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Mair, Jacqueline, Hayes, Lawrence, Campbell, Amy ORCID: <https://orcid.org/0000-0003-3711-3896> and Sculthorpe, Nicholas (2021) Should We Use Activity Tracker Data From Smartphones and Wearables to Understand Population Physical Activity Patterns? *Journal for the Measurement of Physical Behaviour*, 5 (1). pp. 3-7.

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# RaY

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1 **Should we use consumer-grade activity tracker data to understand population**  
2 **physical activity patterns?**

3

4 Submitted 24 February 2021

5

6 Revised 28 June 2021

7

8 **ABSTRACT**

9

10 Researchers, practitioners, and public health organisations from around the world are  
11 becoming increasingly interested in using data from wearable activity trackers, from  
12 companies such as Fitbit Inc, Garmin Ltd, Xiaomi, and Apple Inc, to measure physical activity.  
13 Indeed, large-scale, easily accessible, and autonomous data collection concerning physical  
14 activity as well as other health behaviours is becoming ever more attractive. There are several  
15 benefits of using wearable activity trackers to collect physical activity data, including the  
16 ability to obtain big data, retrospectively as well as prospectively, to understand individual-  
17 level physical activity patterns over time and in response to natural events. However, there  
18 are challenges related to representativeness, data access, and proprietary algorithms that, at  
19 present, limit the utility of this data in understanding population-level physical activity. In this  
20 brief report we aim to highlight the benefits, as well as the limitations, of using existing data  
21 from wearable activity trackers to understand large-scale physical activity patterns and  
22 stimulate discussion amongst the scientific community on what the future holds with respect  
23 to physical activity measurement and surveillance.

24

25 **KEY WORDS**

26 m-Health; quantified-self; big data; surveillance; wearables

## 27 INTRODUCTION

28 Physical activity (PA) and exercise have pronounced positive effects on physical, mental, and  
29 social health and wellbeing and, according to recent estimates, prevent 3.9 million premature  
30 deaths worldwide annually (Strain et al., 2020). Accordingly, global PA guidelines recommend  
31 all adults to undertake 150–300 min of moderate-intensity, or 75–150 min of vigorous-  
32 intensity PA, or some equivalent combination per week (Bull et al., 2020). Such guidelines rely  
33 on population level surveillance methods to regularly monitor PA indicators and inform public  
34 health policy, and the most common approach in this regard is to assess PA using self-report  
35 methods. Self-report remains an accepted method of large-scale data collection due to its  
36 cost effectiveness, unobtrusiveness and adaptability to different country contexts (Troiano et  
37 al., 2020). This is despite the accepted limitations of self-reporting with respect to accuracy,  
38 recall bias and social-desirability (Brenner & DeLamater, 2014; Prince et al., 2008). Advances  
39 in technology over the last two decades have, however, created new possibilities for PA  
40 measurement, not only for population-level surveillance but at an individual-level in terms of  
41 cohort studies, intervention research, and the evaluation of public health promotion  
42 programs. Research-grade devices such as wrist, hip, and thigh worn accelerometers have  
43 been used widely in such studies as they remove the biases associated with self-reporting and  
44 are able to provide a more granular quantification of PA. Nevertheless, research-grade  
45 accelerometers are costly to use at scale and cannot assess the domain or context in which  
46 PA takes place. Furthermore, accelerometers, as with self-report methods, only offer a  
47 ‘snapshot in time’ to infer usual PA behaviour (typically a 7-day period) meaning assessment  
48 of longer-term dynamic patterns of PA, particularly in response to natural events, is either  
49 not possible or not feasible. Over the last 15 years, the emergence of consumer-grade  
50 devices, such as smartphones and wearable activity trackers, has opened new doors in the

51 field of PA measurement. These devices gather rich activity data continuously in a free-living  
52 setting thus providing large-scale and low-cost datasets that could advance our  
53 understanding of PA patterns in a way that was never possible before. While this seems an  
54 exciting prospect, as with any other PA measurement tool, the use of wearable activity tracker  
55 data should be carefully considered before being used in PA research.

56

57 Comparing and contrasting all the available PA measurement methods available to  
58 researchers, practitioners, and public health professionals is beyond the scope of this brief  
59 report. Instead, we focus on the emerging opportunities offered by consumer grade devices,  
60 including smartphones and wearable activity trackers, and how these may be utilised in the  
61 fields of PA surveillance, cohort studies, intervention research, and evaluation of public health  
62 promotion programs.

63

#### 64 **Consumer-grade devices: too good to ignore?**

65 Technological advancements over the last decade, allied to the rapid proliferation of  
66 smartphone use in both developed and developing regions globally (Deloitte, 2017), have  
67 provided new possibilities in monitoring, understanding, and influencing human movement  
68 at scale. Compared to traditional approaches, objective, real-world PA data sets with very  
69 large sample sizes have become relatively low cost for researchers to collect or access.  
70 Consequently, we are now beginning to witness the emergence of big data on PA in the  
71 literature. For example, Althoff and colleagues (2017) recently used minute-by-minute step  
72 count data, collected from the smartphone's inbuilt inertial unit, from over 700,000  
73 individuals across 111 countries, to identify variability in PA levels across the world. With this

74 data they revealed city walkability as a factor associated with PA levels as well as associations  
75 between PA inequalities and obesity.

