Unpacking The

AWARE.ORG 2026 SOBER PREGNANCIES

RESEARCH REPORT

Conducted by

About Aware.org

AWARE.org is a national non-profit organisation funded by the South African alcohol industry and dedicated to reducing alcohol-related harm through evidence-based, coordinated interventions.

The organisation operates through a whole-of-society approach, bringing together:

Government

Academia

Law enforcement

Civil society

Industry

to influence behaviour, strengthen systems and contribute to a more responsible drinking culture in South Africa.

AWARE.org's work is anchored in three strategic pillars:

#NOtoU18: Underage drinking prevention

#DontDrinkandDrive: Road safety

#SoberPregnancies: FASD prevention

About Aware.org

Across these pillars, the organisation combines **prevention, enforcement, education** and **rehabilitation,** moving beyond awareness-led approaches toward measurable behaviour change and systems-level impact.

Prevention

Enforcement

Education

Rehabilitation,

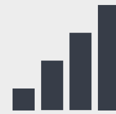
AWARE.org plays a dual role as both a programme implementer and a coordinating platform, aligning stakeholders and scaling interventions nationally. This integrated model enables more consistent delivery, improved accountability and stronger outcomes in addressing complex social challenges related to alcohol harm.

South Africa's FASD crisis in 2026

1 **Fetal Alcohol Spectrum Disorder (FASD) remains one of the most significant and preventable public health challenges in South Africa.**

While global prevalence is estimated at approximately **1%**

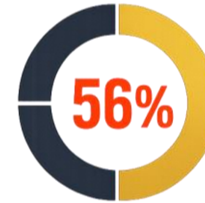
South Africa's rates are among the highest in the world, with national estimates as high as **11%**



significantly higher in certain **high-risk communities.**

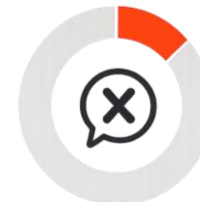
2 Importantly, FASD is not only a health issue, but a systems and social challenge, shaped by deeply embedded behaviours, beliefs and environmental factors.

3 **Research highlights a critical gap between awareness and behaviour:**



While the majority of South Africans recognise that drinking during pregnancy is harmful, 56% report having seen pregnant women consume alcohol in their communities

Only a **small proportion** of respondents can accurately identify FASD, despite high claimed awareness



Harmful myths persist, including beliefs that traditional alcohol is safer, that the placenta protects the baby, or that there are "safe" levels of alcohol consumption

South Africa's FASD crisis in 2026

4

In addition, alcohol consumption during pregnancy occurs within a context of normalised drinking behaviour and social pressure:

Friends and family may **encourage** continued drinking

Partners often **do not reduce** their own alcohol consumption

Abstinence can be perceived as **socially isolating**

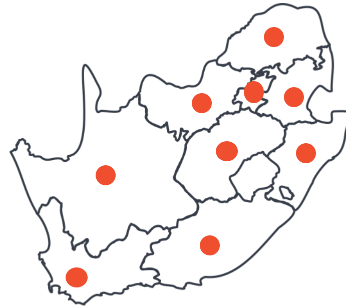
5

These findings point to a clear conclusion:

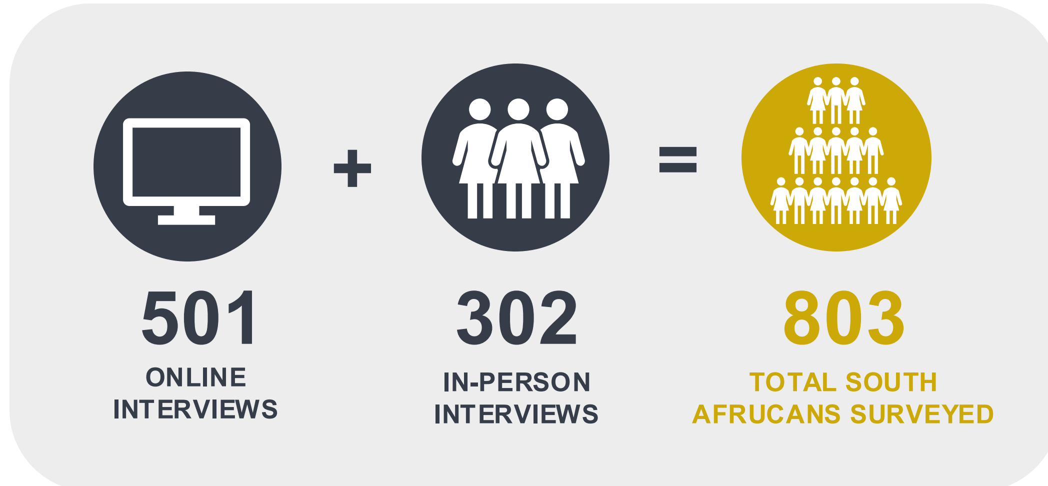
FASD IS NOT AN INDIVIDUAL FAILURE – IT IS THE RESULT OF A SOCIAL AND STRUCTURAL ENVIRONMENT THAT ENABLES HARMFUL BEHAVIOUR.

