



**Integrated Case  
Management  
Guidelines:  
  
Child Abuse**

◆ PAWC (MCWH): Provincial Reference Group ◆

# CHILD ABUSE

## ***Guidelines for management of child abuse for health care workers at primary level (0-14 years)***

<b>GENERAL DANGER SIGNS:</b>	
<b>ALL CHILDREN</b>	<b>YOUNGER THAN 3 MONTHS</b>
<ul style="list-style-type: none"> <li>• Convulsions</li> <li>• Vomits everything</li> <li>• Stridor in a calm child</li> <li>• Severe malnutrition</li> <li>• Lethargic or unconscious</li> <li>• Unable to drink or breastfeed</li> </ul>	<ul style="list-style-type: none"> <li>• Any of the clinical features listed under ALL CHILDREN</li> <li>• Fever (temp &gt;37.5°C axillary)</li> <li>• Low body temperature (&lt;35.5°C)</li> <li>• Bulging fontanelle</li> <li>• Grunting</li> <li>• Chest in-drawing</li> <li>• Fast breathing (more than 60 per minute)</li> </ul>

All children must be cared for properly. Care is providing circumstances for normal physical, mental and social development of the child.

### **DEFINITION**

Child abuse can be seen as intentional maltreatment of a child with the purpose of inflicting injury or harm. The nature of maltreatment can be physical abuse, emotional abuse, sexual abuse or wilful neglect which includes withholding essential nutrition/feeds and care by the persons responsible for the well being of the child. Different types of abuse can overlap. Remember that the child is always the innocent party to the abuse.

### **DIAGNOSIS**

- Most important for the diagnosis is to **consider the possibility of abuse**
- **History of abuse** - by child or accompanying adult
- **Pointers to abuse**
  - Changing stories or vague explanations of "accident"
  - Delay in seeking medical help or not seeking help at all
  - Account of accident not compatible with the injury observed or stage of development (e.g. "Baby too young to roll who falls off bed")
  - Recurrent incidents of trauma
  - Failure to thrive in absence of other causes (Road-to-Health Card/history)
  - Type of injury or position/shape of injury (e.g. bruises on the back or on the back of legs, bruises of different ages, cigarette burns)
  - Psychological/emotional distress (e.g. depression, anxiety disorders)
  - Behavioural indicators (e.g. parasuicide, enuresis, encopresis, pseudoseizures)

## **CHILD CARE AMENDMENT ACT 96 OF 1996**

The Act states in section no 15 (Amendment of section 42 of Child Care Act 74 of 1983) that “Notwithstanding the provisions of any other law every dentist, medical practitioner, nurse, social worker or teacher, or any person employed by or managing a children’s home, place of care or shelter, who examines, attends or deals with any child in circumstances giving rise to the suspicion that that child has been ill-treated, or suffers from any injury, single or multiple, the cause of which probably might have been deliberate, or suffers from a nutritional deficiency disease, shall immediately notify the Director-General (now Director of Welfare) or any officer designated by him or her for the purpose of this section, of those circumstances.”

## **PREVENTION OF FAMILY VIOLENCE ACT NO 133 OF 1993 (SECTION 4)**

This Act states that “any person who examines, treats, attends to, advises, instructs or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such child has been ill-treated, or suffers from any injury the probable cause of which was deliberate, shall immediately report such circumstances: a) To a police official; or b) to a commissioner of child welfare or a social worker...”

## **MULTIDISCIPLINARY TEAM**

Child abuse is always a team effort involving health workers, social workers and other role players such as the Child Protection Unit/SAPS.

## **CLASSIFICATION:**

### **A. Physical Abuse and Neglect**

### **B. Sexual Abuse**

## **A. MEDICAL MANAGEMENT OF PHYSICAL ABUSE AND NEGLECT**

1. Recognise the possibility of abuse, stay calm, and always be professional.
2. Medical history taking essential:
  - to confirm diagnosis
  - to exclude possible medical causes e.g. ITP for bruising or pathological fractures
  - previous medical/surgical history
3. Thorough clinical examination in all cases of abuse including:
  - growth parameters (weight, height, head circumference)
  - general examination of all systems
  - detailed examination of the skin, ears, eyes, mouth
  - fundoscopy if level of consciousness suppressed
  - sexual development
  - anogenital examination for possible sexual abuse
  - signs of intoxication & drug abuse

4. Note taking with detailed sketches of all injuries and scars:
  - Ensure that each page is marked with the child's name date and your legible signature for legal purposes.
  - J88 form to be completed when indicated. (see addendum)
  - Keep a copy for yourself if possible.
  - Write down name and address of accompanying person and name and force number of police officer involved.
  
