Clubfoot treatment at CURE Kenya

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Look how far we've come

The week of 8 August 2011, I visited AIC CURE International Children's Hospital of Kenya in Kijabe. It is the hospital at which I served when my family and I lived in Kijabe from 1997 till 2000. It has changed in numerous ways.

When I started was there, we had five expatriates from North America serving in the capacities of Executive Director, Medical Director, Orthopedic Surgeon, Director of Rehab Department, and Director of General Services. Today, all those positions are filled by Kenyans who are as qualified as any of us from before, if not more so.

The physical space of the plant has been smartly re-arranged and more than doubled by various construction projects funded by USAID and others; there are now four full-sized operating theatres, a private wing for inpatient rooms, and a conference center and resident housing.

My visit focused on the CURE Clubfoot Worldwide (CCW) work there. Kenya's program – CURE Clubfoot Kenya (CCK) or CCW Kenya – was the first country program of CCW. An attempt in 2003 to create a Kenyan program to address clubfoot never gained traction and failed. But in January 2006, the program started again with renewed efforts and strong, focused leadership by Dr. Joseph Theuri, a Kenyan orthopedic surgeon. Dr. Theuri was the first non-western surgeon hired by CURE International, and after spending a number of years under Dr. Tim Mead, he attended Makarere University in Kampala, Uganda, to receive his degree in Orthopedic Surgery. During those years at Marerere, he learned of the Ugandan clubfoot program initiated by Drs. Norgrove Penny and Shafique Parani (both from Canada). That program and its good utilization of the Ponseti method for treating clubfoot intrigued Dr. Theuri and was part of the inspiration for creating CCW Kenya.

CCW Kenya Grows

Since 2006, the Kenyan program has grown from five to 36 clinics, and Dr. Theuri, serving as the country medical director, has trained dozens of Africans both inside and outside of Kenya.

As I observed t the Friday clubfoot clinic at CURE Kenya, within a short time frame I witnessed:

- One of Dr. Theuri's orthopedic surgeon residents – a surgeon from Cameroon – perform a tenatomy.
- One of our patient technicians take off a cast of a child.
- Charity, the country coordinator, and our clinic coordinator, an occupational therapist named Elvis, speaking with a young Masai couple about their child's relapse due to skipping appointments and non-compliance with prescribed use of braces.

Charity and I also spoke with a young, middle-class couple from Nairobi about their child with bilateral clubfeet, their pilgrimage that led them to our clinic, and their complete satisfaction with our program.

The clinic expected 17 families that day; there were more than 25 who came. Esther, the clinic counselor, made certain she spoke with each new family, as well as the Masai couple I mentioned, and all others she could as time and opportunity permitted.

A tradition of quality care

My memories wander back to watching the late Dr. Ponseti talk about his method for treating clubfoot to a group of us (mostly orthopedic surgeons) at the University of Iowa in 2005. He proposed a calm, soothing approach in speaking with the parents in all aspects of the care – even the tenatomy, a simple procedure to release the tendon of the affected foot under local anesthesia in a clinical setting. Dr. Ponseti was reputed to have never made a child cry. The Iowa setting was an auditorium where the baby (patient), the baby's mother, an orthopedic surgeon, the attending nurse, and Dr. Ponseti sat around an exam table for the tenatomy. The stage lights were dimmed, soothing music was softly piped in, and the ambience was enhanced by pastel colored curtains and minimal movements. Dr. Ponseti's younger colleague performed the tenatomy as Dr. Ponseti did the voice over, with the aid of a microphone for the audience's benefit. After the local anesthesia was applied and just as the incision was made, the baby cried. Dr. Ponseti had his counterpart stop, the mother was instructed to nurse the child, and it seemed to me the music volume slightly heightened. The procedure was completed in short order, and a cast was applied quickly.

Last week in Kijabe, we had no music, stage, or audience. For the tenatomies I observed, we had an orthopedic resident, a therapist for casting, two nursing students, and one technician in training observing, besides Charity and me. The mother was informed about what was planned, and she nursed when she thought her child needed it. The baby's understandable discomfort was as noticeable – and quiet – as his counterpart six years previous in Iowa on stage. The child fell asleep soon after the application of the casts was finished. Just like the baby from Iowa five years earlier, this Kenyan baby will have his cast removed and his feet checked for proper positioning, and then have braces fitted for use over the upcoming months.

Dr. Ponseti would be very proud.