The Linguistic Landscape of Muhimbili National Hospital in Tanzania: Its Implication for Access to Information

*Paschal Charles Mdukula**

Abstract
The paper examines the nature of linguistic public signs that constitute what is popularly known as Linguistic Landscape (LL) at Muhimbili National Hospital (MNH) in Tanzania to explain their implication for access to information in the hospital. The study employed the socio-linguistic theoretical framework to examine the nature of the LL of MNH and its implication for access to information as presented through public signs at the hospital. Data for this study constituted photos/public signs from the hospital premises and interview narratives from hospital clients and staff. The data were analysed both quantitatively and qualitatively. Findings show that the LL of MNH is more controlled by top-down than bottom-up actors in which there are three visible languages: English, Swahili, and Chinese. The most preferred language patterns do not guarantee access to information to hospital clients in the public space of the hospital, since some clients fail to understand what is communicated through the signboards placed in the public space of the hospital. They use unfamiliar language pattern(s), mostly in English. This lowers further their participation in promoting health and taking responsibilities of their health concerns while at the hospital.

Key words: *linguistic landscape, Muhimbili, public space, sign*

Introduction

Linguistic tokens constitute what is popularly known as Linguistic Landscape (LL). These have become an integral part of cities and institutions' built environment manifesting the representation of written language(s) in the public space. Written languages range from tiny handwritten pieces of paper expressing notes of welcome to huge advertising billboards put up *in a public hospital promoting healthcare services* (Gorter, 2006:55 *emphasis added*). These linguistic tokens show where an individual is, which language is accepted and, therefore, to know for him/her to navigate well and access various services.

One can appreciate the same when visiting public health facilities such as Muhimbili National Hospital (MNH) in Dar es Salaam, Tanzania. He/she will be invited with different visual linguistic signboards around the hospital compounds. These are meant to

* Assistant Lecturer, Centre for Communication Studies, University of Dar es Salaam, P.O. Box 35040, Dar es Salaam, Tanzania, E-mail: pcharles@udsm.ac.tz

welcome, direct, inform, warn, instruct, and educate hospital clients and the hospital community in general, as they navigate their way through the hospital. However, from a socio-linguistic standpoint, very little is known about whether such linguistic signs in health facilities effectively accomplish the intended function of promoting access to information to the majority of Tanzanians visiting such public hospitals. This paper is a part of a large research-based study that was conducted at MNH in Tanzania between 2016 and 2017.

Why Study the LL of a Public Health Facility?

Although language is spoken and heard, it is also equally represented and displayed through signs for functional or symbolic purposes in public space (Ben-Raphael et al., 2006; Landry & Bourhis, 1997). For the language displayed in the public space to achieve its communicative purposes, it has to be informative and comprehensive to the readers. The language displayed in the hospital's public space is important in enabling access to relevant information for the clients to navigate their way through the hospital's public space. Such a language is geared towards welcoming, directing, informing, warning, instructing, and educating those who seek access to the services provided. Consequently, this helps them make informed decisions about their health plans, healthcare services, rights and responsibilities as well as rules and regulations to follow while navigating their way through the hospital (Schuster et al., 2016).

Nevertheless, no traceable research has explored the LL of public hospitals in Tanzania to determine how it promotes access to information in public hospital settings. Few studies have focused on the LL of medical facilities elsewhere such as Botswana (Akindele, 2011), Malawi (Kamwendo, 2004), the US-Mexico border (Martinez, 2014), South Africa (Saohatse, 2000), and Israel (Schuster et al., 2016). These studies have not looked at the role of the LL in promoting or hindering access to information in their respective hospital settings.

The General Socio-linguistic Situation in Tanzania

Tanzania is a home to many languages used by various people to share and meet their communicative needs in different formal and informal domains. These languages range from ethnic community languages to foreign languages (ECLs) (Petzell, 2012:24). Generally, the linguistic situation of Tanzania is triglossic. There are ECLs, Swahili (spoken by almost 90% of all Tanzanians), and English (Qorro, 2009; Rubagumya, 1990).

The exact number of languages spoken in Tanzania is not clear, though many scholars note that more than 120 languages are spoken in the country. The most recent survey of linguistic situation in Tanzania estimates that 150 languages are spoken in the country (LOT, 2009). The surveyed 150 languages are mostly spoken rather than written. The majority of their speakers are illiterate in the languages.

As for foreign languages, English and French, among others, are spoken by relatively a smaller number of people in Tanzania (Biswalo, 2010; Rubagumya, 1990; Tibategeza, 2009). These people learned these languages in school because they are not publically spoken in informal settings. Nonetheless, Chinese has recently been used in the public space; this shows the dynamics of language contact. As mentioned previously, Swahili is the most widely spoken language in the country. , Likewise, English is the most dominant foreign language, and it is an official language in Tanzania, just like Swahili. In terms of use, the three language groups can be said to fulfil both instrumental and symbolic functions in different settings (Landry and Bourhis, 1997; Ben-Rafael et al, 2006). These are summarised in the following table.

