

## Response to correspondence regarding a call to action on the prevention of fetal alcohol spectrum disorder

**To the Editor:** We thank Profs H Odendaal and H C Kinney for their thoughtful letter regarding our publication in the *SAMJ* titled 'Where is the South African prevention of fetal alcohol spectrum disorder programme? A call to action.'<sup>[1]</sup> Additionally, we appreciate the continued conversation regarding neglected aspects of maternal and child health.

The letter refers to the additive effects of concurrent smoking and alcohol use, as well as the independent effects of smoking during pregnancy, demonstrated in the Safe Passage Study (SPS) by the Prenatal Alcohol in Sudden infant death syndrome and Stillbirth (PASS) Network. This large longitudinal prospectively enrolled study in Cape Town (59% of the cohort) and the USA highlights significant and devastating consequences of alcohol and smoking in pregnancy. The primary outcomes described in the letter include stillbirths and sudden infant death syndrome (SIDS).<sup>[2]</sup> However, other adverse birth outcomes such as prematurity, low birthweight, infant death and longer-term effects on growth and wellbeing were also measured.<sup>[3,4]</sup>

We appreciate the strength of the Safe Passage Study and the importance of the data derived from it in a South African setting where substance use in pregnancy is prevalent. We agree with the professors that the evidence that smoking alone and in combination with alcohol use in pregnancy can result in adverse outcomes measured at birth and early life. Without detracting attention from the importance of these early life events, we highlight fetal alcohol spectrum disorder (FASD) effects throughout the life of the affected person. Owing to the nature of FASD, symptoms may be subtle, and present later in life, or be severe with long-term morbidity and a lifetime of challenges. Longer-term follow-up of the children in the SPS study may yet reveal further insights into the effects of alcohol use in pregnancy.

Alcohol use in pregnancy and FASD are complex, multifaceted issues. Socioeconomic, mental health and behavioural challenges, including addiction, contribute to continued alcohol use. Additionally, alcohol use may occur in isolation, but may also be accompanied by use of multiple recreational substances, often across generations. As substance-use risk factors and treatment strategies frequently overlap, management should be addressed holistically, incorporating education, nutritional support, psychosocial services, especially focusing on maternal mental health, and addiction-related therapies as part of broader harm-reduction approaches.

Prevention strategies should ideally be implemented before pregnancy. Once substance use occurs in pregnancy, effective reduction and, ideally, early cessation require a multidisciplinary approach to prevent adverse maternal, pregnancy and infant outcomes. The aspects we highlighted for FASD (societal education and awareness, prevention of unplanned pregnancies, early pregnancy detection and antenatal education and counselling) are not only relevant to alcohol use, but can be extrapolated to all substance use in pregnancy.

The importance of the availability of safe contraception options, preconception care and early pregnancy recognition cannot be understated. As a country, we have not yet shifted from a narrow focus on preventing unintended pregnancies to a broader emphasis on promoting safer conception. A paradigm shift is needed, both among women and within the healthcare system.

Safer conception enables early identification and mitigation of risks before pregnancy. It supports holistic preparation for pregnancy, including addressing alcohol and smoking, screening for infections and managing existing maternal conditions. To achieve this, we must evolve beyond traditional family planning services, and move toward a model centred on women's overall health and wellbeing.

Early pregnancy recognition and easy access to testing are also important. There are several models that could be explored, including:

- (i) incorporating pregnancy testing as a routine vital sign for all women of reproductive age, enabling immediate initiation of antenatal care when pregnancy is confirmed
- (ii) utilising community health workers to conduct pregnancy testing during household visits
- (iii) integrating pregnancy self-testing into the broader package of women's health self-care interventions, ensuring that women can test easily, privately and at their convenience. This will need a monitored means of linking the women to care upon pregnancy confirmation.

The key questions remain: (i) how do we shift the narrative so that women are educated, empowered and supported to plan pregnancies, improve maternal health and reduce exposures to harmful substances prior to conception, identify pregnancies early and initiate antenatal care soon after recognition; and (ii) how do we develop and eventually integrate a comprehensive women-centred model of care into our resource-limited health system?

The answers lie in close collaboration, dialogue and interventions co-created with women, communities, healthcare workers, researchers, policy-makers, government departments and, dare we say, manufacturers of harmful substances.

In conclusion, we agree that the risk factors for alcohol, tobacco and recreational drug exposure during pregnancy overlap significantly, and their synergistic adverse effects impact pregnancy, birth outcomes and the long-term health of the child. A collaborative, comprehensive prevention programme – supported across sectors and integrated into standard care – is essential to improving maternal and child health.

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