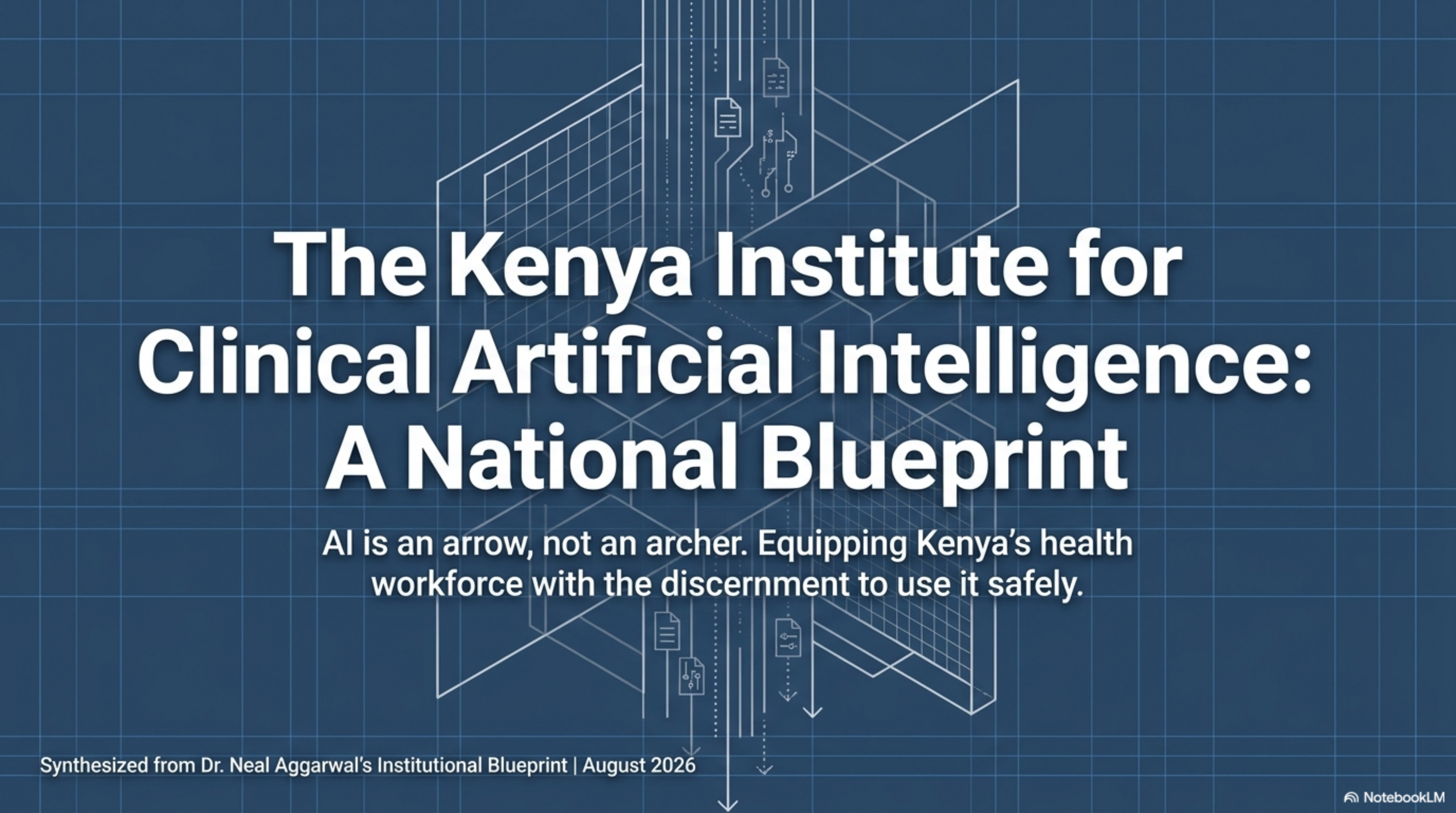


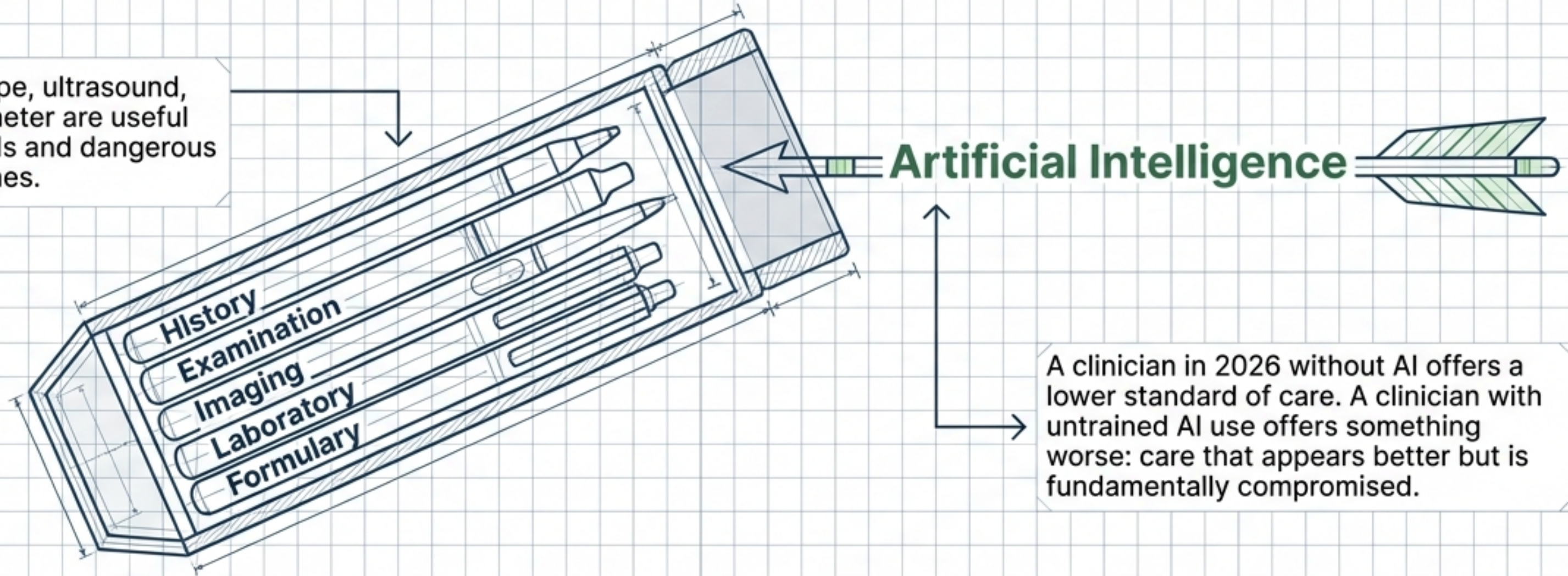


The Kenya Institute for Clinical Artificial Intelligence: A National Blueprint

AI is an arrow, not an archer. Equipping Kenya's health workforce with the discernment to use it safely.

AI is not a new colleague. It is a new instrument in the clinical quiver.

The stethoscope, ultrasound, and pulse oximeter are useful in trained hands and dangerous in untrained ones.



AI is fluent, fast, and confidently wrong in ways no previous tool has been. It requires active discernment, not passive trust.

The Threat of Automation Bias: Fluency creates cognitive offloading.

The Kenyan Context

**16% reduction in
diagnostic errors**

2025 Nairobi study of 40,000
primary-care visits.

