

NTNU - NORWEGIAN UNIVERSITY OF SCIENCE AND
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Using Mobile Technology to Treat Asthmatic Children

by

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IME - Faculty of Information Technology, Mathematics and Electrical
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Declaration of Authorship

We, Esben Aarseth and Aleksander Gisvold, declare that this thesis titled, ‘Using Mobile Technology to Treat Asthmatic Children’ and the work presented in it are our own. We confirm that:

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- Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated.
- Where we have consulted the published work of others, this is always clearly attributed.
- Where we have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely our own work.
- We have acknowledged all main sources of help.
- Where the thesis is based on work done by ourselves jointly with others, we have made clear exactly what was done by others and what we have contributed ourselves.

Signed:

Signed:

Date:

“Don’t put all your Anns in the same basket”

- George Michael Bluth

NTNU - NORWEGIAN UNIVERSITY OF SCIENCE AND TECHNOLOGY

Abstract

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20 per cent of the Norwegian population has or has had asthma by the age of 10. Treating children for asthma is often a cumbersome task. Research has shown that tangible user interfaces and mobile applications have been useful in medical care in a number of different settings. The BLOPP project has previously proved that distraction during treatment has proved positive on the children's experience. We have researched and planned the development of AsthmaBuddy, a tangible user interface, and AsthmAPP, an Android application, with the purpose of motivating children to take their asthma medicine.

Keywords: *Asthma, Self-management, Gamification, Serious games, Tangible User Interfaces, Healthcare Informatics, Mobile Technology*

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Abbreviations

API	A pplication P rogramming I nterface
BLOPP	B arns L egemiddel OPP levelser
CAPP	C hild APP lication
GAPP	G uardian APP lication
GUI	G raphical U ser I nterface
KAPP	K arotz APP lication
NAAF	N orges A stma- og A llergi- F orbund
MMO	M assive M ultiplayer O nline game
NTNU	N orwegian U niversity of S cience and T echnology
REK	R egional C omittees for M edical and H ealth R esearch E thichs
RFID	R adio F requency ID entification
TUI	T angible U ser I nterface

To Tony Wonder! “Did someone say Wonder?”

Chapter 1

Introduction

This chapter will give an introduction to our thesis. It will state the purpose, motivation, research questions and the research method for the study.

1.1 Purpose

The goal of this project is to evaluate the use of mobile applications and a tangible user interface in the treatment of asthmatic children. The project is based on a system made by Aaberg, Aarseth, Dale, Gisvold and Svalestuen in 2012 [4]. We intend to improve their versions of CAPP and GAPP (see Chapter 2) and in addition create a Tangible User Interface from scratch. The new and improved version of CAPP and GAPP will be combined to one application, called *AsthmAPP*. The tangible user interface will be called *AsthmaBuddy*.

The evaluation of the project will be done through co-design sessions and usability tests of different versions of the system.

1.2 Motivation

1.2.1 Asthma among children

According to NAAF, 20% of the Norwegian population has or has had asthma by the age of 10, and 8% of the adult population suffers from asthma [5]. Many of the children find it unpleasant to use their medicine as they often do not understand why the medicine

must be taken. Research done by Åsheim showed that children suffering from HRS-virus¹ were easily distracted and motivated to finish treatments when shown a non-interactive flash-video during the treatment [6]. We aim to research whether use of mobile technology may make the children more aware of their disease and thus make them better understand why they must take their medicine on a daily basis.

1.2.2 Ways asthma affect the parents

In an already hectic everyday life, remembering to give their children medication may be cumbersome for the parents. Often the children do not enjoy taking their medicine, and the children may start an argument, not wanting to finish their treatment. This may result in parents applying the medication incorrectly, applying the wrong treatment, or even forgetting to give the medicine, which in turn have a negative effect on the overall treatment.

1.3 Research Questions

The main goal for this study is to figure out in which ways technology can help children taking their medication. The objective has been composed into the following research questions:

RQ1: How can gamification be used for motivating children to take their asthma medicine?

RQ2: How will the presence of a Tangible User Interface affect children's medication habits?

1.4 Research Method

We want to test the system on 5-7 asthmatic children at the age of 3-7 years. In order to test this by using a systematic approach, we plan to take the following steps, which will be explained in further detail below.

1. We will start out by interviewing parents and domain experts to find out more about children's medication habits. Additionally, we will arrange focus groups for brainstorming purposes.

¹Center for Disease Control : HSRV - <http://www.cdc.gov/rsv/>

2. Give parents a mobile application which instructs children during their medication. This will be a simplified version of our final application.
3. Give parents a mobile application which has gamification elements to it, in addition to the instructions in Step 2.
4. Give the test persons a custom built TUI.

The rationale for doing Step 1 is to create a foundation to build upon on the later steps. Collecting information about how children take their medicine under normal conditions gives us insight into the main problems in relation to taking medication.

The rationale for doing Step 2 is to see if it is enough to have a minor avatar system where the avatar tells the child what to do, and when to do it. This might result in ideas for further research from BLOPP.

The rationale for doing Step 3 is to answer whether gamification have a motivational effect on children, i.e. motivating children to take their medicine on a continuous basis.

The rationale for doing Step 4 is to see if a relational artifact can give children proper motivation for taking their medicine.

During Step 2-4, we want parents to fill out a diary. We will prepare a set of control questions which should be answered. The answers to these control questions may give us additional insight into how the process went.

An example of such a question is *“Did the child have problems using the TUI?”*. The answer to this question might improve over time, once the child has become used to the applications or the TUI.

Through the conducted studies we will evaluate and compare the usage and opinions the parents and children had regarding the use of our system. Through the data gathering in the diaries we will be able to compare directly how the children and parents reacted to the arrival and use of a TUI. We will also conduct interviews to get feedback on how the use of the TUI affected the children. We will mainly interview the parents, since small children may give unreliable answers.

Chapter 2

Background

This chapter will give a brief introduction to the history behind the BLOPP project (2.1). Section 2.2 will give an overview of asthma and how it affects people. Section 2.3 will go into details of the applications that were developed by Aaberg, Aarseth, Dale, Gisvold and Svalestuen during the Autumn 2012. Section 2.4 will give an introduction to some of the current research that has been performed on mobile technology in combination with children and health.

2.1 BLOPP Project

Barns LegemiddelOPplevelser (BLOPP) is a project group working for “Sykehusapotekene i Midt-Norge” (Hospital Pharmacies in Mid-Norway), in cooperation with NTNU and NAAF. Their purpose is to create systems and products that may help during medical treatments of children.

2.2 About Asthma

Asthma is a disease that affects the lungs. Asthma causes wheezing, breathlessness, chest tightness and coughing. It is a chronic disease, but asthma attacks will only occur when something is bothering the lungs. It may be hard to tell if someone has asthma, especially in children under the age five. An asthma attack may include coughing, chest tightness, wheezing and trouble breathing. The attack happens in the body’s lungs, the airways tighten, letting less oxygen pass through.

Asthma can be controlled and asthma attacks avoided by taking medicine at regular intervals. Some of the medicines are taken as a preventive measure to avoid asthma

attacks from occurring. These medicines are Seretide and Flutide. Ventoline is taken before exercise or when an asthma attack occurs, in order to stop/shorten the length of the attack.

People suffering from asthma are often given an asthma control plan, which tells them how often they should take their medication and what to do if an attack occurs. These plans are often parted into three separate health zones, corresponding with how the user feels. In order to make these health zones understandable, a traffic light system is often used (see Appendix [?]). A green light tells what the user should do when all is normal. A yellow light indicates what to do when the user is feeling a bit ill, there may be a lot of pollen in the air or otherwise poor air quality or that the user is recovering from a cold. A red light indicates what to do when the user is feeling ill, or there is an extreme amount of pollen or extremely poor air quality.

2.3 CAPP, KAPP and GAPP

In the autumn of 2012 Aaberg, Aarseth, Dale, Gisvold and Svalestuen were engaged by the BLOPP Project group through the course “TDT4290 - Customer Driven Project” at NTNU ¹. During the period of August 2012 to December 2012 they developed a prototype of a mobile information system consisting of two Android applications and a TUI. One application was developed for parents of a child (GAPP) and one application were developed for children (CAPP). Additionally, they created a Karotz Application (KAPP) targeted at children. In this section, we elaborate on these applications, while a full report of their work is available at [4].

Their prototype is the foundation for our work in this project.

2.3.1 CAPP

CAPP is an Android application targeted at children². It’s main purpose is to guide children through the medication process. Figure 2.3 shows the main page of CAPP. As the target group for the application is children below the age of 8, it is reasonable to assume that not all of them are able to read, this application consists mainly of pictures and animations.

In CAPP, it is possible to start a medication in one of two ways. A parent can either set alarms in GAPP (See Section 2.3.3) for preventive medicines, or a child can access

¹Course Description of TDT4290 - Customer Driven Project - <http://www.idi.ntnu.no/emner/tdt4290/>

²All applications have norwegian as their main language

the medication process directly by pressing the Karotz showed in Figure 2.3, which is the way to start a by-need-treatment.

One of the objectives towards CAPP was to introduce a gamification experience to the medication process. Accordingly, the child gets a golden star in his/her treasure chest once the child is done. However, these stars are not useful for anything else but showing them off.

By clicking the treasure chest, the child is able to see how many stars he/she has aquired. A screenshot showing the inside of the treasure chest is included in Figure 2.2

The last part of this application is an Information-section, where children has a quick reference as to how to take a medicine. A part of the functionality that has not been implemented is voice over for these instructions. Thus, a parent should be close by in order to read the information contained in this functionality. 2.4-2.10 shows the information-part of this application.

