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Enhancing Access to Health Information in Tanzania: Legal Frameworks, University Libraries' Pivotal Role, and Evidence-Based Policy Reforms

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Abstract: *Access to health information is a cornerstone of democratic governance, transparency, accountability, and optimal public health outcomes. Anchored in Article 18 of Tanzania's 1977 Constitution and the Access to Information Act of 2016, this right intersects with global [e.g., International Covenant on Civil and Political Rights (ICCPR) Article 19] and regional [e.g., African Charter on Human and Peoples' Rights (ACHPR) Article 9] instruments. Employing doctrinal legal research, this article analyzes these frameworks while positioning university libraries as critical intermediaries for acquiring, organizing, and disseminating health information to academic and societal users. Key findings reveal substantive barriers; broad exemptions, excessive discretionary powers, and fragile enforcement; compounded by procedural gaps in digital regulation and oversight. University libraries empower users through information literacy, digital repositories, and community outreach, yet face resource constraints and infrastructural challenges. The study concludes that aligning legal entitlements with practical access requires systemic reforms to advance health equity and sustainable development. Policy recommendations include narrowing exemptions with public-interest overrides, establishing an independent Information Commission, introducing tiered sanctions and expedited urgent requests, and fostering library-government partnerships for capacity-building and digital integration.*

Keywords: *Access to Health Information; University Libraries; Right to Information; Public Health Governance; Information Policy Reform*

1. Background Information

Access to reliable health information is a fundamental human right, a pillar of democratic governance, and an essential driver of public health equity (WHO, 2008; Liambomba, 2023). It empowers individuals to exercise autonomy in health decision-making, enables communities to hold authorities accountable, and equips policymakers with evidence to design responsive interventions against epidemics, chronic diseases, and environmental threats (WHO, 2017; Nutbeam, 2000). In low- and middle-income settings like Tanzania, where health disparities are exacerbated by geographic isolation, digital exclusion, and misinformation, equitable access to credible information is not merely instrumental, it is transformative (Mwangakala, 2024; Shao *et al.*, 2025).

Tanzania's legal architecture formally recognizes this imperative. Article 18 of the Constitution of the United Republic of Tanzania, 1977 guarantees freedom of expression and the right *"to seek, receive and impart information and ideas"* without interference. This constitutional mandate is operationalized through the Access to Information Act, 2016 (Act No. 6 of 2016), which mandates proactive disclosure of public interest data, including health and environmental information. Supporting statutes, such as the HIV and AIDS (Prevention and Control) Act, 2008 and the Environmental Management Act, 2004, further embed access within sector-specific governance. Yet, despite this progressive framework, implementation remains fractured. Overbroad exemptions, unchecked discretionary powers, weak enforcement, and restrictive digital content regulations undermine the law's intent, creating a chasm between legal entitlement and practical access (Makulilo, 2020a; Ubena, 2019; TCRA, 2020).

University libraries emerge as pivotal intermediaries in bridging this divide. As institutional repositories, knowledge curators, and public-facing disseminators, they transform abstract rights into tangible resources (Kanyengo, 2009; Mcharazo & Koopman, 2016). Through information literacy training, open-access repositories, community outreach, and digital health platforms, they combat misinformation, enhance health literacy, and support evidence-based practice, functions aligned with Universal Health Coverage (UHC) and SDG 3 (Good Health and Well-being) (Wema, 2024; Mosha & Ngulube, 2023; Katunzi *et al.*, 2025). However,

chronic underfunding, unreliable ICT infrastructure, and regulatory chill limit their reach, particularly in rural and underserved regions (Mvungi & Hashim, 2023; Bulugu & Ponera, 2024).

This article employs doctrinal legal research to critically examine the global, regional, and national frameworks governing access to health information, with Tanzania as a focal case. It integrates three theoretical lenses: the Human Rights-Based Approach (HRBA), which positions information access as integral to the right to health (UN, 1948; ACHPR, 1981); Rogers' Diffusion of Innovations Theory (2003), which elucidates knowledge transmission pathways; and DiMaggio and Powell's Institutional Theory (1983), which explains organizational conformity and resistance under legal and normative pressures. While prior studies have addressed access to information (Ubena, 2015; Makulilo, 2020b) or library functions in isolation (Rukamata, 2022; Mtega, 2012b), this work innovates through interdisciplinary synthesis, centering university libraries as strategic agents of legal and public health reform.

