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# HOLY LAND CHRISTIAN MISSION

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November 24, 1976

Mr. James Holtaway
NE/ME
Room 3317
Department of State
Washington, D. C. 30523

Dear Mr. Holtaway,

On behalf of the Board of Directors of the Holy Land Christian Mission, I am submitting herewith a preliminary proposal outlining several developme projects for the Mount of David Crippled Children's Hospital.

The presentation speaks for itself. I would only add that this organizatic has high confidence in the direct benefits the various projects will provide and in the international significance it may have on the people of the West Bank area.

If you wish any further information I will be delighted to furnish it. I very much appreciate your helpfulness and attention to this very important matter. I will be leaving for Bethlehem on November 30th and will return to the office on December 20th.

Respectfully,

R. Joseph Gripkey

R. Joseph Gripkey
Executive Director
Holy Land Christian Mission

Meeting the needs of the poor and crippled children of the Holy Land has always been the goal of the Mount of David Hospital. Increasing pressures now threaten the success this Hospital has had in reaching its objectives. Something must be done quickly to combat the growing problems the Hospital faces, for the ultimate victim will be the helpless crippled children of the West Bank who have no other place to go for help.

Three areas account for this rising pressure:

1. Lack of bed space. The average Hospital stay of each patient at the Mount of David Hospital is 40-60 days ... over triple the time in most Western or European countries. This lengthy stay naturally affects the admission rate of new patients and leaves us with a waiting list of 2,061 as of September, 1976, compared to 1,488 in September, 1975.

2. The reason for such lengthy hospital stays is the second (and a major) problem in itself. The uneducated people of this area look upon modern medical care and procedures with suspicion and misunderstanding. Because they do not comprehend the need for nor do they follow directions involving post-operative patient care, it is left up to the Hospital to keep patients in-house to insure the successful completion of the rehabilitation program.

3. The high rate of inflation in the country of Israel. The Israeli government put into effect in October, 1976, a price rise of 20% affecting all basic commodities, fuel and public transportation. This 20% rise is added on to an already accelerating inflation scale that has affected this country deeply for the last 4 years. Goods purchased today cost on the average 2 times higher than 4 years ago.

*In an accompanying report, Dr. Ahmed F. Zuaiter, M.B.B.Ch., F.R.C.S. of the Mount of David Hospital, will cover more specifically the unique problems this Hospital faces.

SOLUTIONS

Being the only orthopedic center in the entire West Bank, the Mount of David Hospital is committed to the improvement, expansio and constant updating of the medical care it offers to the children of this area. Therefore, we have approved a three-stage construction program which is designed to meet this demand in the most efficient way. Final plans for the construction will be completed during the latter half of 1977 with construction beginning in 1978.

Fundamental to the expansion program outlined below is the acquisition of additional land by the Mission. A plot of land, consisting of 2,905 square meters directly adjacent to the Mission costing $180,000, is the proposed site for expansion. ?

STAGE ONE: A 50-bed, 1,600 square meter fully-equipped rehabilitation center costing approximately $900,000.

This has been designated as the first stage because of the immediate need we are faced with in providing children, released from the Hospital, a place to be retrained, educated and skilled in order to learn to care for their own needs. Inherent in the operation of this facility is the automatic ability to transfer patients from the Hospital to the rehabilitation center for completion of their care program thus freeing bed space for additional admissions in the present facility.

STAGE TWO: A 1,200 to 1,500 square meter facility costing approximately $600,000 to serve as a school of nursing. Hiring of staff and setting up of the curriculum will require an initial investment of $200,000 and in subsequent years will be maintained at an estimated annual cost of $80,000.

This school will be the only nursing program on the West Bank. The required tuition fees of other schools in Israel proper have limited the ability of area people to establish a career in medicine and at the same time has greatly inhibited our ability to find trained personnel to staff our Hospital.

We look upon this program to be not only of great benefit to the efficient operation of our Hospital but also to the community as well. It will give local people a chance to further themselves through a professional career, it will return money into the local economy through eventual salaries and will also provide an avenue of expression to educate local people as to the benefits of modern medicine and general hygiene.

An offshoot of this program in the future would be the capability, with trained personnel, of establishing health clinics in refugee camps and other poverty areas so that preventive medicine can be practiced and illness treated early.