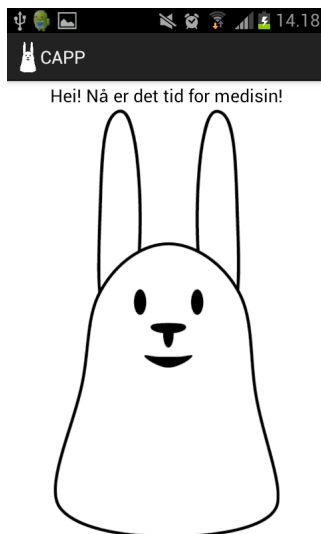


FIGURE 2.1: Starting a treatment



FIGURE 2.2: Inside the treasure chest

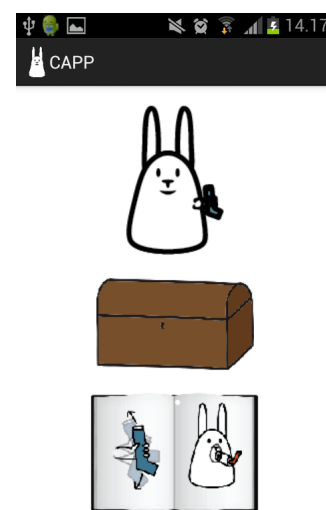
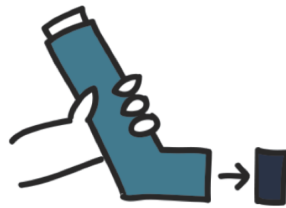
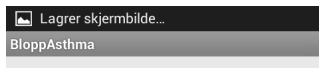


FIGURE 2.3: CAPP main menu



Rist inhalatoren slik at partiklene løsner



Ta hetten av inhalatoren

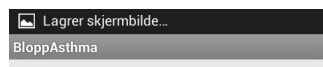


Fest inhalatoren på innhalasjonskammeret

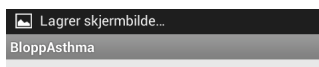
FIGURE 2.4: Instructions 1

FIGURE 2.5: Instructions 2

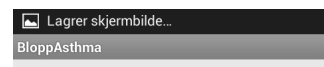
FIGURE 2.6: Instructions 3



Sett inhalatoren på ansiktet til barnet



Trykk på inhalatoren til du hører en lyd

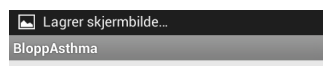


La barnet puste rolig 10 ganger inn og ut

FIGURE 2.7: Instructions 4

FIGURE 2.8: Instructions 5

FIGURE 2.9: Instructions 6



La barnet skylle munnen

FIGURE 2.10: Instructions 7

2.3.2 KAPP

KAPP is the TUI-application targeted at children. The application runs on a Karotz³, which is a small robot bunny (see Figure 2.11). The purpose of the KAPP is similar to CAPP, namely to remind children when it is time to take their asthma medicine and give instructions during treatment. In order to interact with the Karotz, children may use either a Nanoz (a small bunny with an integrated RFID) or by pressing a button on the top of the Karotz' head. It is not possible to do a by-need treatment with a Karotz as a companion.

A basic breakdown of the CAPP and KAPP manuscript is included in Appendix H.



FIGURE 2.11: Karotz. Image source: <http://karotz.com>



FIGURE 2.12: GAPP main menu

2.3.3 GAPP

GAPP is an Android application targeted at the guardians or parents of the children. Some parents have problems with remembering how often their children have taken their medication the last couple of days, when they should take them and how their children's disease has evolved over the a period of time. Thus, GAPP's main puropose is to make parents more aware of their child's disease.

Figure 2.12 shows a screenshot of the main menu of GAPP. The main functionality is separated into *Medical Plan*, *Register Treatment*, *Medicine Log*, *Medical Information* and *Manual*.

³Karotz - www.karotz.com

Medical Plan *Medical Plan* gives parents the option to set up reminders at particular times. It is divided according to the Traffic-Light system (See Appendix G). A child has three separate plans, such that an alarm that is set on the *Healthy*-plan is not automatically set on the *Sick*-plan.

Register Treatment The *Register Treatment*-option gives parents the possibility to register a treatment that is taken in case the child for some reason did not go through the process in CAPP or KAPP. This way, children will be rewarded with stars accordingly. Figure 2.13 shows a screen shot of this process.

Medical Information *Medical Information* gives general information about different medicines, what they do and what they are used for. The three medicines that are currently in the system is Flutide, Seretide and Ventoline. Figures 2.15 and 2.16 shows screenshots from this functionality.

Medicine Log *Medicine Log* shows how many times a child has taken his/her medicine the last couple of days. Figure 2.17 shows a screen shot of this functionality. A red circle marks the current day. A child's health state is displayed by the Green/Yellow/Red bar at the top of each day. In the bottom left corner, it is possible to show how much medicine was taken on a given day. In the bottom right corner, Aaberg et. al. intended to show the pollen distribution for a given day. However, the pollen distribution data is only available during spring and summer, and thus Aaberg et. al created an artificial pollen distribution for demonstration purposes.

Manual The *Manual* is to help “newcomers” to medicate children. For instance, if a relative is watching children with asthma, she could use the application as a reference on how to do the process. At the time being, the manual shows Figures 2.4-2.10.

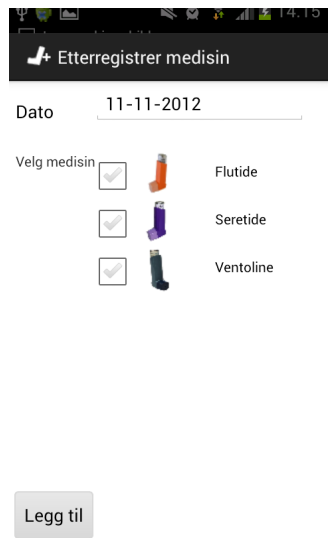


FIGURE 2.13: Register treatment

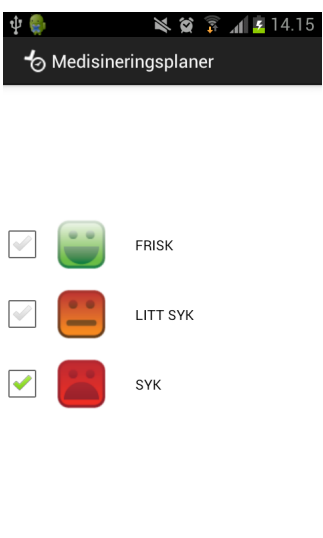


FIGURE 2.14: View plans



FIGURE 2.15: Information 1

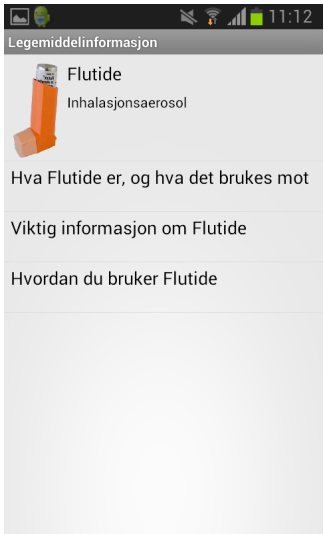


FIGURE 2.16: Information 2

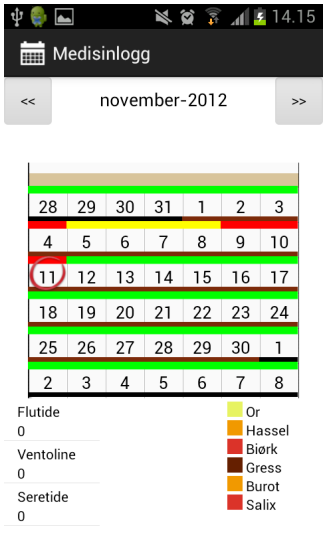


FIGURE 2.17: Medicine log

2.3.4 Known areas for improvement

As Aaberg, Aarseth, Dale, Gisvold and Svalestuen finished their work, they commented on several areas of potential improvement for CAPP, GAPP and KAPP. This document is reprinted in its entirety in Appendix B (after permission from Aaberg, Aarseth, Dale, Gisvold and Svalestuen). The main topics for improvement were

- Reward System
- Distraction sequence for children
- Web application

These comments are used as a basis when we decide what to improve in this project.

2.4 Existing Research

This section will give a foundation on some of the reserach performed on using technology in combination with diseases and children.

2.4.1 Monitoring Asthma with Mobile Technology

Research on self-management of monitoring your asthma condition has already been carried out. Much of this research was carried out by using SMS (Short Messaging System) technology. In 2009, Andhøj et. al.[7] did a feasibility study to check how users would respond to a SMS-reminder. Their methodology was to send SMS a couple of times a day, and have the users respond to their peak flow and answer yes/no questions. Users could then access a web page to see different statistics on peak flows, how they've felt the last couple of days, etc.

They concluded that SMS is a feasible solution for collecting asthma diary data, mainly because the SMS technology was a big part of the participant's everyday life. Although SMS is a great technology to be used for this purpose, few children in our target group are able to use this technology, for obvious reasons. According to *Senter for IKT i utdanningen* (Center for ICT in education), about 40% of Norwegian children below the age of 3 years old have used a tablet, and 6 out of 10 children below the age of 6 have used a touch screen device [8]. Thus our target group is likely to be familiar with the technology we plan to use.