Table 1: Tanzania's Linguistic Repertoire

Language	Instrumental and Symbolic Function
Swahili	Medium of instruction, press, modernity, economic opportunities, communication within Tanzania, identity and national unity, national language, and a lingua franca
English	Judicial system, medium of instruction in secondary and higher education, modernity, parliament, documentation, and international communication
Ethnic community languages	Local communication in informal settings and ethnic identity

Source: Researcher, 2017

Accordingly, this paper aims at addressing the nature of the LL and the way it affects access to information at MNH in Dar es Salaam, Tanzania. To achieve these objectives, the paper was guided by two research questions: i) What is the nature of the linguistic landscape

of MNH? ii) To what extent does MNH's LL promote or hinder access to information in the provision of healthcare services?

Conceptualisation of Linguistic Landscape

Studies on Linguistic Landscape (LL) in the public space are relatively few in the field of socio-linguistics. Those focusing exclusively on the medical field are even scarcer. As a discipline of study, LL gained a radical momentum in the 21st century after a seminal paper by Landry and Bourhis (1997:25). These scholars defined LL as "the language of public road signs, advertising billboards, street names, place names, commercial shop signs, and public signs on government buildings combines to form the LL of a given territory, region, or urban agglomeration." In simple language, LL is a visibility and saliency of language as well as its distribution on linguistic objects in the public space. The use of written language in the public space is the focus of LL studies being used to fulfil information or symbolic functions (Backhaus, 2007; Gorter, 2013; Landry & Bourhis, 1997).

On the other hand, Yavari (2012:16) defines 'public space' as a place par excellence where different languages come into contact. A public space can be a small street, a territory, a commercial centre, or a public institution *like a medical facility in a city* (emphasis added) (Gorter, 2013:19). Being a place where different language groups come into contact, the public space offers LL actors an opportunity to use and identify with the language(s) which affects them in terms of how they access the information expressed in those languages. Literature shows that language use and practice in healthcare delivery systems is one of the important aspects that play a central role in providing therapy, curative drugs, administrative information, and general information that promotes health to clients (Akindele, 2011; Kamwendo, 2004; Martinéz, 2014; Saohatse, 1997; Spolsky, 2004; The Joint Commission, 2007). Commenting on the importance of public signs in health facilities, Schuster et al argue:

> Hospital signage is a critical element in the patients' and visitors understanding of directions, instructions and warnings in the facility. In multilingual environments, organizations need to make sure that the information is accessible in the languages of the people who consume their services (Schuster et al., 2016:23).

This means that studying accessibility of language on signs in the public space that is shared by diverse linguistic population in the country is essentially an important aspect in socio-linguistic studies, because language is supposed to serve the people in their communicative endeavours and accommodate their linguistic needs while trying to access the social services provided.

Constructing the Public Space through Linguistic Landscape

According to Landry and Bourhis (1997:25) and Ben-Rafael et al. (2006:10), linguistic landscape encompasses the visibility of languages on objects that mark the public space such as road signs, street name buildings, places, and institutions, advertising billboards on commercial centres as well as personal visiting cards in public institutions. Such signs for these linguistic objects are issued to the face of the public either by public authorities such as government agencies and associations acting independently without restrictions from the state. Public authorities normally act under the control of legal limits of local and central policies (Backhaus, 2009; Ben-Rafael et al., 2006). However, signs issued by both public authorities and private entities offer themselves to the public walking through and are supposed to use such signs while navigating their way through the facility. The issuance, coordination, and practice of these signs in the public space are done by different social agents.

Linguistic Landscape Actors

Understanding the linguistic landscape of a place means understanding the key actors who make the landscape flourish in a given environment. It is also meant to understand the ideologies behind language choice in the public space as explicitly or implicitly practised by social agents (Bever, 2010:67). For a LL to exist and get shape, there must be actors that are closely involved in creating, advancing, and shaping it. The current study adopts the categorisation by Backhaus (2007) and Gorter (2006). These scholars categorise these agents as top down actors and bottom up actors.

Top-down Actors

These bodies work on behalf of the government. In the context of this study, these include medical insurers and medical supporting agencies such as NHIF and Abbot Fund; medical institutes such as Muhimbili Orthopaedic Institute (MOI) and Jakaya Kikwete Cardiac Institute (JKCI); medical bodies such as Medical Society of Tanganyika (MST), Midwives Association, and the Muhimbili

management and staff. Commenting on top down - bottom up distinction, Ben-Rafael et al. note the following:

> ...The main difference between these two wide categories of LL elements resides in the fact that the former are expected to reflect a general commitment to the dominant culture while the latter are designed much more freely according to individual strategies (Ben-Rafael et al., 2016:10).

