

Provocation Piece | July 2026

Health Is Everyone's Business

How municipalities can become intentional stewards of community health outcomes

By Tsakane Matsilele, NSH Researcher

When a municipality builds a road, it determines whether a pregnant woman can reach a clinic before 20 weeks. When it fails to upgrade a settlement, it increases the risk of flooding, overcrowding, and outbreak. When it neglects sanitation infrastructure, it drives diarrhoeal disease in children under age five. None of these are health department problems. They are planning challenges with tangible implications for health outcomes.

This is the argument that ran through the July 2026 Insight Exchange session on health data for municipal planning: health outcomes are, in a very real sense, a mirror of municipal performance. Clinics and hospitals absorb the failures of poor water, broken sanitation, inadequate transport, and unmanaged population growth.

All the presenters noted that South Africa's health data landscape is richer than its use in planning suggests. The [Department of Health's District Health Information System \(DHIS\)](#) tracks service delivery data, such as immunisations, antenatal visits, and HIV and TB treatment, across all public clinics and hospitals monthly. The [Health Systems Trust's District Health Barometer](#) compares Reproductive, Maternal, Newborn, and Child Health (RMNCH), HIV/TB, non-communicable disease, finance, and workforce indicators across all 52 districts on a benchmarked, longitudinal basis. [Ritshidze](#) – a community-led monitoring initiative – collects real-time data on HIV and TB service delivery from over 300 clinics and community health centres across 20 districts in seven provinces. The [South African Population Research Infrastructure Network's \(SAPRIN\)](#) longitudinal population surveillance provides demographic depth across seven nodes nationally. The NSH's [District Diagnostic Profiles](#) draw on a range of sources to make health indicators accessible to municipal planners.

Health datasets are rarely integrated into the municipal evidence base or used to inform decisions about the built environment, infrastructure, and services that shape population health. Without this integration, opportunities to identify local drivers of poor health and target interventions are often missed.

Beyond the mandate argument

The most persistent barrier to health-informed municipal planning is conceptual. Many municipalities regard health as the responsibility of provincial and national government. Under this logic, an IDP or sector plan that does not engage meaningfully with health data is not seen as negligent – it is simply staying within its mandate.

“Health outcomes in your districts are a mirror of municipal performance. Clinics and hospitals merely absorb the failures of poor water or broken sanitation”



Noluthando Ndlovu,
Health Systems Trust

The session challenged this directly. Social determinants of health – water, sanitation, housing, transport, and settlement density – are almost without exception municipal functions. A municipality that treats health as someone else’s mandate is making a choice about health outcomes, whether it knows it or not. **Planning with health outcomes in mind is not optional. It is the work.**

The translation is concrete. Diarrhoea incidence in children under age five is a direct measure of water and sanitation performance. Low antenatal care uptake before 20 weeks can reflect transport and

access barriers, and not just clinic failures. Rising diabetes and hypertension speak to public space design and food environments. When a municipal planner looks at these indicators, they are looking at a performance record of decisions made about roads, pipes, land use, and infrastructure, not just health policy.

The data is there. The problem is fragmentation

South Africa’s health sector generates extensive data from multiple routine sources. The challenge lies in the fragmentation across systems, spheres, and sectors, and in the limited institutional will to draw these sources together for planning. Within the Eastern Cape, for example, annual primary health care expenditure per capita ranged from R971 in one district to R1 879 in another, a near two-fold difference that is not reflected in any single dataset. It only appears when DHIS service data, National Treasury finance data, and Stats SA population estimates are combined. Each source answers only a narrow question: DHIS tells you how many services were delivered, but not to what proportion of the population. Finance data shows what was spent, but not what it achieved. **The insight lives in the combination.**

The NSH’s District Diagnostic Profiles and the Health Systems Trust’s District Health Barometer demonstrate what these pipelines can look like in practice, drawing on multiple datasets to produce indicators that planners can engage with directly. These are examples of what becomes possible with coordination and investment, showing the types of connections that can be built between health data and municipal planning.

“The challenge lies not in availability but in interpretation, application, and coordination. The question is not whether data exists – it is whether we have built the systems and the will to connect it.”



Mbulelo Cabuko,
National Department of Health

The shared data infrastructure that enables this kind of combination – agreed spatial references, common identifiers, and data-sharing protocols across spheres of government – remains incomplete. DHIS has API capacity, meaning it can exchange data with other systems directly: a technical possibility that has not yet been fully leveraged for municipal planning.

What municipalities are being called on to do is develop the analytical skill to draw from different, unconnected sources and assemble a picture that has implications for planning. The data, in various forms, is already there. The skill is in translating data into planning implications.

Three layers of health data, and the stories they tell

The session surfaced a practical framework for thinking about the different datasets available and what each one uniquely offers. Rather than a single comprehensive source, municipal planners have access to complementary layers of insight.

Width

COVERAGE:
HOW FAR SERVICES
REACH



DHIS and the District Health Barometer show how many services reached how much of the population, benchmarked across all 52 districts. They surface where reach is falling short and point to the municipal decisions about transport, settlement and infrastructure likely driving those gaps.

