fidelra.africa@fidelra.ai
fidelra.ai
linkedin.com/company/fidelra

NAIROBI CITY TWIN / HEALTH

Health

Domain Guide

Move from a synthetic resident to care encounters, facilities and the clinical context included in the published sample.

City	Nairobi
Coverage	Public sample available
List price	$9,995 USD - standalone domain
Guide edition	Striped Donkey V5.89 - 7 September 2026

Use this guide

Read the documented coverage and limitations alongside the published sample and release evidence. Model counts and sample distributions describe their stated source and period. The final accepted order specifies licensed scope, usage rights, duration and delivery.

Useful questions

- Inspect visits and facility context
- Compare encounter and diagnosis fields
- Review longitudinal coverage and clinical limits

Scope and limitations

No synthetic citizen corresponds to a real person, and generated health histories should not be interpreted as reconstructed medical records.

Older health evidence is substantially less granular for some diseases, periods and geographies. Earlier decades are reconstructed from dated public-health reports and broader national or regional evidence where city-specific

observations are unavailable.

Some historical disease counts and health-system indicators are available only at Kenya-wide or broader geographic resolution. Nairobi values derived from those sources are calibrated city estimates and are labeled as such rather than presented as direct city observations.

Unless explicitly modeled via DiseaseRelationship, FCTE does not imply clinical relationship, comorbidity or disease progression merely because multiple conditions occur within the same synthetic population.

Inside this guide

01 How Health fits the City Twin.

02 Known and possible relationships.

03 From population health to healthcare use.

04 Health changes as the citizen does.

05 The city remembers its outbreaks.

06 Historical events aren't decorations.

07 Evidence becomes synthetic health activity.

08 From a structured health event to a narrative you can verify.

09 Take the Nairobi Health demo with you.

10 Synthetic health data has boundaries.

11 Health gets stronger with every release.

12 From an outbreak to one synthetic healthcare visit.

01 How Health fits the City Twin.

FCTE models disease, healthcare access, facilities, visits and population health within the same synthetic city where people live, work, travel, age and experience historical events.

Health records remain connected to the citizens, households, geography, insurance and other city systems that shape healthcare demand.

Nairobi City Twin™ · 1940-2026

02 Known and possible relationships.

Connections follow the published domain scope. Optional, contextual and planned relationships retain their stated limits below.

Domain or context	Relationship and published scope
Demographics	Patient or resident identity, lifespan, sex and ward provide care context. Dated visits must respect the resident lifespan.
Facilities and geography	Visits carry facility and area context where supplied; the same resident can have repeated visits.
Business	Facility-to-business context is optional, not an identity link on every care record.
Insurance	Care eligibility and claims can be analysed alongside health events; the public guide does not expose every physical linkage.
Transport	Mobility incidents can be compared with injury and diagnosis context. This does not assert a direct trip-to-visit join.
Water	The documented area health-profile field is nullable and is not populated by a Water-domain generation model in the cited guide.

Supporting links

Demographics

Insurance

Water

Business

Transport

03 From population health to healthcare use.

FCTE Health represents the health conditions, disease environment, healthcare infrastructure and utilization patterns needed to model healthcare within the wider city.

Health characteristics and risk patterns tied to demographic and geographic context - ward-level socioeconomic health profiles, blood group, chronic condition registries.

Disease definitions, ICD-10 diagnoses, prevalence and temporal behavior - including disease-specific weighting that changes by era and ward.

Hospitals, clinics and other modeled points of care - facility level, ownership, bed capacity and clinical staffing.

Synthetic utilization generated against citizens and healthcare infrastructure - OPD, IPD, emergency, maternity and immunization encounters.

Documented disease events that alter health conditions and healthcare demand during affected periods - 37 real, cited events across Nairobi.

Relationships between citizens, geography, healthcare availability and coverage - including insurance/eligibility channel mix.

Specimens, lab results, diagnostic reports and imaging studies tied to each visit through a real order → result chain.

Care plans, care teams and disease-state transitions tracked as a citizen's condition evolves over time.

Medication dispensing events, modeled as distinct from the prescription order that triggered them.

Patient-reported symptoms and medical device assignments connected to diagnosis and care context.

Synthetic, not clinical: FCTE Health does not reproduce real patient records, diagnoses or medical histories. It generates statistically grounded synthetic health relationships from aggregate evidence and documented modeling rules.