According to Ben-Rafael et al (2006) and Gorter (2006), the official language policy is normally reflected on top down items than bottom up items. This means that the language expected to be seen in the LL will be the one stipulated in the official language policy of the country. However, the extent to which this is the reality with regard to hospitals' public spaces in Tanzania is a matter of discussion.

Bottom-up Actors

These individuals or private companies are not controlled or regulated by any governmental agency; hence, they do not operate within established legal limits of language policy (Ben-Rafael et al., 2006; Gorter, 2006). In the context of this study, bottom up actors include clients from outside the hospital such as catering companies, mobile communication vendors, security guards, and janitors. All these participate in advancing the hospital LL by putting up handwritten or typed notices around their areas of activity. The presence of both top down and bottom up signs is likely to affect the level of accessibility to information among hospital clients and the general community in the public space, when the language used to deliver such information is not accessible to the presumed readers of such signs.

Tanzanian Language Policy and LL Management in the Public Space

The Tanzanian language policy was adopted right away in the early years after independence. It embraced Swahili as an official language, the national language, and the lingua franca (Biswalo, 2010; Legère, 2006) and English as an official language. To exemplify this, Mwalimu Julius Nyerere, the first president of Tanganyika, addressed the National Assembly in 1962 in the national language. The recognition of Swahili by the high-profile person not only paved the way for its dominance in other public spaces but also stimulated the use of the language in the country and promoted its image as a

viable instrument of political integration, social and economic growth (Legère, 2006).

As a rule of thumb, the use of language(s) in a public space, for instance in schools or any other public domain, is determined by the language policy (Backhaus, 2009; Biswalo, 2010; Blackwood & Tufi, 2012; Landry & Bourhis, 1997; Spolsky, 2004). For multilingual countries such as Tanzania, South Africa, and others (see Du Plessis, 2012; LOT, 2009; Saohatse, 1997), language policy is even more necessary to regulate and balance the use of language(s) in the public space to avoid language clashes. This is reflected on the Tanzanian government secular No 1 of 1974 that emphasised the use of Swahili in all public offices, including public signs as elaborated in the section below.

Language Policy and 'Swahilisation' of Tanzania's Public Space

Tanzania's Swahilisation project dates back to the early 1960s when the government stressed much on the use of Swahili for all communications in all its apparatus and administrative organs (Bwenge, 2012; Legère, 2006; Mazrui & Alamin, 1998). The term "Swahilisation of the public space" was also used by Mazrui and Alamin (1998) in their book titled, "*The Power of Babel: Language and Governance in the African Experience*" to mean use of the Swahili language in the public space as the major language of wider communication. The use of Swahili was meant to replace English as the major language of communication in different social, political, and economic domains. This is because most clients meant to receive public social services were Swahili speakers. From the linguistic standpoint, any language is potentially gifted for roles such as instrumental or symbolic in the communication it is expected to fulfil (Bamgbose, 2011; Mazrui & Alamin, 1998). Drawing on this background, the government issued a public circular No 1 in 1974 emphasising the use of Swahili in all public signs and all forms that needed to be filled-in by clients in public offices. The components of the circular (as translated from Swahili to English) included the following:

 i) All official letters between government ministries, departments and regions should be in Kiswahili, except when writing to an expatriate or Technical Assistant Personnel who does not know Kiswahili.

 ii) All memoranda among public officers should be in Kiswahili.

iii) All public signs in public offices should be written in Kiswahili.

iv) All forms to be filled-in by clients in public offices should be in Kiswahili; nevertheless, those that are already in English will continue to be used until they are over, but all forms that will be produced later should be in Kiswahili (URT, 1974).

Based on the researcher's knowledge, the circular was never revoked at any point in time. Therefore, it is still in place though, not reinforced. The Swahilisation of the public space initiative suggests that it was meant to enable easy access to information and service in public offices by the Tanzanian majority who were literate in Kiswahili than any other official language (URT, 1974) - the truth that can be proved right even in contemporary Tanzania.

Theoretical Framework
This paper is grounded in Backhaus' (2005) and Spolsky's (2009) socio-linguistic theoretical framework to investigate the nature of linguistic landscape of MNH in Tanzania and the way it influences access to information in its public space. This theory is based on the constructs such as LL agency, motives for language choice and preference in the LL, presumed readers' experience on the LL, and communicative language function of the LL.