76

77 The questions that could be addressed, and the new insights afforded, by large-scale PA data  
78 from smartphones is an exciting prospect. However, concerns remain over the quality of the  
79 PA data that can be obtained from smartphones, including the validity and reliability of step  
80 detection, the restriction to only ambulatory activity, and their reliance on the individual  
81 carrying the smartphone (Brodie et al., 2018). Wearable activity trackers, although currently  
82 less prevalent than smartphones, are growing in popularity (Deloitte, 2017; Thompson, 2019)  
83 and can address some of these pitfalls. Activity trackers have progressed beyond simple  
84 pedometers and can now provide data on pulse rate, distance covered, moderate-to-vigorous  
85 PA minutes, stair flights climbed, energy expenditure, and sleep. Unlike research grade  
86 devices such as accelerometers, they also blend attractive design with invisible and effort-  
87 free data capture. This combination often results in high adherence (in terms of daily wear  
88 time) for extended periods of time. Additionally, while synchronisation of the activity tracker  
89 to a smartphone application displays summary information to users, these summary data are  
90 calculated from extensive intra-day data gathered at high frequency (e.g., 1 Hz), which are  
91 also stored. High adherence alongside high frequency data capture means individuals  
92 accumulate an extensive data resource that could be utilised to answer important PA  
93 questions.

94

95 Big data analyses from smartphones and wearable activity trackers have, thus far, been cross-  
96 sectional which limits our understanding of PA to a single point in time. However, longitudinal  
97 data from smartphones and wearable activity tracker could also be analysed prospectively or

98 retrospectively, given its perpetual collection and long-term storage. Of note is the unique  
99 opportunity offered by smartphones and wearable activity trackers to analyse data  
100 retrospectively and in response to natural events without the need for foresight. This has had  
101 obvious implications during the coronavirus pandemic when objective accelerometry was  
102 not possible, or feasible, due to the speed and variability with which restrictions were  
103 imposed across the world. As a result, the need for remote and scalable means to both  
104 measure and support PA has become more prominent since the coronavirus pandemic.  
105 Although the use of wearable activity trackers is not without inherent limitations (discussed  
106 further below), we feel they are unique in their ability to be utilised in retrospective cohort  
107 study designs (i.e., when the start of the study is only known after the event).

108

109 Interestingly, to date, there has been almost no independent large-scale reporting of existing  
110 data from wearable activity trackers. This might be due to the complexity of large-scale data  
111 access and processing from commercial wearables. A cross-sectional study of pulse rate data  
112 from over 8 million Fitbit users was recently published by the Fitbit Research team (Natarajan  
113 et al., 2020), reporting a positive relationship between heart rate variability and step count.  
114 Regardless of the study findings, it seems that collecting, processing, and interpreting this  
115 volume of data is possible, but requires an interdisciplinary team including data scientists,  
116 database analysts, and cardiovascular and behavioural scientists, which has so far been  
117 limited to large proprietary companies such as Fitbit. Furthermore, accessing this volume of  
118 data is, so far, only feasible for companies such as Fitbit because they require all users to give  
119 them permission to use the data collected by the device. For independent researchers it is  
120 possible to request access to the data from the user directly. But this would be on an



121 individual basis, therefore, to amass a dataset of 8 million users would require 8 million  
122 individual access requests. The issue of data access is discussed on more detail below.

123

#### 124 **Balancing feasibility against validity, reliability, and sensitivity**

125 When choosing a PA data collection tool or methodology, researchers must balance validity,  
126 reliability, and sensitivity of the approach with the costs and feasibility of its deployment in  
127 the target population. Despite their known limitations (Brenner & DeLamater, 2014; Prince  
128 et al., 2008), self-report methods remain an accepted means by which to collect large-scale  
129 and population-level PA data, particularly where cost and sample size make accelerometry  
130 an unfeasible approach. However, the volume and detail of information that can be obtained  
131 from self-report surveys can be limited, preventing more nuanced analysis of PA patterns.  
132 Device-based methods, such as accelerometry, provide a more valid and reliable estimate  
133 of PA than do self-report measures (Dowd et al., 2018), but also have several limitations. Not  
134 only are accelerometers costly, but their data also must be extracted from each device  
135 individually, making them unfeasible for large-scale use. Data from wearable activity trackers  
136 on the other hand should be considered feasible for large-scale use. Suitable activity trackers  
137 are generally cheaper than accelerometers and their attractive design should translate into  
138 greater wear time. Like accelerometers, they provide continuous data capture, but with the  
139 additional advantage of these data being stored on a central server meaning data retrieval  
140 and analysis can occur remotely and at scale. Thus, in principle, it is possible to analyse the  
141 PA data of thousands of participants worldwide in a manner that is simply not possible with  
142 current research grade accelerometers. Research has shown wearable activity trackers to  
143 have high interdevice reliability for measuring steps, energy expenditure, and sleep (Evenson  
144 et al., 2015), and despite ongoing concerns, the accuracy of wearable activity trackers also

