Oral Testimony from Carolyn Sufrin, MD, PhD, to the Senate Judiciary Committee, Subcommittee on Human Rights

Good afternoon Senator Ossoff and distinguished guests. Thank you for the invitation to participate in this hearing.

My name is Carolyn Sufrin. I am a board-certified obstetrician-gynecologist and a PhD researcher at Johns Hopkins School of Medicine and the Johns Hopkins Bloomberg School of Public Health. I am also a fellow with the American College of Obstetricians and Gynecologists. I have spent the last 17 years working to understand and improve care and conditions for pregnant and postpartum incarcerated women. I have done so by providing clinical care inside a jail, conducting extensive research, publishing over 80 peer-reviewed articles, and writing national guidelines on best practices for care for this population. The views I'm expressing are my own, and do not necessarily reflect those of Johns Hopkins University or Johns Hopkins Medicine.

I got into this work when I was called to a delivery when I was a first-year resident doctor in training in Pennsylvania. Everything about the room was as usual-- IV poles, fetal heart monitoring, a mother about to push a baby into the world. But one thing was different: the mom-to-be was shackled to the bed. Nothing in my medical training had prepared me for this.

Since that night 20 years ago, I have conducted dozens of research studies that have revealed systematic deficiencies in care for incarcerated pregnant and postpartum women. As I began to provide ob/gyn care in a county jail, I tried to find out how many pregnant women are incarcerated and how many give birth. What I found was shocking: there were no such statistics. This was 2015. Less than 10 years ago. So, my team at Johns Hopkins conducted the Pregnancy in Prison Statistics, PIPS, study. From 2016-2017, 22 state prison systems, the Bureau of Prisons, and the 5 largest jails reported monthly pregnancy outcomes to our study.[1] We found that there were 3,018 admissions of pregnant patients to these facilities in one year, and over 1,000 of these pregnancies ended in custody, with 897 births. When we extrapolate these PIPS data nationally,[2] we estimate that there are nearly 58,000 admissions of pregnant individuals to U.S. jails and prisons per year. And yet PIPS was a one-time study, and could not include all 50 states or all 3,000 plus jails. There remains, to this day, no full national count of pregnancy and births in prisons.

If we do not know how many pregnant women are behind bars, then people think they don't exist. And if people think they don't exist, then it makes it easy for prisons and jails to neglect their health care needs.

Indeed, this is what my and others' research has shown, and what you have heard from Ms. Laboy's mother and Ms. Umberger. There are no mandatory standards for pregnancy care that prisons and jails must follow. So research has shown that access to such care is variable, often substandard or even absent. For instance, in a survey my team conducted of all U.S. jails, only 31% did routine pregnancy testing within 2 weeks of arrival. If jails don't test for pregnancy, then they can proceed as though there are no pregnant women in custody. This means that many pregnant patients will have time-sensitive medical needs that go unaddressed.

My research has also documented alarming deficiencies in lifesaving care for the estimated 8,000 incarcerated pregnant women with opioid use disorder, OUD.[3] Although the long-established standard of care in pregnancy is treatment with methadone or buprenorphine, in our national survey of jails, only

32% of them provided pregnant patients with access to these medications.[4] Even at facilities that did provide treatment in pregnancy, three-quarters of them forced patients to go off medications after the baby was born. This puts mothers and babies at risk for severe harm, including deadly overdose.

When it comes to the issue of shackling pregnant women, it is well established that this increases risk of medical harms during labor and throughout pregnancy. 41 states and the District of Columbia now have laws prohibiting the practice. However, these are not always followed. In PIPS, 4 DOCs had policies or practices that violated state law and allowed shackling;[5] and my obstetrician colleagues in states with anti-shackling laws tell me of officers shackling pregnant patients all the time, over-applying the exceptions that these laws have.[6] The fact that, in 2024, pregnant women are shackled while giving birth, putting them and their babies at risk, is a profound assault on their dignity, safety, and human rights.

The time is long past due to change conditions for incarcerated pregnant and postpartum women. They deserve access to comprehensive, quality medical care. We must recognize the connections between the maternal mortality crisis and incarceration, and we can start by collecting national scale data that link maternal health outcomes with incarceration. Because without data, we cannot know the full scope of the problems—and their solutions. Our nation's conscience must see that what happens—or does not happen—to pregnant women behind bars is a human rights issue. The time to act is now.

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Sufrin C, Beal L, Clarke J, Jones R, Mosher WD. Pregnancy Outcomes in US Prisons, 2016-2017. Am J Public Health. 2019 May;109(5):799-805. doi: 10.2105/AJPH.2019.305006. Epub 2019 Mar 21. Erratum in: Am J Public Health. 2020 Feb;110(2):e1. doi: 10.2105/AJPH.2019.305006e. PMID: 30897003; PMCID: PMC6459671.

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5. Kramer C, Thomas K, Patil A, Hayes CM, Sufrin CB. Shackling and Pregnancy Care Policies in US Prisons and Jails. *Matern Child Health J*. 2023;27(1):186-196. doi:10.1007/s10995-022-03526-y

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