**Fetal Alcohol Spectrum Disorder (FASD)**

**Part 1: How health insurance and lack of it impacts health outcomes in relation to FASD**

There is a big difference in terms of health outcomes between FASD patients who are insured and those who are not. Those with medical insurance have an easier and cheaper access to healthcare compared to the uninsured ones. Given that FASD has no cure and can only be controlled, patients without medical cover not only find it difficult to access healthcare but also experience the worst form of care. A study that was conducted in the US in the year 2016 revealed that out of every ten uninsured people with FASD, two of them could not receive treatment due to its high cost (Karen, Jennifer & Ashley, 2016).Further studies also established that uninsured adults suffering from FASD have a higher mortality rate compared to their insured counterparts because they are unable to receive preventive treatment against other chronic illnesses given the vulnerability of their bodies. Insured patients are most likely to settle their medical bills without any difficulty, and this attributes to positive health outcomes. However, uninsured patients find it very difficult to settle their medical bills even if they can access health care. In most cases, they end up with huge medical debts given that they come from a humble economic background (Robin, Michael & Emily, 2007).

**Part Two: FASD and Population disparities**

As a result of FASD, many populations have experienced disparities. In South Africa, the weight of black children, the length of their palpebral fissure and their head circumference have been very important determinants of FASD among them. These determinants are unique compared to those of other populations. It is believed that these measures, for black South African children, are as a result of poor nutrition which is a different case in other populations (Viljoen et al. 2005). It is, however, important to note that these findings are considered very key in the clinical setups of all other populations because they can be used to determine whether children are suffering from developmental defects or not. In the plains of India and Italy, the diagnosis of children for FASD does not involve the findings from South Africa in any way since they are considered irrelevant. Even though head circumference, weight, and height show a significant level of variation when used as FASD predictive features among different populations, all children suffering from FASD throughout the world have shown some deficits in these features (Duimstra et al.,1993). The only difference that comes in in the case of South African Children is the aspect of nutrition.

Part Three: Religious/Spiritual beliefs and values in relation to FASD

Several studies were conducted in the United States, South Africa, and Italy to determine whether the aspect of spirituality and religion had any influence on the prevalence of FASD. The study mainly targeted women since they were the carriers of the unborn children and their behavior during pregnancy affected the health of children in one or the other. The studies found out that women who fully adhere to the teachings of major religions like Christianity and Islam and were very much prayerful were less likely to take alcohol during pregnancy and hence, have a reduced chance of giving birth to children with FASD (May et al., 2005). On the other hand, women who never went to church or any religious gatherings had a higher chance of giving birth to children with FASD because a majority of them had a higher tendency of drinking alcohol. However, the Italian study proved to be partially exceptional for reasons attributed to the nature of their religions given that cases of FASD were high even among children of mothers who are considered religious and prayerful  ([Viljoen et al. 2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860552/#b70-arh-34-1-15)).

**References**

Duimstra C, Johnson D, Kutsch C, et al. (1993). A fetal alcohol syndrome surveillance pilot project in American Indian communities in the Northern Plains. *Pub Health Rep*. 108(2), 225–229.

Pollitz K, Tolbert J, and Semanskee A. (2016). *Survey of Health Insurance Marketplace Assister Programs and Brokers.* Retrieved from *<*<https://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/>>

May PA, Gossage JP, Marais AS, et al. (2008). Maternal risk factors for fetal alcohol syndrome and partial fetal alcohol syndrome in South Africa: A third study.*Alcoholism: Clinical and Experimental Research*. 32(5), 738–753.

Cohen R. A., Martinez M. E., and Zammitti E. P. (2007). Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January – March 2017. Retrieved from < <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf>>

Viljoen DL, Croxford J, Gossage JP, et al. (2002). Characteristics of mothers of children with fetal alcohol syndrome in the Western Cape Province of South Africa: A case-control study. *Journal of Studies on Alcohol*. 63:6–17.

Viljoen DL, Gossage JP, Adnams CM, et al. (2005). Fetal alcohol syndrome in a South African community: a second study of a very high prevalence area. *J Stud Alcohol*. 66(5), 593–604.