2.4.2 Children and Mobile Devices

In 2013, www.babies.co.uk posted results on a poll they had posted on how many toddlers are using smartphones or tablets each day[9]. Over 1000 participants responded, and according to the survey, 14% of the responders allowed children to use smartphones or tablets more than 4 hours a day. Considering the normal awake time of a small child, they spend a considerable amount of their day playing with a smartphone. With this in mind, we aim to make an application that is used for a short period of time with each use. AsthmAPP and AsthmaBuddy is not a toy or a game. AsthmAPP and AsthmaBuddy will be tools for helping the children.

2.4.3 Children and Gestures

Abdul Aziz et. al. [10] performed a study on which gestures children are able to comprehend when playing with an iPad. She tested 33 children's ability to do gestures on a variety of applications suited for children. The children were between the age of 2-12 years old, 3 children in each age group. The study showed the following restrictions:

- 2 year old children have difficulties with pinching, and are unable to drag and drop, spread and rotation of the device, and are not able to focus on the application.
- 3 year old children have difficulties to drag and drop until they are told to do so, in addition to having problems with pinch and spread.
- 4 year old children have difficulties to drag and drop.

Children at age 5 and above are able to do all the normal gestures at a tablet. As CAPP is currently only available for mobile devices, this is a cause for discussion. The main part to notice is pinching and drag and drop. An iPad is fairly large relative to the size of these children's hands. There is reason to believe that gestures may be more difficult on smaller screens, however, we were unable to find research supporting this claim. In order to make AsthmAPP as child friendly as possible, it only uses "swiping" gestures and button presses for navigation.

2.4.4 Assessment of Existing Asthma Applications

In 2012, Huckvale et. al. [11] conducted an assesment on the existing asthma-related applications on both Google Play ⁴ and App Store ⁵. They assessed 103 different apps with english as the native language. Out of these applications,

"No apps for people with asthma combined reliable, comprehensive information about the condition with supportive tools for selfmanagement" [11].

They concluded that doctors should be careful when recommending apps for patients with the purpose of self management of asthma.

2.5 State of the art

Mobile computing is evolving at a rapid pace, and finding new ways to use it in health care is a rising research problem. This section covers the state of the art of some of the

⁴Google Play - <http://play.google.com>

⁵Apple App Store - <http://www.apple.com/itunes/features>

areas in which mobile technology is being used with a combination of either gamification or tangible interfaces.

2.5.1 Sisom

Sisom ⁶ is a software created to increase the communication level between physicians and children. It is an interactive game, where the user follows an avatar through different “worlds” of health care subjects. For instance, the avatar takes a boat to a hospital. Here the users can look around in the room and express how they feel when they are giving a blood sample. The results showed that when children played the game before a consultation with his/her physician, children were better prepared and the communication had a better quality, and children participated more during the consultation [12].

2.5.2 Measuring Blood Pressure

iHealth ⁷ , Withings ⁸ and other companies have created blood pressure monitors which are synchronized towards mobile applications. They allow easy monitoring over periods of time and make it possible to share measurements to both friends, family and doctors.

2.5.3 Controlling Your Diabetes

Cellnovo ⁹ has created a system that helps controlling diabetes. It consists of a handheld device for measuring blood sugar level, a pump that controls the flow of insulin and a web interface that allows one to access the information. The interface helps users to check for trends and patterns in their blood sugar level, which motivates users to continue applying the correct treatment. It also allows users to send information to physicians, which helps them make decisions regarding how patients are managed.

2.5.4 Quit Smoking

There are lots of mobile applications that are helping people to quit smoking. For instance, *The Norwegian Heart and Lung Patient Organization* has developed an app called “Røykeslutt” ¹⁰ . The application shows what the body is going through after a

⁶Sisom - <http://www.communicaretools.org/sisom/>

⁷iHealth - http://www.ihealthlabs.com/wireless-blood-pressure-monitor-feature_32.htm

⁸Withings - <http://www.withings.com/en/bloodpressuremonitor/features>

⁹Cellnovo - <http://www.cellnovo.com/>

¹⁰Røykeslutt - <https://play.google.com/store/apps/details?id=no.lhl.roykeslutt>

specific amount of days, which is a huge motivational factor, considering what we have read in the reviews of the application. Additionally, they show how much money a user has saved at a particular time, which can be seen as “gamifying” the element of money in order to motivate users.

2.5.5 Wii Fit Plus

Nintendo Wii has gamified the way people train at home with Wii Fit and later Wii Fit Plus ¹¹. It gives a user the ability to choose their own training programme, including Yoga, Strength and Aerobics. Users can easily track their progress over several months. Additionally, it allows children to stay healthy, by having games that depend on their movement. For instance, if a child flaps their arms up and down, they fly a bird on the screen.

¹¹Wii Fit - <http://wiifit.com>

Chapter 3

Gamification

This chapter will give a description of the term “Gamification”, describe some of the uses of Gamification and how we plan to use Gamification in our solution.

3.1 What is Gamification?

“Gamification” as a term was first mentioned by Currier in 2008[13], but did not become a wide-spread term before 2010.

There are many different ways of describing gamification. Deterding, Dixon, Khaled and Nacke[14] define Gamification as:

“Gamification is the use of game design elements in non-game contexts.”

Huotari and Hamari[15] defines gamification as:

“Gamification is a process of enhancing a service with affordances for gameful experiences in order to support user’s overall value creation.”

Deterding, Dixon, Khaled and Nacke’s definition is often commonly referred to, because of it’s simplicity and understandability for people who have little or no connection to traditional games or game consoles.

Today gamification is a much used term both in programming and in the spoken language. Smartphone applications and manufacturers have helped make the term gamification a widespread notion. Examples of this is the application Foursquare, which is built around gamifying “checking in” at restaurants, historical sites and similar places¹. Apple developed a Game Center for iOS in 2010, giving every iPhone/iPod and iPad

¹Foursquare - www.foursquare.com

user a hub for challenges, awards and other gamelike activities ², which made every iOS user a potential target for Gamification. Lately there has been many games built singularly around gamification, such as Cookie Clicker ³ or Farmville ⁴. Even game consoles like Playstation 3 and Xbox contain gamification support per default, with their achievement/trophy systems ⁵ ⁶. While there are many users of such games, they are often critiqued for using gamification to lure players into playing.

3.2 What is Serious Games?

The term “serious game” became a concept with the emergence of the Serious Game Initiative in 2002 [16]. Their website defines serious games as:

“The Serious Games Initiative is focused on uses for games in exploring management and leadership challenges facing the public sector. Part of its overall charter is to help forge productive links between the electronic game industry and projects involving the use of games in education, training, health, and public policy.”

This definition has been critiqued for being too narrow, and not including any reason as to why businesses should care. An anonymous author⁷ posted an essay on www.lostgarden.com criticizing the definition and suggesting the following definition:

“Serious Games: The application of gaming technology, process, and design to the solution of problems faced by businesses and other organizations. Serious games promote the transfer and cross fertilization of game development knowledge and techniques in traditionally non-game markets such as training, product design, sales, marketing, etc.”

Since its debut in 2002, serious games has later grown to becoming a multi-billion industry. Pilots are being trained in simulators, lecturers make lecture quizzes for students [17], Swedish firefighters have used serious games for training [18] and persons suffering from diabetes have the ability of using serious games for learning about the illness. These are just a few of the many ways of using serious games.

Foldit is a very interesting example of how a serious game may lead to knowledge and solving bigger problems than the game itself [19]. Foldit is a massive multiplayer online game (MMO). The objective for the player is to fold protein following a set of rules.

²Apple Game Center - <http://support.apple.com/kb/HT4314>

³Cookieclicker - <http://orteil.dashnet.org/cookieclicker/>

⁴Farmville - www.farmville.com

⁵Xbox - <http://xbox.com>

⁶Playstation - <http://playstation.com>

⁷The essay is only signed with the name 'Danc'. Still, we regard this essay interesting and relevant, and it has been mentioned in several scientific publications.

The system records how players fold protein and learns patterns for interaction. Humans have much higher skills at interacting with 3D objects than computers, and the system learns patterns and techniques from the players. By playing Foldit, researchers were able to solve the crystal structure of the M-PMV retroviral protease⁸ [20].

Serious Games and gamification have many similarities, whereas serious games are mainly targeted towards making education or learning more fun, gamification is used in a number of different ways. We seek to learn from the successful uses of serious games when developing AsthmAPP.

3.3 Discussion about Gamification

Gamification is a much discussed theme, where there does not seem to be an agreement as to which gamification is a useful or not. Antin and Churchill argues that gamification may be used for goal setting or instruction [21]. Goal setting challenge the users to meet the mark that is set for them, and is known to be an effective motivator [22].

Bogost goes as far as naming gamification as “marketing bullshit”, used as a way of moneytizing bad business [23]⁹.

McGonigal’s studies on how rewards are perceived over time show that:

“After three hours of consecutive online play, gamers receive 50 percent fewer rewards (and half the fiero¹⁰) for accomplishing the same amount of work.” [25]

Steinung arguments for gamification not being powerful enough to make a task interesting [26]. Simply adding points, badges, a leveling system or similiar, won’t make a task interesting on its own. Since gamification is based on behavioural pshychology, poor design may be perceived as interesting, for a shorter period of time [26]. Zichermann makes a similar statement, saying gamification needs to take ethical precautions [27].

While McGonigal’s research dives into how rewards are percieved when playing over a longer consecutive time, our intent is to make the user spend only small amounts of time using the application. AsthmAPP is a tool, not a time-waster.