**BENEFIT ONLY SEEN AMONG CLINICIANS
WHO USED THE TOOL WELL.**

The Threat

Physician receives **20 hours** of AI literacy training.

System presents plausible, fluent, incorrect output.

Cognitive Offloading: Clinician effort drops (anchoring).

Clinician **accepts** the clinical error.

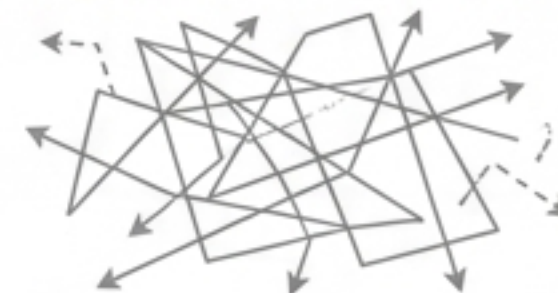
The Safe Zone: Trained Scepticism

Under-trust
(Missing actual diagnoses)

Over-trust
(Accepting hallucinations)

The First-Mover Advantage: Why Kenya can lead the world in clinical AI safety

Wealthy Global Systems
(Fragmented / Vendor-Led)



Governance

Singular national regulatory councils
(KMPDC, Nursing Council)

Continuous Learning

Mandatory, centrally administered CPD
architecture (e.g., KMPDC 50 points/year)

