



QUANTITATIVE RESEARCH METHODS

Title: An evaluation of the electronic health readiness of healthcare professionals in the Democratic Republic of Congo (DRC) for the planned Digital Health Investment Roadmap

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1. Introduction

The healthcare sector has experienced a revolution because of technology. Numerous advances in the sector's digitalisation have been due to contractual to the use of computing systems and software (Ahuja et al., 2020). Mediocre healthcare has augmented mortality and morbidity rates in many countries. In addition, a poor healthcare system has also led to the collapse of national prosperity and the profitability of companies (WHO,2013). According to the literature, the utilisation of electronic health(eHealth) records has brought several advantages to the healthcare sector including increased performance, the quality of healthcare, as well as a productive return on capital (Grieger et al. 2007).

According to The Humanitarian Agenda (2015), the DRC has a severe deficit in public health infrastructure (FIC, 2015). This shortage is primarily due to a lack of health technologies. Historically, the Democratic Republic of Congo, also known as Zaire, is a country that may be minerally wealthy and full of resources like diamonds, gold, and zinc, particularly in the eastern of the country where battles are ongoing. Conflicts with armed groups from Rwanda and Uganda have plagued the nation for more than 20 years (ICF, 2015). This nation requires more healthcare technology and equipment than before, as well as improved healthcare policies. There should be a set of policies in place for the healthcare technology, which power brokers should base their policies on reality when establishing them (Buse et al., 2005). The purpose of this study is to assess (describe, compare, and explain) the readiness of professionals' adaptability to the future implementation of an e-Health system using a survey as a method of inquiry. The study will focus on the nursing industry since the majority of employees in healthcare are nurses.

At this stage, E-Health is described by writers as the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision-making" (Elizabeth, 2019).

With the support of this research, investors will be able to determine a path for standardising the DRC's different digital platforms, training several healthcare professionals, and computerising a lot of health centres.

The Significance and Potential Contributions of the Study

This research will contribute to knowledge in all different mentioned fields of computer science, innovation management, and healthcare service provision as well as academically; this research and its validated tool could be of great interest to many companies around the world specialising in information systems solutions where they could invest their money, knowledge and expertise into an unknown region of central African countries such as Congo. Therefore, the study can contribute directly to any future planning towards ehealth business. In addition, this project will provide to healthcare policy makers an important insight on how to facilitate the adoption of

ehealth solutions as well as helping them to understand which healthcare organisational factors make the greatest contribution towards successful implementation.

Research objectives

This study's goal is to assess hospital staff members' (particularly nurses') intentions to adopt a potential e-health system in the DRC. The study will evaluate the level of preparedness of medical staff in Kinshasa, the DRC's capital, for the eventual installation of the eHealth system. The study's objectives are to:

- assess the country's readiness for the eHealth system.
- identify the factors that influence intentions to use the system and accurately predict any cultural differences.
- contribute to new knowledge on the DRC's acceptance of technology in healthcare contexts.
- and propose concrete steps for a quicker and more efficient implementation of the eHealth system in Kinshasa for the management of healthcare and government operations.

Raising research question

This study aims to pinpoint and investigate the factors that affect the adoption of technology in underdeveloped nations. The following inquiries about research have been made as a result:

QR1: What key organisational elements in Kinshasa are most likely to have an impact on healthcare technology?

QR2: What actions will have an influence on Kinshasa's adoption of healthcare initiatives and e-health systems?

Q3. What institutional resources and capabilities are influencing the deployment of e-health in the Kinshasa healthcare system?

2. Literature Review, Conceptual framework and hypotheses

Understanding terminologies associated with this research

Technology is a set of techniques and methods and the process that follows, which is a function of scientific knowledge applied to practical ends (Collins, 2022). In developed countries, technology is used to administer health care, and this is what has made these countries progressive (Lavander et al 2016).

Healthcare Technology, therefore, is a set of computer equipment that is created to make medical services efficient, process information, and manage the supply chain of services and medicines. The potential of the healthcare sector is around 2 trillion dollars and is full of great potential. Significance of technology in healthcare (Bulletin, 2022).

Current theories of technology approach in the healthcare industry and Criticisms

There are several theories of innovation and technology. Many of these theories have been used in organisations and businesses, and they have been the basis of major decisions in those organisations. These innovations have been the subject of research and investigation and have militated in the evolution of science and society. Some of the most influential include:

2.1. Innovation Diffusion Theory

Technology and innovation are considered pillars of organisational progress in many companies (Henrich, 2001). Diffusion of Innovation Theory (DOI) was developed by E.M. Rogers in 1962. It is an old theory incorporated into the social sciences. This theory started as a tool in communication to show how a product evolves and grows in the market and spreads in a particular environment. (Singer, 2019). For the most part, organizations adopt new innovations especially when they launch a new product in the market (Hameed and Counsell, 2014).

Furthermore, Vaccaro et al. (2012), say that in order to adopt technologies, organizations need to adopt new forms of competence, and this will have an impact on the way they organise themselves. Hameed and Counsell (2014) say that organisations that adopt innovations are also flexible to technology. It is also necessary to mention that there are several factors that encourage the adoption of technology and innovation, including the environment, individuals, organisations, and changes (Camisón-Zornoza et al., 2004).

