DEPUTY MINISTER IN THE PRESIDENCY FOR WOMEN, YOUTH AND PERSONS WITH DISABILITIES

REPUBLIC OF SOUTH AFRICA

KEYNOTE ADDRESS

BY

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AT THE

AWARE.ORG THE FETAL ALCOHOL SPECTRUM DISORDER WEBINAR

"BEYOND AWARENESS: WHY FASD PERSISTS IN SOUTH AFRICA"

ON

4 JUNE 2026 | VIRTUAL | 10:00

Programme Director;
CEO of AWARE.org, Mr Mokebe Thulo;
Representatives of AWARE.org and the Frontline Research Group,
Representatives of government, civil society, Healthcare professionals, Researchers, Advocates and Community Workers;
Distinguished guests;

Allow me to begin by thanking AWARE.org for convening this important national conversation and for commissioning research that forces us to move beyond comfort, beyond slogans, and beyond the narrow assumption that awareness alone can change the conditions of people's lives.

The theme of this webinar, ***"Beyond Awareness: Why FASD Persists in South Africa"***, is both a diagnosis and a challenge. It tells us that our country does not only suffer from a shortage of information. It suffers from a deeper crisis in which knowledge is often trapped inside unequal lives, where a woman may know that alcohol is harmful during pregnancy, but still lives in a household, a community, a workplace, an economy and a culture that make healthy choices difficult to sustain.

That is why this conversation matters.

We are meeting in the month of June, a month in which South Africa remembers the courage of the youth of 1976. 50 years ago, young people rose against an apartheid system that had made inequality official, that had turned exclusion into law, and that had attempted to break the mind

of a generation through inferior education. They demanded more than classrooms. They demanded dignity. They demanded a future.

As we reflect on Fetal Alcohol Spectrum Disorder today, we must ask ourselves a difficult question: what does it mean to honour the youth of 1976 if, 50 years later, many children are still born into conditions that compromise their development before they even take their first breath?

FASD is not only a medical issue. It is a social justice issue. It is a women's rights issue. It is a child development issue. It is a disability rights issue. It is a youth futures issue. It is a care-work issue. It is a poverty issue. It is a historical issue. It is a question about the kind of society we are building and the kind of future we are prepared to protect.

One of the most sobering ways to begin this conversation is to look at what we spend on as a nation. It has been reported that South Africans spent approximately R7.7 billion on alcohol in just one week between 25 December 2024 and 1 January 2025. Let us sit with that number for a moment. In one festive week, alcohol spending reached a figure that is more than three times the annual allocation of the Department of Women, Youth and Persons with Disabilities for the 2026/27 financial year.

Our Department has been allocated around R2.2 billion for the entire financial year, and of that amount, about R1.8 billion is transferred to the National Youth Development Agency to support youth development, entrepreneurship, skills development and paid service opportunities. The operational resources available to the Department itself are far smaller than the magnitude of the mandate we carry.

This comparison is not raised to shame people who celebrate, or to deny that people seek moments of joy in a difficult economy. It is raised because budgets reveal values, and spending patterns reveal culture. When a society can spend billions of rands on alcohol in a single festive week, while departments tasked with women's empowerment, youth development and disability inclusion must stretch limited resources across an entire year, we must have the courage to ask whether our social priorities are aligned with our constitutional promise.

The question is not only, "How much alcohol do South Africans drink?" The deeper question is, "Why has alcohol become so central to how many of us cope, celebrate, socialise, mourn, escape, belong and survive?"
To answer that question, we must go back into history.

South Africa's relationship with alcohol did not emerge innocently. It was shaped by colonial conquest, racial capitalism, migrant labour, spatial dispossession and apartheid social engineering. In parts of our country, particularly in the wine-producing regions of the Western Cape, alcohol was not merely a beverage. It was once a wage.

The notorious dop system paid farmworkers partly in cheap wine, entrenching dependence, weakening bargaining power, and turning addiction into an instrument of labour control. It was not an accident. It was a system. It was a method through which bodies were exploited and communities were destabilised. It taught generations that the pain of poverty could be numbed, that the violence of work could be endured, and that alcohol could be used to manage the anger of the oppressed.

Although the formal system was abolished, its legacy did not disappear with the stroke of a pen. Apartheid did not only leave behind broken infrastructure and racial inequality. It left behind social habits, inherited trauma, economic exclusion, community wounds and patterns of substance use that continue to move through families and generations.

This is why we must be careful not to speak about FASD as though it is simply the result of individual failure. FASD is preventable, yes, but prevention is not achieved by blaming women. Prevention is achieved by changing the conditions that place women, children and families at risk.

The research being launched by AWARE.org and Frontline Research Group is therefore important because it confirms what many communities have long known: awareness alone is not enough. Many South Africans know that drinking during pregnancy is harmful, and yet alcohol consumption during pregnancy persists because behaviour is shaped by more than information.

Behaviour is shaped by poverty, trauma, mental health, partner dynamics, family pressure, social norms, unemployment, addiction, misinformation, and the availability and aggressive marketing of alcohol.