Research architecture: An evidence-based approach

To capture the ground truth in a replicable and cost-effective manner, a heterogeneous sampling approach was designed, combining online and in-person interviews **across all 9 provinces in South Africa.**



In March 2026, Frontline Research Group's (FRG) researchers used a single offline and online data collection platform to survey 803 South Africans, cutting across South Africa's linguistic and geographic divides.



The self-complete online survey was fielded first and remaining quotas were filled offline to **balance on the targeted national distribution** based on province, age, gender and population group.

The in-person interviews were typically older and less urbanised respondents while online tended to be more urbanised (still including rural respondents) and younger as expected during the sample design.

IN-PERSON
Interviews were typically

- Older
- Less urbanised respondents

ONLINE

- Urbanised (including rural respondents)
- Younger

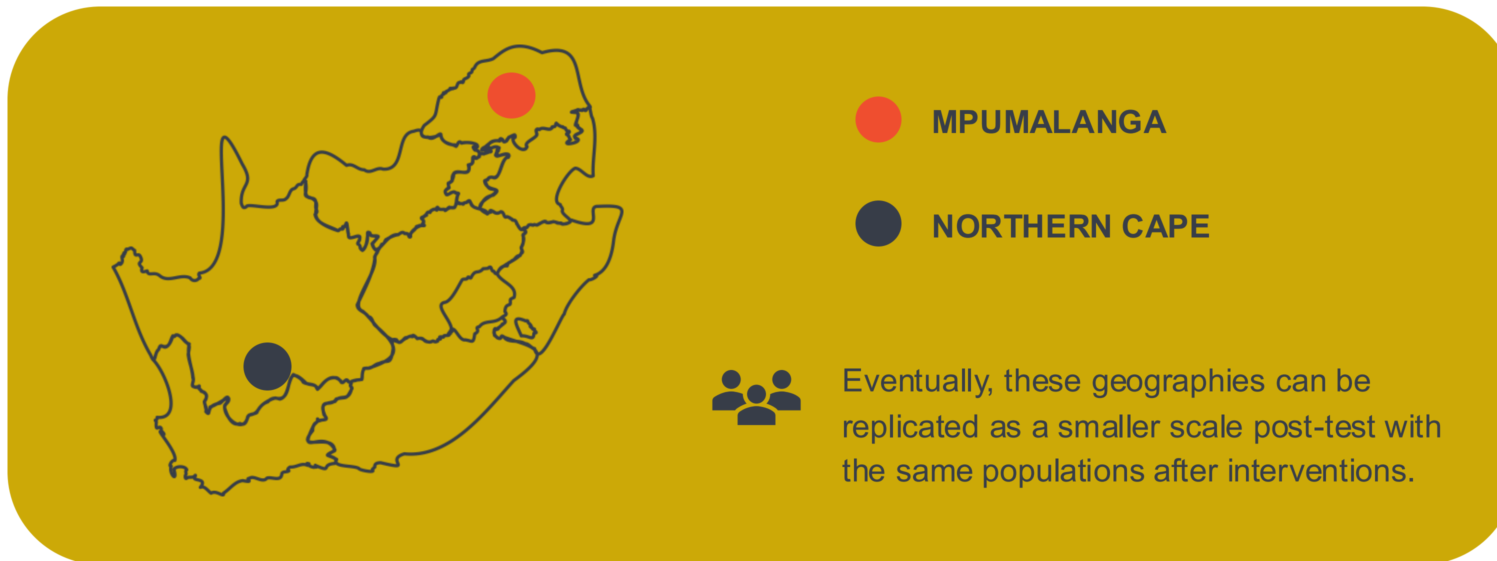
The study was executed in:

- English
- Afrikaans
- isiZulu
- Sesotho
- Sepedi

and was **limited to ~20 mins** to minimise respondent fatigue and used visual aids where feasible to ensure data accuracy and respondent engagement.

Research architecture: An evidence-based approach

Critically, the methodology included strategic **"booster quotas"** in **Mpumalanga** and the **Northern Cape**, not as random allocations but in anticipation of geographies where Aware.org and SANCA are preparing to launch high-impact interventions.