STAGE THREE: The construction of a 200-bed hospital with all necessary support facilities costing approximately $4,000,000. This figure includes equipping the facility.

This new Hospital and rehabilitation center will double our capabilities in helping the children of the West Bank while eliminating the structural and design problems we encounter in our present pre-fab structure.

With the overall improvement of health care in the West Bank aided by these three facilities, this Hospital could be eventually opened to a broader patient category thus covering other needs.

INTERIM PROGRAM FOR INCREASING CAPACITY OF
PRESENT HOSPITAL WHILE EXPANSION IS UNDERWAY.

Vehicles and personnel are needed to transport children who are in the post-operative stage of recovery and who require intensive physiotherapy sessions daily to and from the Hospital.

In order to best utilize the capacity of the Hospital, additional equipment and personnel are needed in other areas as well.

This program will make it possible to maintain constant supervision of the care they are receiving at home, to spot any indications of negligence or abuse, i.e., broken casts, lost or damaged braces, etc., until the child has fully recovered and is able to function normally.

We estimate that this program will cost $488,000 the first year.

BREAKDOWN ON COSTS OF INTERIM PROGRAM

| | | |
|---|---|---|
| 4 ambulance vehicles | $65,000 | |
| 4 drivers | 15,000 | |
| Maintenance on vehicles, including gasoline, servicing, insurance, etc. | 50,000 | |
| | | $130,000 |
| Expansion of Physio-therapy department to handle the increased patient load | | |
| Remodeling to allow for more effective use of available space | 20,000 | |
| Additional physiotherapy equipment required | 100,000 | |
| Personnel (three therapists) | 45,000 | |
| Housing (rental costs) to provide quarters for additional personnel | 10,000 | |
| | | $175,000 |
| Additional surgical costs involved (bed space released by putting this Interim Program into effect will allow for increase in number of operations it is possible to perform). This will include costs of casting materials, supplies, medicines, etc. | 140,000 | |
| | | $140,000 |
| The Hospital has its own full-time brace-maker but it would be impossible for him to keep up with the demands generated by the implementation of this program. Since the braces are crafted by hand, in our shop the materials used must be malleable and thus are often of insufficient strength for the rough abuse caused from life in the villages and camps. | | |
| Standardized brace making kits can be purchased with all-size, ready-made parts in quantities of 100 pieces each for an initial cost of $40,000. The proper size is selected and the finished brace constructed from the preformed parts, making it a sturdy applicance which would meet the standards desirable. | 40,000 | |
| One additional person added to the staff at a cost of $3,000 per year. | 3,000 | |
| | | $ 43,000 |

One of the most important achievements this Hospital has made is the building of a framework for rapport and trust with the people of the West Bank area. This is especially important because of the understandable fearfulness and suspicion they maintain toward modern medicine. It has been only through our successes in the treatment of their children ... proving our value and capabilities to them ... that this fear has been lessened.

In order that this new trust not be broken, it is essential for the Hospital to grow with the needs and demands of the community lest we fall short and lose this hard-won faith.

REPORT BY DR. ZUAITER

Fatmeh a little girl who came to us at age 11, is an excellent example of the difficulty we face in our function as a medical center in a culture where time means little and proper care of the out-patient is neither recognized nor understood.

This girl was brought to the Hospital completely paralyzed and unable to walk. She had never stood in her entire life, for she had suffered this paralysis from an attack of polio as an infant.

As often happens in this area of the world, Fatmeh's condition was ignored by her parents. To their way of thinking it was an act of God--fate. Upon the urging of an archaeologist visiting their village, the parents gave their permission for him to bring the girl to the Mount of David Hospital.

Upon examination, I realized that multiple operations would be necessary, possibly as many as eight. Time had hardened once-supple bones and muscles, increasing the deformity and the difficulty in achievi a good correction. Had Fatmeh's parents brought her to a hospital when she first became ill, or even immediately following the course of the disease her whole life could have been different.

I performed the operations on Fatmeh and she left this Hospital able to walk for the first time in her life with the use of crutches and braces What a change she had undergone while here She laughed and smiled talked eagerly of her new abilities and with a nutritional diet had gained weight.