A woman does not make decisions in isolation. She makes decisions within a life. She makes decisions inside relationships. She makes decisions inside economic constraints. She makes decisions under stress. She makes decisions in communities where drinking may be normalised and abstaining may be mocked. She makes decisions in a society where alcohol is advertised as freedom, status, celebration, masculinity, femininity, escape and belonging.

And so, if we want to prevent FASD, we must stop pretending that the only solution is to tell pregnant women not to drink. Of course, that message is essential. There is no known safe amount of alcohol during pregnancy, and that must be communicated clearly and consistently. But if the message ends there, it becomes incomplete. It can even become unjust.

A rights-based approach says: let us give women the knowledge, but let us also give them support. Let us give families the information, but let us also give them services. Let us call for personal responsibility, but let us also demand social responsibility. Let us speak about prevention, but let us also speak about poverty, gender inequality, untreated addiction, trauma, unemployment, and the burden of care.

South Africa has one of the highest reported rates of FASD in the world. FASD can lead to lifelong challenges, including learning difficulties, developmental delays, attention and memory challenges, poor impulse control, language difficulties, mental health problems, disrupted schooling and vulnerability to conflict with the law.

But behind each of these words is a child. Behind each statistic is a family. Behind each diagnosis is a caregiver trying to navigate a complex world with too little support. Behind each affected child is often a mother or grandmother carrying the hidden labour of care.

This is why the issue of unpaid care work must be brought into the centre of the FASD conversation.

When a child is born with FASD, the cost is not only carried by the health system or the education system. It is carried in the home. It is carried by women who must attend clinic visits, manage behavioural challenges, support learning difficulties, negotiate with schools, explain the child's needs to relatives, protect the child from stigma, and provide daily care that is often invisible and unpaid.

In many cases, this care is provided by mothers and grandmothers who are already economically vulnerable. They may have to leave work, reduce working hours, abandon education opportunities, or forgo income because the care needs of the child are intense and continuous. In this way, FASD deepens gender inequality. It turns a preventable public health issue into a lifelong private burden carried by women.

This is why our Department's work on care must speak to FASD. When we say that unpaid care work must be recognised, reduced, redistributed and supported, we are also speaking about the women who care for children with developmental disabilities. We are speaking about households that carry the social cost of alcohol harm long after the bottle has been emptied and the profit has been banked.

We must also situate FASD within the mandate of the Department of Women, Youth and Persons with Disabilities.

For women, FASD prevention is about bodily autonomy, reproductive justice, freedom from violence, access to healthcare, mental health support, economic empowerment and the right to live in environments that enable healthy choices.

For youth, FASD is about the future. It is about whether children have the developmental foundation to learn, thrive, participate and contribute. It is about preventing a cycle where young people affected by FASD are punished for behaviours that society failed to understand and support.
For persons with disabilities, FASD is about inclusion. It demands early diagnosis, accessible services, inclusive education, trained teachers, social protection and an end to stigma. It requires us to see persons with FASD not as problems to be managed, but as human beings with rights, dignity, potential and the need for support.

Our Constitution is itself an intersectional document, born at the meeting point of race, gender, class and culture. It promises not only formal equality, but substantive equality that takes account of context, history, disadvantage and lived reality. Intersectional justice is simply the living application of that constitutional promise.

An intersectional approach to FASD asks us to recognise that a poor rural woman does not experience pregnancy in the same way as a middle-class urban woman. A young woman in a farmworker community does not encounter alcohol culture in the same way as someone living in a secure suburb. A woman living with violence does not make choices under the same conditions as a woman living with support. A child with FASD in a well-resourced school does not experience disability in the same way as a child in an overcrowded classroom with no specialist support.

This means our interventions must be layered, human and honest.

International best practice teaches us that effective responses to alcohol-related harm require more than awareness campaigns. The World Health

Organization and global public health evidence point to what are often called the “best buys”: increasing the price of alcohol through taxation, restricting the availability of alcohol, and limiting or banning alcohol marketing. These measures work because they do not only speak to individuals; they change the environment in which choices are made.

For FASD specifically, international practice points us toward multi-sectoral action. Health systems must screen, counsel and refer. Social development systems must support families affected by substance-use disorders. Education systems must identify and support learners with FASD. Justice systems must understand disability and diversion. Labour and economic development systems must address poverty and unemployment. Municipalities must regulate local alcohol availability. Communities must transform norms. Families and partners must share responsibility.

We must learn from countries that have developed national FASD strategies, diagnostic guidelines, surveillance systems, caregiver supports and school-based interventions. We must adapt these lessons to our own context, because South Africa’s alcohol crisis is deeply linked to our own history of racialised exploitation and inequality.

Our government has not been silent on alcohol-related harm. The National Drug Master Plan provides a framework for reducing the demand, supply and harm associated with substances. The Central Drug Authority continues to coordinate work on substance abuse. The Department of Social Development has advanced policy work on prevention and treatment for substance-use disorders.