5. Special investigations where indicated:
  - With bruising - FBC/clotting profile
  - With fractures/long-standing abuse - skeletal survey where available
  - With neglect/malnutrition - serum albumin/globulin
  - Alcohol level of suspected/serum glucose
  
6. Notification and referrals:
  - Director of Social Services - forms (see addendum)
  - Social worker (hospital or community)
  - South African Police Service where indicated
  
7. Refer urgently if:
  - Any general danger signs are present (see front page)
  - Severe injury - first stabilise the patient
  - Head injury - needs CT scan
  - If surgical/orthopaedic treatment is indicated
  
8. **Ensure the safety of the child** before discharge in consultation with other members of the team. Places of safety e.g. hospital (if medical reason), family member or place of safety as arranged by the social worker. Resource list will be available at the local district office (see addendum).
  
9. **Follow-up** i.e. medical and/or social work where indicated.

## B. MEDICAL MANAGEMENT OF SEXUAL ABUSE

### DEFINITION

Sexual abuse in children is the use of a child for sexual gratification.

### TYPES OF SEXUAL ABUSE

Intercourse (e.g. vaginal penetration, extra-genital, anal, oral)

Fingering

Fondling

Voyeurism and exhibitionism

Child pornography

**Disclosure of sexual abuse by a child must always be taken seriously.**

**Abuse must also be suspected in:**

- Vaginal discharge
- Sexualised behaviour and other behaviour problems
- Dysuria and frequency
- See general points under "Pointers to abuse"

**MEDICAL EXAMINATION****A. General principles**

- **The medical examination must not be traumatic for a child.**
- Stay calm, act professionally and show empathy.
- Reassure mother and explain examination to mother and child as you go along.
- Examination must be done with a third person present e.g. mother or member of nursing staff.
- A private area is needed (if the door can't be locked put a "do not disturb" sign on the door).
- Genital/anal examination should be done once only.
- It is usually not urgent unless the latest incident of abuse has occurred in the preceding week, but should be done as soon as possible.

**B. General physical examination**

- Must be done to exclude concomitant physical abuse and/or neglect.
- To gain the child's confidence, accustom him/her to instruments e.g. otoscope.

**Specific points to look for and record:**

- Weight and height
- Mouth for signs of oral sex
- Past or present injuries
- Stage of sexual development

**C. Genital and anal examination****Technique**

- A small child is best examined sitting on the mother's lap, back to the mother with the mother holding the legs.
- Older children should be offered the choice of sitting on a chair, the mother's lap or lying on the bed for examination.
- Avoid hand-knee position - abuser often uses it. The anus can be examined in the lateral position.

Expose female genitalia by gentle lateral traction on the buttocks or labia majora. It is very easy to create mucosal tear at the fourchette in little girls.

- **All the physical evidence of sexual interference will be at or external to the hymen. Digital internal examination is NEVER indicated in the prepubertal child.** Vaginal penetration in prepubertal girls causes severe damage.
- Examination under general anaesthetic is only necessary with severe trauma and obvious vaginal bleeding.

#### **Look for and record:**

- **Female genitalia**

- Vaginal discharge
- Labia majora - trauma or bruising.
- Clitoris - evidence of trauma.
- Urethra-evidence of trauma.
- urethral prolapse(may be cause of bleeding)
- bruising
- Labia minora - especially the inner aspects and posterior margin
- Hymen -appearance
  - shape - variations of normal e.g. annular, crescent or septate hymen
  - oedema and inflammation
  - margin - clefts, irregularities, lacerations and tears
  - adhesions to vagina or labia
  - orifice diameter (with gentle lateral traction on the labia) is normally 5-6mm in young girls and up to 8mm as puberty approaches. Measure with a rounded Tine ruler on the end of the spatula.
- Fourchette - recent damage or old scarring