There are different levels of individuals who adopt technology and innovation:

- Innovators: These are people who take risks to implement a concept or an idea whatever it would cost.
- Early Adopters: These are leaders who instigate change in organisations and are ready to commit to influencing others.
- Early majority - These are people who do not take too much risk but wait to gather the evidence before making an innovation-decision
- Late Majority - These people wait for innovation and technology to be tested by many before testing it for themselves
- Laggards - They are conservative and traditional people. Reliability tests

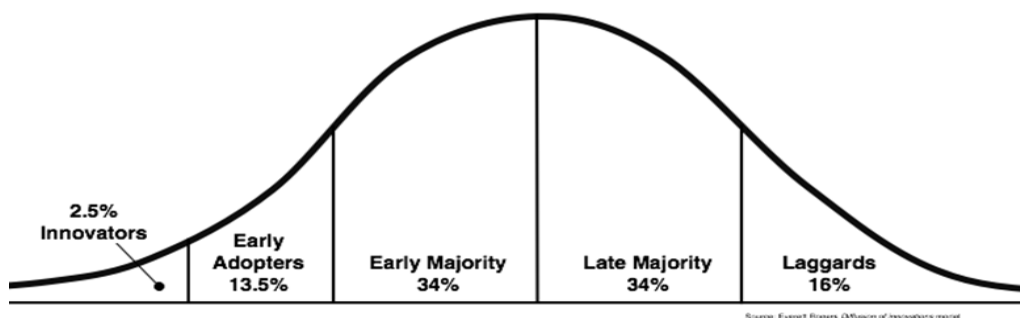


Figure 1: Available at <http://blog.leanmonitor.com/early-adopters-allies-launching-product/>

There are a lot of limits to the diffusion of innovation theory; this theory has been criticised as not belonging to the healthcare sector or is not applicable to the healthcare model. It does not promote the participatory method in public health procedures. It works well when it is necessary to adopt certain technologies, but it does not help in prevention and anticipation.

Many sectors have used this theory, such as in communication, agriculture, public health, criminal justice, social work, and marketing. In the health system, this theory is used to adopt certain applications in the health system, such as when it is necessary to adopt a certain treatment system to improve certain living conditions in society (Singer, 2019).

2.2. Concerns-based Adoption Model

Hall (1979) developed the Concerns-Based Adoption Model in response to the need for a model specific to educational environments due to their traditional top-down approach to change (CBAM). CBAM advances innovation adoption from the perspective of those who are impacted by the innovation's adoption as well as those charged with implementing change, generally in the education system.

There are a lot of limits to the concerns-based Adoption Model. Even though the CBAM model views teachers as adoptees rather than implementers, they also take the role of change agents in order for effective implementation to happen in the school environment. One could think of students as change recipients, but the CBAM model only tends to focus on instructors' concerns due to their role as change agents. One more noticeable limitation of this theory is its apparent emphasis on teachers' negative attitudes toward innovation. Opinions established about innovation, whether positive or negative, can all influence its adoption (Straub, 2009).

2.3. Technology Acceptance Model (TAM)

According to Davis' (1985) TAM, a potential adopter's attitude and expectations of the innovation influence the likelihood of its adoption (Davis, 1985).

TAM focuses on two key concepts: how the potential adopter perceives the innovation in terms of its ease of use – how easy the innovation will be to learn and implement – and its possible contribution – the extent to which the innovation will enhance the customer's personal or job-related effectiveness (Straub, 2009).

Davis believed that the easier the technology is to use, it has a direct effect on perceptions of usefulness because the simpler an adopter sees an innovation to be able for using, the more likely they will use it and enjoy greater productivity, proving helpful to the innovator (Davis, 1985). Davis concluded that there was a stronger relationship between perceived effectiveness and technology adoption than between perceived usefulness and adoption. He deduced from his findings that no matter how simple technology is to understand, people will not adopt it if they do not perceive it to be beneficial in enhancing their productivity (Davis, 1989).

TAM was used to evaluate the adoption of technology in a study conducted in the United Kingdom that looked at the key factors influencing whether someone joined an online travel community. This

research examined suitability, usefulness and ease of use, and perceived usefulness. The researchers came to the conclusion that all elements were significant in deciding to participate in social travel communities (Agag and El-Masry, 2016).

The TAM has been extensively criticised for its lack of explicative power, casualness, and practical application (Chuttur 2009). Benbasat and Barki assume that the Technology Acceptance Model has misled many researchers into believing that they are making progress in their quest for knowledge. Furthermore, several researchers have become confused while attempting to adapt the model to the changing technological environment (Benbasat & Barki 2007). It focuses on individual IT use without considering the social implications. According to Lunceford, the model does not consider factors such as the cost and structure of where they live and work, which influence their decision to adopt the technology (Bagozzi, 2007).

2.4. The Chocolate Model

The Chocolate Model refers to organisational innovation adoption and change. It is organised around four components: change, adopters, the change agent(s), and the organisation – CACAO when abbreviated for ease of recall and use in planning. The Chocolate Model, unlike Rogers' Innovation Diffusion Theory, can be used to plan for the change process and organisational innovation (Dormant, 2011). The procedure is as described in the following: first, determine whether the change is a new structure or an improvement (Dormant, 2011). This is comparable to Rogers' (2003) adoption process's first step of seeking knowledge. The second step is to evaluate the change's early adopters. Third, define the agents of change; a strategy is created at this point. The next step is to analyse the organisation where the change process is expected to take place, as well as evaluate the greater picture of the organisational change, and how it affects other aspects of the organisation. The plan may be revised before implementation based on the findings of the organisation theory (Dormant, 2011).

2.5. Comparing and Contrasting the Innovation Models

On the one hand, the distinction between technology adoption theory and the diffusion Innovation model is that adoption refers to the phase in which technology is chosen for use by a person or company, whereas diffusion did refer to the phase in which the technology spreads to general use and application.