In order to achieve a meaningful use of gamification Nicholson[28] suggests using a user-centered design approach[29] when developing system with elements of gamification.

⁸Mason Pfizer Monkey Virus - http://microbewiki.kenyon.edu/index.php/Mason_pfizer_monkey_virus

⁹While this is not a scientific publication, we found it interesting and relevant to the discussion

¹⁰Fiero is an italian term for personal triumph[24]

3.4 Use of Gamification in AsthmAPP

Stapleton argues that:

A variety of [serious game] applications can be thought of here [in Health Care] such as games as a form of motivation and reward for patients undergoing some form of treatment. Games could also be to distract patients during certain procedures such as dental work, for example.[30]

We agree with Stapleton with the fact that serious games can create a motivation factor for children to take their medicine, as children do not necessarily understand why they need to take it.

In AsthmAPP we aim to use gamification as a distraction and rewarding element for the children. Instead of putting a lot of predefined badges, rewards, experience points or other rewarding elements, we let the users choose their own rewards, which implies that users can decide what works best for them.

The children are rewarded with stars based on their health state. The rationale behind this is that the children may have to take more medicine when they have a cold or there is a lot of pollen in the air. The parents have access to a administrator menu where they may set new rewards for the children. The children will then be able to order the rewards when they have earned a sufficient number of stars. This way the parents and their children create their own gamification environment. Examples of possible rewards could be to give their child an extra 10 NOK in allowance, taking them to soccer matches or even to the local amusement park. It is an option where the only boundary is the imagination and how much cost and effort parents want to put into it.

The rewards will appear on a “milestone” basis. We do not want children to feel they lose something if they buy a reward, which some might experience if stars were taken away from them. We do not want to force parents into giving away rewards they can not afford or do not wish to use. Therefore we will be testing the application without the gamification elements, in order to find how introduction of gamification elements will affect the use. The use of rewards is also optional and decided by the user, making the user in control of how they wish to gamify the experience. We do not wish to have the children spending too much time using the application, since using a tablet or phone at such a young age is considered unhealthy, which is taken into consideration with making an application which is mostly used “outside” the digital application itself. The children may receive rewards and use the TUI without touching the smart phone.

Chapter 4

Tangible User Interfaces

This chapter will introduce the reader to Tangible User Interfaces, and elaborate on some existing research that has been done on the concept.

4.1 About Tangible User Interfaces

In 1997, Ishii et. al. presented an article called “Tangible Bits: Towards Seamless Interfaces between People, Bits and Atoms”. They established the term “Tangible User Interface” (TUI) as a way to move beyond the dominant model of Graphical User Interfaces. The objective of TUI was explained to *augment the real physical world by coupling digital information to everyday physical objects and environments* [31]. Thus, TUIs are about giving physical objects a digital meaning.

The earlier mentioned Karotz is an example of a tangible user interface. It lets the user interact with a rabbit instead of a desktop or tablet, which contains digital information.

4.2 Examples of Use

Using TUIs instead of GUIs has been proven to work in several different settings. In this section, we will give an overview on some of the domains in which the concept has been proven to work.

Learning Terrenghi et al. designed a cube for learning, giving children quizzes where answers had the shape of text or images [32]. Children could then rotate the cube in order to get the correct answer pointing upwards, like a dice. They concluded that the

TUI gave children a different set of affordances that prompted a great initial engagement [32].

Collaborative Learning Scarlatos et. al. created a system called TICLE (Tangible Interface in Collaborative Learning), which are used to help children solve a Tangram [33].

Interactive Storytelling Zhou et. al. designed a cube for storytelling, using a head mounted display and a “Magic story cube” in order to let children explore the world while being told a story [34]. Stanton et. al. created a “Magic Carpet”, giving children possibility to influence a story in the classroom [35].

Social Context Marble Answering Machine is an invention by Durrell Bishop, dating back to 1992[36]. The interface allows users to drop marbles into a play-back indent on the system, which plays a recorded message.

4.3 Effects of Robots

In 2003, Wada et. al. conducted a study on how the introduction of robotics affected the elderly [37]. They conducted a study at a day service center in Japan, where they placed a robotic seal, named Paro, together with the elderly. It had recently been found that animals have a positive effects on blood preassure, depression and loneliness. They placed a robotic seal in the care center, and analyzed the reactions from the elderly.

The results showed that their mood was better after interacting with Paro over five weeks, and became worse once Paro was removed. In addition, nurses burnout rate decreased during the experiment, which implied that the subjects had easier days when Paro was there. The study showed that their quality of life improved after Paro was introduced.

4.4 Are Tangible Interfaces more fun?

In 2008, Xie et. al. performed a study on how children reacted using different interfaces in order to solve a jigsaw puzzle [38]. The different interfaces were a physical interface (i.e. a standard jigsaw puzzle), a TUI and a GUI. Their findings were mainly that children enjoyed playing with the different interfaces equally. However, the children

were more likely to start a puzzle over again if the interface were physical or tangible, which implies that a repeated task is more likely to be performed if they're playing with a tangible or physical interface, while it becomes boring to do the same task over and over again on a graphical user interface. It is worth mentioning that the puzzles were being solved by groups of two, and considering the GUI was a computer with one mouse, they didn't get the same sharing experience as with the other interfaces.

4.5 How to create a TUI

Ullmer states that a tangible user interface should embody the following four properties [39]:

1. Physically Embodied
2. Physically Representational
3. Physically Manipulable
4. Spatially Reconfigurable

Ullmer states that these four properties describe physical artifacts as representations and controls for digital information.

Ullmer proposes three different classes of TUI's: Interactive Surfaces, Token and Constraints, and Constructive Assemblies. These classes are partly based on varying degree of support for continuous and discrete forms of interaction [39].

4.5.1 Token + Constraint Approach

The "Token + Constraint" approach centers on a hierarchical relationship between tokens and constraints. Tokens may be placed within or removed from the compatible constraints. The physical shape of the tokens and constraints display whether or not the tokens are compatible or not. This approach support a combination of continuous and discrete interactions.

Strenghts of token + constraint approach Ullmer states that interpretive constraints will help to express which of the physical tokens can take part within a given interpretive constraint, which physical configurations these physical tokens can take and the demarcation between interaction regions with different computational interpretation.

These interpretive constraints may help to simplify the human perception since humans are good at comparing shapes and forms. It may help human manipulation since interpretive constraints provide an increased sense of kinesthetic feedback from the manipulation of tokens.

4.5.2 Design Approach to TUI's

A lot of material exists on the potential benefits of TUI's, but few exists on how to actually create them. Champoux proposes a mechanism to design TUI's based achieving fitness between the form and its context [2]. He proposes three classes of questions, which corresponds to the different development phases of TUIs:

- Defining the boundaries
- Orienting the components
- Fitting the components

By answering the questions in Table 4.1, his mechanism will ease the development phase.

Defining the Boundaries	Orienting the Concepts	Fitting the Components
BO1: What should the user experience?	OC5a: What is the nature of the interaction for each sub task? (Continuous vs Discrete vs Assembly)	FC7: What are the relations between the objects and the actions?
BO2: What are the human task?	OC5b: What are the electromechanical and physical ergonomic constraints for this task?	FC8: What is the task order when using the artefact?
BO3: What would the artefact represent and control?	OC6: Does the sub-task need any relational interaction?	
BO4: What are the conventions? (Physical ergonomics vs electromechanical)		

TABLE 4.1: The eight questions stated by Champoux [2]

We consider Question **OC5b** as irrelevant for our purposes, as we will have a stationary artefact without any electromechanical and physical ergonomic properties, i.e. moving arms, waving ears, etc. The other question are relevant to the development of AsthmaBuddy.

4.6 Co-design

This section will describe co-design and how we plan to use a co-design approach when developing our TUI and the gamification aspect of AsthmAPP.

4.6.1 What is co-design?

Co-design is a product, service, or organization development process where design professionals empower, encourage, and guide users to develop solutions for themselves. Co-design encourages the blurring of the role between user and designer, focusing on the process by which the design objective is created [40]. By encouraging the trained designer and the end user to create ideas and solutions together, the final result will be more appropriate and acceptable to the end user [41]. Albinsson et. al. [41] discovered that having a co-design approach to development of a e-mail sorting system lead to the ability of easier conflict management, ability to centre innovation on the client/customer and made it easier to manage a project with an unknown outcome. While co-design has been around for over 40 years, it draws its roots from user-centered design and participatory design. Co-design differs from user-centered design approaches in that it acknowledges that the client or beneficiary of the design may not be using the artifact itself [42].

4.6.2 Using co-design to build AsthmaBuddy and AsthmAPP

Based on the research we have read, and recommendations from domain experts, we have decided to try a co-design approach to develop the gamification aspect of AsthmAPP and our TUI; AsthmaBuddy. When developing AsthmaBuddy, we will build a low-fidelity prototype which we can show to a group of test persons and domain experts. These sessions will take place at a usability lab in order to make sure we record all answers we get during the sessions. A session will consist of us showing the functionality and design of the current prototype, a test where the test persons may use the prototype in order to get to know it better and an interview/brainstorming where the test persons may give feedback. In order to achieve useful feedback we will answer the questions stated in Table 4.1 beforehand, thus limiting the options of the participants to a reasonable level.

Based on the feedback and ideas from the co-design session we will build a new prototype which we will bring back to the next co-design session. These sessions will be arranged at regular short intervals, so we may get much feedback and ensure that we do not go off track when developing AsthmaBuddy.