Singular National Standard

Infrastructure

Clean six-level health structure
(Community units to national referral)

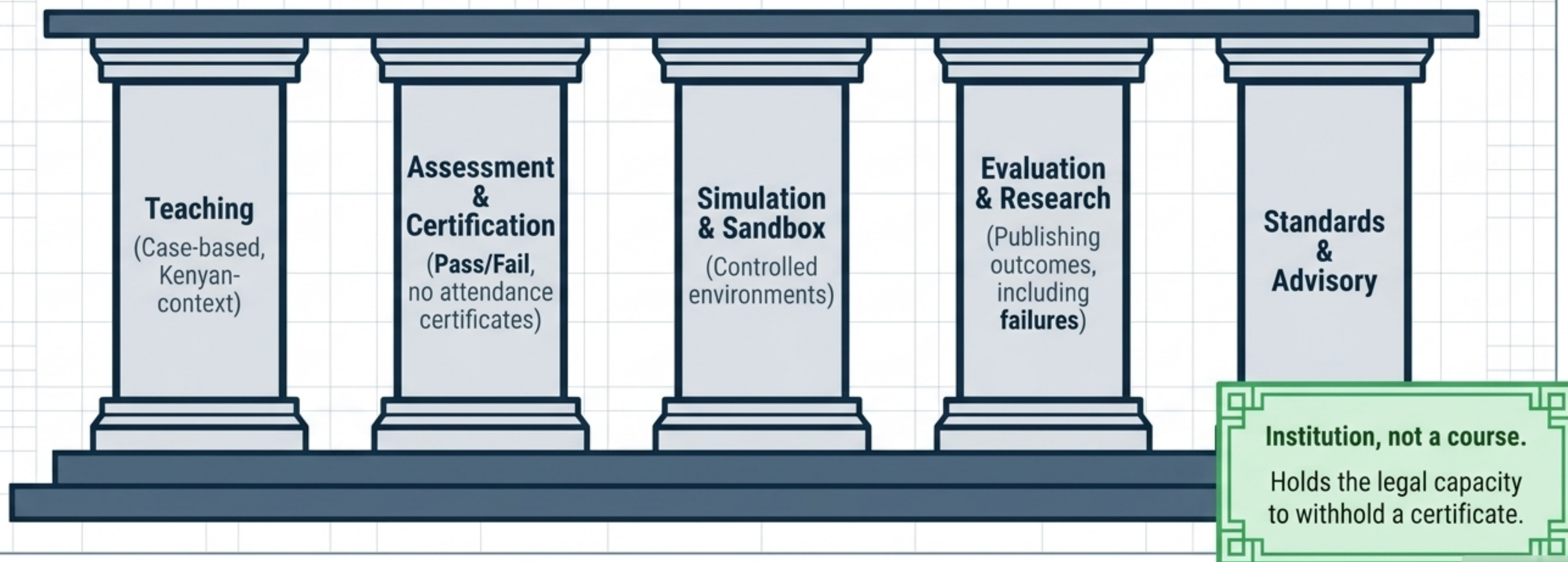
Policy

Digital Health Act 2023 & National
AI Strategy (2025–2030)

While wealthy systems distribute the problem across thousands of uncoordinated medical schools and vendors, Kenya can establish a singular, accountable national standard before habits calcify.

The Mandate: A permanent, publicly-accountable training institution.