Fatmeh returned home with instructions for a rigid program of exercise and physio-therapy sessions scheduled to complete her treatment. But her parents could not understand the necessity of continuing the physio-therapy treatments in our out-patient clinic, nor of the need in limiting her strenuous activity. I must add that here in the West Bank,

transportation to the Hospital for treatments puts a great strain on the family of any child. Few people have access to cars, and if they do, it costs them two or three days salary to pay the fare. The same is true of public transportation. It is expensive and runs at odd hours. The trip is usually a family affair because society here dictates that a woman cannot travel alone. Therefore, the father must leave his work without pay in order to bring the child in for treatments.

The archaeologist who had found Fatmeh returned some months later to visit her and found instead a miserable child, once again trapped by her afflictions. Her crutches and braces were broken from her efforts to walk in the mountainous region where she lived. He brought her to us once again. But, what were we to do? We are a Hospital, not a home for those who need rehabilitation. Another child needs the bed, too.

So, this is our dilemma. Fatmeh's case is only one example of having our corrective work negated by improper care in the home or having the vital physio-therapy treatment appointments missed. After many experiences of having children returned to us with broken plasters and lost corrective shoes, we are forced to adapt our treatment of such cases to the culture.

Today we keep the child not only through the plaster and traction, but also through the initial rehabilitation stages to insure that our work is not destroyed by carelessness and neglect. Keeping a child in one of our Hospital beds beyond the normal turnover rate naturally means the demand for these 100 beds becomes even greater. Our average hospital stay involves 40 to 60 days. In a Western or European country, this time will be only 14-21 days. There a child can go home with a plaster because he is released into suitable home life conditions or he can be placed in a rehabilitation center where he completes his treatment. On the entire West Bank, there is not one center that can properly follow-up on the work we do.

This problem of increased duration of hospitalization has three effects. One, our waiting list has grown to an enormous figure of 2,061 as of September, 1976, compared to 1,488 in September, 1975. Two, we are limited in the number of cases we can be treating at one time. Our operating schedule would allow for more major surgeries had we the bed space to care for the patient. Three, we encounter difficulty in securing adequate staff due to the tremendous work load in this area. We are talking of children in plasters or traction. Children who must be fed washed, taken to physio-therapy, entertained and loved. Our staff is mostly local, trained in house and subject to the same societal rules and transportation difficulties that our children's parents must function under. With better staff housing, improved dormitory conditions, etc. the problem of work schedules would not be as severe.

Inherent in this problem of lack of bed space is deciding who we admit first. Naturally we admit emergency cases on a 24-hour, seven-day-a-week basis. These cases are generally fractures, 10-15% of which have been treated by bonesetters. Many times we are at 100% occupancy when an emergency patient arrives. We set up extra beds, crowd them between two others; we do anything to avoid the parents taking this child to a bonesetter.

A bonesetter is an unskilled practitioner who has had the "craft" passed down from father to son. He sets the broken bone with wet rags, soaked in a mixture of egg, flour and lemon. The rag is then wrapped around the area and splinted with sticks. The tighter they wrap and the louder the child screams, the better they believe it will heal. The end result, which we have to correct, is a Volkman's contracture which has resulted from obstruction of circulation to the area and results in a severe deformity.

Aside from emergency cases, the first cases we are intent upon admitting are the congenital hip deformities and club feet deformities. Right now, even though we have an average of 20 congenital hip cases in the Hospital at any given time, we have another 250 waiting to be admitted. It is so important to treat these as soon as possible because even one month's delay can make a big difference in the ability to make a proper correction.

We have over 60 severe club foot cases on our waiting list right now. It occurs approximately in one to four babies per thousand births here in the West Bank, according to my studies. It is twice as common in males as in females.

Of course, in such a deformity and in most congenital deformities on the whole, the best results are achieved if the patient is seen immediately after birth. In the Western world treatment has generally begun within the first two or three months of birth. But, again culture enters the picture here. We do not see such cases until they are three or four, even eight and nine years old. They have walked on the foot all this time and on the average it has rotated over 90 degrees. The skin is tight and the tendons are so contracted that an operation is very difficult.

When I first joined the Hospital and began working on such deformities we were faced with failure after failure. I was following textbook rules, procedures that did not apply to such extreme deformities caused by time and use. We had to develop new techniques to allow for this culture. This same thing is true in our cases of congenital hip deformities. A normal textbook rotation of the hip would be of little meaning to a child living on the West Bank. These methods were developed for Western cultures where tables and chairs are used. Here, people sit on the ground, on the floor. This requires an entirely different rotation in order to accommodate the position.