Structured in five parts, the analysis: (1) maps international and regional legal benchmarks; (2) dissects Tanzania's statutory regime and its public health implications; (3) evaluates the operational role of university libraries; (4) identifies structural, procedural, and socio-digital barriers; and (5) proposes an evidence-based reform agenda. By exposing the disconnect between legal promise and lived reality, this study advances a cohesive policy blueprint to strengthen transparency, institutional capacity, and digital inclusion, ultimately aligning Tanzania's information ecosystem with democratic accountability, health justice, and sustainable development.

2.0 International and Regional Legal Frameworks on Access to Information

Access to information is a universally recognized human right and a bedrock of democratic governance, enabling transparency, accountability, and informed public participation (UN, 1948; Banihashemi, 2023). In health contexts, it is indispensable for evidence-based policy, disease surveillance, and individual empowerment, particularly in resource-constrained settings where misinformation can amplify morbidity and erode trust (WHO, 2017; Sanders, 2021). This section maps the hierarchical legal architecture; global, regional, and sub-regional; that underpins the right to access information, with a focus on its intersection with public health.

2.1 Global Standards: From Declaration to Binding Obligation

The Universal Declaration of Human Rights (UDHR, 1948) establishes the foundational norm in Article 19: *"Everyone has the right to freedom of opinion and expression; this right includes freedom to… seek, receive and impart information and ideas through any media and regardless of frontiers."* Though not legally binding, the UDHR is widely regarded as customary international law and has shaped subsequent treaties (UNHRC, 2016).

The International Covenant on Civil and Political Rights (ICCPR, 1966) elevates this right to a binding obligation under Article 19(2): *"Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds…"* General Comment No. 34 (2011) authoritatively interprets this to include access to information held by public bodies, irrespective of format or origin, subject only to narrowly tailored restrictions (Human Rights Committee, 2011, para. 18). States must ensure proactive disclosure, especially of data affecting public health, safety, or the environment (para. 19). The UN Special Rapporteur on Freedom of Opinion and Expression has consistently affirmed that denial of access to public health data violates Article 19 (Hussain, 1995; UN, 2013).

2.2 Regional Frameworks: African Normative Convergence

The African Charter on Human and Peoples' Rights (ACHPR, 1981), ratified by Tanzania in 1984, codifies the right in Article 9(1): *"Every individual shall have the right to receive information."* This concise provision has been expansively interpreted. The Declaration of Principles on Freedom of Expression and Access to Information in Africa (2019) elaborates in Principle 26(1) a state duty to facilitate access, including through active publication of public interest information (African Commission, 2019). Principle 26(4) mandates that restrictions be prescribed by law, necessary, and proportionate, with a public interest override in Principle 26(5) requiring disclosure where transparency outweighs harm.

The African Union Model Law on Access to Information (2013) operationalizes these principles, mandating expeditious and affordable access (s. 2(1)), proactive disclosure of health and environmental data (s. 9(1)), and independent oversight via an Information Commission (ss. 6, 7A). Though not binding, it serves as a reform benchmark across the continent.

2.3 Sub-Regional Harmonization: EAC and SADC

The East African Community (EAC) Treaty (1999) commits member states to transparency and good governance (Art. 6(d)), implicitly supporting information access, though lacking a dedicated protocol. The SADC Protocol on Public Participation (2018) emphasizes citizen engagement but

stops short of enforceable access rights. In contrast, South Africa's Promotion of Access to Information Act (PAIA, 2000), upheld in landmark rulings such as Brümmer v Minister for Social Development [2009] ZACC 21 and Arena Holdings v SARS [2023] ZACC 13, exemplifies judicial enforcement of narrow exemptions and public interest overrides, offering a comparative model for Tanzania (Republic of South Africa, 2000).