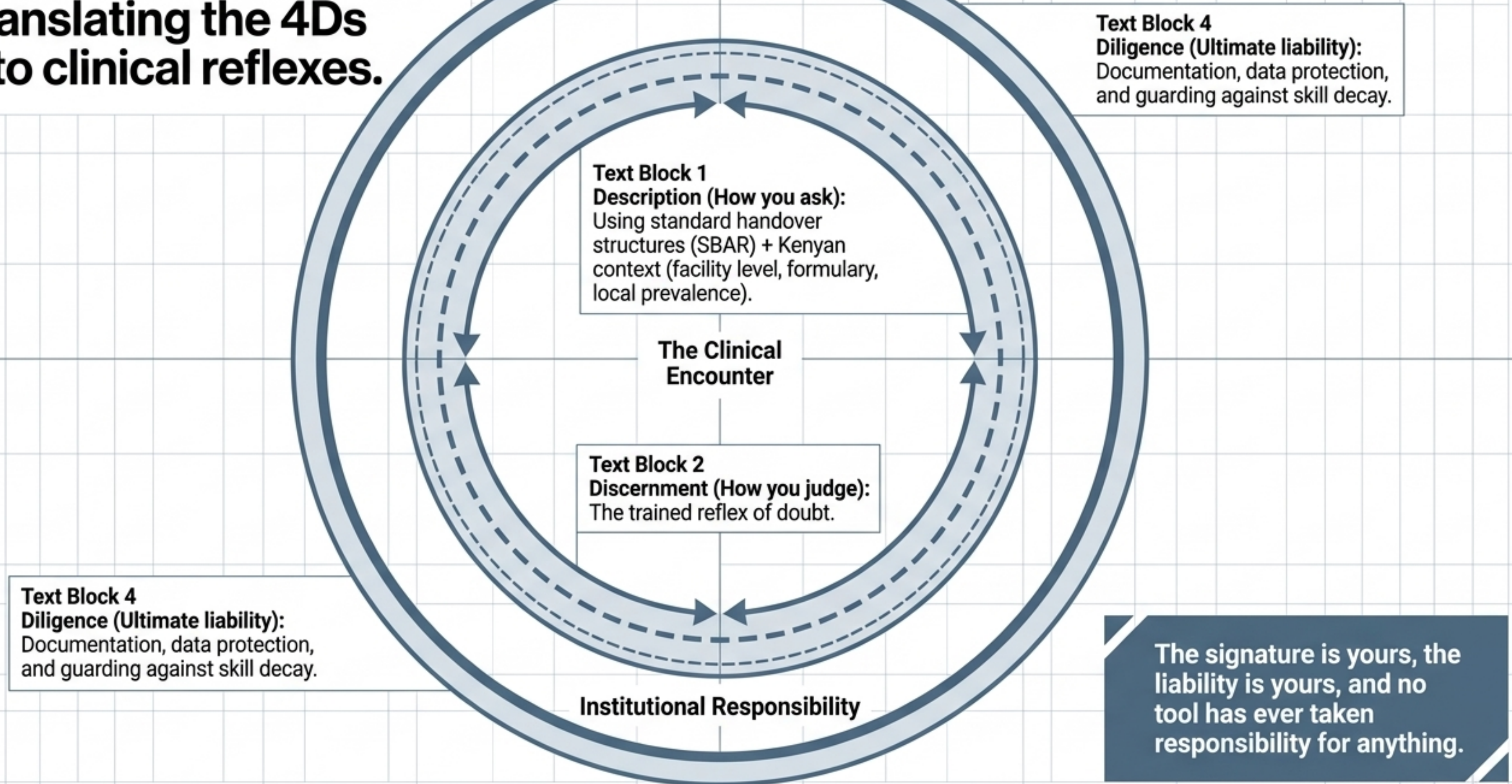
Every clinician in Kenya can use AI safely, sceptically, and to the patient's benefit—and can prove it.



Modalities of Risk: Naming the interaction before acting.

Modality	Definition & Example	Clinical Risk
Automation 	AI performs independently on direct human instruction. Example: Drafting a discharge summary.	Unreviewed output entering the record.
Augmentation 	AI and human co-execute iteratively. Example: Working a difficult differential.	Anchoring—the clinician's own reasoning is quietly revised.
Agency 	Human configures AI to perform future tasks. Example: Triage assistant left running on a queue.	Harm at scale with no human in the room.

The Intellectual Spine: Translating the 4Ds into clinical reflexes.



The Pedagogy of Scepticism: Drilled reflexes, not lecture topics.



The Independent-Impression Rule

Form and record your own clinical impression before viewing AI output to prevent anchoring.



Seeded-Error Simulation

One in three sandbox encounters contains deliberate, realistic clinical errors (e.g., wrong dose for renal impairment).