The sample structure was based on Statistics SA Census 2022 results and 2025's mid-year population estimates and weightings was applied to down-weigh the booster interviews and ensure exact alignment to South African national population.

The total sample of n=803 provides a precision level of ~3.5% at a 95% confidence level. Note that while the national findings carry a high degree of confidence, the provincial-level data should be viewed as indicative.

The instrument

FRG and Aware.org developed a ~20 min questionnaire that was administered in both data collection methods (only difference was implementation guidelines for the face-to-face interviews for enumerators). Multiple training sessions were conducted with the fieldwork teams in various provinces to ensure that implementation was similar regardless of geography.

At no point were any personal details collected and enumerators were sensitised to the questions and topic. No adverse effects were encountered during fielding.

MAIN STRUCTURE OF THE INSTRUMENT INCLUDED:

1. DEMOGRAPHICS AND CONSENT

a. After explaining the aim research and practical considerations, respondents were reassured of anonymity and voluntary participation. If they agreed to participate a series of demographic questions were asked to confirm eligibility (100% of respondents would qualify if they fitted into the required demographics)

   i. Only respondents 18 years and older was included in this study.

b. Geography: Province living in currently and distinguishes between **urban, peri-urban, and rural environments.**

c. Standard variables including age (18+), gender, population group, marital status, education level, and employment status to allow for data segmentation

20mins Questionnaire length

Administered in both data collection methods

Multiple training sessions. With field work teams in various provinces

NO ADVERSE EFFECTS ENCOUNTERED DURING FIELIDING

The instrument

2. MATERNAL HEALTH AND COMMUNITY CONTEXT

a. **Lived experience:** Establishes the respondent's direct or indirect experience with pregnancy.

b. **Barriers to care:** Identifies the primary challenges expectant mothers face, such as financial stress, lack of partner support, and access to quality healthcare.

c. **Support networks:** Explores who women turn to for advice, ranging from mothers and partners to medical professionals and religious leaders.

3. HABITS, AWARENESS, AND FASD KNOWLEDGE

a. **Health literacy:** Measures the respondent's understanding of what constitutes a healthy pregnancy, specifically focusing on the avoidance of alcohol.

b. **FASD recognition:** Tests specific knowledge of Fetal Alcohol Spectrum Disorder (FASD), including where information was previously sourced (e.g., clinics, radio, social media) and the accuracy of their understanding regarding its preventability and symptoms.

c. **Observational data:** Asks respondents about the prevalence of drinking during pregnancy and unplanned pregnancies within their specific communities.

20mins Questionnaire length

Administered in both data collection methods

Multiple training sessions. With field work teams in various provinces

The instrument

4. MISCONCEPTIONS AND TRADITIONAL BELIEFS

a. **Myth busting:** Critically evaluates the prevalence of specific cultural and traditional myths, such as:

b. The perceived safety of traditional beer (Umqombothi) compared to commercial alcohol.

c. Beliefs regarding "yellow bone" babies, witchcraft, or the protective nature of the placenta.

d. The misconception that children can "grow out" of FASD or that safe levels of alcohol exist during certain trimesters.

Designed to uncover and challenge harmful myths and cultural beliefs with sensitivity and respect.

5. ENVIRONMENTAL AND SOCIAL DRIVERS

a. **Illicit alcohol:** Gauges the accessibility and perceived harm of "home-brew" or fake/illicit alcohol within neighbourhoods.

b. **Social norms:** Investigates the pressure placed on pregnant women by friends and family, as well as the perceived responsibility of male partners to reduce their own drinking.

c. **Stigma vs. support:** Explores whether heavy drinking is viewed as a "bad choice" or a "disease/addiction" and if poverty and trauma are recognised as underlying drivers of consumption.

Focuses on understanding the social environmental, pressures, and structural factors that influence behaviours.

The instrument

6. TRUSTED MESSENGERS AND COMMUNICATION CHANNELS

a. **Support services:** Identifies which organisations are most trusted, such as SANCA, Alcoholics Anonymous, or local clinics.

b. **Preferred media:** Determines the most effective future channels for health messaging, including WhatsApp, radio dramas, or community murals.

Despite being lengthy in content, the questionnaire flowed well and no concerns were picked up in field during piloting and testing or fieldwork.

SUMMARY OF FINDINGS

Factors Contributing To Alcohol Consumption And Continued Use During Pregnancy

Financial constraints and access to healthcare

Financial stress is the leading challenge expectant mothers face today as noted by **70%** of respondents. Considering high unemployment rates, gender inequality in the workplace, and the reliance on social grants, these financial stresses are expected.