- **Male genitalia**

- Penis - look particularly at the frenulum of the prepuce

- **Anus (both sexes)**

- Mucosal folds - these should be symmetrical
- Anal tone
- Reflex anal dilatation - with lateral traction on the buttocks the anus will normally pucker up. With reflex dilatation the anus opens and the inside of the rectum is visible. This may be a sign of sodomy but it is also seen with constipation.
- Fissures or tears - record position
- Bruising - do not confuse this with dilated anal vessels

## **SPECIAL INVESTIGATIONS FOR SEXUAL ABUSE**

### **COLLECTION OF SPECIMENS FOR MEDICAL PURPOSES**

1. Vaginal swab for:
  - MC and S (wet swab in culture media first to decrease pain and irritation)
  - Chlamydial immunofluorescence (request specifically)
2. Blood for VDRL/RPR and HIV

#### **If abuse happened within the last 4 days:**

Use the contents of the Crime Kit supplied by the police (Dry swabs to be done before swab for MCS).

1. Take vaginal and/or rectal swabs and smear on to the clean glass slide. Allow slide to dry (without use of fixing agent). Specify only the site of origin of the smear on the slide label. Put used swabs and slide into the Crime Kit.
2. Blood: 3-5ml in a plain tube (collect at the same time as blood for VDRL and HIV).
3. Saliva: 3-5ml in a plain urine collection tube.
4. Blood or semen stained clothing to be collected for evidence into a paper bag (not plastic).

#### **Procedure**

1. On the J88 form specify which specimens have been taken (This will avoid you having to make another statement to the police).
2. Label the Crime Kit and hand the sealed Crime Kit to the police officer. The kit must remain in the doctor's possession until it is handed over and not be left unattended.
3. See Appendix for completion of J88.

#### **REFER TO SOCIAL WORKER IF NOT ALREADY DONE.**

#### **Treatment**

1. Treatment of sexually transmitted diseases (STD's):
  - Chlamydia: Erythromycin 50mg/kg/day in 3-4 doses x 10-14 days
  - Syphilis (not neonatal):
    - (i) Benzathine penicillin 50 000u/kg (max dose 2.4 million units) IMI weekly x 3 weeks)
    - (ii) If allergic to penicillin: Over 8 years doxycycline first day 4mg/kg divided in 2 doses and then 2mg/kg/day x 15 days. Under 8 years: erythromycin 50mg/kg/day x 30 days
  - Gonorrhoea: Ceftriaxone IMI stat: under 45kg, 125mg; over 45kg, 250mg
  - Genital herpes: Refer for treatment
  - Trichomonas vaginalis: Metronidazole 7,5mg/kg/dose 3 x/day for 5 days
  - Gardnerella vaginalis infection: Metronidazole 7,5mg/kg/dose 3 x/day for 5 days
  - HIV prophylaxis may become available for all acute rape cases.



2. Pregnancy prophylaxis  
In recent rape (within 72 hours) in menarchal girls:
  - Do pregnancy test to exclude existing pregnancy prior to rape.
  - If negative give 2 tablets Ovril 28 and 1 tablet metoclopramide stat. Repeat 12 hours later. Provide 2 Ovril tablets extra in case of vomiting
  - If patient is on rifampicin or anticonvulsant treatment, use 4 tablets Ovril 28 per dose
  - Repeat pregnancy test after 6 weeks.

### **Follow-up needed to**

1. Get results
2. Treat STD's
3. Repeat bloods after three months (RPR/VDRL and HIV)

Give follow-up appointment in 1-2 weeks when results will be available:

### **If infection does not clear consider:**

1. Foreign body
2. Continued interference

### **Retreat for syphilis if:**

1. Signs and symptoms persist
2. The titre stays the same or has increased

Where possible liaise with social worker to see on the same date.

### **REFERRAL CRITERIA**

1. Severe trauma/bleeding - refer urgently to secondary or tertiary hospital after prior arrangement. Stabilise first if necessary.
2. If vaginal discharge persists refer non-urgently.

## **SOCIAL WORK INTERVENTION**

Health services serve as gatekeepers for children on non-accidental injury. These children require both medical and social work interventions. Due to the high number of cases, social workers need to develop interventions, which address the crisis and facilitate the child's healing process.