Adversarial Rounds

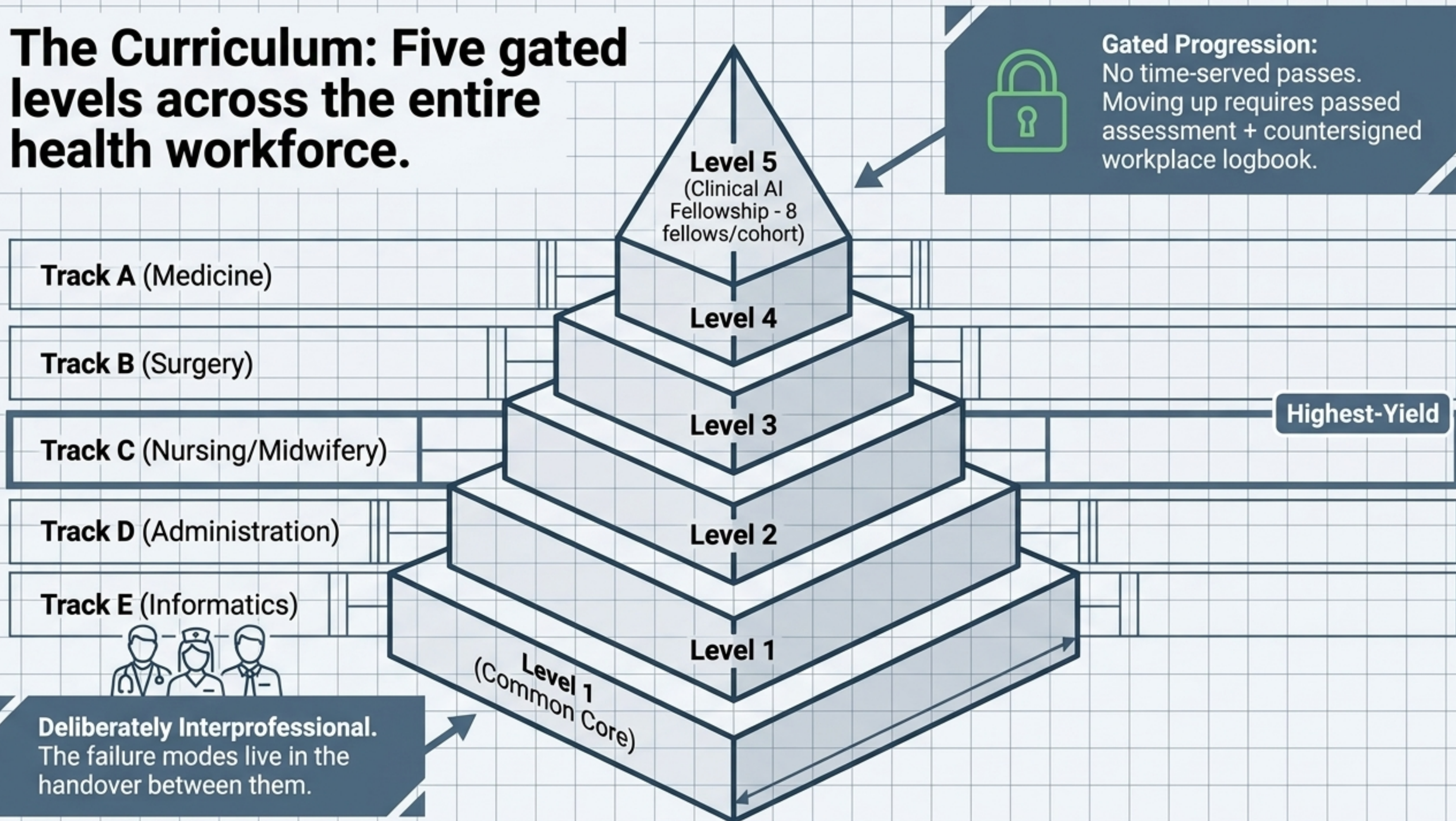
Learners explicitly break AI models using cases from their own practice to build a shared catalogue of failure modes.