The third biggest concern expectant mothers are said to face include access to quality healthcare or clinics. This sentiment was more prevalent amongst full-time employed individuals and those with tertiary qualifications. This could be linked to the cost of private healthcare in South Africa.

Norms and beliefs

Public awareness and education remains key to behaviour change. Many respondents (**35%**) reported that traditional medicine can cure babies born with alcohol related harm.

Additionally, one in five respondents believe that fake/ illicit alcohol is less likely to harm the unborn baby, that children born with FASD has a genetic predisposition towards it and that the placenta protects the baby from alcohol.

Campaigns aimed at educating the public on FASD should focus on debunking incorrect beliefs and misinformation by sharing detailed information on the topic.

Partner support

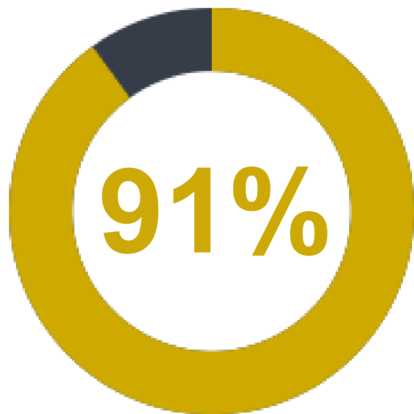
Support from the partner or husband is known to increase maternal wellbeing. Even though a third of respondents believe that expectant mothers turn to their partners for advice and support, more than **50%** of respondents feel that the lack of support from a partner or husband is a key challenge expectant mothers face.

Half of all respondents, however, noted that the most important source of advice and support for expectant mothers is an older relative or mother. This reliance on maternal lines reflects a support system that often side-lines partners and husbands, leading to unintended social consequences.

Agency And Responsibility

91% of respondents stated that unplanned pregnancies are common in their communities. Globally four in ten pregnancies are unplanned. At least half of the respondents believe that unplanned pregnancies are one of the main reasons women drink alcohol, before they realise that they are pregnant.

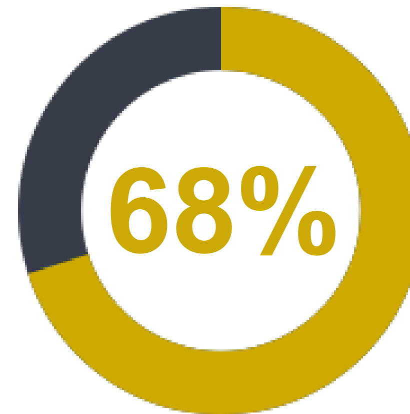
Most people recognise the danger of drinking while pregnant, and **76%** note that one must avoid all alcohol to ensure that a baby is born healthy. In rural communities this sentiment looks slightly different, with only **68%** noting the importance of abstinence as compared to urban communities (**80%**).



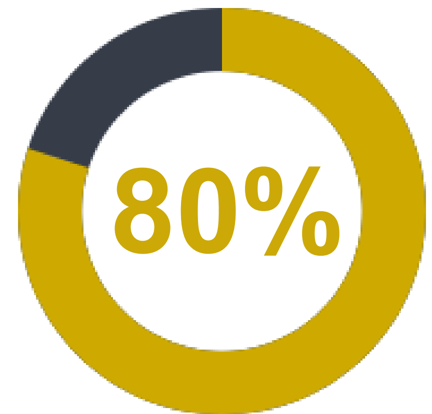
of respondents stated that unplanned pregnancies are common in their communities.

4 in 10

Pregnancies are unplanned (gloably).



Residents in rural areas recognise the danger of drinking while pregnant, and that one must avoid all alcohol to ensure that a baby is born healthy.



Residents in urban areas recognise the danger of drinking while pregnant, and that one must avoid all alcohol to ensure that a baby is born healthy.

Agency And Responsibility

56%

Respondents claim to have seen pregnant women drinking alcohol in their community.

32%

Respondents have heard of pregnant women drinking alcohol in their community.

89%

Respondents believe that a mother should be blamed for the harm to her baby if they consumed alcohol during pregnancy.

Despite this, **56%** of respondents claim to have seen pregnant women drink alcohol in their community, while a further **32%** have heard of this happening. **89%** of respondents believe that the mother should be blamed for harm to their baby if they consumed alcohol during pregnancy.

Public Perception And Its Implications

Many sources note that alcohol use and abuse is the result of systemic failure in a community. It is widely accepted that behaviour is learnt, and if children see parents drinking, it normalises alcohol consumption. The research findings suggest that public alcohol use has been largely normalised in our societies.