2.4 Synthesis and Implications

These instruments form a coherent normative cascade: from the UDHR's moral imperative to the ICCPR's legal duty, reinforced by African regional elaboration and sub-regional alignment. Table 1 (below) synthesizes key provisions, principles, and implementation gaps.

Table 1: International, Regional, and Sub-Regional Legal Frameworks on Access to Information

S/No	Level	Instrument / Case	Key Provision(s)	Core Principles	Implementation Remarks
1	Global	UDHR (1948), Art. 19	Right to seek, receive, impart information	Freedom of expression, transparency	Customary law; foundational
2	Global	ICCPR (1966), Art. 19(2); GC 34	Access to public body information	Active disclosure, proportionality	Binding; health data inclusion
3	Global	UNHRC Res. (2016, 2022)	Access as democratic enabler	Digital inclusion, journalist safety	Persuasive; calls for legislation
4	Regional	ACHPR (1981), Art. 9(1)	Right to receive information	Participation, accountability	Binding on Tanzania
5	Regional	Declaration (2019), Principle 26	Duty to facilitate; public interest override	Necessity, proportionality	Interpretive authority
6	Regional	AU Model Law (2013), ss. 2, 9	Expeditious access; proactive disclosure	Independent oversight	Reform template
7	Sub-Regional	EAC Treaty (1999), Art. 6(d)	Transparency, good governance	Harmonization	Soft commitment
8	Sub-Regional	SADC Protocol (2018)	Citizen engagement	Participation	Non-binding
9	National (Comparator)	South Africa: PAIA (2000); *Brümmer* [2009], *Arena Holdings* [2023]	Constitutional access right	Judicial enforcement	Best practice model

Despite normative clarity, implementation lags. Tanzania has no precedent interpreting Article 18 or the Access to Information Act, 2016 in light of ICCPR or ACHPR obligations, a critical gap this article addresses.

3. Access to Public Health Information and Legal Frameworks in Tanzania

Tanzania's legal framework for access to public health information is ambitious in design but fragile in execution. Article 18 of the Constitution of the United Republic of Tanzania, 1977 enshrines a justiciable right to seek, receive, and impart information, creating a constitutional foundation for transparency in health governance. This mandate is operationalized through the Access to Information Act, 2016 (Act No. 6 of 2016), which imposes affirmative duties on public authorities to disclose information "necessary for the exercise or protection of any right" (s. 5(1)) and mandates proactive publication of data affecting public health, safety, or the environment (s. 9). Sectoral laws reinforce this architecture: the HIV and AIDS (Prevention and Control) Act, 2008 balances confidentiality with anonymized public health data dissemination (s. 16(1)), while the Environmental Management Act, 2004 establishes a Central Environmental Information System (ss. 172–177) to support evidence-based health and ecological decision-making.

Despite progressive frameworks, systemic weaknesses; broad exemptions, executive discretion, restrictive digital laws, and lack of independent oversight; undermine effective access and perpetuate opacity, harming vulnerable groups (Makulilo, 2020a; Ubena, 2019). University libraries, as knowledge gateways, remain limited in providing reliable health information, particularly in digital and rural contexts (Mvungi & Hashim, 2023; Bulugu & Ponera, 2024).

3.1 Constitutional and Statutory Foundations

Article 18(a)–(d) of the Constitution guarantees:

- Freedom of opinion and expression;
- The right to seek, receive, and impart information across borders;
- Freedom from interference in communication; and
- The right to be informed on public matters.

The Access to Information Act, 2016 transforms this into enforceable obligations. Section 5(1) grants individuals access to information held by public or private bodies when required to protect a right. Section 9 mandates proactive disclosure of health, environmental, and safety data. The Environmental Management Act, 2004 (ss. 4–5, 172–177) further embeds public participation and access to environmental health information as core principles, aligning with the precautionary and polluter pays doctrines.

3.2 Digital Restrictions and Regulatory Overreach

The Electronic and Postal Communications Act, 2010 and its Online Content Regulations (2018, 2020, 2022) impose draconian controls on digital health information. Regulation 16(1) (GN No. 538/2020) criminalizes "prohibited content" under vague categories, enabling preemptive censorship of legitimate public health discourse. Regulation 4(2) and 9 impose licensing and compliance burdens on educational platforms, chilling university libraries' open-access initiatives (Ubena, 2019; TCRA, 2020). The 2022 Amendments (GN No. 136)—ostensibly protecting children, retain broad discretionary powers without procedural safeguards, violating ICCPR Article 19(3) and ACHPR Declaration Principle 26(4) requirements for necessity and proportionality (TCRA, 2022).