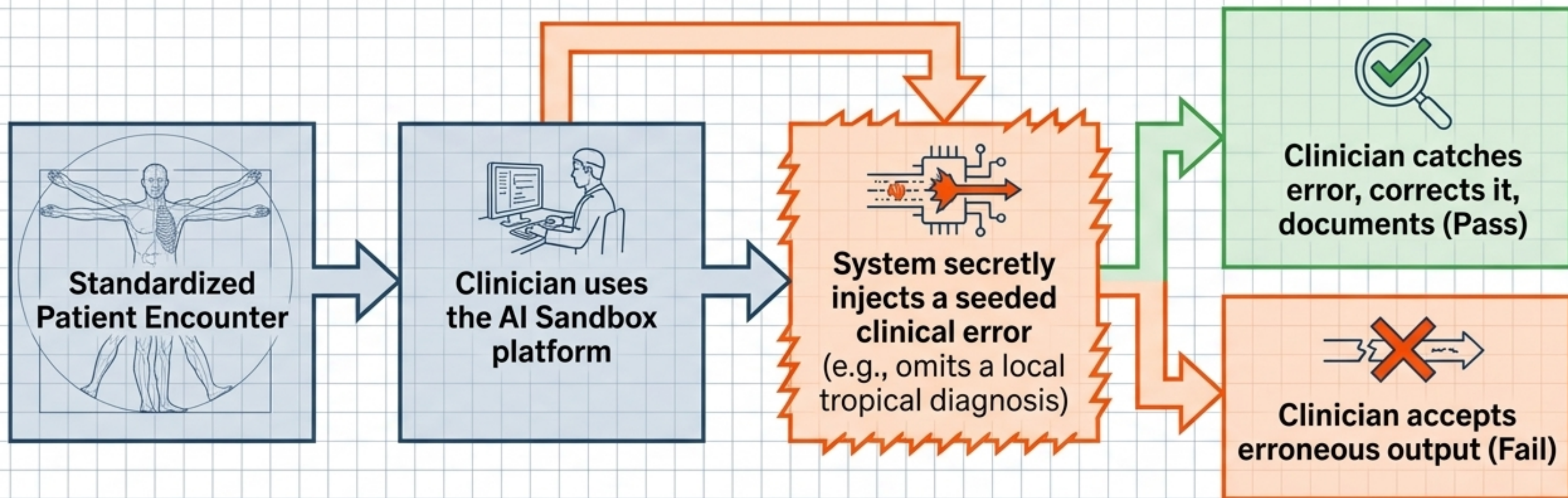
Bias Taught Locally

Abstract bias lectures fail. We teach on Kenyan realities: skin models **failing on dark skin**, AI **suggesting unavailable drugs**, or **mistranslations** from Kiswahili/Dholuo.

The Curriculum: Five gated levels across the entire health workforce.

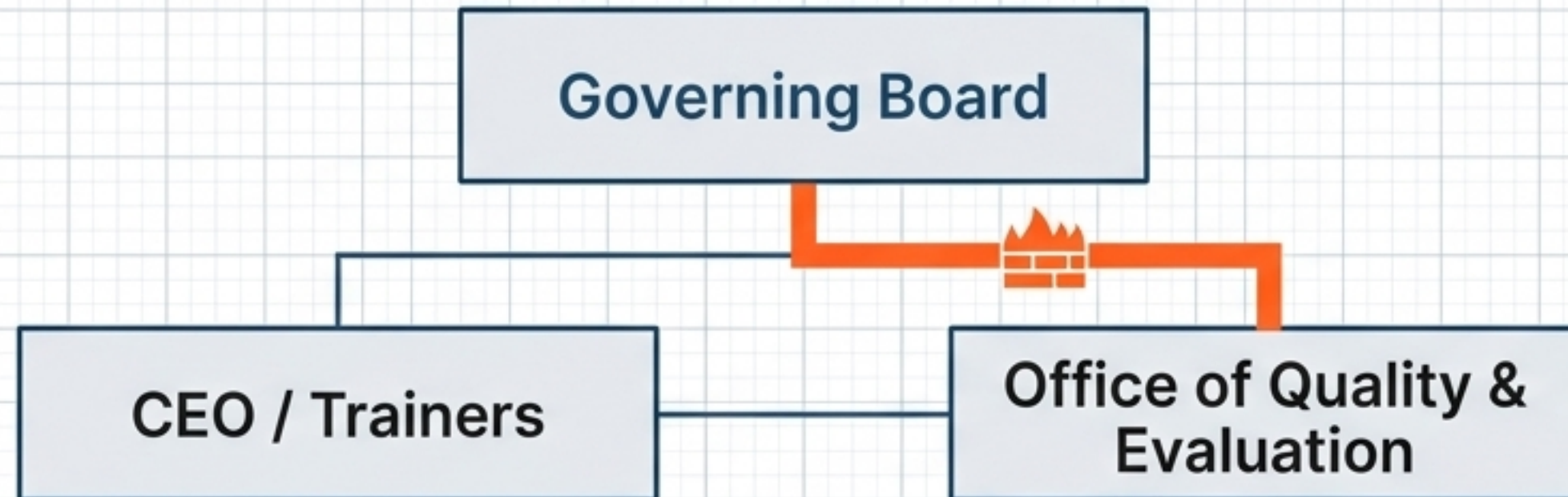


The AI-OSCE Sandbox: Measuring error-catch rates as a conjunctive pass requirement



Error detection is non-negotiable. You cannot compensate for failing to catch an AI error with excellent communication skills.

Structural Independence: An institution comfortable with its own negative findings.



Vendor Independence

No vendor funds curriculum for their own products. Platform must be model-agnostic by architecture.