63% of respondents say that people in their community drink alcohol in public every day and that access to illicit alcohol is very easy. Only a third of respondents however view people drinking heavily as being sick/ having a disease/ addiction. Social tolerance towards binge or heavy drinking is therefore high.

Although 56% of respondents believe that friends and family would support an expectant mother who chooses to stop drinking during her pregnancy, they would continue to drink around her. Social media posts frequently show responses from women stating that they crave beer or alcohol during pregnancy and want to engage socially with their friends and family. In many cases these support structures also want the expectant mom to continue drinking. This is evident in the results too where **28%** of respondents state that friends and family think an expectant mom who abstains from alcohol is too serious or acting better than them. Furthermore, **26%** believe that friends and family would pressure her to have one so that she is not so stressed. This sentiment could be embedded in public perception that drinking a small amount of alcohol (one or two glasses), is safe for baby (**16%**).

Behaviour change campaigns should address the dangers of drinking during pregnancy while pushing for social support of abstinence. It becomes the responsibility of the community to drive social change and not only the mother and direct family.

Factual Understanding Of FASD

The majority of respondents are aware of the dangers of drinking during pregnancy, with 78% stating that they are aware of health conditions or disabilities that a child can be born with if a mother drinks during pregnancy.

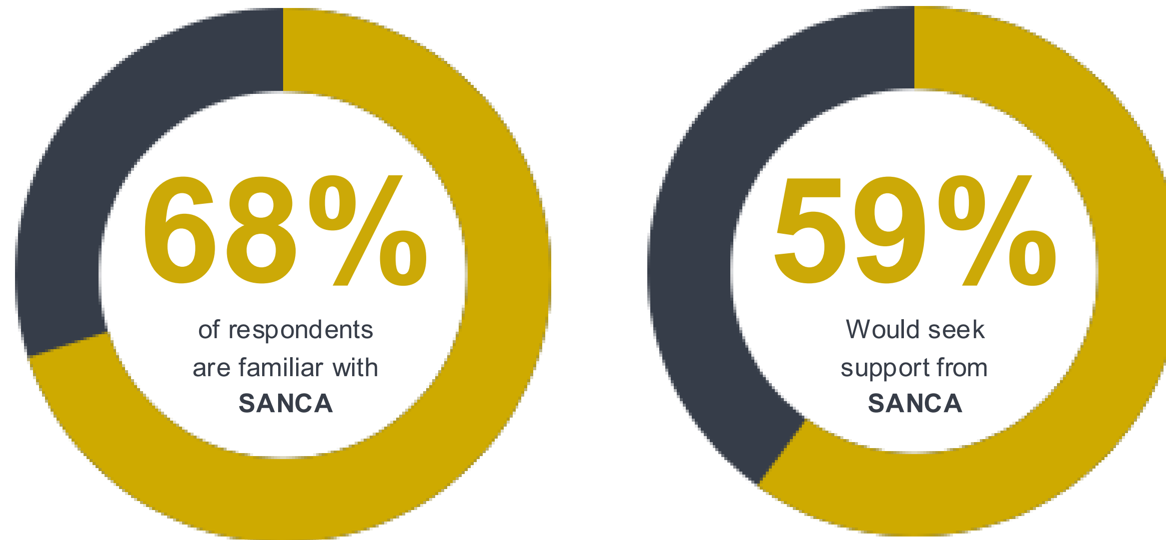
The awareness is however not underpinned by more detailed knowledge of the actual symptoms of these health conditions or disabilities. Down Syndrome was strongly linked to drinking during pregnancy. **22%** of respondents mentioned FASD while another **8%** mentioned alcohol syndrome. When prompted about FASD, recall was higher with up to **51%** of respondents stating that they are aware of FASD.

Awareness is mostly driven through hospital and clinic visits. This highlights the important role that healthcare providers play in educating expectant mothers and their partners about the Do's and Don'ts during pregnancy. Take-home pamphlets explaining the dangers of alcohol use and abuse should be clearly outlined. This includes the effects of once-off, occasional and frequent consumption of alcohol on the unborn baby, and the long-term implications it may have.

Television and social media can be successfully used to further support campaigns and drive awareness amongst the public since many people have heard about FASD through these channels. Common misunderstanding and beliefs can be addressed and correct information shared through public health campaigns. These include the belief that children can grow out of FASD as the brain develops (**45%** stating this to be true), and that there is a safe amount of alcohol that can be consumed during certain stages of pregnancy (**24%**). Regional nuances should be considered when developing these messages.