Backhaus (2005) came up with two important questions about LL agency: *linguistic landscape by whom*, which refers to creators, coordinators or sign writers and *linguistic landscape for whom*, which refers to the sign readers or presumed readers –people who are the target of the signs created by *linguistic landscape by whom*. He further stresses that, for LL to flourish, there must be actors. These actors can be government agents (top-down) or individuals (bottom-up). This is what is referred to as *linguistic landscape by whom*; in most cases, it operates within legal limits as substantiated by the language policy of the state. Therefore, the presumed LL is there to serve a certain group of actors (linguistic landscape for whom) in the public space.

Likewise, Spolsky (2009) shared almost the same constructs as Backhaus' theoretical notions. Thus, Spolsky's perspective attempted to address why people choose a certain language over the other in signing the public space and the impact that can be realised from that choice. Akin to Backhaus, Spolsky's socio-linguistic perspective

propounded three basic theoretical constructs in analysing the LL of a selected public space. These include the sign-writer's skill, the presumed reader, and the symbolic value.

These constructs take on board the agents and functions of LL in the public space. The first theoretical construct states, "Write a sign in a language you know." This explains the preference of the writer of the sign; normally, writers pick the language they know best –the language they are literate in. The second theoretical construct states, "Write a sign in a language that is known to the audience." The approach focuses on the communicative function of LL signage in the public space as a realisation of the fact that the sign is meant to address a communicative function in the public space; hence, it has to be known by the consumers. The third theoretical construct states, "Write a sign in your own language or in a language with which you wish to be identified." This accounts for the symbolic function of language in the public space and the choice of signs that asserts ownership (Ben-Rafael et al, 2006). This theoretical construct helps to explain the nature of the written signs in the public space of MNH as to whether they are posted based on informational or symbolic functions.

These theoretical constructs help in guiding this research via explaining who the actors in the LL of the hospital are, why a certain language pattern is preferred, and how it affects access to information among the presumed readers of the signs.

Methodology
This study employed a mixed case study design –a design that has not been widely applied in the field of linguistic landscape. This design presents a particular case of study in a specific area of a public institution –in this case –the hospital. Thus, the findings of this study are specifically meant for this case. The study adopted a mixed method research design to analyse public signs quantitatively and interview data qualitatively. The mixed methods design brings together the best qualities of both quantitative and qualitative approaches (Terrell, 2012). Observation and unstructured interviews were the main methods of data collection. Photographic data were collected through observation using a digital camera and a notebook. Moreover, the interviews were conducted with human respondents at the hospital; the data were captured using an audio-tape recorder and a notebook.

The Research Site, Sampling Procedures, and Sample Size
The study was conducted at Muhimbili National Hospital in Dar es Salaam in which two sources of data were involved: public signs/photographs and human respondents. The human respondents were divided into three categories: hospital clients (patients and family members), hospital staff (doctors, nurses, and administrators), and a representative from the ministry of health. The researcher visited the MNH and took photos of the signs in the specified areas of activity using a digital camera. In total, 225 public signs were collected from different areas of activity at the hospital during the field survey and 20 human respondents were interviewed to supplement information that could not be obtained through public signs. Accordingly, the study employed a non-probability sampling procedure in which a purposive sampling technique was used to collect data in the form of public signs in the specified areas of activity of the hospital and some section of human respondents such as hospital staff (administrators) and a ministry representative. The justification for using this technique is that, it subjected the researcher to specific signs in the specified areas of activity and specific people who were believed to have rich information pertaining to the study.

Another section of the participants for the interviews (outpatients, family members and hospital staff) was sampled through convenient sampling. This technique was employed because getting specific patients, families, doctors and nurses was not easy. These are always busy with different matters at the hospital. In these categories, therefore, only those who were willing to spare few minutes of their time for the interviews were involved. The aim was to get their views and experience on the LL at the hospital. The 225 signs collected met the established criterion to be included in the sample as units of analysis; that is, signs without text were not considered for the analysis. In addition, signs sought to fulfil communicative function such as health promotion, regulatory, administration, rights and responsibilities of hospital staff and clients were the focus during the field survey. Besides, language patterns (that is, whether monolingual or bilingual) on the sign and linguistic landscape sources (that is, whether top down or bottom up) prompted the researcher in collecting the photographical data.

Data Analysis, Findings and Discussion
Photographed public signs from different areas of activity in the hospital were analysed quantitatively using SPSS (Version 24). The

analysis was based on an established coding system, namely linguistic agency (that is, top down and bottom up), language choice and preference on the sign (that is, monolingual or bilingual), and the communicative function of the sign (for instance, health promotion, regulatory, administration, rights and responsibilities of hospital staff and clients). The primary data from the respondents were thematically analysed. Various themes were established from the data. They focused on the factors that motivate the LL at MNH, attitudes and perceptions towards language use and practice in the LL of MNH, the role of LL in promoting or hindering access to information at MNH. These themes are presented in the following tables and figure:

Table 2: Linguistic Signs Based on LL Actors

Linguistic Landscape Actor	Sign Frequency	Valid Percent
Top-down actor	217	96.4
Bottom-up actor	8	3.6
Total	225	100.0

Source: Fieldwork, 2016

Table 2 shows the large number of signs produced by the hospital management, staff, and other government agencies (top down). Thus, 217 of the collected signs were top down, equals 96.4% of the total signs analysed. On the other hand, only a few were bottom up signs; they were eight, which equals 3.6% of the total signs. Therefore, the top down agents were the main key actors in issuing, shaping, and maintaining the linguistic landscape ecology of the hospital. Table 2 below shows the language choice and distribution, based on top down and bottom up categories.