Regarding the development of AsthmAPP, we will focus mainly on the gamification aspect during the codesign sessions. The test persons will be asked to test out the application at home, and give feedback on how the test went. The first version of AsthmAPP has a very open and user-controlled system for the rewards (see Section 3.4). While this is an idea we consider appropriate initially, this may change based on user experience and feedback. The reward system using stars will also need testing, since we have little knowledge of how this is perceived by children over time.

4.7 Challenges when creating TUI

Working with GUI's is quite easy from a usability point of view. Assuming that every potential user has used some sort of GUI-based application before, there should not be any fundamental affordance problems when creating a desktop application. What a user expects from a computer mouse is simply given beforehand. However, with TUIs, no such expectations from the user exist. Bellotti et. al. [3] has found several research challenges with creating usable TUIs and ubiquitous systems. This section will elaborate on some of the questions we have to ask ourselves when we are creating our TUI.

Bellotti et. al. found five basic issues considering communication between a human and a system; Address, Attention, Action, Alignment and Accident. These issues were then asked as questions, which exposed several challenges. Some of the challenges they found considered ubiquitous computing, assuming there are several possible target systems at the same location. Table 4.2 shows an appropriate subset of their findings, with our project in mind.

Basic question	Exposed Challenges
Address: How do I address one of many possible devices?	How do disambiguate intended target system. How to not address the system.
Attention: How do I know the system is ready and attending to my actions?	How to embody appropriate feedback, so that the user can be aware of the system's attention. How to direct feedback to zone of user attention.
Action: How do I effect a meaningful action, control its extent and possibly specify a target or targets for my action?	How to identify and select a possible object for action
Alignment: How do I know the system is doing (has done) the right thing?	How to make system state perceivable and persistent or query-able. How to direct timely and appropriate feedback. How to provide distinctive feedback on results and state.
Accident: How do I avoid mistakes	How to control or cancel system action in progress. How to disambiguate what to undo in time. How to intervene when user makes obvious error

TABLE 4.2: The challenges of interacting with TUI [3]

Some of the challenges that we immediately think will be especially hard for us to counter are:

- How to control or cancel system action in progress.
- How to make system state perceivable and persistent.
- How to embody appropriate feedback, so that the user can be aware of the system's attention.

An overview of how we plan to deal with these challenges is included in Section 6.2.3

Chapter 5

Usability

This chapter will give a brief definition of what usability is, and how user tests can help us improve it. Since the applications are targeted at both children and adults, we will give a description of how the usability tests for these groups will differ.

5.1 What is usability?

There are many ways to describe the term usability.

The International Organization for Standardization(ISO) uses the following definition of the term usability [43]:

“Extent to which a system, product or service can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction in a specified context of use.”

The same document defines the term “context of use” as:

“Users, tasks, equipment (hardware, software and materials), and the physical and social environments in which a product is used.”

These definitions cover how the system is used, the user’s thoughts about the use and the context of the system. This can be broken down further into several subgoals in order to achieve better usability, and to give a better insight as to what usability is. These subgoals are:

1. How precisely is the user able to perform a task by using the application?
2. How much resources(for example time, or number of tries) was used to perform the given task using the application?

3. How many errors occurred?
4. Did the user find the use satisfactory?

User-centered design is a way of taking extra precautionary measures by having the end user in mind throughout the process. By using this technique the aforementioned goals are achievable. User-centered design is about getting feedback from the users during the design and development process. Being able to imagine how the end user would solve this problem, and consolidate the users when in doubt is a fundamental part of user-centered design. The user's opinion is the measure of how well the system performs and the user's feedback defines how the design scores on usability.

Schneiderman stated eight golden rules in order to achieve a good usability of computer systems[44]. In his rules he mentions consistency, informative feedback, reducing short term memory load and permitting easy reversal of actions. These eight golden rules have since their publication become a central part of usability engineering.

Today usability is extremely important in order to achieve success for a system. The users expect a functional and easy-to-use system. From the user's point of view, working with a product which is easily understood, leads to increased productivity, which again may lead to increased sales/usage [45]. Proper usability engineering may also lead to lower costs for the developers and higher chances for projects being finished on time [46].

5.2 How to test usability

There are many approaches to creating a good user experience. Having knowledge of expert opinions is always a good idea, and using user-centered design techniques is also a choice. According to Rubin's handbook of usability testing [47], developers should get feedback from users by users tests at different stages of development. According to Rubin, having a user-centered approach will help the developers to address the weakest parts of their system, and give feedback on design decisions.

A user-centered design can be done in many different ways and at different stages of the product life cycle [48], as shown in Table 5.1:

Method	Purpose	Phase of the project life-cycle
Background interviews and questionnaires	To collect data and to understand the user better	When starting the project
Focus groups	Discover design issues and receive feedback	At an early stage
On-site observation	To both collect information of the context the system will be used in, and find the primary problems the users may have	At an early stage
Role playing / simulations	Will give a broader understanding of what the user expects from the system	Early to mid stage of the project
Automated evaluation	Gives feedback on deviations from standards or best practices. This method excludes actual users, but is based on well tested principles	Mid to end of the project
Usability testing	To measure the usability of the system and provide feedback on very specific elements that are poorly designed	Abras [48] says it should be at the end of the project while others [49] think it should be done in iterations throughout the project
Interviews and questionnaires	Gives a qualitative measurement of how good or bad the system is	End of the project

TABLE 5.1: Methods of user-centered feedback

Usability Testing The purpose of usability testing is to increase the usability of a system. At the same time, performing these usability tests may save the developers some time and reduce the cost of the project by removing errors and poor design at an early stage [50].

The usability testing can be performed in different ways [49]. At the early stages of the project, low-fidelity prototypes are a good option since they will provide feedback and take proportionally little time to make, making it easier to have more iterations of testing. The different testing methods include a potential user of the system performing

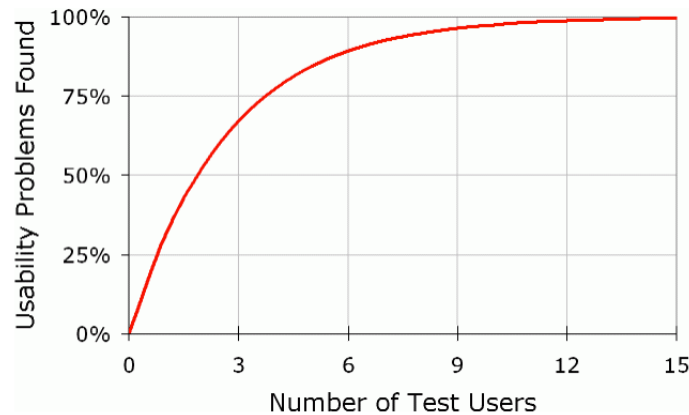


FIGURE 5.1: Number of users needed to find percentage of errors according to J. Nielsen[1]

tasks to provide real data. Observing and recording each usability test may help the developers to analyze their system, and correct the flaws [50].

Before starting the usability tests, the developers should plan goals for what they want to know about the system [51]. This will ensure that the purpose of the test is fulfilled. The developers should then plan tasks according to the desired results. These tasks should allow the user to explore the system, or the parts the developers wish to test, giving the test person some time per task, in order not to stress the test person.

After being planned, the test should be run on a number of different test persons. From Figure 5.1, you can see that as the number of participants increases, the number of undetected errors decrease.

Nielsen states that after five user tests, 85% of the errors have been found [1]. Molich[52] states that six test persons is the ultimate number. Faulkner [53] states that while six test persons *may* find 85 % of the errors, they may also find considerably less. In Faulkner's research, a number of five test users found between 55 % and 100 % of the errors, while 20 test persons found between 95 % and 100 % of the errors.

In addition to the practical usability tests, we will use techniques such as background interviews, focus groups and on-site observations. The interviews will be performed in order to achieve a set of control data we can use for comparison when performing later usability test and codesign sessions. As mentioned in 4.6, we plan on arranging focus group sessions at an early and mid stage of the development of our TUI. These sessions will help us develop our TUI and eliminate usability issues at an early stage. We also plan on using the technique of on-site observation by letting children operate our TUI freely, in order to observe interaction between the children and the TUI.

Testing environment The next thing to consider when performing usability testing is the testing environment. It should resemble the environment in which the system will be used. To make the most of the tests, it is wise to perform videotaping of the tests. This will help when reviewing the results from the test. If the tests are being recorded, a consent from the test person or his/her parent will be required.

Before the test persons arrive, a test leader should be chosen, to guide the test persons through the process. The test leader should be in charge of testing and act as an interviewer to help the participant to “think-aloud” [54]. The test leader should answer questions from the participants, but be careful not to give away information that may affect the results of the test.

After the tasks are done, it is necessary to gather loose ends and obtain answers to all the questions that may remain unanswered. A system usability scale (SUS) [55] may be a good way to grade the usability of the system together with the observations made during the test. The SUS scale will reflect on how satisfying the usability is in the eyes of the users. Bangor et. al. [56] have made a scale based on the SUS-forms from different system usability tests, in order to make it possible to compare the mean score of a system with what is an acceptable level of usability. In our testing, we will make use of a Norwegian version, developed by Svanæs (see Appendix A), which will be answered by the test users or the parent of the test user.

5.3 How to test usability on children and toddlers

While usability testing on children and toddlers have the same basic approach as testing on adults, there are many more precautions to be followed. Hanna et. al. [57] lays out some of these precautions. They recommend not using children that are skilled with computers since they may find the tasks too easy and will not produce useful data. Since children these days have a higher skill with computers thanks to the invasion of tablets and smart phones [9], this may not be great of a concern.