The Role Of Support Services And Exploring Public Messaging

Awareness of SANCA is high, with respondents noting that they are familiar with the organisation. The majority of respondents would seek support from SANCA for themselves or a friend if they experience alcohol harm.



This is followed by Alcoholics Anonymous and the Department of Social Development Substance Abuse 24hr helpline. Its seems that independent sources of support have higher preferred usage than local entities where respondents could potentially know the person assisting them. **This points to potential stigma avoidance.**

The Role Of Support Services And Exploring Public Messaging

Social media drives the highest level of awareness of the dangers of alcohol consumption during pregnancy, while TV and Radio are also popular platforms. Despite this, nearly **70%** of the respondents mentioned that they would like to learn more about FASD and sober pregnancies through local clinic workshops. This highlights the importance of a dialogue and discussion between the trusted healthcare providers and the public. TV and Radio still play and important role, and dramas aired on these platforms are popular. People would like to receive messages on various platforms and could include medical advice and detailed information through clinic settings, re-enactments and role playing through dramas on TV and radio, and short-form content on social media to name a few.

46%

Social Media drives awareness

43%

Television drives awareness

39%

Radio drives awareness

Considering that **64%** of respondents feel that communities **DO NOT** receive enough information about the risks of alcohol consumption during pregnancy, the call to action is clear. More frequent, more detailed and more varied discussion and information is required.

Pressure From All Sides

The Aware.org Sober Pregnancies Report strips away the illusion of choice, revealing that for many expectant mothers, alcohol is daily part of life and often a survivalist coping strategy.

Secondary research suggests that economic pressures on mothers are substantial and the research found that regardless of employment level:

7 in 10 respondents

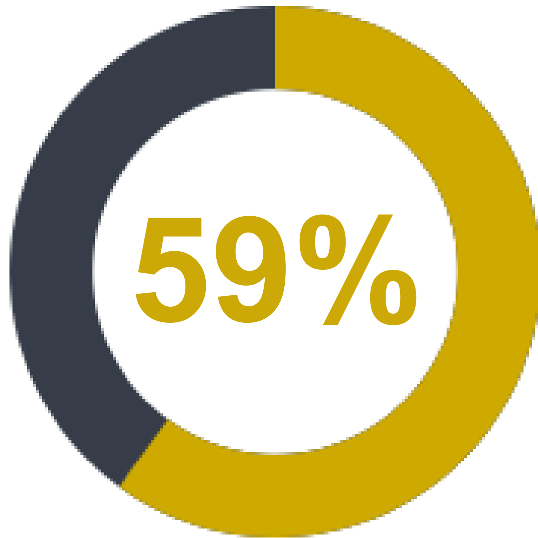
noted that financial stress or lack of income is the main challenge expectant mothers face today.

More than half cited a lack of support from fathers or partners. This reflects the well-documented South African phenomenon of fragile families and is particularly high among single (never married) respondents at 59%, but even married respondents cite it as a top challenge.

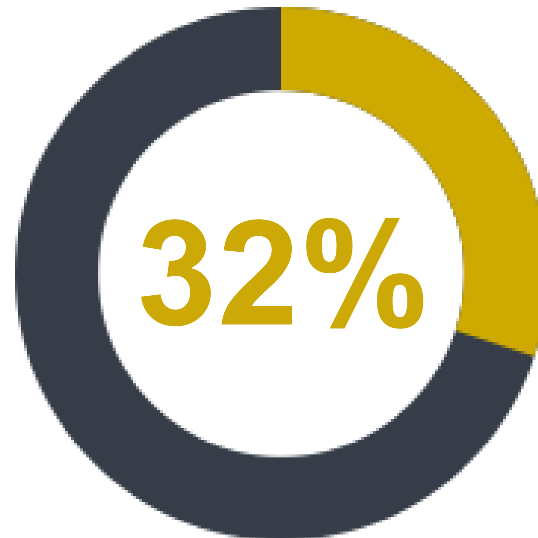
Pressure From All Sides

42% names access to quality healthcare as major concern, but the provincial breakdown is telling: Gauteng (48%) and KwaZulu-Natal (49%) report higher levels of healthcare concern despite being more urbanised.