### **STEPS/ROLES OF INTERVENTION**

#### **1. Assessment/Facilitate disclosure:**

#### ***Interviewing role***

- Clarify your role i.e. talking about worries, no examination/hurting.
- Give child choice about being interviewed alone or with caregiver/mother (above two points should be covered even before taking a history).
- If you remain the "case manager", a history can be obtained from the child, where possible. If it appears that referral is necessary, obtain a brief history from mother or

caregiver prior to referral (the use of dolls, drawings and stories are often very useful in facilitating a disclosure from the child). Social workers should be trained in using dolls, drawings, etc.

- Believe the child - Tell the child that you believe him/her.
- Be supportive and empathetic and tell the child that the incident was not his/her fault.
- Be age-appropriate in how/where you sit and language used.
- Do not interrupt the child's train of thought.
- Do not lead the child's disclosure i.e. avoid leading questions e.g. did the woman/man touch you?
- Liaise with medical doctor. Get information regarding injuries and treatment.
- Check risk factors e.g. abuser still in the home.

## **2. Facilitating the healing**

### ***Therapeutic role***

- Contain the child and parent/caregiver by providing a safe and supportive environment (a child friendly corner in the office) for intervention. If possible, interruptions during the interview should be limited.
- Debrief the child i.e. provide a space for him/her to talk about the abuse in a manner in which he/she is re-experiencing the abuse.
- Focus on mother's strengths and/or concerns and her role as central to the child's healing process.

## **3. Teach safety skills**

### ***Empowerment role***

- Provide body awareness, find out and use words for body parts familiar to the child.
- Explain good and bad touches.
- Teach: "Say no, run away and tell a trusted adult".
- Child should be aware of bribery and threats.
- Possibility of abuser being a known and trusted adult or a stranger.

**4. Safety of the child*****Protection role***

- If a child is at risk for further abuse when discharged and urgently in need of protection a form 4 detention order can be issued to remove the child to place of safety (as prescribed in the Information Guide for social workers on the Practical Application of the Child Care Act 74 of 1983, as amended and regulations). This should always be arranged in liaison with the District Office of the Department of Social Services (District Offices - see addendum).

**5. Monitoring and follow up*****Monitoring role***

- Monitor symptoms of post-traumatic stress e.g. recurrent re-experiencing of the abuse, avoidance of traumatic emotions, hyperarousal, sleep disturbances).
- Support through future traumas e.g. further medical interventions, police statements or court involvement.
- Prepare the child for court when necessary and support through the court process.
- Prepare the child for possible teasing by peers/school mates.
- Monitor symptoms of recurrent abuse by follow-up appointment.

**6. Informing and counselling*****Advocacy role***

- Provide information regarding police and court involvement.
- Network in order to assist with the understanding of the legal process.
- Advise parent/caregiver of parenting skills to address the crisis and handle the child.
- Advise parent/caregiver of signs of concern e.g. behaviour changes in terms of child's mental state and post-traumatic stress.
- In some cases liase with school teacher, warning about behaviour changes i.e. withdrawal, sensitivity, etc. (always obtain permission from parent/caregiver first).

**REASONS FOR REFERRAL**

- If a child's safety and ongoing protection is in question.
- If child's mental state requires more specialist/psychiatric intervention.
- Information needed for a proper referral: incidence, family circumstances, symptoms.

**REPORTING TO PROVINCIAL REGISTER**

A report should be made on the appropriate form (form 25/26 as prescribed in Child Care Act Regulations) and sent to local Department of Social Services.

**THE ROLE OF THE NURSE IN CHILD ABUSE****INTRODUCTION**

The nurse may be the first contact person at the primary health facility when a child and caregiver enters the health system.

Protecting the child is the nurse's first and primary concern. It is of paramount importance that the nurse familiarises him/herself with the clinical intervention process at specific health centres.

## PROCEDURE

1. See introductory pages of this Child Abuse Protocol.
2. The medical management of physical abuse and neglect should be followed to step 3.

**Do not examine in case of sexual abuse, as presently the nurse's testimony is not accepted in court.**

3. In the case of sexual abuse and trauma reassure the mother/caregiver and child and inform her/him that you have to refer to a doctor for further management.
4. Stabilise the medical condition, e.g. bleeding, fractures, etc. before referral to hospital.
5. Write a referral letter to the relevant referral institution and inform the Dr in Charge that you are sending the patient for special investigations and further management.
6. Ensure that all relevant information is entered in clinical records.
7. Referral and notifications:
  - Refer all cases to medical officer for further investigations and management and completion of J88 form.
  - Notify the District Office for referral to the social worker and the Child Protection Unit or the South African Police Service (see addendum for District Office details).
8. Refer urgently to drainage hospital if:
  - Severe injury
  - Head injury
  - Severe bleeding
  - If urgent medical, surgical or psychiatric (e.g. suicide risk) intervention is required.
9. Follow-up after discharge to ensure safety of the child.