On the other hand, the Chocolate Model and the TAM have similar change attributes. Adopters, like TAM practitioners, evaluate the relative benefit of the innovation or change (Dormant, 2011) and did refer to it as "perceived usefulness" in TAM (Straub, 2009). Adopters also consider the innovation's convenience and suitability as the "perceived ease of use" in TAM (Dormant, 2011; Straub, 2009). The adaptability of the innovation to the specific needs of the adopters and the social impact of the change, what the change will mean for the social structure as well as the climate of the organisation, are two elements not discussed in TAM but mentioned in the Chocolate Model (Dormant, 2011).

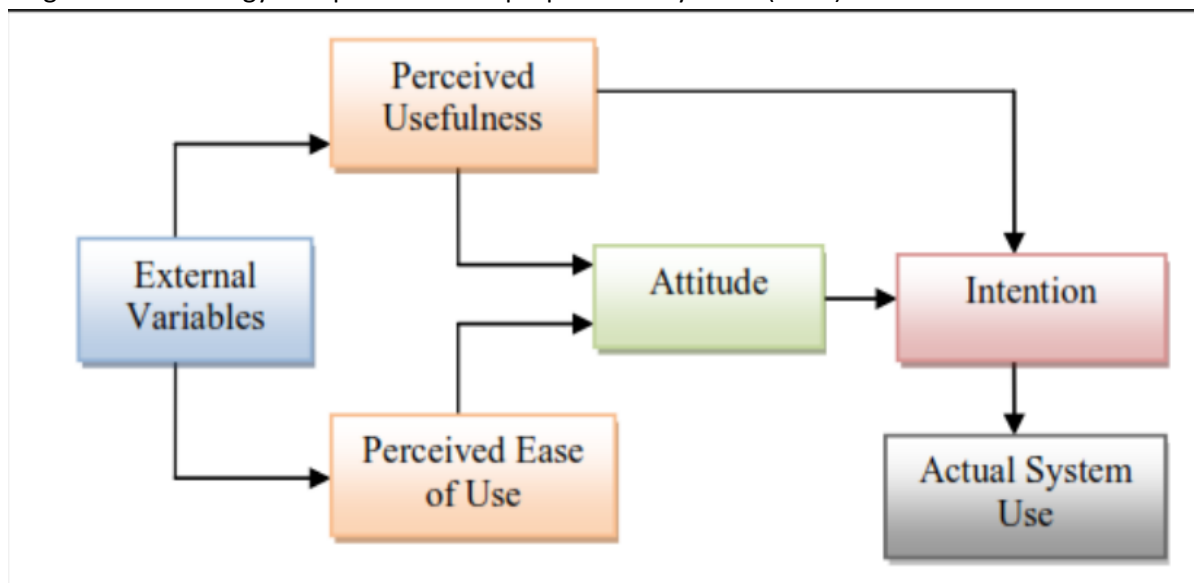
2.6. Chosen theoretical frameworks for this research

This research project focuses on the Technology Acceptance Model (TAM), which considers the model's use in various areas, especially in the healthcare technology sector. The model is appropriate for technology adoption use and acceptance rather than for corporate or institutional applications that require information technology integration (Ajibade, 2018).

Historically, Davis created the Technology Acceptance Model (TAM) in 1986. According to Phichitchaisopa and Naenna (2013), the TAM is based on assessing rational thinking, which includes knowing consumers' intentions to adopt new technology.

Davis (1989) developed the (TAM), which supposes that when consumers perceived a form of technology to be efficient and easy to use, they will be willing to use it. Consequently, the more employees realise that the processes will make their activities simpler, the more likely it is that they will use it and accept the new technology as useful (Dillon & Morris, 1996). The TAM model is based on the theory of reasoned action, which states that social actions are motivated by an individual's behavior and are intended to predict information system use (Lin 2007).

Figure 2: Technology Acceptance Model propounded by Davis (1989)



Similarly, employees in the healthcare industry will have a different type of work, and it is expected that they will be handled differently as compared to change implementation. According to Chau and Hu (2002), doctors are evidently the primary crew and interested parties in e-health technological innovation. When compared to operators and managers in typical business settings, these doctors' decisions on technological innovation approval may differ.

Chau and Hu (2002) explored TAM as well as other theories that primarily focused on the decisions of healthcare professionals to accept technology. The ultimate findings from the study recommend that TAM, with an explanatory power of 42%, may be more suitable than other approaches.

However, several considerations must be taken in order to adopt a conceptual framework, and researchers must be keenly aware of the multiple limits imposed that are innate in such an endeavour.

One of the TAM's limitations is the factor that refers to user behaviour, which is undoubtedly examined through subjective means such as behavioural intention (BI) such as social influences.

It was also critiqued for failing to account for the residual variation in behaviour intention (Abbasi et al., 2011). Besides that, its constraints involve obstacles such as IT facilities or contextual factors in developing countries that prevent individuals from taking full advantage of electronic health records (Abbasi et al., 2011; Chen et al., 2002; Moon and Kim, 2001; Mathieson et al., 2001).

As a result, Maruping et al. (2006) proposed that behavioural expectations, rather than behavioural intention, should be used to predict employees' intentions regarding the use of technology. As a result, implying that attitudes to the use of technologies in the workplace are based on perceived usefulness and ease of use (Armenteros et al, 2013) may have portrayed the TAM as a theoretical masterpiece.

According to Bashange (2015), many of the pertinent accessible literature which relates to the TAM considers it as a dependent variable rather than a means of determining the forces that influence behaviour. The TAM, as according Zahid et al. (2013), does not account for extrinsic factors like age and education, which may impact acceptance and desire to adopt technology.