Public Accountability

Pass rates, failure rates, and incidents of AI-related harm ⚠ published annually.

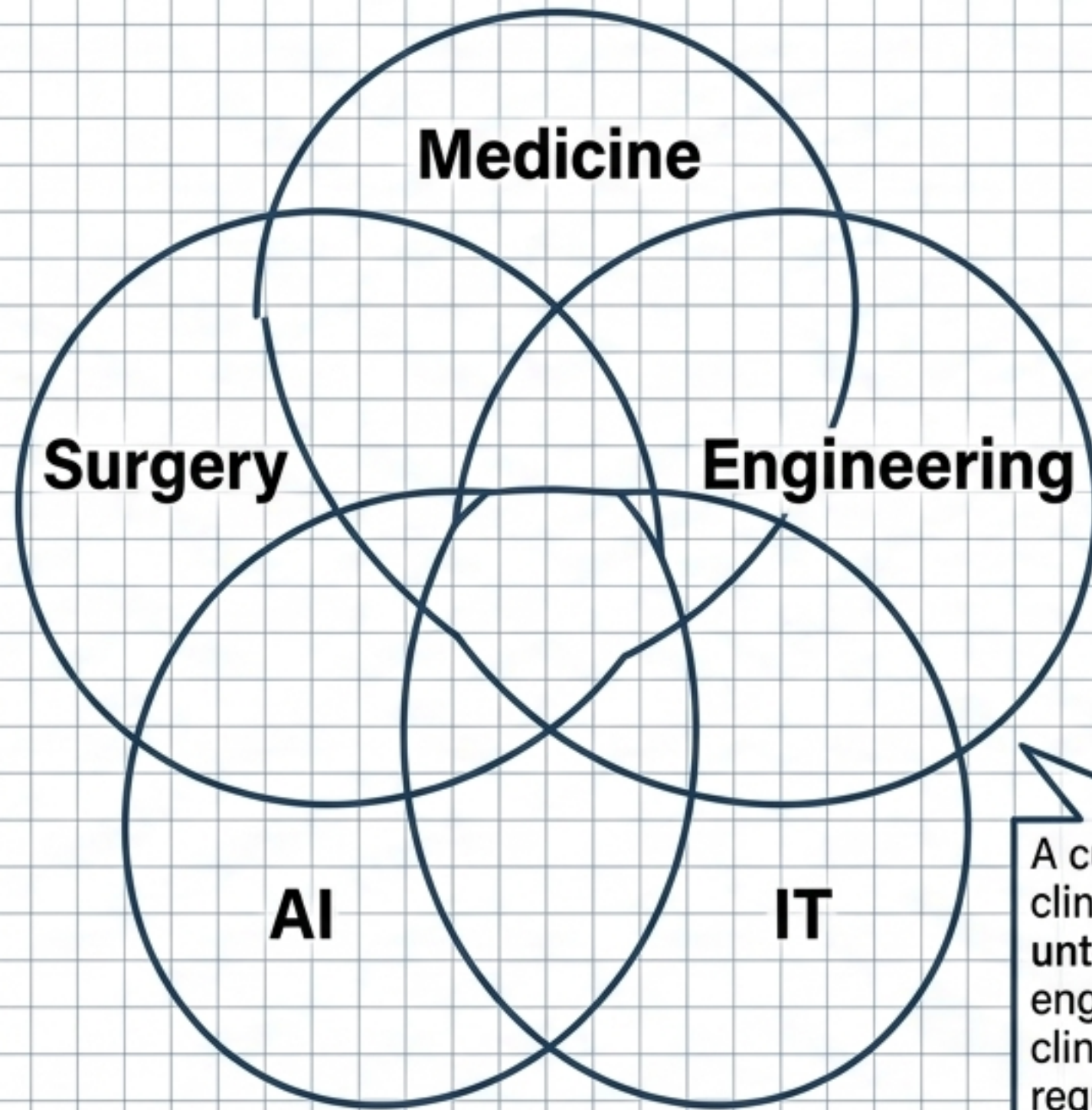
Patient Oversight

A 12-member lay panel reviews the curriculum. If we cannot explain it to patients, we don't understand it well enough to teach it.

The Paradigm Shift: Why this model is unprecedented globally.