Table 3: Language Choice and Distribution

Language on Signs	Top-down Signs	Frequency %	Bottom-up Signs	Frequency %
Swahili	60	26.6	3	1.3
English	75	33.3	-	-
Swahili-English	31	13.7	-	-
English-Swahili	21	9.4	-	-
Swahili-Chinese	1	0.5	-	-
Chinese-English	5	2.3	-	-
Mixed languages	24	10.7	5	2.2
Total	217	96.5	8	3.5

Source: Fieldwork, 2016

The results in Table 3 indicate that monolingual signs are the mostly preferred patterns in the linguistic landscape of the hospital. In this pattern, monolingual English signs outnumbered Swahili pattern by 6.7%. This suggests that the top down actors preferred English to other languages in communicating information to the public through signboards. Figure 1 below presents signs from the top-down and bottom-up categories. As mentioned above, the top down category preferred English while the bottom up category preferred Swahili to English and Chinese.

Figure 1: Signs from Top-down and Bottom-up Categories

Photo 1: Top-down Sign   **Photo 2:** Bottom-up Sign

This result shows that clients are excluded from benefiting the information presented in either monolingual English or monolingual Swahili. Consequently, this affects their ability to process information as they navigate their way in the hospital compounds.

Table 4: Language Choice and Preference in the General LL of MNH

| Language Choice Preference	Sign Frequency	Valid Percent
Swahili only	79	35.1
English only	82	36.4
Swahili-English	33	14.7
English-Swahili	25	11.1
Swahili-Chinese	1	0.4
Chinese-English	5	2.2
Total	225	100.0

Source: Fieldwork, 2016

Table 4 shows three visible languages in the LL of MNH: English, Swahili, and Chinese. These follow either monolingual or bilingual patterns. Similarly, the data suggest that English is the default language when it comes to language choice and preference at MNH. From the data, only 64 signs were bilingual or were translated from either English to Swahili, Swahili to English or Chinese to English. Interview data show that the influence from external donors such as Abbot Fund, a desire to create an international atmosphere, as well as the composition of clients and staff have a great influence on language choice of signs in some of hospital facilities. Therefore, the use of English is a strategy to accommodate them easily. Moreover, most hospital clients at MNH preferred Swahili to other languages. In contrast, most hospital staff preferred English to other languages; these were from top-down category – a category that largely seems to influence the language choice and use at the hospital than any other LL agents. Conversely, it is clear that, whether signage at MNH is done exclusively in Swahili or English, the practice would not guarantee access to information based on the contemporary composition of the hospital clients and staff. A more inclusive linguistic strategy that can accommodate most clients in this public space is necessary.

Table 5: Language Pattern on Bilingual and Mixed Words

Translation pattern	Sign Frequency	Valid Percent
Word-to-word Translation	26	40.6
Partial Translation	10	15.6
Free Translation	4	6.3
Mixed Words	24	37.5
Total	64	100.0

Source: Fieldwork, 2016

Another language pattern noted in the data was translation for bilingual signs. Findings indicate that 64 signs were either translated or presented with mixed languages. Among these, 26 were translated word-to-word while 10 were partially translated. In addition, four (4) followed a free translation pattern. The other 24 signs had mixed languages, mostly English and Swahili. These can be seen in Figure 2.

Figure 2: Mixed Language Signs with Swahili and English Words
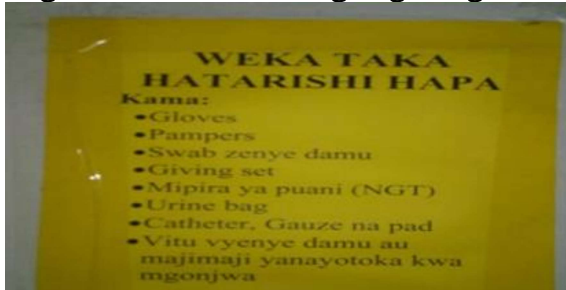
Photo 1: Mixed Language at Phrase Level   Photo 2: Partial Translation

This applies the same to mixed words on signs as presented in Figure 2. However, incomplete or partial translation and use of mixed languages leaves a lot to be desired as far as access to information in the public space is concerned.