Since our application is targeted at children with asthma, we want to test the system on children suffering from asthma in addition to children from the same age group, not suffering from asthma. These children will most likely have a different approach to the system and may give different feedback.

Hanna et. al. also point out changes that should be made to the testing environment as mentioned in 5.2. They recommend making the testing environment more suitable for children by placing colourful posters on the walls. Children of young age may be afraid

of “the Doctor’s Office” and we will need to make adjustments to avoid frightening the children upon their arrival at the test lab.

As mentioned by Donker and Markopoulos [58] talk-aloud is very useful technique when doing usability testing with children. Talk-aloud is a technique where the children talk about what they are doing instead of what they are thinking.

5.4 Usability testing on mobile devices

We plan on doing usability testing in testing lab or quiet testing office. The application’s main environment for use will be at the user’s home, which may be noisier and more hectic than our testing lab. Kaikkonen et. al. states that the similarity between testing environment and place of use is not too important, the test user will still be able to complete the tasks and find the same number of errors citekallio2005usability. This claim is supported by Beck et. al. who discovered that the test persons found more usability problems when sitting down, compared to when walking on the street [59].

Schusterich et. al.[60] published a guide on how to build the perfect infrastructure for usability testing on mobile devices, in 2007. They describe how generic infrastructure issues, mobile device-specific issues and usability study context issues should be taken into consideration. Shcusterich et. al. recommends having a number of cameras recording from different angles in order to capture unbiased interaction patterns of the mobile device.

5.4.1 Emulator versus device

When developing for mobile devices such as Android, it is possible to run an emulator on a pc, instead of running the application on an Android device. The emulator emulates the use of a mobile device on screen. Input must be given by mouse-clicks on buttons/screen elements. The Android emulator emulates use of system resources corresponding to a given Android device, in order to not act faster or slower than a real device. While this may be true in theory, it is not always true in practice. The emulator is often much slower than an actual device.

The question arises, should one do usability testing on an emulator or on a real device? Using the emulator allows for easier capture of the interaction with the device, since it allows screen recording of user input and easier capture of the user when interacting with the emulator. Using a computer as a test object may be more positively perceived

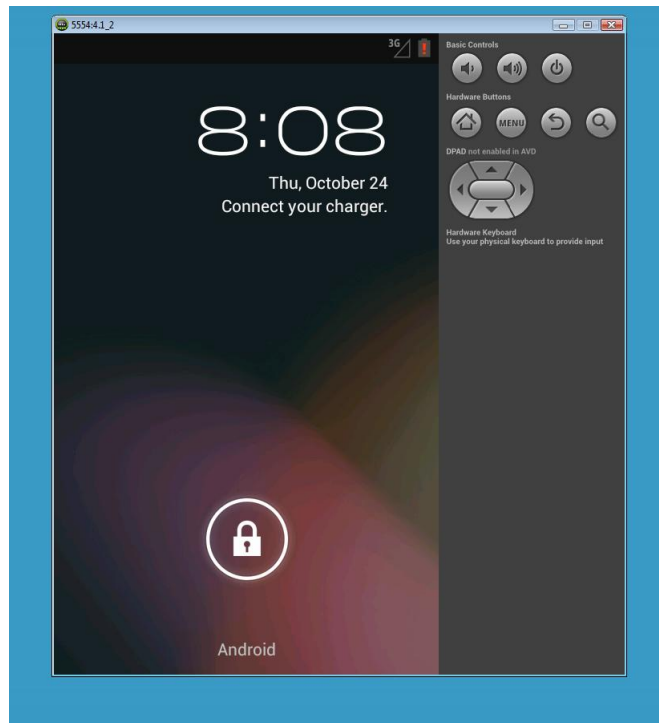


FIGURE 5.2: The Android Emulator running an emulation of Android 4.1

by the test user rather than installing the test application on their device or having them doing tests on our device.

Using a real device has the benefit of being an actual device, and may lead to a more realistic interaction pattern when using the application. While a number of screen recorders for Android devices exist, these require that the device is rooted ¹, which is not an option for us. The use of a real device also allows the use of gestures, which is a benefit in contrast to the emulator which can simulate swiping.

Beitol and Cybis[61] compared doing usability testing on a tripod-mounted device to an emulator and using a device in the field. They found that many users found the tripod-mounted device difficult and unnatural to operate. The users found 80% of the usability issues on the emulator, but Beitol and Cybis points out that use of an emulator may depend on the similarity between the emulator and the device.

Based on the research we have read we decided to do the usability testing on a real device, in a usability test lab.

¹Android Rooting - http://en.wikipedia.org/wiki/Android_rooting

Chapter 6

Introducing: AsthmaBuddy

This chapter will give a brief introduction into the TUI we are planning to create, named AsthmaBuddy.

6.1 Introduction

From our experiences with Karotz ¹, we have decided that we do not want to go further with it. The thought behind Karotz is great, but the thought is, in our subjective opinion, poorly executed. If we were to test the concept at people's homes, we would need to preconfigure the units down to the smallest details. Just the fact that we would have to ask families for their WiFi-credentials before testing a system, should be reasons enough. Additionally, the Karotz API is only documented in French, which makes it considerable harder to develop for. The largest challenge by using Karotz is it's price. A Karotz starters kit costs \$200, not including customs to Norway. Making such a large investment on a product parents have no experience with is going to be quite difficult from a commercial standpoint.

We have also taken a brief look into Arduino, which is an open source electronics prototyping platform [62]. We have seen some of the projects that have been done in Arduino, and have found that they require competence and knowledge we simply do not have, i.e. digital design and circuit boards.

The idea we have found most exciting, both for ourselves and as a solution, is Raspberry Pi [63]. It is a cheap computer with the size of a credit card, with the original intention of teaching british school children about computer programming [64]. Since its release

¹Karotz - www.karotz.com

early in 2012, the Raspberry Pi has sold more than 1 million units, and it is highly popular among computer enthusiasts [65].

6.2 What do we want to create?

On a high level of abstraction, what we want to create is a discrete artifact children can have at their rooms, which can remind them to take their medicine, and help them through the process. Our plan for the time being is basically to wrap the Raspberry Pi inside a toy, i.e. teddy bear, a doll, or some other popular, medium sized toy. We do not intend to answer the question of which wrapping is ideal for this product. For the time being, we have given the product the name *AsthmaBuddy*.

We consider the following as the minimum set of abilities for our TUI:

- Ability to connect to a network, either through ethernet or WiFi, though both are preferred.
- Play sounds through speakers
- Ability to read RFID-chips
- Display information about the color of the asthma medicine through LED-lights

6.2.1 A basic scenario

In order to get a basic understanding of what we are trying to achieve here, we have included a basic scenario below. Assume that we have our Raspberry Pi inside a teddy bear.

1. (AsthmaBuddy): Cough, cough. Come over here kiddo
2. (Kid approaches)
3. (AsthmaBuddy): I need my asthma medicine now. Could you please help me?
The color of the medicine is displayed on my belly.
4. (Child finds the medicine)
5. (When the child holds the medicine towards the mouth of AsthmaBuddy, the RFID chip on the medicine is read, which instructs AsthmaBuddy to continue).
6. (AsthmaBuddy): Thanks. Now it is your turn to take your medicine.
7. (AsthmaBuddy): This medicine, makes it easier for you to breathe.
8. (AsthmaBuddy): Now, find your mask and put it over your nose and mouth. You need to press the button at the top of your medicine before you start breathing.

9. (AsthmaBuddy): (Counts for the amount of seconds needed)
10. (AsthmaBuddy): Great job!

The idea behind having a voice to AsthmaBuddy is to establish a two-way communication between children and the artifact. We want children to actually care for our product, which may be achieved through giving the artifact a sense of personality.

6.2.2 Components

RFID We will be using RFID-technology to let children interact with AsthmaBuddy. Our plan is to attach an RFID-chip to each of the childs' medicines, which in turn can be read by AsthmaBuddy. For instance, during step 5 in the above scenario, a child can hold the medicine towards the mouth of the bear. The type of the medicine is read by AsthmaBuddy, who can notify the child if he/she is taking the wrong medicine.

Speakers The speakers will be used to play prerecorded messages from AsthmaBuddy.

Connect to network Ideally, we want to attach a WIFI shield to our Raspberry Pi, making it able to connect wirelessly. The benefits of this is that it makes the TUI portable. However, this might include having to preconfigure the system as with Karotz as mentioned in Section 6.1. This makes it a problem we will have to research further before deciding on a solution for our prototype. Information we want to send through the network consists mainly of alarm notifications set by parents, i.e. when AsthmaBuddy should give signals that it needs medication.

LED-lights Through LED-lights, we intend to show the color of the medicine that is to be taken. As we cannot assume children are able to read, or to remember the name of the medicine, Aaberg et. al. have found that showing the color is a feasible solution to show which medicine should be taken [4].

6.2.3 Dealing with Bellotti's Challenges

The main challenges Bellotti has identified (see Table 4.2) is "*How to control or cancel system action in progress*" and "*How to specify and select a possible object for action*". We have previously stated that there are two cases in which a child will take their medicine, *by need* and *as a preventive measure*. An issue that could rise is how to detect when a child needs to take a medicine by need. Preventive medicines will fire alarms on

AsthmaBuddy, and the child automatically knows that the system is “awake”. However, when a child needs to take it by need, there is no other intuitive way to show that the AsthmaBuddy is awake than using LED-lights, which are the key for the system to work. Thus, the solution to the second challenge is usage of LED-lights. Cancelling operations, however, is difficult to find a “good” solution from a usability standpoint.