Global Status Quo	The Kenya Institute Vanguard
Fragmented, elective, localized optimization.	Singular, national, mandatory CPD-aligned standard.
Vendor-led, tool-focused.	Structurally independent, pedagogy-led (judgment over tools).
Attendance-based certificates.	Competency-gated, simulated AI-OSCE with seeded errors.
Abstract lectures.	Localized to Kenyan epidemiology, supply chains, and languages.
Satisfaction scores (Kirkpatrick Level 1).	Workplace behavioral tracking and patient outcomes (Kirkpatrick Levels 3 & 4).

Multidisciplinary Convergence: The 70-person establishment



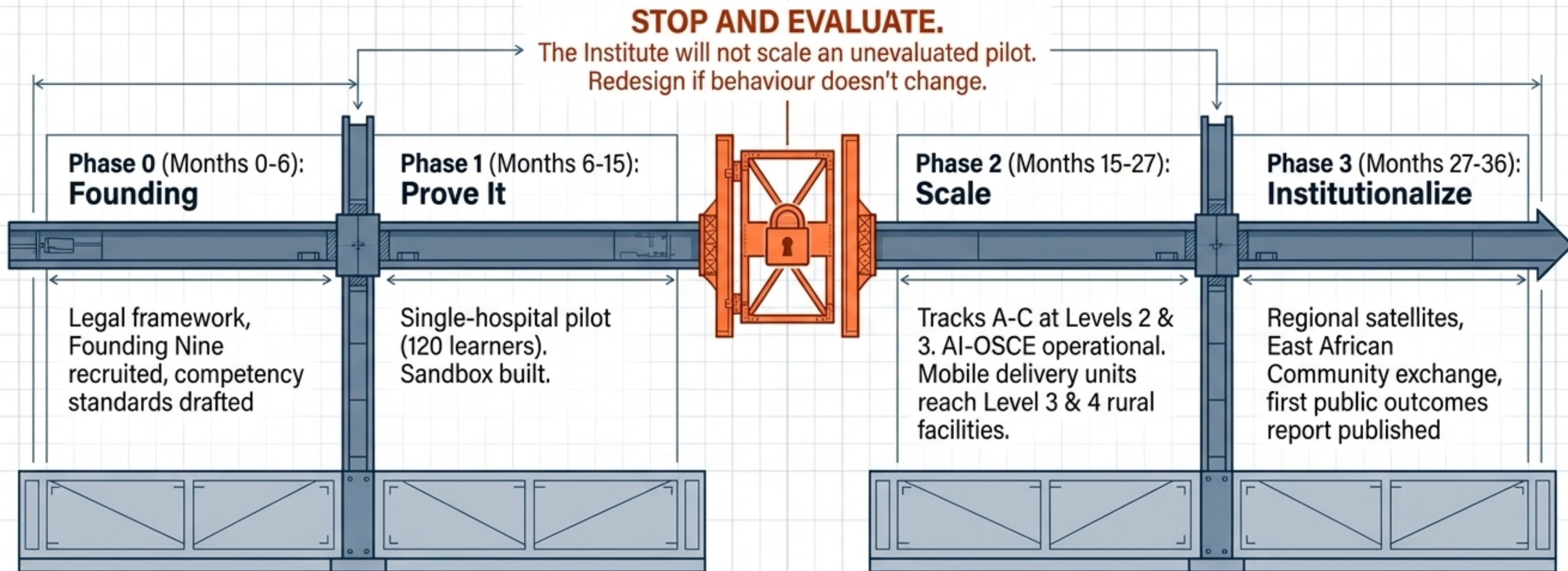
A curriculum written by clinicians alone is **unteachable**; written by engineers alone, it is clinically dangerous. It requires all five disciplines.

The 'Founding Nine' Critical Hires

- CEO (Medical/Technical)
- Director of Pedagogy
- Head of Assessment (Psychometrician)
- Head of Engineering
- Clinical Lead (Medicine)
- Clinical Lead (Surgery)
- Clinical Lead (Nursing)
- Head of Quality
- Operations Manager

Steady-state requires **70** core posts. **Evaluators** do not report to trainers. Curriculum modules are co-authored by a clinician and an instructional designer.

The 36-Month Rollout Sequence: Scaling data, not momentum.



The 5-Year Vision: What success looks like.

15,000+

Clinicians certified across all cadres, with rural reach tracking workforce distribution, not just Nairobi proximity.

5

Consecutive Cohorts evaluated on error-catch rates with published reliability data.

Level 4

Outcomes proven—measurable impact on documentation, escalation times, and patient safety.

Every health system on earth is going to have to solve this problem. Kenya can solve it first, solve it in the open, and hand the solution to the rest of the world.