3.3 Substantive Barriers: Exemptions and Discretion

Section 6 of the Access to Information Act permits denial on grounds of *"public interest"* or "national security" without narrowly defined criteria or a harm test. This ambiguity enables arbitrary refusals of epidemiological data, clinical guidelines, or emergency protocols—directly undermining public health readiness (Liambomba, 2023). In contrast, South Africa's PAIA (2000) and judicial precedents (Brümmer [2009] ZACC 21) mandate strict scrutiny and public interest overrides, a model Tanzania has yet to adopt.

3.4 Institutional Weaknesses: Oversight, Sanctions, and Urgency

- Oversight (s. 19): Internal reviews by institutional heads and final ministerial appeals lack independence, breaching General Comment No. 34 (para. 46) and AU Model Law (ss. 6–7A) standards.
- Sanctions (ss. 22–23): Criminal penalties exist for obstruction but not for unlawful refusal or delay, fostering impunity (Brinkerhoff, 2004).
- Procedural Timelines (ss. 10–14): A uniform 30-day response window with no expedited track for health emergencies violates AU Model Law urgency provisions and jeopardizes timely interventions (Mendel, 2008).

Tanzania's framework formally aligns with international norms but functionally deviates through restrictive interpretation and institutional capture. University libraries, as de facto implementers, are uniquely positioned to expose and bridge these gaps, yet require legal and policy reinforcement to fulfill their mandate.

4. The Role of University Libraries in Facilitating Health Information Access

University libraries in Tanzania are pivotal agents in operationalizing the right to health information, functioning as knowledge hubs, capacity builders, and community bridges (Kanyengo, 2009; Mcharazo & Koopman, 2016). They transform abstract legal entitlements, under the Access to Information Act, 2016 and Article 18 of the Constitution into actionable, evidence-based resources for students, researchers, healthcare practitioners, and the public. Through information literacy programs, digital repositories, open-access initiatives, and targeted outreach, they counter misinformation, enhance health decision-making, and support Universal Health Coverage (UHC) and SDG 3 (Wema, 2024; Mosha & Ngulube, 2023). This section dissects their multifaceted roles, grounded in empirical and institutional evidence, while highlighting enablers and structural constraints.

Table 2: Legal Frameworks and Constraints in Access to Public Health Information

S/N	Theme	Key Findings	Legal References	Implications for University Libraries
1	Constitutional Right	Art. 18 guarantees access as a fundamental freedom	Constitution (1977)	Libraries translate rights into actionable health resources
2	Statutory Duty	ss. 5, 9 mandate access and proactive disclosure	Access to Information Act (2016)	Enables curation of official health data
3	Sectoral Integration	HIV/AIDS and environmental laws support health data access	HIV/AIDS Act (2008); EMA (2004)	Facilitates interdisciplinary health-environment repositories
4	Digital Constraints	Vague online content rules criminalize legitimate dissemination	EPOCA (2010); GN 538/2020; GN 136/2022	Restricts digital health platforms and OER
5	Exemptions	s. 6 allows broad, untested denials	Access to Information Act (2016)	Forces libraries to guide users through appeals
6	Oversight	s. 19 relies on executive-led review	Access to Information Act (2016)	Undermines trust in library-mediated requests
7	Sanctions & Timelines	Gaps in penalties and urgency mechanisms	ss. 10–14, 22–23	Delays critical health information delivery

4.1 Promoting Health Information Literacy and Capacity Building

Information literacy is the core mandate of university libraries. Structured workshops, orientation sessions, and curriculum-integrated training equip users with skills to locate, evaluate, and apply credible health information (Kwafoa *et al.*, 2025; Rukamata, 2022). In public health crises, such as COVID-19 or cholera outbreaks, libraries serve as rapid-response nodes, curating official guidelines, peer-reviewed studies, and real-time epidemiological data to inform community interventions (Ali & Gatiti, 2020; Mosha & Ngulube, 2023). Virtual learning environments (VLEs) and blended training models have expanded reach, with librarians adapting services to hybrid formats (Wema, 2021).

