. Performance Based National Detention Standards (PBNDS): PBNDS 2011 (revised Dec. 2016).

9-1.1 Part 4: Care; 4.3 Medical Care.

9-1.2 Part 4: Care; 4.4 Medical Care (Women).

9-2. Family Residential Standards, 2020:

9-2.1 Part 4: Care; 4.3 Health Care.

9-2.2 Part 4: Care; 4.4 Health Care (Females).

9-3. American Correctional Association (ACA): 4th Edition.

9-3.1 4 ALDF-4C-13 Pregnancy Management.

9-4. National Commission on Correctional Health Care (NCCHC): Standardsfor Health Services in Jails, 2018:

9-4.1 J-B-06 Contraception.

9-4.2 J-F-05 Counseling and Care of the Pregnant Inmate.

10. PRIVACY AND RECORDKEEPING. ICE uses detainee health records and information maintained in accordance with the DHS/ICE-013 Alien Health Records System of Records to provide for the care and safety of detainees. IHSC limits

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access to detainee health records and information to those individuals who need to know the information for the performance of their official duties, and who have appropriate clearances or permissions. IHSC secures paper records in a locked cabinet or room when not under the direct control of an officer or employee with a need for the paper record to perform their duties.

10-1. IHSC staff complete annual training on the protection of patient health information and Sensitive Personally identifiable information.

10-2. IHSC staff reference the Department of Homeland Security Handbook for Safeguarding Sensitive PII (Handbook) at DHS Handbook for Safeguarding Sensitive PII for additional information concerning safeguarding sensitive PII.

10-3. All relevant documents produced or provided in accordance with this Directive must be maintained in accordance with an applicable National Archives and Records Administration (NARA) General Records Schedule (GRS) or a NARA-approved agency-specific records control schedule. If the records are not subject to a records schedule, they must be maintained indefinitely by the agency. In the event the records are subject to a litigation hold, they may not be disposed of under a records schedule until further notification. Prior to the disposition of any records referenced in this directive, ICE Records Officer approval must be obtained.

11. **NO PRIVATE RIGHT STATEMENT:** This directive is an internal policy statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.

12. **POINT OF CONTACT:** Chief, Medical Services Unit.

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