Table 6: Signs According to Communicative Language Function

Sign Function	Frequency by Language Function	Language Pattern	Frequency by Language Order	Percentage
Administrative	176	English only	67	29.8
		Swahili only	61	27.1
		English-Swahili	18	8
		Swahili-English	26	11.6
		Swahili-Chinese	1	0.4
		Chinese-English	3	1.3
Health promotion	22	English only	7	3.1
		Swahili only	8	3.6
		English-Swahili	2	0.9
		Swahili-English	5	2.2
Regulatory discourse	23	English only	7	3.1
		Swahili only	7	3.1
		English-Swahili	5	2.2
		Swahili-English	2	0.9
		Chinese English	2	0.9

Rights/responsibility	4	Swahili only	4	1.8
Total	**225**		**225**	**100.00**

Source: Fieldwork, 2016

The results in Table 6 clearly indicate different communicative functions of language as presented by signs in the LL of the hospital. These communicative functions were the focus of this paper. Such functions focused on providing access to information to the majority of hospital clients. The findings show that, on average, English only and Swahili only monolingual signs dominated the public space; they were about 70% of all signs. Thus, those who were less literate in one of the mostly used languages were disadvantaged. They could not access information pertaining to administration, health promotion, regulations, and right and responsibilities.

Discussion

The language patterns analysed indicate that the nature of MNH's LL is controlled by the top-down actors than the bottom-up actors. Monolingual English is the mostly preferred language in terms of presence, dominance, and availability in the public space of the hospital (cf. Backhaus, 2007). This result is in line with Schuster et al (2016) on language accessibility in Israel's public hospitals. These scholars found out that monolingual English was more preferred than other languages. They suggested that signage in the public space should take into account the mostly encountered group, those who will be able to access and read such signs. This is because, when information is presented in a language that is not accessible to the reader, it becomes worthless in that public space. Importantly, public signs are meant to enable hospital clients to access information related to directions, instructions, warnings, and health promotion. Therefore, the institution's management should ensure that information is accessible in the languages of the people who utilise their services. This finding is in line with Schuster (2012) and Schuster et al. (2016) on language accessibility in the public space. That is, the language use on signs has to consider the commonly encountered group(s) of clients visiting the facility than to assume that everyone understands the language used on signs. Based on the nature of the language patterns preferred at MNH, research findings show that the LL of the hospital does not guarantee access to

information to the majority of hospital clients –especially the visitors and patients admitted to the hospital.

Furthermore, the analysis of the patterns of translation, especially partial translation and free translation on these signs, indicate that they fail to promote access to information. Less proficient clients failed to comprehend the messages presented on the signs. In addition, the translated signs were not correct in terms of the information they were trying to convey; therefore, they seemed to serve a different goal (cf. Martinez, 2014).

Nevertheless, MNH's environment does not seem to be linguistically friendly to many of her diverse clients. As noted previously, the majority of Tanzanians are proficient neither in English nor in Chinese (Bwenge, 2012:54). Additionally, those who are not proficient in Swahili, although a few, face the same difficulties in navigating their way through the hospital's environment. Accordingly, inclusive linguistic strategies to accommodate clients with diverse linguistic needs and to ensure access to information by the majority are crucial (Schuster et al., 2016; U.S. Department of Health and Human Services, 2013). One of such strategies, for instance, is to adopt bilingual signage.

Interview data showed further that knowledge of LL and language policy among hospital clients and hospital staff is very little. Consequently, knowing their role in shaping and advancing the LL at the hospital is difficult. An interview with an officer coordinating the creation and placement of signs at the hospital indicated that no institutional policy has been put in place to manage language use on signs at the hospital.

Conversely, both hospital clients and hospital staff show positive attitudes towards the current LL of the hospital; nevertheless, the clients seem to benefit very little from the monolingual English public signs. Apparently, the majority of Tanzanians like to identify themselves with English (Symbolic function), although their literacy and proficiency in the language is very low (Bwenge, 2012; Mkumbo, 2014).

Similarly, when asked about the extent to which the LL of the hospital was promoting access to information, many clients, on one hand, said that it was doing so to a very small extent because of the language patterns used on signs. Members of hospital staff, on the

other hand, held that it was promoting access to information. They argued that not all signs were meant for hospital clients. The excerpt below is illustrative:

> ...not everything written in the public space is meant for our customers, other signs are meant for our own operations within the hospital, so we do not expect the outsider to understand.

Their argument defeats the whole concept of accessibility and dissemination of information in the public space because the core sections of the clients who are also the target are left out; hence the services, products, and the environment in which the services are provided become worthless to them.