For instance, if AsthmaBuddy starts counting seconds on a treatment before a child is ready, there will be a need to reset this counter, or basically at any point during a treatment, go back to the last step. At the moment, the only solution we are able to see at this problem is to use RFID-chips to backtrack, modelling the treatment process as a statemachine.

6.3 Planned modifications of existing system

As far as the software goes, we intend to keep the main parts of the architecture Aaberg et. al. created, with the exception of Karotz being replaced by AsthmaBuddy.

We intend to improve the mobile applications by modifying the following:

In addition to all modifications listed in [6.1](#) , we need to develop a framework which can be used for basic asthma operations, such as starting treatments, receiving credits, etc. As the design should be highly modifiable, these basic operations should be identical across the two platforms.

Modification	Rationale	Priority
Modifying the mobile applications to become one single application. CAPP and GAPP will thus become AsthmAPP	Having two applications is hard to work with, especially when they're so closely connected. It is thus simpler both for us and the user to use one application	High
Support a reward system where parents are able to specify their own rewards	We need to give some sort of reward system in order to motivate children.	High
Support display of air quality measurements provided by Norwegian Institute for Air Research	Asthma is a disease that is closely coupled with air quality in the area. Making this data easily accessible for parents will hopefully help the parents to control their children's disease better.	Medium
Modify the GUI of the mobile applications to meet design guidelines	At the time being, there are little to no consistency among views. This is important to make it easier to use.	High
Improved distraction sequence for children	The current distraction sequence can easily become boring for children over time.	Medium
Support several medications during the same treatment sequence.	At the time being it is not supported. Taking more than one medicine at the time occurs more often than one might think	Low

TABLE 6.1: Intended modifications and their rationale

Chapter 7

Usability Tests

7.1 Purpose

Usability tests is usually performed for detecting errors in a system. We want to use usability tests in a slightly different approach. In addition to discovering errors, we will observe how children take their medicine in combination with technology. We will use the results of the usability tests in order to find potential for improvement and design ideas for the product.

The tasks given to the participants will be created with routine use of the application in mind. Usability tests will be performed with the help of participants with no prior knowledge of the application. These participants will be chosen in order to get valuable feedback on usability problems with the current design and structure, and to prevent invalid feedback from users who already know how to perform the tasks. In addition, this situation mirrors everyday life of the users.

7.2 Test Method

The execution of the usability tests will be based on the theory described in [Section 5.2](#) and [Section 5.3](#).

Before each test, we will perform a quick-and-dirty pilot test in order to discover critical errors that could make an impact on the result.

To ensure that the participants have the wanted background, we will ask them to fill in two forms when registering for the usability tests. These are added in [C](#) and [D](#).

The participants will be given an Android mobile device to perform tasks on. The different tasks will be given one by one in order to complete. The participants will be introduced to the “think-aloud”-method, and will be told to ask questions during the process, even though the test leader is not allowed to answer these questions during the test. The main reason for gathering questions is for discussion afterwards or to facilitate the “think-aloud”-method.

Upon finishing the tasks, the participants will be asked to answer the forms in Appendix A and E. The test leader will finish the test by asking questions regarding what the participants thought of the system and answer the questions that may have occurred during the test. We will also ask parents how they felt the medication process went, so that they can compare it to their daily situation at home, and whether or not they got the impression that the product could be helpful.

The results will later be analyzed to work out the improvements needed to be done to the system. The errors will be rated after level of severity [50].

- Critical (Level 1) - Prevents the participant from completing the task.
- Significant (Level 2) - Generates significant problems when trying to complete the task.
- Minor (Level 3) - Have minor effect on the usability of the application.
- Non-essential (Level 4) - Enhancements to the system. When a participant states that “it would be nice to have this”.

7.2.1 Scenario and tasks given to the users

We plan to use test users that speak fluent Norwegian, since the application has Norwegian as its main language. Therefore the scenario and tasks will also be written in Norwegian. The exact scenario and tasks handed to the participants can be found in Appendix F, but for convenience the next paragraph gives a short summary of the scenario and tasks.

The scenario explained that the user was a parent of a 4-year-old child with asthma. They have recently been to the doctor, and will now have to set up treatment plans according to advice given by the specialist. Since they have little experience with asthma, they would have to look up information about the medicines and how the treatment will be done. In order to motivate the child to continue taking his/her medicine, they will have to add a reward via the application menu. Finally, they would have to look through the calendar log in order to find correlations between the child’s health state and use of medicines.

Chapter 8

Conclusions

20% of the Norwegian population has or has had asthma by the age of 10. Treating children for asthma is often a cumbersome task which may lead to arguing and sub-optimal treatment. Research has shown that TUIs and mobile applications have been useful in medical care in a number of different settings. By combining gamification with TUIs and mobile technology, we believe that children may be motivated to take their medicines and become more aware of their own disease. While there is much research on the effect of TUI's in treatment of patients, there are still very few systems that have seen a mass-market release. We believe that the development of AsthmaBuddy, through a codesign approach will give an indicative result as to how well TUI's can be used for treatment of asthmatic children.

Serious games have given us an idea of how to balance gamification elements properly. The many different uses and approaches on how to develop such games, have given us valuable insight and knowledge. We have learned that when developing a system targeted at children, it is important to use non-obtrusive gamification elements. Applications which have focus on money-spending and in-app-purchases have also recieved much critique for trying to trick money out of the user. By letting parents and their children decide upon what the rewards are going to be, we give an opportunity for better motivation factors for both children and their parents.

We have chosen to develop a TUI in addition the Android application. The rationale behind this decision is that TUIs are often percieved as more fun to operate when performing a repetetive task (4.4). We believe that a friendly looking TUI will be percieved in a more positive manner than a smartphone application by the children, while the parents will have more flexibility and making it easier for them to keep control with the smartphone application. Inspired by Ullmer [39] we have chosen a token+constraint approach for our TUI; AsthmaBuddy. The design and development of the TUI will

most certainly be the most challenging part of our research. With the help of domain experts and potential end users, we are sure that the iterative design and development of AsthmaBuddy will in turn lead to a successful TUI.

We are eager to continue our research and the development of AsthmaBuddy and AsthmAPP.

Appendix A

Norwegian SUS form

This Norwegian version of the SUS form was developed by Svanæs, D. in 2006.

Noen spørsmål om systemet du har brukt.

Vennligst sett kryss i kun en rute pr. spørsmål.

	Sterkt uenig						Sterkt enig		
1. Jeg kunne tenke meg å bruke dette systemet ofte.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
2. Jeg synes systemet var unødvendig komplisert.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
3. Jeg synes systemet var lett å bruke.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
4. Jeg tror jeg vil måtte trenge hjelp fra en person med teknisk kunnskap for å kunne bruke dette systemet.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
5. Jeg syntes at de forskjellige delene av systemet hang godt sammen.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
6. Jeg syntes det var for mye inkonsistens i systemet. (Det virket "ulogisk")	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
7. Jeg vil anta at folk flest kan lære seg dette systemet veldig raskt.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
8. Jeg synes systemet var veldig vanskelig å bruke	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
9. Jeg følte meg sikker da jeg brukte systemet.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5
10. Jeg trenger å lære meg mye før jeg kan komme i gang med å bruke dette systemet på egen hånd.	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	1		2		3		4		5

|

Appendix B

Further Work

*This appendix is reprinted from the final report of 'BLOPP - Development of a prototype for treatment of asthmatic children, using Android and Karotz'*¹ [4]

This chapter gives an overview of some of the ideas both the customer and the developers had for further development of the application. This includes a description of further development, analysis of the user groups and work towards NAAF and the health department. The main part of the work to be done after the end of this project is connected to requirements that has been taken out of this project due to limitation of time and resources. Other issues remaining is connected to the security and privacy of the patient's treatment log and storing sensitive information. Section ?? ² lists the overall requirements that have not been implemented during the project. These requirements has either been requested early in the process of have been brought up during discussions and meetings with the stakeholders.

B.1 Improvements

The following sections describes the ideas we had for future improvements to the applications. It is parted into subsections for improvements in the fields of database records, the reward system, the distraction and the web application.

B.1.1 Rewardsystem

The children's application (CAPP) is all about changing the children's view of medication to something positive. It shall be a motivation for the children to take their

¹Reprinted with permission from Aaberg, Aarseth, Dale, Gisvold and Svaestuen

²This section is not included in the thesis, and will therefore on purpose result in '??'

medication. It is therefore an important task to entertain them and give them some form of reward when they take their medication. As for now, we have given stars to the child after completed medication. The stars are in a treasure chest where the child can see how many stars he or she has. This is a simple reward, but worked fairly well during the user tests. However, it may be boring over time.

The initial idea was to have a shop where the children could buy clothes and other items to their avatar. The stars earned from finishing treatments would serve as credits in the shop. This was not implemented due to time restrictions. It is also possible to take this to the real world, e.g. that the child gets a lollipop for every 10th star, but this would have to be supervised by the parents.

There is an endless line of opportunities for this reward system, and we chose the simplest implementation, so we would have something to test.

B.1.2 Distraction sequence for children

During our workshop, we came up with a lot of ideas for distractions for the children. These would range from simple animation sequences, like what we decided to implement, to more complex things like games that would not require a lot of movement and could therefore help during longer treatments.

The distraction sequence is one of the fields where we feel it has more or less never ending possibilities for improvement, and as more research into what children finds distracting, but not to the point where they can't take their medicine, this distraction sequence can be evolved.