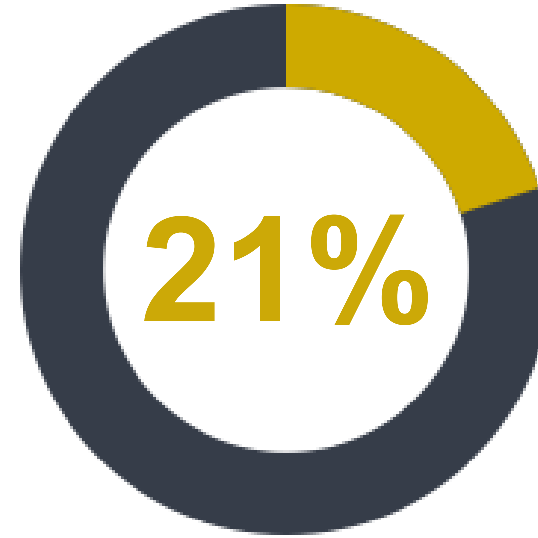
There is also a fascinating split in how support is perceived across urban and rural areas: Respondents in urban areas are more likely to complain about the lack of partner support Vs those in rural areas feel the lack of family/friend support more heavily than urbanites. Urbanisation in SA often leads to the nuclearisation of the family, where if a partner fails, there is no safety net. In rural areas, the "village" still exists, but the data suggests it may be fraying or overburdened by poverty.



Respondents in Urban areas are more likely to complain about the lack of partner support



Respondents in rural areas feel the lack of family/friend support



Respondents in Urban areas feel the lack of family/friend support

The Matriarchal Support System

When asked who expectant mothers turn to for support, more than half said her mother or an older female relative – this reliance was stronger among female respondent at **61%**, compared to only **46%** among men. As education rises this matriarchal reliance decreases but has implications for knowledge sources advice from a grandmother in a rural area on alcohol use during pregnancy would arguably differ from a medical professional. This also has the unintended consequence of further excluding fathers. Cheng et al., 2016) confirms that paternal absence is a direct driver of antenatal anxiety, depression, and unhealthy behaviour.

37% of men believe the partner is the most important person, but only **25%** of women agree but in a counter-intuitive finding, rural women **(43%)** are far more likely to cite the partner as the most important compared to urban women **(25%)** further strengthening the hypothesis of differentiated support structures. Only **27%** of the total sample view a nurse or doctor at the clinic as the most important person for advice.

The implication is that any campaign cannot just target pregnant women. It must target the women who advise them. The fact that **61%** of women turn to their mothers/aunts and that **16%** turn to sisters or friends means the majority of a woman's influential circle is female dominated. Conversely, the medical system is failing to be the most important voice for **73%** of the population.

When it comes to sober pregnancies, intergenerational health education would be more successful than simple patient-centred care.

The Knowledge Gap And Hidden Harm

While 78% of South Africans know drinking during pregnancy is problematic, only 17% can actually name FASD or identify its symptoms. This is further complicated by dangerous folklore and medical myths that persist despite decades of public health messaging.

The traditional beer myth

17% believe traditional beer (Umqombothi) is safer than spirits, a figure that rises to 43% in the Northern Cape.

The traditional cure

35% of respondents (47% in rural areas) believe FASD can be cured with traditional medicine if treated early.

The sperm myth

22% believe the father's sperm, rather than the mother's drinking, causes alcohol-related defects.

The placenta shield

20% incorrectly believe the placenta acts as a shield against alcohol.

The "Yellow Bone" myth

14% (and 28% in the Northern Cape) believe traditional beer results in a lighter-skinned ("yellow bone") baby.

The genetic fallacy

22% believe FASD is purely a genetic predisposition that runs in families.

This knowledge gap implies an agency problem. While 91% of respondents acknowledge that unplanned pregnancies are the primary reason women drink before they even know they are pregnant, 89% still believe the mother should be blamed for any resulting harm. We recognise the systemic causes, yet we persist in individualising the punishment.

The Knowledge Gap And Hidden Harm

73% of South Africans claim to have heard of health conditions caused by drinking during pregnancy. However, when asked to name this condition, it is clear that this knowledge is often imprecise:

Spontaneous recall:

22%

of those who claim awareness can actually name FASD or derivatives of this term.

Symptom-based knowledge:

37%

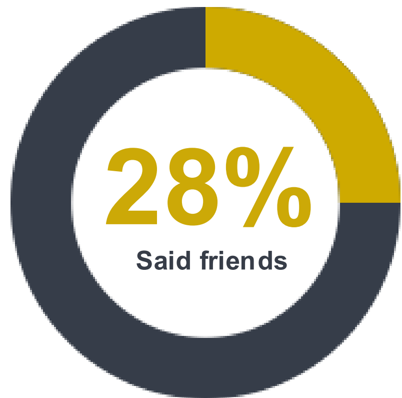
of respondents can explain the symptoms (e.g., describing physical or cognitive delays) but lack the formal medical label for the condition.