Provincial governments, particularly in areas heavily affected by FASD, have worked with organisations such as the Foundation for Alcohol Related Research, FAS FACTS, Early Years and others to implement programmes such as Healthy Mother Healthy Baby and Baby on Board.

AWARE.org itself continues to play an important role through research, national dialogue, responsible drinking advocacy, underage drinking prevention and FASD awareness initiatives. The research being discussed today adds important evidence to the national conversation by showing that the awareness-behaviour gap is shaped by social norms, misinformation and systemic challenges.

However, we must also be honest. These efforts remain fragmented. They do not yet amount to a fully integrated national FASD strategy with the scale, resources, accountability mechanisms and cross-government coordination required by the magnitude of the problem.

This is where we must move from programmes to systems.

A novel approach to FASD in South Africa should rest on three pillars: prevention, support and rights.

The first pillar is prevention. Prevention means clear public messaging that no amount of alcohol is safe during pregnancy. But prevention also means reducing alcohol availability in high-risk communities, regulating advertising, strengthening enforcement around illegal liquor outlets, expanding access to contraception, providing mental health services, treating substance-use disorders, and ensuring that women are supported long before pregnancy and throughout pregnancy.

The second pillar is support. Support means that pregnant women struggling with alcohol dependence must be met with care, not condemnation. It means community health workers trained to identify risk and offer brief interventions. It means referral pathways that actually work. It means expanding mentor-mother and peer-support models. It means ensuring that clinics, schools and social workers can work together around the needs of the mother, the child and the family.

The third pillar is rights. Rights mean that children with FASD must not be abandoned by the state or stigmatised by society. They must receive early diagnosis, inclusive education, reasonable accommodation, psychosocial support, and pathways into skills development and meaningful participation. Rights mean that caregivers must be recognised. Rights mean that women must not be blamed for structural failures. Rights mean that the liquor industry must be held accountable for its social footprint.

We also need to change the narrative.

For too long, many conversations about FASD have carried a tone of accusation, as though the primary task is to point a finger at pregnant women. That approach fails. It fails morally because it strips women of context. It fails practically because stigma drives people away from services. It fails politically because it allows society, communities, families, men, government and industry to escape responsibility.

We need a new narrative: FASD prevention is everyone's responsibility. Men must be part of prevention. Partners must support alcohol-free pregnancies. Families must stop normalising drinking during pregnancy.

Taverns and liquor outlets must act responsibly. Traditional leaders, faith leaders and community organisations must help reshape norms. Health workers must screen and support without judgment. Educators must identify learners with empathy. The private sector must stop profiting from harm while leaving communities to carry the burden. Government must coordinate better and fund what works.

The whole of society must become the protective environment that every child deserves.

Our task is not to moralise poverty. Our task is to transform the conditions that make alcohol harm so widespread. We are not here to rehearse despair; we are here to reorganise courage.

We must strengthen research and data so that we know where FASD is most prevalent, which interventions work, where services are absent, and how families experience care. We must strengthen primary healthcare so that every antenatal visit becomes an opportunity for respectful screening, counselling and support. We must strengthen education so that teachers are trained to recognise the signs of FASD and respond with support rather than punishment.

We must strengthen social protection so that families affected by FASD are not left to navigate the system alone. We must strengthen community mobilisation so that prevention messages live in churches, mosques, temples, traditional spaces, stokvels, sports clubs, workplaces, taxi ranks, schools, clinics and digital platforms. And we must strengthen regulation, because it is not enough to tell individuals to resist a culture that is constantly being sold to them.

Distinguished guests, the children affected by FASD are not statistics. They are South Africans whose potential must not be written off. The women affected by alcohol dependency are not failures. They are human beings who deserve support. The caregivers carrying the burden are not invisible. They are workers of love, often unpaid, often unsupported, and often exhausted.

This is why today's conversation must not end as a webinar. It must become a programme of action. It must inform government planning, community mobilisation, service design, public education and industry accountability.

As the Department of Women, Youth and Persons with Disabilities, we stand ready to work with partners across government, civil society, research, communities and the private sector to ensure that FASD is addressed as part of our broader mandate of building an inclusive, caring and rights-based society.

We must move from awareness to behaviour change. We must move from behaviour change to structural change. We must move from fragmented initiatives to coordinated systems. We must move from blaming women to supporting families. We must move from silence to accountability.

50 years after 1976, the future still calls. It calls us to protect children before harm begins. It calls us to support women before crisis deepens. It calls us to recognise care before caregivers collapse. It calls us to build communities where health is easier than harm, where dignity is stronger

than stigma, and where every child has the chance to become fully themselves.

Hope is not a candle we admire from a distance. Hope is a fire we are responsible for feeding.

Let us feed that fire through prevention. Let us feed it through care. Let us feed it through justice. Let us feed it through evidence. Let us feed it through courage.

Together we can build a South Africa where no child is left behind before birth, where no woman is blamed for the wounds of society, where no caregiver carries the burden alone, and where the promise of our Constitution becomes visible in the lives of those who have waited too long.

I thank you.