On the other hand, concealed personality qualities typically inspire behaviour, making quantifying behaviour exceedingly challenging.

EHealth adoption may be one of the innovative management tools used to achieve the Kinshasa targets and objectives in health care, particularly for the monitoring of long-term diseases. Numerous research has been conducted in recent years to investigate the feasibility and potential of technology in healthcare in delivering healthcare services such as diabetic patient management. The theory of technology acceptance and innovation diffusion are useful theories in health care survey situations, but they must be incorporated into a model which includes variables related to human and social change processes, as well as organisational management, which have a strong influence on organisational operations and health care effects.

TABLE 1: Definitions of variables in TAM

Variables	Definitions	References
Perceived usefulness	An individual's perception that using an IT system will enhance job performance	(Holden and Karsh 2010)
Perceived ease of use	An individual's perception that using an IT system will be free of effort	(Holden and Karsh 2010)
Behavioral intention	An individual's motivation or willingness to exert effort to perform the target behavior	(Holden and Karsh 2010)
Use (USE)	One specific behavior of interest performed by individuals with regard to some information technology (IT) system	(Holden and Karsh 2010) Holden,R.J and Karsh,B.T(2010) : <i>Journal of Biomedical Informatics</i> ; The Technology Acceptance Model: Its past and its future in health care

Conceptual framework

The conceptual framework, which is derived from the TAM framework, explains the interaction between the dependent variables (of the user) Behavioural Intention and Computer Use Behavior and the independent variables (of perceived usefulness and perceived ease of use). The behavioural intention variable aids in capturing the direct impact of perceived usefulness on actual system use

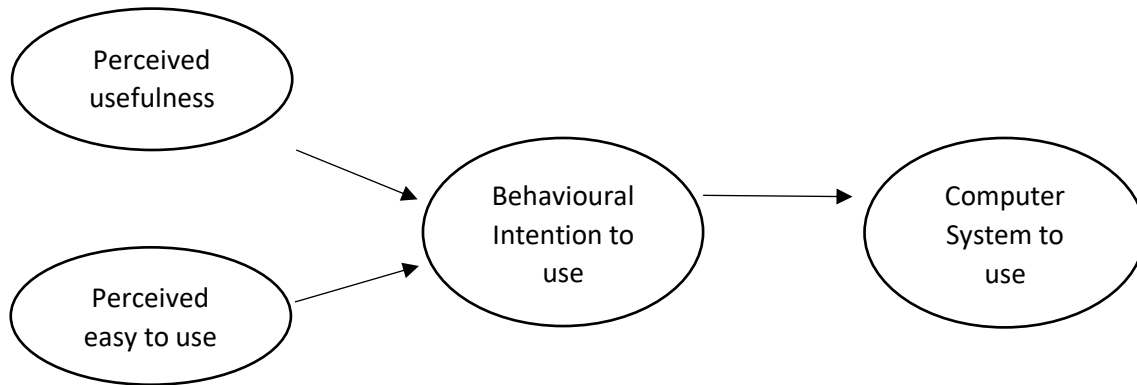


Figure 1: Conceptual framework

Hypotheses

To address the research questions, four hypotheses were established. The necessity for a conceptualised model of technology adoption in healthcare was emphasised by Walter and Lopez (2008) and Holden and Karsh (2010). Consequently, the following hypotheses were :

- H1: Perceived usefulness and perceived ease of use will significantly predict healthcare professionals' intentions to use the e-Health system
- H2: Behaviour intention will predict healthcare professionals' intentions to use the e-Health system indirectly, through the effects of perceived usefulness
- H3: Computer use intention is enhanced by the perceived usefulness
- H4: The adoption (or acceptance) of the e-health depends on the computer use intention

Gap in the literature

According to Bernstein et al. (2007), the healthcare industry needs to concentrate on innovation to maintain and enhance both clinical and operational processes. Therefore, it is crucial to recognise the role that information and communication technologies (ICT) play in the healthcare sector (Clark,2007).

Wilson et al. (2012) discovered that there were no published studies from developing countries on the use of e-Health tools to record clinical issues and protect patients.

Understanding how big of a problem there is in Kinshasa is made very difficult by this information gap.

3. Research Design and Methods

Every research project needs to have a sound methodology at its foundation. According to Grix (2002), each study may have its own methodology, which is also defined as the examination of assumptions and procedural procedures for producing information." Other writers characterise methodology as "being systematic analysis of the theories underlying the techniques used in a given research (Ishak and Alias, 2005). It's crucial to emphasise that "Methodology provides the theoretical underpinning for determining the approach that is most appropriate for a particular research topic. In quantitative research that makes use of technology, surveys are the most widely used method of data collection, according to Burkle et al. (2001). Fink (1995) and Patten (2007) both support the use of quantitative research to look at participants' attitudes and actions. The degree to which the variables under study are connected can be expressed using quantitative technique. The research instrument is developed for quantitative methods. Bourque and Feilder (1995) advised that questionnaires be created by doing a relevant literature search. The authors did, however, suggest using standardised questionnaires. Standardised questionnaires provide the benefit of having already been validated and allowing results to be compared across research. Bourque and Feilder also suggested that questionnaires be developed by adopting and adapting questions from past studies.

The most popular uni-dimensional scale for evaluating all variables is the Likert scale. In 1932, the five-point bipolar response scale was developed. Participants rank quality from best to worst using ratings ranging from 2 to 10. Five point Likert scales was used in this research in order to make a dataset that were used for the study's analysis.