Conclusion

This paper investigated the nature of LL of Muhimbili National Hospital, the only national referral hospital in Tanzania. The study also looked at its influence in promoting or hindering access to information in the public space of the hospital. The findings showed that MNH's LL is dominated by three languages: English, Swahili, and (to a lesser extent) Chinese. The study indicated that many of the analysed signs were monolingual. Very few of them were bilingual. This situation excluded some clients from accessing the information contained in the public signs. Both quantitative and qualitative data revealed communication problems due to unmanaged LL practices at the hospital. These stem from the lack of clear policies, procedures, and guidelines. In this regard, the LL of the hospital does not seem to guarantee access to information to many hospital clients.

In terms of functions of LL, both informational and symbolic functions are manifested in the LL of MNH. Power relation seems to influence the continued use of monolingual English in the space dominated by Swahili speakers. In addition, the findings on do not appear to reflect the linguistic situation in the country, which is triglossic. This study suggests using the language of the commonly encountered groups at the hospital and adapting a bilingual policy on signage. This policy will address, among others, the need for each sign posted in the LL of the hospital to be translated into another language, which is accepted as official and which can linguistically accommodate the diverse linguistic needs of the clients visiting the hospital.

References

Archibald, M. M. (2016). Investigator Triangulation: A Collaborative Strategy with Potential for Mixed Methods Research. *Journal of Mixed Methods Research*, 10(3): 229–250.

Akindele, O. (2011). Linguistic Landscapes as Public Communication: A Study of Public Signage in Gaborone Botswana. *International Journal of Linguistics*, 3: 1–11.

Backhaus, P. (2005). Signs of Multilingualism in Tokyo: A linguistic Landscape Approach. Unpublished PhD Thesis, University of Duisburg-Essen, Tokyo.

_____ (2006), Multilingualism in Tokyo: A Look into the Linguistic Landscape. *International Journal of Multilingualism*, 3(1): 52–66.

_____ (2007). *Linguistic Landscapes. A Comparative Study of Urban Multilingualism in Tokyo*. Clevedon–Buffalo–Toronto: Multilingual Matters Ltd.

_____ (2008). The linguistic landscape of Tokyo. In M. Barni & G. Extra (eds.). *Mapping Linguistic Diversity in Multicultural Contexts*. Berlin: Mouton de Gruyter: 311–333.

_____ (2009). Rules and Regulations in Linguistic Landscaping: A Comparative Perspective. In D. Gorter & E. Shohamy (eds.). *Linguistic Landscape: Expanding the Scenery*. New York: Routledge: 157–172.

Barni, M. & Bagna, C. (2010). Linguistic Landscape and Language Vitality. In E. Shohamy, E. Ben-Rafael & M. Barni (eds.). *Linguistic Landscape in the City*. Bristol: Multilingual Matters: 126–140.

Ben-Rafael, E., Shohamy, E., Amara, M. H & Trumper-Hecht, N. (2006). Linguistic Landscape as Symbolic Construction of the Public Space: The Case of Israel. *International Journal of Multilingualism*, 3(1): 7–30.

Bever, O. A. (2010). Linguistic Landscapes of Post-soviet Ukraine: Multilingualism and Language Policy in Outdoor Media and Advertising. Unpublished PhD Dissertation. University of Arizona.

Biswalo, T. (2010). Policy Processes in Relation to Language in Tanzania: Examining Shifts in Language Policy. Unpublished PhD Dissertation, University of Illinois.

Blackwood, R. & Tufi, S. (2012). Policies vs. Non-Policies: Analysing Regional Languages and the National Standard in the Linguistic Landscape of French and Italian Mediterranean Cities. In Gorter, D., Marten, H. F. & Mensel, L. V. (eds.).

Minority Languages in the Linguistic Landscape. London: Palgrave Macmillan: 109–126.

Blackwood, R. (2015). LL Explorations and Methodological Challenges: Analysing France's Regional Languages. *Linguistic Landscape*, 1(1/2):38–53.

Bwenge, C. (2009). Language Choice in Dar es Salaam's Billboards. In F. McLaughlin (ed.). *The Languages of Urban Africa*. New York: Continuum International Publishing Group: 152–177.

_____ (2012). Business Signs in Dar es Salaam: A Sociolinguistic Perspective. *Language in African Performing and Visual Arts*, 1: 48–59.

Coulmas, F. (2005). *Sociolinguistics: The Study of Speakers' Shoices*. Cambridge: Cambridge University Press.

Creswell, J. W. (2003). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (2nd ed.). London: Sage Publications.

Du Plessis, T. (2012). The Role of Language Policy in Linguistic Landscape Changes in a Rural Area of the Free State Province of South Africa. *Language Matters*, 43(2): 263–282.

Garvin, R. T. (2011). Emotional Responses to the Linguistic Landscape in Memphis, Tennessee: Visual Perceptions of Public Spaces in Transition. Unpublished PhD Thesis, Indiana University of Pennsylvania.