Depth

QUALITY:
WHAT THE EXPERIENCE
OF CARE IS LIKE



Ritshidze goes beyond reach to ask what people experience when they arrive at a healthcare facility. Staffing levels, waiting times, supply chain reliability, and accessibility for key populations – captured at the facility level in real time – reveal dimensions of the health system that administrative data simply cannot see.

Depth over time

TRAJECTORY:
HOW POPULATIONS AND
OUTCOMES CHANGE
TRENDS



SAPRIN tracks the same communities year on year, showing how populations, vulnerabilities and health outcomes shift over time. It can reveal whether municipal interventions such as infrastructure upgrades, housing projects, and densification are improving health conditions and where new vulnerabilities are emerging. It can also pick up on health trends.

The translation gap: From health language to planning language

Health
Statistic

Planning
Decision

Even where the data exists, a gap remains between a health statistic and a planning decision. Health indicators are technically accessible but hard to act on for a spatial planner or infrastructure manager whose training lies elsewhere, resulting in community health needs being insufficiently integrated into planning decisions.

The NSH's live demonstration using the O.R. Tambo district showed what translation looks like in practice. Facility counts mean little in isolation, but when set against population growth data, one local municipality emerged as a point of infrastructure crisis: a 44% population increase since 1996, with one clinic now serving over 16 000 people compared to 6 900 in a better-resourced neighbouring municipality. That is a capital investment priority, not a health statistic. The data was already there. The translation made it actionable.

"On its own, a facility count tells us very little. When you start engaging with data – combining it with population trends, growth rates, and infrastructure – you start to pick up trends that become reasons to implement better. That is the value of the combination."



Phemelo Mahamuza,
National Strategic Hub

Three ways to improve this emerged from the session:

- 1 Spatialise**
Overlaying health indicators on settlement patterns and infrastructure networks lets planners locate health burden in space and connect it to decisions they make.
- 2 Build analytical capacity**
Reading diarrhoea incidence as a water infrastructure signal, or low antenatal uptake as a question about service access, is a learnable skill that needs deliberate investment across planning teams.
- 3 Act sooner**
Municipalities are better placed than national departments to respond to data quickly – their proximity to communities and budget flexibility make this possible, if mandate and data literacy support it.

Health as a collective responsibility: A systems thinking approach

The deepest challenge is not about data or capacity; it is about how municipalities understand their own role in health outcomes. When health data is not routinely considered in spatial planning, infrastructure investment, or service delivery decisions, the result is compliance outcomes rather than health outcomes.

A systems-thinking approach asks municipalities to see themselves as active producers of health. When a community's outcomes worsen, the question is not only what the clinic should do, but also what the municipality should address within the conditions it controls: how people move through the area, how they reach services, and how settlement growth has outpaced that of a facility.

"Even though you might not be responsible for something, you are still responsible for understanding how it influences the area that you are looking after. Health does not understand that it needs to operate within silos."



Andre Rose,
SAPRIN

Ritshidze's monitoring work demonstrates the accountability this makes possible. A campaign drawing on facility-level data led to a 77% increase in three-month ARV supply in one Free State district. Data that communities generate can drive systemic change, but only if municipalities are willing to receive it and act on it.

"The data we collect does not sit on a shelf. We publish it, share it, and engage duty bearers with it. Municipalities need to see themselves as those duty bearers, and act accordingly."



Ndivhuwo Rambau,
Ritshidze / Treatment Action Campaign

Collective responsibility means accountability for health outcomes is shared across housing, water, transport and spatial planning, and not necessarily delegated to a single department. Every planner whose decisions shape how people live is also shaping how healthy they are.

Four directions worth pursuing

1 **Treat health data as a core planning input**

Municipal planners should consider health indicators as part of their evidence base, not only in IDP situational analyses, but in the everyday decisions that shape the built environment and service access.

2 **Build the capacity to draw from multiple, unconnected data sources**

It is not viable to expect that health insights arrive pre-packaged or that data is fully centralised. The skill is knowing which sources exist, and in developing the analytical ability to combine them into a picture with planning implications.

3 **Integrate community-generated evidence into planning cycles**

Ritshidze and similar initiatives produce real-time, facility-specific intelligence on the quality and reach of health services. Municipalities should explore structured mechanisms for this evidence to inform infrastructure prioritisation, ward-level planning and service delivery decisions.

4 **Build the inter-governmental relationships that enable data to flow**

Shared spatial references, common identifiers, and working relationships across the Department of Health, National Treasury, Stats SA, and the NSH are what make the connections between datasets possible. This is as much an institutional challenge as a technical one.

The central provocation

- Health outcomes are a mirror of municipal performance. Where in your planning processes does health data actually shape a decision?
- South Africa is data-rich but insight-poor across health and planning because no single actor has taken responsibility for drawing it together. Who in your municipality is doing that work?
- What would it take for a municipal planner, infrastructure manager, or housing officer to use health data as fluently as demographic data?

Session resources

District Health Barometer
(Health Systems Trust)



Ritshidze Community Monitoring



South African Population Research
Infrastructure Network (SAPRIN)
Data Repository



District Health Information System (DHIS)



NSH District Diagnostic Profiles



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