Likert-scale as described below in this study: Items were assessed on a 5-point Likert scale (strongly disagree to strongly agree)

1 - Strongly Disagree

2 – Slightly Disagree

3 – Neutral

4 – Slightly Agree

5 – Strongly Agree

Sampling in Quantitative Research

In general, the study needs to have a better sampling strategy. The research tool for our study will be

centred on hospital healthcare staff (nurses) in Kinshasa, the capital of the Democratic Republic of the Congo. Due to this aspect, a more extensive survey is required to understand the attitudes of a larger group of healthcare workers.

Types of Sampling:

-Probability Sampling: Each unit (or person) in the population has a greater than 0% chance of being chosen for the sample in this method. This allows for the precise calculation of the chance that any unit in the population could be chosen (Denscombe ,2007).

Each unit (or member) has an equal chance of being chosen.

-Non-Probability Sampling: In this case, it is unlikely that some components or portions of the population will be chosen.

On the basis of presumptions about the target population, elements are chosen.

- **Simple Random Sampling:** This method involves selecting units (population members) at random (Morris 1989).

- **Purposive Sampling** (another type of non-probability sampling):

- Here, the researcher chooses the sample based on who he/she thinks would be appropriate for the study.

This sampling approach is primarily used where there is limited number of people with the context expertise that is relevant to the study that is being carried out

Fig 2: Sampling

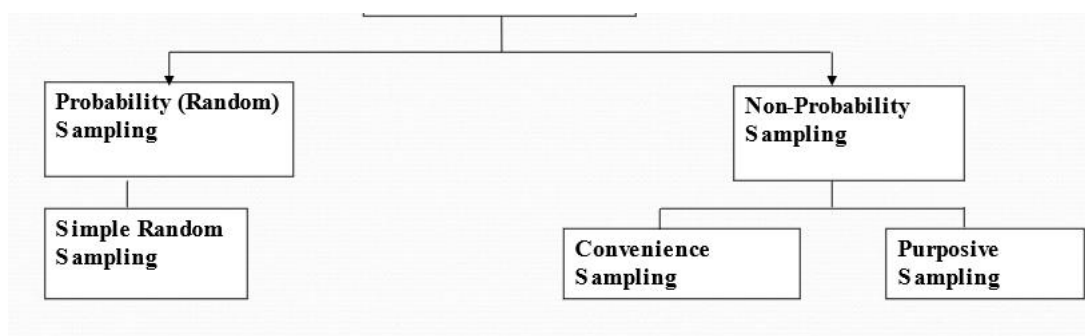


Table 2: Constructs and Measurement items derived (or modified) from previous studies

	Constructs	Measurement Items	Sources
Dependant Variables	Behavioural Intention to use	1. I plan to use e-Health system if it is implemented 2. I envisage to use e-Health system if it is implemented 3. I plan to use e-Health system if it is implemented	Venkatesh and Davis (2000); Mun et al. (2006); and Venkatesh and Balla (2008)
	Computer System to use	1. Computers make me feel uncomfortable 2. Working with a computer makes me nervous 3. Computers do not scare me at all 4. Computers make me feel uneasy	Teo et al (2008); Devane et al. (2010); and Morton and Wiedenback's (2010)
Independent variables	Perceived usefulness	1. Using e-Health system at work would improve my job performance 2. Using e-Health system at work will improve my job productivity . 3. Using e-Health system at work would enhance my effectiveness 4. Overall, I would find e-Health system useful for my work	Venkatesh and Davis' (2000) Hyun et al. (2009); Morton and Wiedenbeck (2009); and Wilkins (2009)
	Perceived easy to use	1. I would find e-Health system easy to use 2. Interacting with e-Health system would be easy and Understandable 3. Interacting with e-Health system would not require a lot of mental effort 4. I will easily work with e-Health system	Venkatesh and Davis' (2000) Morton and Wiedenbeck's (2009)

4.Data Analysis: Ensuring reliability and validity of data and examining the hypotheses for the research.

Data analysis

4.1. Data reliability

To ascertain the reliability of the dataset used, we use Cronbach's alpha test for internal consistency of the variables with more than one item and the outputs are as given below;

a. Reliability of the variable perceived usefulness

Reliability Statistics

Cronbach's Alpha	N of Items
.992	4

From the table given above, it can be seen that the Cronbach's alpha of 0.992 with regard to the variable perceived usefulness shows high level of internal consistency since a reliable scale should be greater than 0.7.

b. Reliability of the variable perceived ease

Reliability Statistics

Cronbach's Alpha	N of Items
.989	4

The perceived ease variable items have a Cronbach alpha of 0.989 and this implies that the scale of measurement is reliable and thus further analysis as far as data is concerned may be carried out.

c. Reliability of the variable behavioural intention

Reliability Statistics

Cronbach's	
Alpha	N of Items
.993	4

As given above Cronbach's alpha of 0.993 shows high level of internal consistency of the scale of measurement and thus our data is reliable.

d. Reliability of the variable computer use behaviour

Reliability Statistics

Cronbach's	
Alpha	N of Items
.996	4

This variable computer use scale is reliable as well as given by a Cronbach's alpha of 0.996.