04 Health changes as the citizen does.

Health is not a single status field attached to a citizen - it moves through the same lifecycle stages every other domain does.

Health events remain temporally constrained by the citizen's demographic history - healthcare activity cannot occur before the citizen exists or after applicable lifecycle boundaries. Four certification checks enforce this directly: certification check (registration ≥ birth), certification check (visit ≥ birth), certification check (visit ≥ registration) and certification check (visit ≤ death) - all four caught real, large-scale violations (up to ~72% of rows) before being fixed, and all four pass live today.

A related but distinct boundary sits at the other end of the timeline: a record that was valid when generated but drifts past the platform's own in-universe "today" (NowDate). A 2026-08-05 audit traced a four-link chain of exactly this - future-dated Patient cascading into Visit, Condition, Prescription and Claim - back to a single unbounded date window, fixed the generation model, and retroactively corrected 1,096,381 live rows across Nairobi. Three new checks now close this permanently: certification check , certification check , certification check . See the full audit →

Supporting links

the full audit →

05 The city remembers its outbreaks.

Select a marker below to see the underlying evidence.

37 documented events shown as 4 markers per city above - the full calendar (83 year-weighted rows, including polio, HIV, typhoid, H1N1, TB and smallpox eras) is available via the source catalogue.

Explore Historical Health Events →

Supporting links

Explore Historical Health Events →

06 Historical events aren't decorations.

Historical health events alter population-level enrollment and diagnosis tendencies during documented windows. Certification verifies directional historical response at release level; exact coefficients, probability adjustments and internal methods are intentionally withheld.

Historical health events alter population-level enrollment and diagnosis tendencies during documented windows. Certification verifies directional historical response at release level; exact coefficients, probability adjustments and internal methods are intentionally withheld.

The event modifies generated healthcare utilization according to documented FCTE rules - it does not assert an exact real-world causal visit count.

07 Evidence becomes synthetic health activity.

Health generation follows a controlled clinical lifecycle from population and geography through facility access, patient context, visits, diagnoses and downstream care records. Exact phase ordering, per-condition generation models, probabilities and orchestration are not published.

Directly supported by health statistics, surveillance or published evidence - e.g. WHO Disease Outbreak News, NCDC situation reports.

Calculated from observed health evidence - e.g. living-population baselines from Citizen/Death cohort data.

Disease burden, care access, outbreak timing and population-health distributions are calibrated to cited health evidence and validated at release level. Exact weights and thresholds remain controlled.

Individual synthetic assignments are generated under controlled domain rules. Exact sampling, assignment order and parameterization are not published.

View Health Generation Methodology →

Surveys, public-health reports and demographic health statistics.

Surveillance reports, outbreak records and epidemiological publications.

Published healthcare activity and service-use evidence where available.

Health facility, infrastructure and geographic sources.

Official and peer-reviewed evidence for documented outbreaks and health shocks.

Open Health Source Catalogue →

Supporting links

View Health Generation Methodology →

Open Health Source Catalogue →

08 From a structured health event to a narrative you can verify.

Choose a synthetic Nairobi encounter. The narrative is assembled only from facts present in the encounter or from explicitly declared derivations. Select a narrative line to see why it is there.

The underlying encounter contains vital signs but no recorded diagnosis, medication, procedure, laboratory result or referral. FCTE does not invent missing clinical facts.

GROUNDED claims come directly from the synthetic encounter. DERIVED claims use declared, reproducible transformations of recorded values. This preview does not add speculative clinical content.

Grounded narratives can also surface semantic inconsistencies that are difficult to notice when records are reviewed only as rows and fields.

Table columns 1, 2, 3, 4, 5 (first column repeated)

Demo	Synthetic resident	Encounter	Date	Care facility

Table columns 1, 6, 7, 8, 9 (first column repeated)

Demo	Clinical record	Grounded narrative	Claims	Grounding

Table columns 1, 10 (first column repeated)

Demo	Open

Supporting links

Open Grounded Narrative Demo →

Download JSON ↓

Download these 4 records as JSON ↓

Explore Health Data →

09 Take the Nairobi Health demo with you.

Download the same public synthetic examples used in this Health preview. Use them to inspect structure, test research workflows, prototype analytics or evaluate grounded narrative behavior.