I might add one thing here on admission practices. We had to make a decision as to who we admit first. As I have explained, the sooner we treat congenital hip and club foot deformities the better, so they are admitted first. Cases involving post polio paralysis, such as Fatmeh's, are admitted at a less frequent rate unless the case involved is very young. This is because even though the damage may be severe, the harm done by waiting in these cases is of less significance than in others.

One subject that I am very sad about is our inability to admit any further cases of osteomyelitis. This has been a very recent decision and until we can make some changes in the physical structure of this Hospital, it will have to stand.

Cases of osteomyelitis have to be isolated, otherwise they infect clean cases. In our Hospital, we do not have an isolation ward as we have only one long ward. Keeping these cases isolated from the others became an extreme hardship on our staff, affecting everyone's efficiency and bringing undue risk of infection to our other patients.

As you can see, the culture of this area enters into every aspect of the functioning of this Hospital. Treatment could be begun sooner if a greater understanding of the need could be reached. More bedspace could be freed if a greater understanding of proper follow-up care and treatment could be reached.

I speak over the radio once a week, telling of new medicines and treatments, describing symptoms of illness, etc. This has helped to a certain extent in educating the people. We have realized the benefits in seeing a few children brought to us as babies after their parents heard the broadcast. But, those who can afford a radio in this area are in the minority. We live in a place of great poverty, of isolation from the progress of the rest of the world.

Even the government's attempt to stop polio has failed. It is sad to see a curable disease still running rampant today, but here it does! People are suspicious of the vaccine. Sometimes they bring their children to a mobile clinic once or twice, but fail to finish the series. Many times, the people distributing the vaccine are not careful, forgetting to refrigerate it and so it spoils. I might add that we are not allowed to get involved with the distribution of the vaccine. This is considered to be a government program.

So Mount of David Hospital admits to this very day, polio cases. In everything from congenital hip deformities to post-polio paralysis we have achieved great success. Our patients leave our Hospital well and happy. The frustration is that more could benefit, more could have happier and healthier lives, if the Mount of David Hospital could touch their lives sooner.

Dr. Ahmed F. Zuaiter
M.B.B.Ch., F.R.C.S.
Medical Director
Mount of David Hospital
Bethlehem

HOLY LAND CHRISTIAN MISSION
MOUNT OF DAVID CRIPPLED CHILDREN'S AND ORTHOPAEDIC HOSPITAL
BETHLEHEM

General Statistics for the Year - 1975

| | Under 21 Years | | Over 21 Years | | Total |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| **1. OUT-PATIENTS** | | | | | |
| New Patients | 1236 | 928 | 696 | 811 | 3671 |
| Follow-Up Appts. | 1881 | 1565 | 970 | 1299 | 5715 |
| Total Out-Patients | 3117 | 2493 | 1666 | 2110 | 9386 |
| **2. Total & SURVEY OF ADM.** | | | | | |
| New Patients | 150 | 117 | 26 | 42 | 335 |
| Orphan Home | 49 | 32 | -- | -- | 81 |
| Employees | -- | -- | 1 | 3 | 4 |
| Re-Admitted | 113 | 68 | 16 | 13 | 210 |
| Ref. from other Hospitals | 12 | 13 | 1 | 2 | 28 |
| Total Admissions | 324 | 230 | 44 | 60 | 658 |
| **3. TYPES OF CASES ADMITTED** | | | | | |
| Traumatology Cases | 23 | 9 | 3 | 1 | 36 |
| Cold Cases | 291 | 207 | 34 | 54 | 586 |
| Emergencies | 15 | 12 | 6 | 3 | 36 |
| **4. DISCHARGES** | | | | | |
| New Patients | 148 | 89 | 29 | 34 | 300 |
| Orphan Home | 46 | 24 | -- | -- | 70 |
| Employees | -- | -- | 1 | 3 | 4 |
| Re-Admitted | 98 | 58 | 12 | 11 | 179 |
| Ref. from other Hospitals | 9 | 11 | 2 | 1 | 23 |
| Total Discharges | 301 | 182 | 43 | 47 | 575 |