4.2. Data validity

In order to assess the validity of the data about the variables, looking at the relationship that exists among the given variables which is made possible by the

application of correlation analysis, firstly we ascertain the relationship that exists between the first four items of the variable perceived usefulness as shown below.

a. Perceived usefulness

Correlations

		Perceived usefulness s1	Perceived usefulness s3	Perceived usefulness s2	Perceived usefulness s4
Perceivedusefulness1	Pearson	1	.992**	.980**	.965**
	Correlation				
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
Perceivedusefulness3	Pearson	.992**	1	.980**	.959**
	Correlation				
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
Perceivedusefulness2	Pearson	.980**	.980**	1	.948**
	Correlation				
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100
Perceivedusefulness4	Pearson	.965**	.959**	.948**	1
	Correlation				
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

As given above, there exists positive linear association among the given variables which is said to be statistically significant at 1% level of significance as shown by the probability value($p < 0.01$), holding to this fact, it can be justified that the four variables are valid and thus fit for analysis in order to answer the research hypothesis.

b. Perceived ease

		Correlations			
		Perceivedease se1	Perceivedease se2	Perceivedease se3	Perceivedease se4
1	Perceivedease Pearson	1	.946**	.946**	.992**
	Correlation				
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
2	Perceivedease Pearson	.946**	1	.966**	.955**
	Correlation				
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
3	Perceivedease Pearson	.946**	.966**	1	.948**
	Correlation				
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100
4	Perceivedease Pearson	.992**	.955**	.948**	1
	Correlation				

Sig. (2-tailed)	.000	.000	.000
N	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

For the case of variable perceived ease, the variable is also said to be valid since the relationship among its items is significant, the variables have positive significant relationship at 0.01 level of significance.

c. Behavioral intention

Correlations

		BehavioralIntention1	BehavioralIntention2	BehavioralIntention3	BehavioralIntention4
BehavioralIntention1	Pearson Correlation	1	.980**	.985**	.955**
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
BehavioralIntention2	Pearson Correlation	.980**	1	.989**	.975**
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
BehavioralIntention3	Pearson Correlation	.985**	.989**	1	.965**
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100

Behavioral intention 4	Pearson	.955**	.975**	.965**	1
	Correlation				
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Behavioural intention is valid since the relationship between two of its items is significant at 1%.

d. Computer use behaviour

Correlations

		computeruse behaviour1	computeruse behaviour2	computeruse behaviour3	computeruse behaviour4
computerusebehaviour1	Pearson	1	.985**	.989**	.985**
	Correlation				
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
computerusebehaviour2	Pearson	.985**	1	.980**	1.000**
	Correlation				
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
computerusebehaviour3	Pearson	.989**	.980**	1	.980**
	Correlation				
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100

computerusebehavio ur4	Pearson	.985**	1.000**	.980**	1
	Correlation				
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Computer use behaviour is a valid variable as far as the hypothesis under investigation is concerned. Here , the items in the variable do have a positive significant relationship which is as well said to be statistically significant at 1%.

4.3. Regression output

In our first research hypothesis, checking how significant perceived ease and perceived usefulness are important in predicting the intention to use e-health system, the response variable in this case was computer use intention and the regression output is as shown below.

a. Hypothesis 1

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.985 ^a	.970	.969	.19898

a. Predictors: (Constant), Perceivedease1,

Perceivedusefulness1

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	123.519	2	61.760	1559.790	.000 ^b
	Residual	3.841	97	.040		
	Total	127.360	99			

a. Dependent Variable: computerusebehaviour1

b. Predictors: (Constant), Perceivedease1, Perceivedusefulness1

In the model summary given above, 96.9% of the total variation is explained by the predictor variables and thus the model is said to be statistically fit for making predictions. Furthermore, the f-statistic is also said to be significant hence model reliability; thus, Failure to reject the null hypothesis at 1% level of significance and conclude that perceived ease and usefulness do predict computer use behaviour and with this the stakeholders in that sector should uphold this.

b. Hypothesis 2

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.985 ^a	.969	.969	.19922

a. Predictors: (Constant), BehavioralIntention1

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	123.471	1	123.471	3110.973	.000 ^b
	Residual	3.889	98	.040		
	Total	127.360	99			

a. Dependent Variable: computerusebehaviour1

b. Predictors: (Constant), BehavioralIntention1

The predictor variables give 96.9 % of the total variation in the model and thus it is said to be statistically fit. The f-statistic as well proves the fitness of the model at 1% level of significance. Hence with regard to our hypotheses, we conclude that behaviour intention predicts the healthcare professionalism to use e-health system through the perceived usefulness.

c. Hypothesis 3

Correlations

		Perceiv	Perceiv	Perceiv	Perceiv	comput erusebe haviour 1	comput erusebe haviour 2	comput erusebe haviour 3	comput erusebe haviour 4
Perceiv eduseful ness1	Pe ars on Cor rel atio n	1	.980**	.992**	.965**	.981**	.980**	.992**	.980**
	Sig.		.000	.000	.000	.000	.000	.000	.000
	(2- tail ed)								
	N	100	100	100	100	100	100	100	100

Perceived usefulness2	Perceived usefulness2 on Correlation	.980**	1	.980**	.948**	.985**	1.000**	.980**	1.000**
	Sig. (2-tailed)	.000		.000	.000	.000	.000	.000	.000
	N	100	100	100	100	100	100	100	100
Perceived usefulness3	Perceived usefulness3 on Correlation	.992**	.980**	1	.959**	.989**	.980**	1.000**	.980**