Gorter, D. (2006). Introduction: The Study of the Linguistic Landscape as a New Approach to Multilingualism. *International Journal of Multilingualism*, 3(1): 1–6.

_____ (2013), Linguistic Landscapes in a Multilingual World. *Annual Review of Applied Linguistics*, 33:190–212.

Kamwendo, G. H. (2004).*Language Policy in Health Services: A Socio-linguistic Study of a Malawian Referral Hospital*. Helsinki: Helsinki University Printing House.

Landry, R. & Bourhis, R. (1997), Linguistic Landscape and Ethno-linguistic Vitality: An Empirical Study. *Journal of language and Social Psychology,* 16(1): 23–49.

Languages of Tanzania Project (2009). *Atlasi ya Lugha za Tanzania*. Dar es Salaam: Mradi wa Lugha za Tanzania, Chuo Kikuu cha Dar es Salaam.

Legère, K. (2006). J. K. Nyerere of Tanzania and the Empowerment of Swahili. In Martin, P., Joshua A. F. & JoAnne N. A. (eds.). *Along the Routes to Power': Explorations of Empowerment through Language*. Berlin. Mouton de Gruyter: 373–403.

_____ (2007). Vidunda (G38) as an Endangered Language? *In Selected Proceedings of the 37th Annual Conference on African Linguistics*, 43–54.

Lewis, M. P. (ed.) (2009). Ethnologue: Languages of the World (6th ed.).

Maho, J. & Sands, B. (2003). *The languages of Tanzania: A Bibliography*. Goteborg: Act Universitatis Gothoburgensis.

Martínez, G. A. (2014). Vital Signs: A Photo Voice Assessment of the Linguistic Landscape in Spanish in Healthcare Facilities along the U.S-Mexico Border. *The Journal of Communication and Health*, 1: 1–21.

Mazrui, A. A. & Alamin, M. (1998). *The Power of Babel: Language and Governance in the African Experience.* Oxford: James Currey.

Mkumbo, K. (2014, Machi). Kiingereza Tunakipenda lakini Hatutaki Kujifunza. *Raia Mwema.*

Petzell, M. (2012). The Linguistic Situation in Tanzania. *Modernasprāk*, 1: 136–144.

Reh, M. (2004). Multilingual Writing: A Reader-oriented Typology-with Examples from Lira Municipality (Uganda). *International Journal of the Sociology of Language*: 1–41.

Rubagumya, C. M. (1990). Language in Tanzania. In Rubagumya, C. M. (ed.). *Language in Education in Africa: A Tanzanian Perspective*. Clevedon (UK): Multilingual Matters Inc: 57–83.

Saohatse, M. C. (2000). Solving Communication Problems in Medical Institutions. *South African Journal of African Languages*, 20(1): 95–102.

Schuster, M. (2012). Language Accessibility of Signage in Public Settings: A Case Study of a Healthcare Service. *SALALS*, 30(3): 311–324.

Schuster, M., Elroy, I. & Elmakais, I. (2016). We are Lost: Measuring the Accessibility of Signage in Public General Hospitals. *Lang Policy* (2017), 16: 23–38.

Scollon, R. & Scollon, S. W. (2003). *Discourses in Place: Language in the Material World*. London and New York: Routledge.

Shohamy, E. (2006). *Language Policy: Hidden Agendas and New Approaches*. Routledge: London.

_____ (2012). Linguistic Landscape and Multilingualism. In M. Martin-Jones, A. Blackledge & A. Creese (eds.). *The Routledge Handbook of Multilingualism*. London: Routledge: 538–551.

_____ (2015). Linguistic Landscape Research as Expanding Language and Language Policy. *Linguistic Landscape*, 1(1/2): 152–171.

Shohamy, E., Ben-Rafael, E. & Bam, M. (eds.) (2010). *Linguistic Landscape in the City*. Bristol: Multilingual Matters.

Spolsky, B. (2004). *Language Policy*. Cambridge: Cambridge University Press.

_____ (2009). Prolegomena to a Socio-linguistic Theory of Public Signage. In E. Shohamy & D. Gorter (eds.). *Linguistic Landscape: Expanding the Scenery*. New York: Routledge: 25–39.

Spolsky, B. & Cooper, R. L. (1991). *The Languages of Jerusalem*. Oxford: Oxford University Press.

Tibategeza, E. R. (2009). Language-in-Education Planning in Tanzania: A Sociolinguistic Analysis. Unpublished PhD Thesis, University of the Free State, Bloemfontein.

U.S. Department of Health and Human Services (2013). National Standards for Culturally and Linguistically Appropriate Service in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.

United Republic of Tanzania (1974). *Government Secular No.1 on Use of Swahili in Public Offices*. Dar es Salaam: Government Printer.