Average Days of Hospitalization: $\frac{18914}{575} = 33$

5. OCCUPANCY STATISTICS:

Maximum Capacity ..... 100

Average % of Utilization during the Years..... 106.2

6. Next Possible appointment date on which a new patient may see Dr, Zuaiter in the out-patient Clinic: (Month) Day - Year 28.5.1

7. No. of patients on waiting list to come in at the end of the Year 1633

## THEATRE

1. Total Operations Performed during the Year 1975 = 1345

| 2. NO. OF PLASTERS | SPINA | ABOVE KNEE | BELOW KNEE | SPICA | ABOVE ELBOW | BELOW ELBOW | TOTAL |
|---|---|---|---|---|---|---|---|
| Plaster Room | 1 | 144 | 678 | 176 | 61 | 72 | 1132 |
| Theatre | 1 | 262 | 209 | 203 | 100 | 30 | 805 |
| Total Plasters | 2 | 406 | 887 | 379 | 161 | 102 | 1937 |

| 3. NO. OF PLASTERS | Re-Inf. | Removal P.O.P. | Walking Sole | Total |
|---|---|---|---|---|
| Plaster Room | 97 | 137 | 22 | 256 |
| Theatre | 155 | 33 | 7 | 195 |
| Total Plasters | 252 | 170 | 29 | 551 |
| Grand Total for Plaster | 2488 | | | |

## X - RAY

| 1. RADIOGRAPHY DONE FOR | No. OF PATIENTS | NO. OF EXPOSURES |
|---|---|---|
| Out-Patients | 2444 | 3626 |
| In-Patients | 866 | 1323 |
| Orphan Home | 48 | 64 |
| Employees | 61 | 96 |
| Emergencies | 123 | 197 |
| Theatre | 143 | 170 |
| Total No. Of Patients | 3685 | |
| Total No. of Exposures | | 5476 |
| Average No. Exposures per Patients | | 1.5 |

## LABORATORY

| | Under 21 Years | | Over 21 Years | | Total |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| **1. TOTAL PRECEDURES:** | | | | | |
| Out-Patients Tests | 108 | 100 | 130 | 113 | 451 |
| In-Patients Tests | 1058 | 720 | 244 | 241 | 2263 |
| Orphan Home Tests | 43 | 87 | --- | --- | 140 |
| Emergencies | --- | --- | 2 | --- | 2 |
| Employees | --- | --- | 177 | 278 | 455 |
| Total Precedures | 1219 | 907 | 553 | 632 | 3311 |
| **2. TOTAL PATIENTS:** | | | | | |
| No. Out-Patients Tested | 90 | 84 | 86 | 62 | 322 |
| No. In-Patients Tested | 558 | 418 | 96 | 112 | 1184 |
| Orphan Home | 41 | 59 | 2 | --- | 102 |
| Emergencies | --- | --- | 2 | --- | 2 |
| Employees | --- | --- | 89 | 187 | 276 |
| Total of Patients Tested | 689 | 561 | 275 | 361 | 1886 |
| Average No. Tests/Patient | 1.8 | | | | |

## PHYSIOTHERAPY

| 1. NUMBER OF UNITS | OUT-PATIENTS | IN-PATIENTS |
|---|---|---|
| Short Wave Diathermy | 16 | --- |
| Microwave | 2485 | 37 |
| Radiant H. Infrared | 4466 | 381 |
| Wax Bath | 811 | 320 |
| Ultrasound | 1818 | 209 |
| Medicomonolator | ---- | --- |
| Mycdyne | 1923 | 149 |
| Massage | 10380 | 1557 |
| Exercises | 12256 | 20038 |
| Hyder Tank | ---- | --- |
| St m Packs | ---- | --- |
| Hydrocollator | 2248 | 2060 |
| Traction | 456 | 23 |
| Whirl Pool | 481 | 1726 |
| Total Procedures | 37340 | 26500 |

| 2. NO. OF PATIENTS | Under 21 Years | | Over 21 Years | | Total |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| Out-Patients | 225 | 609 | 581 | 671 | 2086 |
| In-Patients | 452 | 380 | 50 | 48 | 930 |
| Total No. of Patients | 677 | 989 | 631 | 719 | 3016 |
| No. of Out-Patient Sessions | 2391 | 2107 | 2619 | 2963 | 10080 |
| No. of In-Patient Sessions | 7042 | 8127 | 593 | 557 | 16319 |
| No. of Out-Patient Procedures | | | | | 37340 |
| No. of In-Patient Procedures | | | | | 26500 |
| Average Procedures / Out Patient Treatment | | | | | 17.9 |
| Average Procedures / In Patient Treatment | | | | | 28.5 |