Communal knowledge is often anecdotal rather than educational. People might see the effects in their neighbourhoods but haven't been reached by formal health campaigns that codify these observations into a named, preventable disorder. One of the most revealing findings is that 19% of respondents spontaneously identify Down Syndrome as a condition caused by maternal drinking. With Down Syndrome as the most visible or known developmental disability it is being used as a proxy for all birth-related anomalies. The implication is that they may disregard FASD-specific prevention messaging, as the cause of the disability is fundamentally misunderstood.

The Normalisation Of Binge Drinking

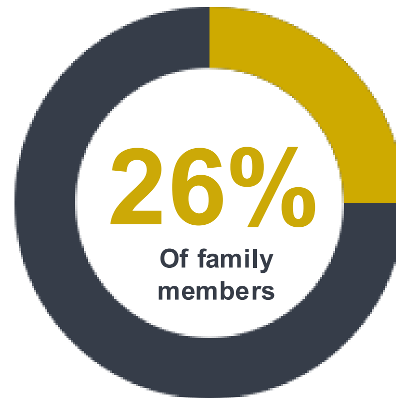
Expectant mothers in South Africa do not drink in a vacuum; they live in a system of normalised binge drinking. In the Northern Cape, 87% of residents see public drinking daily, and 89% report that illicit or "home-brew" alcohol is very easy to obtain.

The is further reinforced by peer and partner pressure:



view an abstaining mother as acting better than the group or being too serious.

are unlikely to reduce their own drinking to support the mother’s sobriety.



will actively pressure a pregnant woman to have just one drink to manage her stress.

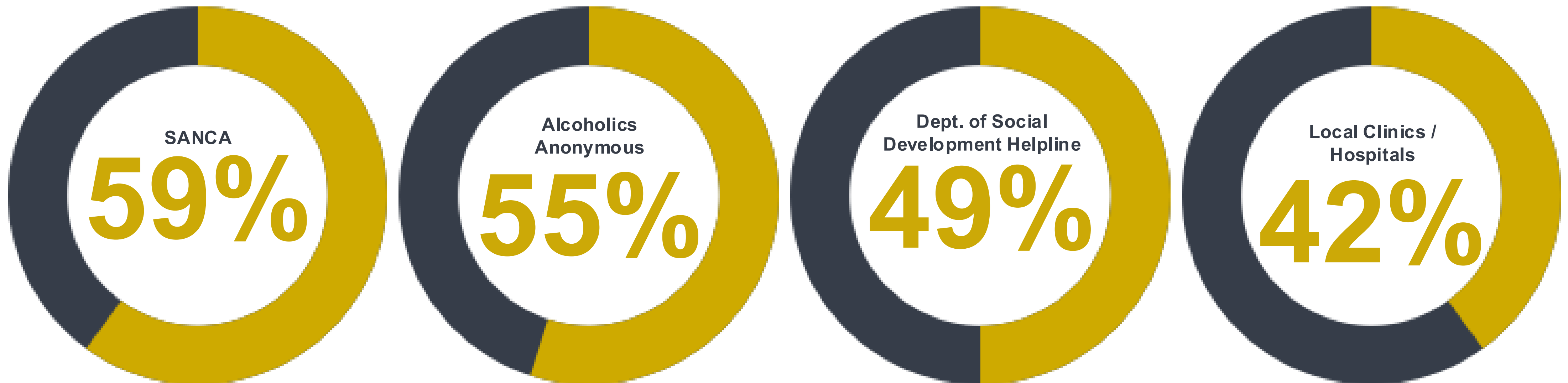
In this environment, sobriety is treated as a social transgression rather than a health priority.

Who Do Communities Hear?

South Africa's defence against FASD is about to lose a major pillar as the Foundation for Alcohol Related Research (FARR) is scheduled to close in May 2026 creating a void in the research and NGO space, leaving the burden on a few remaining institutions.

When looking for help, the South African public has clear preferences that prioritise institutional trust and anonymity to avoid stigma:

Preferred Support Channels (Ranked):



Who Do Communities Hear?

While social media and television drive awareness, they fail to drive behavioural change. Majority of respondents prefer clinic-based workshops. Efficacy is found in dialogue, mothers want to talk to trusted healthcare providers, not just listen to a broadcast message.

46%

Social Media drives awareness

43%

Television drives awareness

70%

Respondents prefer clinic-based workshops.

The final takeaway is a shift in narrative: FASD is a community issue, not a maternal failure. It is the inevitable result of structural inequality and normalised social harm and if South Africa is to take FASD seriously, we must stop blaming the mother and start fixing the environment.

THANK YOU

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association for alcohol responsibility and education