	Sig	.000	.000		.000	.000	.000	.000	.000
	.								
	(2-tail ed)								
	N	100	100	100	100	100	100	100	100
Perceiv Pe		.965**	.948**	.959**	1	.951**	.948**	.959**	.948**
eduseful ars									
ness4 on									
Cor									
rel									
atio									
n									
	Sig	.000	.000	.000		.000	.000	.000	.000
	.								
	(2-tail ed)								
	N	100	100	100	100	100	100	100	100

comput Pe	.981**	.985**	.989**	.951**	1	.985**	.989**	.985**
erusebe ars								
haviour on								
1 Cor								
rel								
atio								
n								
Sig	.000	.000	.000	.000		.000	.000	.000
.								
(2-								
tail								
ed)								
N	100	100	100	100	100	100	100	100
comput Pe	.980**	1.000**	.980**	.948**	.985**	1	.980**	1.000**
erusebe ars								
haviour on								
2 Cor								
rel								
atio								
n								

	Sig	.000	.000	.000	.000	.000		.000	.000
	.								
	(2-tail ed)								
	N	100	100	100	100	100	100	100	100
comput Pe erusebe ars haviour on 3 Cor rel atio n		.992**	.980**	1.000**	.959**	.989**	.980**	1	.980**
	Sig	.000	.000	.000	.000	.000	.000		.000
	.								
	(2-tail ed)								
	N	100	100	100	100	100	100	100	100

comput Pe	.980**	1.000**	.980**	.948**	.985**	1.000**	.980**	1
erusebe ars								
haviour on								
4 Cor								
rel								
atio								
n								
Sig	.000	.000	.000	.000	.000	.000	.000	
.								
(2-								
tail								
ed)								
N	100	100	100	100	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

In the third hypothesis where we seek to check whether computer use is enhanced by the perceived usefulness, we note that we fail to reject the null hypothesis and conclude that indeed computer use intention is perceived by usefulness , since there exists a positive linear association which is significant at 1%, an increase in one of the variable lead to the increase of another variable, thus causality.

d. Hypothesis 4

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.981 ^a	.963	.962	.21438

a. Predictors: (Constant), computerusebehaviour1

Here, 96.2 % of the total variation is explained by the predictor variable in the model where we considered the relationship that exist between computer use behavior and perceived usefulness.

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	116.406	1	116.406	2532.948	.000 ^b
	Residual	4.504	98	.046		
	Total	120.910	99			

a. Independent Variable: Perceivedusefulness1

b. Predictors: (Constant), computerusebehaviour1

The f- value which is significant at 1% makes the model to be fit as well hence it may be used to make predictions about the future. With regard to this, the adoption e-health system depends on the computer use.

Conclusion based on analytical Results

For the reliability tests done on the four variables (perceived usefulness, perceived ease, behavioural intention and computer use behaviour), all the variables were found to have high internal consistency which was greater than 0.9 and thus they were considered fit for analysis in order to answer our hypothesis of the research. In addition, the variables were also subjected to validity tests and relationship among the variables was investigated, notably the relationship was found to be positive linear which was found to be statistically significant at 1% hence them being valid for analysis. Finally, the data was subjected to regression analysis and the models provided adjusted R-squared of more than 95% hence the conclusion is made that that was the total variability explained by the predictor variables as far as the model is concerned. The f-statistic was statistically significant as well thus, the models were fit to predict outcomes of the data. Perceived usefulness enhances computer use intention as their relationship was found to be statistically considerable at 1%.

5. Reflecting on the module.

This term I took a quantitative research methods module with Doctor Promise. Throughout this term the topics have been demanding yet endurable, however, I managed to do well in my research and deliver it with confidence. I believed that it would be hard to understand, especially considering the fact it was online, however, I gathered and learned many quantitative skills important for my research.

First, the lecturer taught me skills that we would use to do my future research in quantitative. For example, I knew that I had to take a sample from a large group of individuals for it to be accurate. This was one of many skills I was taught, and it helped me prepare myself when I collected my data. Now I know I must get a sample larger than 100 people to meet the standard required for accurate results. I also learned in my class how to define my hypotheses and how to test them and draw a conclusion based on the results. I also learned how to confirm the reliability of my data.

Another key skill that I will always retain is how to derive the measurement item from the construct. Whilst confirming the normal distribution there were three things that I learned that I will never forget. The first was to draw a histogram. This was important because if the points on the histogram track the straight line, your data will follow the normal distribution. In addition, the normal distribution can be confirmed by Skewness and kurtosis (Kurtosis value between -2 and +2 or Kolmogorov and Smirnov test). I also learned regression analysis. This helped me understand the relationship between the dependent variable and the independent variable. It enables the researcher to capture several collinearity diagnoses from a conditioning level. Because of this, I am now able to understand the regression analysis which gives a clear picture and enables me to have the boldness to make a solid conclusion based on statistical evidence (if there is an association of influence on one factor). Another thing I learned in this model was how measurement items of the construct must be taken from a previous study, if not, there will need to be a focus group. I believe that this information was very important because I will now not lose time by doing a focus group as I will always focus on previous studies as instructed.

On the other hand, whilst completing my research I came upon many difficulties. One of these is the technical issue. Some days there were problems with the internet so I couldn't join the meeting or even at some points, I would be randomly kicked from the meeting. Furthermore, I found it challenging not being able to communicate with others face-to-face which would have been easier, in my opinion. I would have preferred working in small groups and occasionally returning to the teacher for guidance, which is the basic classroom model. However, thankfully there were recordings of all the videos and meetings which was important to me as I was able to catch up on everything that I missed during the lecture.

Another drawback was learning during whilst holiday season, specifically, summer as there were kids at home and it was difficult to find peace and a quiet place for learning. If I could've redone this, I would have preferred doing this work in a classroom environment where there are few distractions.

To sum up this module, I was very enriched by this course and I feel I am ready to take my pragmatic approach for my thesis.