## PHARMACY

| 1. PATIENTS RECEIVING MEDICINE | Under 21 Years | | Over 21 Years | | Total |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| Out-Patients | 22 | 16 | 194 | 314 | 546 |
| In-Patients | 310 | 253 | 56 | 130 | 759 |
| Orphan Home | 306 | 297 | --- | --- | 603 |
| Employees | 26 | 24 | 182 | 143 | 373 |
| Emergencies | 69 | 51 | 57 | 61 | 238 |
| Total Patients Receiving Med. | 733 | 641 | 499 | 648 | 2521 |

| 2. ITEMS DISPENSED | Under 21 Years | | Over 21 Years | | Total |
|---|---|---|---|---|---|
| | Male | Female | Male | Female | |
| By Out-Patients | 60 | 26 | 280 | 460 | 826 |
| By In-Patients | 701 | 546 | 261 | 54 | 1562 |
| By Orphan Home | 432 | 428 | --- | --- | 860 |
| By Employees | --- | 52 | 38 | 304 | 245 |
| Emergencies | 25 | 31 | 42 | 24 | 122 |
| Total Items Dispensed | 1270 | 1069 | 887 | 783 | 4009 |

TYPES OF APPLIANCES

| | O/PATIENT | I/PATIENT | NEW | R/NEW | REP. | TOTAL |
|---|---|---|---|---|---|---|
| Long Leg Caliper | 17 | 28 | 45 | -- | -- | 45 |
| Below Knee Caliper | -- | 3 | 3 | -- | -- | 3 |
| Pelvic Belt | 1 | 4 | 5 | -- | -- | 5 |
| Lumbo Sacral Spine | -- | 1 | 1 | -- | -- | 1 |
| Insoles | 51 | -- | 51 | -- | -- | 51 |
| Surgical Shoes | 22 | 35 | 57 | -- | -- | 57 |
| Corected Shoes | 61 | 22 | 24 | 12 | 47 | 83 |
| Abduction Hip Splint | 13 | 2 | 15 | -- | -- | 15 |
| Collar & Cuff | -- | 2 | 2 | -- | -- | 2 |
| Walking Heel | 4 | 1 | 5 | -- | -- | 5 |
| Straight Last Shoes | 6 | 1 | 7 | -- | -- | 7 |
| Elbow Crutches | 1 | -- | 1 | -- | -- | 1 |
| Arch Feature Shoes | 6 | 1 | 7 | -- | -- | 7 |
| Thomas Heel | 12 | 2 | 10 | -- | -4 | 14 |
| Night Splint | 5 | -- | 5 | -- | -- | 5 |
| Abduction Boots | 14 | 3 | 17 | -- | -- | 17 |
| Finger Splint | 2 | -- | 2 | -- | -- | 2 |
| Abduction Arc Brace | 8 | 16 | 24 | -- | -- | 24 |
| Weight Caliper | 2 | 4 | 6 | -- | -- | 6 |
| Back Belt | -- | 1 | 1 | -- | -- | 1 |
| Back Brace | 1 | -- | 1 | -- | -- | 1 |
| Adjustment of Brace | 21 | 10 | -- | -- | 32 | 32 |
| Gradual Sloping | 2 | 1 | 2 | -- | 1 | 3 |
| Auxillary Crutches | 3 | 1 | 4 | -- | -- | 4 |
| Bucket Toped Caliper | -- | 2 | 2 | -- | -- | 2 |
| Von Rozen Splint | 2 | -- | 2 | -- | -- | 2 |
| Spinal Support | 2 | -- | 2 | -- | -- | 2 |
| Internal Rotation Shoes | 1 | -- | 1 | -- | -- | 1 |
| Artifical Limb | 1 | -- | 1 | -- | -- | 1 |
| Malwakee Brace | 1 | -- | 1 | -- | -- | 1 |
| Total | 257 | 142 | 302 | 12 | 85 | 399 |

/HB