Published: November 2018

Foetal Alcohol Spectrum Disorder in the Cape Provinces of South Africa, 1978-2018

Gavin Williams - Emeritus Fellow at St Peter's College, University of Oxford.

In South Africa, the '*dop*' (tot) system refers to the institutionalised practice of giving wine to male farm workers at regular intervals during the working day throughout the working week. Farm workers could be given a bottle of cheap wine, which they shared with their families at the end of the day. Providing workers with wine in lieu of wages has been illegal, though practised, from 1809.

Foetal Alcohol Spectrum Disorder (FASD) refers to an array of symptoms. Its elements will not necessarily be associated with one another and vary among those affected. FAS/ 'Full' FASD is distinguished from 'partial' FASD (pFASD), which in turn was separated from Alcohol-Related Neurone Developmental Disorder (ARND). The prevalence of FASD (FAS + pFASD) and pFASD recorded on farms and in rural towns in the Western and Northern Cape is much higher than in towns and farming districts anywhere else in the world. FASD is generally agreed to be an outcome of women drinking when they are pregnant. It is most often the consequence of 'binge drinking'; consuming large quantities of alcohol over brief periods. Conceptions of FASD and interpretations of its consequences continue to be controversial.

Lemoine, a French paediatrician, identified the symptoms of the condition in 1967 (1). Jones and Smith named it in 1973 at the University of Seattle (2). In South Africa, clinicians first described cases in 1978 (3, 4), then in 1984 (3-5), and its effects in 1985 (6). These were not followed-up in South Africa for another decade.

Winegrowing and FASD

Two obvious problems stood in the way of the conventional assumptions of the relations of viticulture to the *dop* system and FASD. The first are matters of fact: Farm workers now drink more beer than wine; and alcohol abuse and the prevalence of FASD extended beyond the Cape wine and fruit farms. In 1995/6, Croxford and Viljoen found high levels of alcohol abuse 'which extends into pregnancy' in areas peripheral to the Winelands (7). The first three 'waves' of recorded prevalence of FASD of 4.6%, 7.4%, and 8.9% IN 1997, 1999, and 2002 among children in their first school year in a Winelands district (8, 9). Subsequent research outside the winegrowing areas found levels of 11.9% in 2006 in De Aar, a collapsing railway junction in a sheep-farming area in the Karroo, and 10 per cent in Aurora, a wheat farming in the coastal area of the Western Cape in 2011 (10-12).

The second is a problem of explanation: Men prefer to drink in *shebeens*; women mainly drink beer in groups at home at weekends. It is not *prima facie* evident that regular consumption of alcohol by men working on wine farms during the working week should be the reason for weekend binge drinking among women and of FASD.

Epidemiologists have classified, counted, compared, calculated and correlated the prevalence of FASD among children in their early years. They confirmed the clear association between the extent and concentration of the consumption of wine and beer during the trimesters of pregnancy and the statistical relations among age, gender, weight, nutrition and diet, genetic inheritance and medical conditions, and the features and disabilities of FASD children. Measurement becomes more difficult after that; explanation even more so. The incidence and prevalence of FASD varies in geographical and historical contexts, according to the intersecting relations among race, social stigmas, relations among women, and mutual relations and compromises between partners. The international literature takes little account of research in and on South Africa, which would inform contentious debates. The most evident lack in the professional literature is to investigate the lives and values of the women and of the men who do *not* drink in places where drinking is commonly a norm.

Reducing the prevalence of FASD

It may be easier to say that FASD 'is entirely preventable' than to create the circumstances in which it is prevented. Mothers of children with FASD may find themselves held socially responsible within their communities and by the reminder that FASD is, indeed, completely preventable. Engagements with individuals and communities have in some places proved able to reduce the prevalence of FASD. A 'holistic approach' to 'interventions' combines public information, campaigns directed at girls and women who are most likely to be placed in vulnerable

situations and intensive work among those most at risk from heavy drinking before and during the early months of pregnancy, and time-limited counselling. These depend on people with complementary professional skills, training, and flexibility to work with clients as they grow from childhood into adolescence and adulthood.

Researches and practices are primarily carried out by Universities and NGOs which depend predominantly on funding by institutions outside South Africa---and by the liquor industry. National and regional governments have set out Master Plans for collaboration among institutions. However, they have not recognised FASD as a national crisis in public health (13). They can and should provide funds to support research and interventions to reduce the prevalence of FASD and to facilitate assistance to people with FASD by those who are responsible to and for them, without taking them over.

Funding: The St Peter's College Research Fund and the Review of African Political Economy have contributed to the costs of this research.

Gavin Williams - Emeritus Fellow at St Peter's College, University of Oxford. Research interests: historical sociology. gavin.williams@spc.ox.ac.uk

References:

1. Lemoine P. The History of Alcoholic Fetopathies Journal of Fetal Alcohol Syndrome Intern. 2003;1(e2).
2. Jones KL, Smith DW. Recognition of the fetal alcohol syndrome in early infancy. The Lancet. 1973;302(7836):999-1001.
3. Beyers N, Moosa A. The fetal alcohol syndrome. South African Medical Journal 1978;54(14):575-8.
4. Hayden M, Nelson M. The fetal alcohol syndrome. South African Medical Journal. 1978;54(14):571-4.
5. Johnson C, Hill ID, Bowie M. Fetal alcohol syndrome with hydrocephalus. A case report. South African Medical Journal. 1984;65(18):738-9.
6. Palmer C. Fetal Alcohol Effects. South African Medical Journal. 1985;68:779-80.
7. Croxford J, Viljoen D. Alcohol consumption by pregnant women in the Western Cape. South African Medical Journal. 1999;89(9).
8. London L. The 'dop' system, alcohol abuse and social control amongst farm workers in South Africa: a public health challenge. Social Science and Medicine. 1999;48(10):1407-14.
9. London L. The Dop System, Alcohol Abuse and Social Control among Farmworkers in Stellenbosch. South African Medical Journal. 1999;88(9):102-15.
10. Olivier L, Urban M, Chersich M, Temmerman M, Viljoen D. Burden of fetal alcohol syndrome in a rural West Coast area of South Africa. South African Medical Journal. 2013;103(6):402-5.
11. Olivier L, Viljoen D, Curfs L. Fetal alcohol spectrum disorders: prevalence rates in South Africa: the new millennium. South African medical journal. 2016;106(Supplement 1):103-6.
12. Urban MF, Chersich MF, Fourie L-A, Chetty C, Olivier L, Viljoen D. Fetal alcohol syndrome among grade-one children in the Northern Cape Province: prevalence and risk factors. South African Medical Journal. 2008;98(11):877-82.
13. Olivier L. Fetal Alcohol Spectrum Disorders in South Africa: a twenty year journey. Doctoral thesis, Univerity of Maastricht,. 2017:33-34:83-4.