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7. Appendix

Reliability tests

Reliability Statistics

Cronbach's Alpha	N of Items
.992	4

Reliability Statistics

Cronbach's Alpha	N of Items
.989	4

Reliability Statistics

Cronbach's Alpha	N of Items
.993	4

Reliability Statistics

Cronbach's Alpha	N of Items
.996	4

Validity tests

Correlations

		Correlations			
		Perceivedusefulness1	Perceivedusefulness3	Perceivedusefulness2	Perceivedusefulness4
Perceivedusefulness1	Pearson Correlation	1	.992**	.980**	.965**
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
Perceivedusefulness3	Pearson Correlation	.992**	1	.980**	.959**
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
Perceivedusefulness2	Pearson Correlation	.980**	.980**	1	.948**
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100
Perceivedusefulness4	Pearson Correlation	.965**	.959**	.948**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Correlations			
		Perceivedeas e1	Perceivedeas e2	Perceivedeas e3	Perceivedeas e4
Perceivedeas1	Pearson Correlation	1	.946**	.946**	.992**
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
Perceivedeas2	Pearson Correlation	.946**	1	.966**	.955**
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
Perceivedeas3	Pearson Correlation	.946**	.966**	1	.948**
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100
Perceivedeas4	Pearson Correlation	.992**	.955**	.948**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Correlations			
		BehavioralIntention1	BehavioralIntention2	BehavioralIntention3	BehavioralIntention4
BehavioralIntention1	Pearson Correlation	1	.980**	.985**	.955**
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
BehavioralIntention2	Pearson Correlation	.980**	1	.989**	.975**
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
BehavioralIntention3	Pearson Correlation	.985**	.989**	1	.965**
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100
BehavioralIntention4	Pearson Correlation	.955**	.975**	.965**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Correlations			
		computerusebehaviour1	computerusebehaviour2	computerusebehaviour3	computerusebehaviour4
computerusebehaviour1	Pearson Correlation	1	.985**	.989**	.985**
	Sig. (2-tailed)		.000	.000	.000
	N	100	100	100	100
computerusebehaviour2	Pearson Correlation	.985**	1	.980**	1.000**
	Sig. (2-tailed)	.000		.000	.000
	N	100	100	100	100
computerusebehaviour3	Pearson Correlation	.989**	.980**	1	.980**
	Sig. (2-tailed)	.000	.000		.000
	N	100	100	100	100
computerusebehaviour4	Pearson Correlation	.985**	1.000**	.980**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Hypothesis tests output

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.985 ^a	.970	.969	.19898

a. Predictors: (Constant), Perceivedease1, Perceivedusefulness1

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	123.519	2	61.760	1559.790	.000 ^b
	Residual	3.841	97	.040		
	Total	127.360	99			

a. Dependent Variable: computerusebehaviour1

b. Predictors: (Constant), Perceivedease1, Perceivedusefulness1

		Perceivedusefulness1	Perceivedusefulness2	Perceivedusefulness3	Perceivedusefulness4	computerusebehaviour1	computerusebehaviour2	computerusebehaviour3	computerusebehaviour4
Perceivedusefulness1	Pearson Correlation	1	.980**	.992**	.965**	.981**	.980**	.992**	.980**
	Sig. (2-tailed)		.000	.000	.000	.000	.000	.000	.000
	N	100	100	100	100	100	100	100	100
Perceivedusefulness2	Pearson Correlation	.980**	1	.980**	.948**	.985**	1.000**	.980**	1.000**
	Sig. (2-tailed)	.000		.000	.000	.000	.000	.000	.000
	N	100	100	100	100	100	100	100	100
Perceivedusefulness3	Pearson Correlation	.992**	.980**	1	.959**	.989**	.980**	1.000**	.980**
	Sig. (2-tailed)	.000	.000		.000	.000	.000	.000	.000
	N	100	100	100	100	100	100	100	100
Perceivedusefulness4	Pearson Correlation	.965**	.948**	.959**	1	.951**	.948**	.959**	.948**
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.000
	N	100	100	100	100	100	100	100	100
computerusebehaviour1	Pearson Correlation	.981**	.985**	.989**	.951**	1	.985**	.989**	.985**
	Sig. (2-tailed)	.000	.000	.000	.000		.000	.000	.000
	N	100	100	100	100	100	100	100	100
computerusebehaviour2	Pearson Correlation	.980**	1.000**	.980**	.948**	.985**	1	.980**	1.000**
	Sig. (2-tailed)	.000	.000	.000	.000	.000		.000	.000
	N	100	100	100	100	100	100	100	100
computerusebehaviour3	Pearson Correlation	.992**	.980**	1.000**	.959**	.989**	.980**	1	.980**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000		.000
	N	100	100	100	100	100	100	100	100
computerusebehaviour4	Pearson Correlation	.980**	1.000**	.980**	.948**	.985**	1.000**	.980**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	
	N	100	100	100	100	100	100	100	100

** . Correlation is significant at the 0.01 level (2-tailed).

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.985 ^a	.969	.969	.19922

a. Predictors: (Constant), BehavioralIntention1

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	123.471	1	123.471	3110.973	.000 ^b
	Residual	3.889	98	.040		
	Total	127.360	99			

a. Dependent Variable: computerusebehaviour1

b. Predictors: (Constant), BehavioralIntention1

Variables Entered/Removed^a

Model	Variables Entered	Variables Removed	Method
1	computerusebehaviour1 ^b	.	Enter

a. Dependent Variable: Perceivedusefulness1

b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.981 ^a	.963	.962	.21438

a. Predictors: (Constant), computerusebehaviour1