## APPENDIX

### COMPLETION OF J88 FORM

(To be read with accompanying specimen form)

- This is used as official evidence in court cases. There is often considerable delay between completion of the form and a court appearance and the form is often the only information that the doctor will have at his/her disposal in court.
- Complete it legibly.
- See the accompanying example of J88 form for details.
- In general it is preferable to document the findings in detail rather than any conclusions which may be drawn from them.
- If the findings are clear-cut, say so in "14(a)".
- If the findings are equivocal say in "14(a)" that the findings may be compatible with a history of sexual interference.
- Avoid terms "no penetration" or "hymen not seen"/"absent". Legal penetration is past the labia majora NOT the hymen. Describe exactly what you see.
- If investigations were done, write "results outstanding" in "14(a)" to avoid writing another affidavit.
- If no physical evidence of abuse is observed, do not write "no evidence of abuse".

**WESTERN  
DEPARTMENT OF SOCIAL SERVICES – DISTRICT OFFICES**

Office Head	Office	Postal Address	Street Address	City	Postal Code	WorkPhone	Fax number	Service Area
Mrs V Petersen	Head Office	Private Bag X9112	Minelli House, 50 Buitenkant Street	CAPE TOWN	8000	021/410-3400	021/461-0114	
Ms M Harris	Bellville Office	Private Bag X50	Omnia Building, 107 Voortrekker Road	BELLVILLE	7535	021/940-7100	021/948-3024	Goodwood Bellville Kuilsrivier Eersterivir Blackheath Blue Downs Stellenbosch Strand Somerset-West Parow Kraaifontein Ruitervacht Bellville-South Belhar Delft Brackenfell Bothasig/Richwood Bonteheuwel Durbanville Macassar/Firgrove Sir Lowry's Pinelands/Thornton Elsiesriver/Bishop Lavis BloekombosWallacedene Scottsdene Joostenbergvlakte Klapmuts

Office Head	Office	Postal Address	Street Address	City	Postal Code	WorkPhone	Fax number	Service Area
Mr L Woldson	Wynberg Office	Private Bag X25	C/o Myhard Street and Stasie Road	WYNBERG	7824	021/761-8790	021/761-9998	Wynberg Claremont Plumstead Hout Bay Constantia Simons Town Fish Hoek Muizenberg Steenberg Rondebosch Retreat Mowbray Meadowridge Lavender Hill Kenilworth Healthfield Bergvliet Zeekoeivlei Southfield Phillippit Pelican Park Ottery Lotusriver Grassy Park Diepriver Westlake Tokai Kommetjie Kalkbaai Noordhoek Masiphumelele Squatter Camp Scarborough Da Gama Park

Office Head	Office	Postal Address	Street Address	City	Postal Code	WorkPhone	Fax number	Service Area
Mrs W van der Post	Ahtlone Office	Private Bag X11	Melofin Centre, Old Klipfontein Road	ATHLONE	7760	021/696-8038/9; 696-8040	021/696-8072	Athlone Hanover Park Landdown Heideveld Bridgetown Surrey Estate Welcome Estate Manenberg Wetton Crawford/Rondebosch East Rylands Thambo Square Kenwyn
Mr C Bailey	Atlantis Office	Private Bag X4 Private Bag 428	C/o Neil Hare and Thoma Henshilwood Roads	DASSENBERG VREDENBURG	7350	021/577-1084	021/577-3209	Atlantis Malmesbury Vredenburg Saldanah Laaiplek St Helena Bay Patenoster Mamre Philidelphia Melkbosstrand
Mrs B Gardiner	Mitchell's Plain Office	Private Bag X10	Ward 11, Lentegeur Hospital	MITCHELL'S PLAIN	7785	021/371-2118	021/371-2189	Mitchell's Plain
Mrs D Wewers	George Office	Private Bag X6508	Rentzburg Court, 42 Courtney Road	GEORGE	6530	044/874-2020/2010	044/873-5422	George Mosselbay Knysna Albertinia Heidelberg Plettenbergbaai Pacaltsdorp