4.2 Bridging Legal Rights and Practical Access

Libraries act as intermediaries between citizens and government, guiding users through formal information requests under the Access to Information Act (ss. 10–14), interpreting exemptions, and supporting appeals when access is denied (Mtega, 2012b). Institutional repositories and open educational resources (OER) democratize access beyond campus walls, mitigating rural–urban digital divides (Morgan-Daniel *et al.*, 2023; Bulugu & Ponera, 2024). Innovative models, such as mobile libraries and partnerships with rural health centers, extend reliable health information to underserved populations (Katuli-Munyoro, 2021).

4.3 Curating Specialized Collections and Enabling Digital Transformation

University libraries maintain specialized health sciences collections, including clinical databases (e.g., PubMed, HINARI), evidence-based guidelines, and local research outputs, critical for professional development and policy formulation (Mitra & Parida, 2022). The shift to digital preservation and open-access platforms has reduced cost barriers and accelerated knowledge diffusion (Swain & Pathak, 2024). In Tanzania, OER adoption is growing among faculty for teaching and research, though student engagement lags due to infrastructural deficits and low digital literacy (Bulugu & Ponera, 2024; Mosha & Ngulube, 2023).

4.4 Community Engagement, Partnerships, and Long-Term Impact

Beyond academia, libraries engage in public health advocacy through outreach campaigns, health literacy clinics, and collaborations with ministries, NGOs, and international bodies (Rubenstein, 2018; Mwangakala, 2024). These efforts influence health-seeking behavior, reduce stigma (e.g., in mental health or HIV), and foster evidence-informed community action (Katunzi *et al.*, 2025). Hybrid preservation strategies, combining physical and digital archiving, ensure long-term accessibility, particularly for time-sensitive clinical data (Ayungo, 2025).

Table 3: Strategic Roles of University Libraries in Health Information Access

S/N	Role	Key Activities	Public Health Impact	Regional Comparators
1	Information Literacy	Workshops, VLE training, critical appraisal	Reduces misinformation, empowers decision-making	Ghana, Kenya (Kwafoa *et al.*, 2025)
2	Legal–Practical Bridge	Request guidance, appeals support, OER	Enables equitable access, bypasses bureaucratic delays	South Africa (community libraries)
3	Digital Curation	Repositories, OER, clinical databases	Supports research, CPD, policy	East Africa OER growth (Mosha & Ngulube, 2023)
4	Community Outreach	Partnerships, mobile units, advocacy	Improves health behaviors, reduces stigma	Zambia, Zimbabwe (Katuli-Munyoro, 2021)

Despite their potential, resource constraints, regulatory restrictions, and infrastructural fragility limit scalability (Mvungi & Hashim, 2023). Strategic investment in ICT, staff training, and policy alignment is essential to elevate libraries from passive repositories to proactive public health partners.

5. Challenges in Accessing Health Information Through University Libraries

University libraries in Tanzania are strategically positioned to democratize health information, yet they confront multilayered barriers that erode their transformative potential. These challenges span infrastructural deficits, socio-cultural dynamics, regulatory constraints, resource scarcity, and systemic inequities, collectively perpetuating a cycle of exclusion that disproportionately affects rural, low-literacy, and marginalized populations (Shao *et al.*, 2025; Badr *et al.*, 2024). This section synthesizes empirical evidence to dissect these impediments, framing them within public health equity, digital justice, and institutional resilience paradigms.

5.1 Infrastructural and Digital Divide Barriers

Unreliable ICT infrastructure remains the most pervasive bottleneck. Rural campuses suffer from intermittent connectivity, low bandwidth, and frequent power outages, rendering digital repositories and online databases inaccessible (Mtega, 2012a; Yoon *et al.*, 2020). Subscription costs for premium health databases (e.g., UpToDate, Cochrane) are prohibitive, forcing reliance on limited open-access alternatives (Sultan & Rafiq, 2021). The COVID-19 pandemic exposed these fragilities: while urban institutions pivoted to virtual services, rural libraries struggled to

maintain even basic access (Ali & Gatiti, 2020; Rafiq et al., 2021).