B.1.3 User testing of the guardian application

GAPP has not yet been user tested on actual parents of asthmatic children. This has to be done to get an understanding of how they interact with the system, and to get knowledge about what they think of an application of this type. This is a system to make it easier for the guardians to give their children medications. While it is important that the children likes the system, it is also important that the parents feel it helps them give their children their medicines, without it being a big time waster.

B.1.4 Web application

There is a possibility of making this application as a web application, as a whole. By extracting the functionality and running it on a web service it would make it easier for

people to use it across platforms. Done right, it may run on all devices with an internet connection. This may also give an easier integration with external information such as air pollution forecast, pollen forecast, temperatures, etc. Since our application is written in Java, using Android SDK, it will not run on an internet server as is. Making a web application will require an almost complete refactoring of the source code.

B.1.5 Support for more children

Currently, the application only use one child, but there are implemented support for using more children. Each child has its own id (childId), and support for more children can be implemented without much change of the existing code. There should also be considered using accounts for the guardians connected to the children, in case of the guardians having more than one asthmatic child.

B.2 Ideas and minor improvements

Webinterface The doctors may prefer to set up the users medication plans through a web interface on their computers. This part may be integrated into existing systems.

Other devices The application are fitted for a phone running the Android operating system. For the future it should also be scalable to tablets. There may be more interesting for a child to work on a tablet than a phone. There will also be much more space for content. This extra space gives greater potential of the reward system. It should also be available on other operating systems than Android, e.g. iOS or Windows Phone. This will improve the availability for the users, not limiting them to Android phones.

Overall graphical design The priorities have been to make the major functionality work. We have used lots of time making the applications understandable and easy to use, but there is still a great potential in making the applications interaction design better.

Personalize the system The application may be more personalized. E.g. "It's time to take medication" could be "It's time to take medication, Eric". By involving the users name more in the system, they may feel more appreciated.

Integration of external elements The distraction part of the application may be integrated with a story or other external elements. I. eg. a story where the children will need to take medicine in order to get the next part of the story.

Appendix C

Questionnaire. Demographics

Vennligst besvar spørsmå lene under, før vi begynner testen.

Kjønn
Alder
Utdanning
Yrke

Appendix D

Interview conducted before usability testing

Experience with computers
Access to internet
Time spent online per day
Has a smartphone
SMS Usage
Has facebook account
Uses electronic reminders (calendar, to-do list etc)

Appendix E

Draft for Interview Conducted after Usability Test

Nå som du har gjennomført testen ønsker vi å vite hva du synes om applikasjonen.

Hvordan synes du gjennomføringen av oppgavene gikk?	
Var det noe du opplevde som vanskelig?	
Hvorfor var det vanskelig?	
Har du brukt noe(n) lignende applikasjon(er) tidligere?	

Appendix F

Scenario and tasks

Du er verge til et barn på 4 år. Dere har nylig vært hos en lege med spesialkompetanse på barnesykdommer. Barnet har fått diagnostisert astma. For å enklere holde orden på at medisinene blir tatt til riktig tid, på riktig måte, har du lastet ned applikasjonen AsthmAPP. Systemet har ikke behov for at du registrerer navn eller lignende, for du ønsker ikke at slik informasjon kommer på avveie. For at du best mulig skal kunne benytte deg av AsthmAPP, er det nødvendig at du gjennomfører noen oppgaver.

Oppgave 1: Du skal sette opp en medisineringsplan i henhold til anbefaling fra legen. For enkelhets skyld skal du kun endre medisineringsplanen for barnet når det er helt friskt. Legg til en varsel for “Flutide” kl 13:37 og en varsel for “Seretide” kl 18:30. Velg deretter å følge denne medisineringsplanen.

Oppgave 2: Barnet ditt tok allerede en dose med medisin da dere var hos legen. Du ønsker å starte loggføringen med en gang. Etterrigstrer bruk av Seretide kl 12:51 i dag.

Oppgave 3: Du ønsker å motivere barnet ditt til å ta medisinene sine uten at det skal bli en krangel hver gang. Lag en premie barnet ditt kan få dersom hun/han har fulgt medisineringsplanen sin. Som premiebilde kan du ta et bilde med kameraet på telefonen, og premietekst og antall stjerner velger du selv.

Oppgave 4: Se hvordan barnet ditt ligger an i forhold til målet du satte i forrige oppgave?

Oppgave 5: Det er nå gått to uker, og du ønsker å se hvordan du og ditt barn har fulgt medisineringsplanen. Let gjennom loggen for å se om dere har gjort jobben på en god nok måte.

Du har nå gjennomført testen. Vennligst fyll inn skjemaene for å forklare hvordan du oppfattet bruken av applikasjonen.

Appendix G

Asthma Traffic Light System

Your ASTHMA ACTION PLAN
Your appointment is at 10:00 am tomorrow or the next day that your doctor's office is open. Please call your doctor's office to confirm or call to change your appointment time.

GREEN ZONE: DOING WELL

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeping through the night
- Healthy, no cold symptoms

YELLOW ZONE: CAUTION

- First sign of a cold
- Exposure to known trigger
- Cough or wheeze
- Tight chest
- Coughing at night
- Problems working or playing
- Some trouble breathing

RED ZONE: DANGER

- Cannot work or play
- Getting worse instead of better
- Medicine is not working
- Breathing is hard and fast
- Nose open wide
- Ribs showing
- Trouble talking

Emergency Department

KAPI'OLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN
An Affiliate of Hawai'i Pacific Health

Triggers: Respiratory infections
Other: _____

Need info: Call ER at 983-8637

Want to take an Asthma Class: Call 983-6336

Use these medicines EVERY DAY even when well

MEDICINE	HOW MUCH	HOW OFTEN / WHEN
Pulmicort	1 ampule	1 or 2 times daily
OR		
Flovent	1 to 2 puffs	Daily

There are several other possible medicines such as Advair and Singulair. Discuss this with your doctor. These are preventive medicines to prevent bad cough and wheezing.

For asthma with exercise: Use albuterol as needed

Continue Green Zone control medications and add:

MEDICINE	HOW MUCH	HOW OFTEN / WHEN
Albuterol	1 ampule	Now and repeat in 20 minutes, plus every 3 to 4 hours
Xopenex		
OR		
Albuterol or Xopenex inhaler	2 to 4 puffs	

Prednisolone or prednisone Call your doctor now for dose and how often to give it

Move to the RED ZONE if no improvement

Take these medications and CALL YOUR DOCTOR NOW

MEDICINE	HOW MUCH	HOW OFTEN / WHEN
Albuterol or Xopenex	1 ampule	Give treatment every 20 minutes, up to 3 times in a row on your way to the ER or doctor's office
OR		
Albuterol or Xopenex inhaler	3 to 5 puffs	

Prednisolone or prednisone Dosing will be done by ER or your doctor's office

KMCWC ED Ver. Nov 4, 2009

GET HELP FROM A DOCTOR NOW! THIS IS AN EMERGENCY. IF YOU CANNOT CONTACT YOUR DOCTOR, GO DIRECTLY TO THE NEAREST E.R. OR CALL 911.

Appendix H

Manuscript

During a medication process, CAPP and KAPP speaks to a child. The following is a breakdown on the manuscript the applications follow.

1. Hei, jeg heter Blipp. Nå er det på tide å ta pustemedisin. Trykk på hodet mitt, så forteller jeg deg mer. *Hi, my name is Blipp. It's time to take the breathing medicine. Press my head, and I'll tell you more.*
2. Hent den C medisinen og masken du puster i, og trykk på hodet mitt når du har hentet dem. *Get the C medicine and the mask you breath in, then press my head when you have fetched them.*
3. Rist den C medisinen. Trykk på hodet når du er klar. *Shake the blue medicine. Press my head when you are ready*
4. Av den C medisinen skal du ta 1 puff. Sett på deg masken og gjør deg klar. Trykk på hodet mitt, så teller jeg mens du puster inn og ut. *You are going to take 1 spray of the C medicine. Put on your mask and get ready. Press my head, and I'll count when you breathe in and out.*
5. Når jeg sier i fra, skal du trykke 1 gang. Trykk på hodet mitt, så begynner jeg å telle. *Upon signal, press the medicine one time. Press my head, and I'll start counting.*
6. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.
7. Nå var du flink. *You did great*
8. Som belønning får du N stjerner i skattekista di. *As a reward, you'll get S stars in your treasure chest.*

The above script has the following properties:

$C \in \{Blue, Orange, Purple\}$ $S \in \{1, 3, 5\}$

Appendix I

Constraints

By law, we have some constraints in order to proceed start usability testing. This Appendix cover these.

I.1 The Health Register Act

Norway has specific laws for storing of medical information. The most significant law is “The Health Register Act¹” [66]. This law regulates who is allowed to store health records and how they store the records.

The most significant consequences is that the information has to be stored on servers on Norwegian soil. This eliminates the option of using cloud-based services such as Amazon EC2, Windows Azure or Google App Engine.

In addition, we need permission from *REK* ² in order to store medical records in the application. If the application were ever to be deployed to Google Play, we would need permission from *The Data Protection Authority*, but it not required if the application is just for research purposes. Our application is still pending.

I.2 Measures for Anonymization

Pursuant to section 16 of the Health Register Act [66] all information that may identify a person, must be encrypted, i.e. it should be impossible to find which person a specific record corresponds to by looking at a database dump.

¹Lov om helseregistre og behandling av helseopplysninger

²<https://helseforskning.etikkom.no/> - i

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