Office Head	Office	Postal Address	Street Address	City	Postal Code	WorkPhone	Fax number	Service Area
Mrs E Jooste	Beaufort-West Office	Private Bag X504	117 Donkin Street	BEAUFORT-WEST	6970	0201/3204/ 0201/4989	0201/2128	Beaufort-West Murraysburg Laingsburg Prins Albert Matjiefontein Nelspoort Prins Albertweg Merweville Letjiesbos
Ms A du Plessis	Oudtshoorn Office	Private Bag X2	C/o Arnold de Jager and Mars Streets	BRIDGTON	6623	044/2741106 044/272-8977	044/2741612 044/272-4007	Oudtshoorn Uniondale Calitzdorp Ladysmith Van Wyksdorp De Rust
Mr C Marais	Paarl Office	Private Bag X3026	C/o Nuwe and Derksen Streets	PAARL	7620	021/871-1682	021/872-0049	Paarl Simondium Wellington Franschhoek Klapmuts
Mrs J Jacobs	Piketberg Office	PO Box 20	Die Wingerdblok 15, C/o Lang and Trek Street	PIKETBERG	7320	0261/31156/7	0261/31347	Piketberg Hopefield Langebaan & Langebaanweg Moorreesburg
Mrs M Kotze	Vredendal Office	Private Bag X2	C/o Waterkant and Tuin Street	VREDENDAL	8160	0272/132096	0272/132142	Vredendal Van Rhynsdorp Clanwilliam Citrusdal Lambertsbaai Graaffwater Klawer

Office Head	Office	Postal Address	Street Address	City	Postal Code	WorkPhone	Fax number	Service Area
Mrs M Tiger	Worcester Office	Private Bag X3052	Leaders Building, Fairbain Street	WORCESTER	6850	023/342-2400	023/347-5181	Worcester Bredasdorp Caledon Hermanus Grabow Ceres Tulbach/Wolsley Bonnivale Swellendam Montague Robertson
Mrs A van Zyl	Cape Town Office	PO Box 131	48 Queen Victoria Street	CAPE TOWN	8000	021/424-6020	021/423-8331	Kaapstad Seepunt Maitland Observatory Kampsbaai Woodstock Soutriver Kensington Milnerton Marconi Beam
Ms Jobela	Khayelitsha Office	Private Bag X11	Bonga Road, Site B, Lingelethu-West	KHAYELITSHA	7785	021/364-1330	021/364-1337 021/361-4973	Khayelitsha
Ms M Mtya	Gugulethu Office	P/a Athlone Private Bag X11	Service Area of Athlone	ATHLONE	7760	021/638-5151	021/638-5117	Gugulethu Thambo Square Phola Park New Rest Barvelona Kanana & Tick Hostels
Ms M Mtya	Nyanga Office	P/a Athlone Private Bag X11	Service Area of Athlone	ATHLONE	7760	021/386- 1208/9	021/386-4030	Nyanga Browns Farm Mau-May Cross Roads KTC Millers Camp Boys Town

Office Head	Office	Postal Address	Street Address	City	Postal Code	WorkPhone	Fax number	Service Area
Miss GN Masina	Langa Office	P/a Athlone Private Bag X11	Service Area of Athlone	ATHLONE	7760	021/694-1860	021/694-1863	Langa Joe Slovo Squatter Camp

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## Contributors

J Arendse, K Blackbeard, L Camagu, Cloete, C Coetzee, A Dhansay, L Dudley, A Fox, N Huskisson, P A Hendricks, G Hussey, W Kampher, H Louw, M Johnson, S Mehtar, A Morison, B Mostert L Mzilikazi, G Riedeman D Sanders, S Schaaf, E Smith, A Smith, G Swingler, P Van Heerden, B Van Niekerk, M Wates, H Zar, E Zollner.

Chairpersons: F Desai, M Hendricks, and L Olivier

Cape Metropolitan Council, Cape Town City Council, PAWC: MCWH, Child Health Unit, UCT: Red Cross Hospital, Karl Bremer Hospital, UWC, SAP and Tygerberg Hospital.