Structured encounter details, readable narratives, claim evidence and grounding summaries from the technology preview above.

A spreadsheet- and notebook-ready sample for inspecting synthetic health records and testing analysis or research workflows.

Continue into the public data explorer when you want to inspect the wider Health domain without downloading a file.

Need the release evidence instead? Certification and realism results remain available in the dedicated evidence views.

Supporting links

Download JSON ↓

Download CSV ↓

Explore Health Data →

View Health Certification →

View Health Evidence →

10 Synthetic health data has boundaries.

No synthetic citizen corresponds to a real person, and generated health histories should not be interpreted as reconstructed medical records.

Older health evidence is substantially less granular for some diseases, periods and geographies. Earlier decades are reconstructed from dated public-health reports and broader national or regional evidence where city-specific observations are unavailable.

Some historical disease counts and health-system indicators are available only at Kenya-wide or broader geographic resolution. Nairobi values derived from those sources are calibrated city estimates and are labeled as such rather than presented as direct city observations.

Unless explicitly modeled via DiseaseRelationship, FCTE does not imply clinical relationship, comorbidity or disease progression merely because multiple conditions occur within the same synthetic population.

Informal, unreported and historically undocumented healthcare use is not directly observable. Visit generation therefore samples a controlled share of the eligible population rather than pretending to represent a universal registry (certification check). The sampling rate is a disclosed calibration choice and remains subject to realism review.

Some longitudinal diagnosis context uses current rather than period-specific geography. The measured impact is small and remains a disclosed model boundary; the public site does not publish the exact affected-record count or internal weighting method.

The current Patient population and eligibility-channel mix are generated through the Health eligibility model and remain calibration targets rather than fixed empirical truths. These are tracked realism gaps, not referential-integrity defects: every generated Patient row remains internally consistent with its linked citizen and health records.

View All Health Limitations →

Supporting links

View All Health Limitations →

11 Health gets stronger with every release.

A transparent record of what changed, what was verified, and how the synthetic health system improved over time.

Nairobi Health data refresh - 21/21 structural checks now pass (closed the last disclosed visit-dating regression) and two independently-discovered defects were fixed at the source: a TB diagnostic flow and a transport-accident diagnosis flow could each attach a diagnosis to a maternal/child-health visit outside its clinical scope, confirmed live and closed with 0 remaining violations. Also closed: specimen/lab-result linking, TB confirmatory-result date ordering, and a disease-state transition date-ordering edge case.

Traced and corrected a future-dating issue affecting patient registration, visits, conditions, prescriptions and claims - 1,096,381 records corrected across Nairobi. Three new checks added to catch this permanently. Full audit →

Removed unnecessary performance restrictions from record generation, Nairobi, with no service disruption.

Performance improvement to claims processing (the largest single cost in data generation, cut by roughly two-thirds) and a diagnosis-calculation restructure, independently verified against 5,000 real visits with zero discrepancies.

Closed a performance issue that had stalled data generation for nearly 15 hours, by adding missing indexes across four clinical records.

Fixed a patient-record generation crash affecting citizens with multiple household history entries; verified against the real failing case.

Fixed an error-handling gap that had been masking the true cause of a release run-generation failure behind a generic error message.

Standardized health-domain deployment release processes for consistency across cities.

Platform-wide scheduling reorganization to reduce cross-domain generation risk.

Added enrollment-year weighting to patient eligibility, driven by real population and historical-event data, per city and year.

Supporting links

Full change log →

Full audit →

View Full Health Change Log →

12 From an outbreak to one synthetic healthcare visit.

A real, documented event in the historical health calendar - intensity multiplier 3.00, the highest of any entry in the table, sourced to the global pandemic period.

Male, DOB 1991-05-01 - a real Patient record eligible during the outbreak window.

A confirmed U07.1 (COVID-19) diagnosis on a real, currently-live Visit row, dated inside the documented outbreak period.

The diagnosis, visit and patient records above are live in Nairobi today - Health generation certified 21/21 structural PASS.

Available as Standalone Domain · Multi-Domain Bundle · Full City Twin™

Supporting links

Explore This Record →

View the analysis example →

See the Evidence →

Review licensing & delivery details →

View Pricing & Licensing →

Browse Health Data →

Explore Multi-Domain Access →