5.2 Information Literacy and User Competency Gaps

Despite strong training programs, fragmented curricula, language barriers (English-dominant resources vs. Swahili-speaking users), and low baseline digital literacy hinder effective utilization (Mtega, 2012c; Rukamata, 2022). Health misinformation, amplified via social media, further erodes trust in library-curated sources, particularly in mental health and reproductive health domains (Naeem *et al.*, 2021; Ahad *et al.*, 2023).

5.3 Socio-Cultural and Gendered Dimensions

Cultural stigma, especially around HIV, mental health, and sexual/reproductive health, deters users from seeking formal information (Daraz, 2025; Ndege *et al.*, 2025). Women in rural areas often rely on informal networks (e.g., traditional birth attendants) due to access barriers and patriarchal norms, resulting in lower health literacy and poorer outcomes (Kassim & Katunzi-Mollel, 2020; Mwangakala, 2024).

5.4 Institutional and Resource Constraints

Chronic underfunding limits collection development, staff training, and technological upgrades (Mvungi & Hashim, 2023). Personnel shortages, with many librarians lacking specialized health sciences training, compromise reference services and evidence synthesis (Barsha & Munshi, 2024). Regulatory overreach under the Online Content Regulations (2020, 2022) imposes compliance burdens that chill open-access health content dissemination (Ubena, 2019).

5.5 Systemic Health Information Ecosystem Weaknesses

Fragmented national health information systems (HIS) produce poor-quality, siloed data, delaying evidence-based interventions (Maokola *et al.*, 2011). Telemedicine and digital health platforms, potential library partners, face readiness gaps in rural settings (Agbeyangi & Lukose, 2025; Qoseem *et al.*, 2024).

Table 4: Multidimensional Challenges in Health Information Access via University Libraries

S/N	Challenge Domain	Key Barriers	Evidence Base	Equity Implications
1	Infrastructure	Unreliable internet, power, high costs	Mtega (2012a); Yoon *et al.* (2020)	Widens rural–urban divide
2	Literacy	Low digital/health literacy, language gaps	Mtega (2012c); Kwafoa *et al.* (2025)	Excludes low-education users
3	Socio-Cultural	Stigma, gender norms, misinformation	Ndege *et al.* (2025); Mwangakala (2024)	Disproportionately harms women, stigmatized groups
4	Institutional	Underfunding, staff shortages, regulation	Mvungi & Hashim (2023); Ubena (2019)	Limits service quality and innovation
5	Systemic	Weak HIS, telemedicine gaps	Maokola *et al.* (2011); Badr *et al.* (2024)	Undermines evidence-based public health

Addressing these requires targeted, multisectoral interventions: infrastructure investment, culturally tailored literacy programs, policy reform, and public–private–academic partnerships (Liambomba, 2023; Mwakisiki, 2025). Without such action, university libraries risk remaining elite enclaves rather than engines of health justice.

6. Conclusion

Access to reliable health information is indispensable for human dignity, democratic accountability, and health system resilience, particularly in low-resource settings like Tanzania, where misinformation and structural inequities exacerbate morbidity and mortality (WHO, 2017; Liambomba, 2023). This study has demonstrated that while Article 18 of the *Constitution of the United Republic of Tanzania, 1977* and the Access to Information Act, 2016 establish a robust normative foundation, their practical efficacy is severely compromised by overbroad exemptions, executive discretion, digital censorship, institutional capture, and enforcement inertia. These legal and procedural failures create a pervasive transparency deficit that undermines evidence-based public health governance, disease prevention, and equitable service delivery.

University libraries emerge as critical linchpins in this ecosystem. As knowledge custodians, literacy champions, and community connectors, they translate constitutional and statutory entitlements into actionable intelligence, curating clinical guidelines, facilitating OER, and empowering users to navigate bureaucratic and digital barriers (Wema, 2024; Mosha & Ngulube, 2023). Yet, their transformative potential is systematically constrained by infrastructural fragility, resource scarcity, regulatory chill, and socio-cultural

resistance, leaving rural, low-literacy, and stigmatized populations disproportionately excluded (Shao *et al.*, 2025; Mwangakala, 2024).

The analysis reveals a paradox of abundance and scarcity: Tanzania possesses a progressive legal framework aligned with ICCPR, ACHPR, and AU standards, yet implementation gaps perpetuate a culture of secrecy and information asymmetry. This disconnect not only violates human rights obligations but also jeopardizes public health outcomes, delaying epidemic responses, weakening health literacy, and eroding trust in institutions. University libraries, if strategically empowered, can serve as catalysts for systemic reform, bridging legal promise with lived reality.

Ultimately, realizing the right to health information demands more than legal recognition, it requires institutional re-engineering, digital inclusion, and cross-sectoral synergy. Only through evidence-based policy reform can Tanzania transform its information ecosystem into a public good that advances health justice, democratic resilience, and sustainable development in line with UHC and SDG 3.

7. Recommendations for Reform

To operationalize the right to health information and elevate university libraries as strategic public health partners, Tanzania must pursue a coordinated, evidence-informed reform agenda. The following seven targeted recommendations—structured across legal, institutional, digital, and capacity dimensions, offer a roadmap for transformative change:

i. Narrow Exemptions with Mandatory Public Interest Overrides Amend Section 6 of the *Access to Information Act, 2016* to:
   - Define "public interest" and "national security" with precise, harm-based criteria;
   - Introduce a statutory public interest override mandating disclosure when health, safety, or transparency benefits outweigh potential harm (aligned with ACHPR Declaration Principle 26(5) and AU Model Law s. 9). *Impact*: Reduces arbitrary denials of epidemiological and clinical data; empowers libraries to challenge refusals.

ii. Establish an Independent Information Commission Create an autonomous oversight body (or empower CHRAGG) with:
   - Investigatory, adjudicatory, and sanctioning powers;
   - Mandatory annual reporting on compliance and health data disclosure. *Impact*: Ensures impartial appeals, builds public trust, and aligns with General Comment No. 34 (para. 46).

iii. Introduce Tiered Sanctions and Accountability Mechanisms Expand Sections 22–23 to impose:
   - Administrative fines and disciplinary action for unlawful refusal/delay;
   - Performance audits of public health data disclosure. *Impact*: Deters impunity, incentivizes proactive release of vital health information.

iv. Implement Expedited Processing for Public Health Emergencies Revise Sections 10–14 to include:
   - A 72-hour response track for requests involving life, health, or environmental risk;
   - Library-led triage hubs for urgent community submissions. *Impact*: Enables rapid dissemination during outbreaks (e.g., cholera, Ebola).

v. Invest in Digital Infrastructure and Library-Led Health Hubs Launch a national digital health information strategy with:
   - Subsidized broadband and solar-powered ICT in rural campuses;
   - University libraries as regional health information nodes with dedicated OER portals and telemedicine integration. *Impact*: Bridges digital divide, scales evidence-based practice (Badr *et al.*, 2024).

vi. Scale Culturally Tailored Information Literacy Programs Mandate curriculum-embedded health literacy training across tertiary institutions, with:
   - Swahili-language modules, community radio tie-ins, and peer educator networks;
   - Library-led stigma-reduction campaigns (HIV, mental health). *Impact*: Enhances user competency, counters misinformation (Kwafoa *et al.*, 2025).

vii. Forge Tripartite Partnerships: Government–Libraries–Civil Society Establish formal MOUs between:
   - Ministry of Health, university libraries, and NGOs for co-curation of health repositories;
   - Annual health information summits to align policy, practice, and research. *Impact*: Creates a sustainable ecosystem for knowledge production and dissemination.

These reforms; feasible, scalable, and rights-aligned; position Tanzania to lead Africa in integrating information access with public health governance. University libraries, as trusted intermediaries, must be central to this vision.

Declaration of Conflict of Interest

I hereby declare that there are no known competing financial interests or personal relationships that could have influenced the research and findings presented in this paper.

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