145 continues to improve. In a recent systematic review of 67 studies, Fitbit devices were found  
146 to provide a relatively accurate measure of free-living steps (within  $\pm 10\%$ , 50% of the time)  
147 when compared to research-grade accelerometers (Feehan et al., 2018). Garmin activity  
148 trackers are also reported to have good-to-excellent correlation coefficients and acceptable  
149 ( $<10\%$ ) mean absolute percentage errors with respect to step count (Evenson & Spade, 2020).  
150 While the accuracy of wearable activity trackers in measuring step count in free-living settings  
151 is considered to be acceptable for normal walking pace (Evenson & Spade, 2020; Feehan et  
152 al., 2018; Fokkema et al., 2017), they do not yet provide a valid measure of moderate-to-  
153 vigorous PA (Redenius et al., 2019) or walking at very slow or very fast speeds (Fokkema et  
154 al., 2017). However, considering this evidence is based on devices manufactured up to 2015,  
155 refined algorithms over the past 5 years have likely further improved accuracy.

156

157 For intervention research the responsiveness, or sensitivity, to change in PA over time may  
158 be a more important consideration than the validity of the tool. When examining the  
159 effectiveness of an intervention in changing PA it is paramount that the measurement tool  
160 employed is capable of detecting change. Research has shown the responsiveness indices for  
161 self-report and device-based methods to vary not just by tool, or device, but by PA variable  
162 measured. Reeves et al. (2010) compared the responsiveness of the Community Health  
163 Activities Model Program for Seniors (CHAMPS) questionnaire, the Active Australia  
164 Questionnaire (AAQ), and two items on exercise from the US National Health Interview Survey  
165 (USNHIS), and reported responsiveness indices ranging from 0.15 (AAQ) to 0.27 (USNHIS) for  
166 walking duration and 0.25 (AAQ) to 0.32 (CHAMPS) for moderate to vigorous intensity PA  
167 duration per week. Swartz et al. (2014) compared two research-grade accelerometers, the  
168 Actigraph GTX3 (ActiGraph LLC, Pensacola, Florida, USA) and the activPAL (PAL Technologies

169 Ltd, Glasgow, Scotland, UK) and found both to have comparable responsiveness to change  
170 across a range of free living physical activity and sedentary behaviour variables (standardised  
171 response mean values between 0.159 – 0.436). Donnachie and colleagues (2020) compared  
172 a self-report PA measure (the International Physical Activity Questionnaire; IPAQ) and an  
173 accelerometer (activPAL), and found both to have comparable and moderate standardised  
174 response mean values of 0.54 (activPAL) and 0.59 (IPAQ) for total PA duration per day. There  
175 appears to be no evidence on the responsiveness to change of wearable activity trackers. This  
176 surprisingly under-researched topic warrants further attention by the PA research  
177 community.

178

179 We have an array of options to measure elements of PA (such as duration, intensity, type,  
180 domain, context, and quality), but no single tool can fully capture the complexity of PA  
181 behaviour. Consumer-grade devices offer new opportunities for combining PA data collection  
182 methods. For example, passive sensing of movement using a smartphone or wearable activity  
183 tracker, combined with synchronised ‘smart’ self-report techniques, such as ecological  
184 momentary assessment, could address many of the issues outlined previously. With further  
185 evidence to support the validity, reliability and sensitivity of such methods, this approach  
186 could provide powerful insights into PA patterns and help us better understand PA behaviour.

187

### 188 **The issue of data harmonisation**

189 Another issue researchers must consider when evaluating device-based PA measurement  
190 tools is the harmonisation or comparability between devices from different manufacturers.  
191 Data harmonisation is an essential step if researchers wish to conduct analyses on data  
192 derived from different sources (Pearce et al., 2020). While all activity tracking devices gather

193 raw uni- or tri-axial accelerations, each manufacturer applies different algorithms to process  
194 the data into its summary form thereby influencing the comparability of the data gathered.  
195 Therefore, researchers who wish to use data from multiple devices/manufacturers to  
196 increase sample representativeness and reach will need to consider data harmonisation using  
197 statistical models derived from validation studies (Pearce et al., 2020). This could be  
198 problematic when algorithms change, and validation data are no longer available.  
199 Manufacturers of research-grade devices publish open source algorithms allowing  
200 researchers to evaluate the impact of changes on measurement properties (Evenson et al.,  
201 2015), however consumer-grade device manufacturers keep this information proprietary.  
202 The use of different proprietary algorithms by each consumer-grade device manufacturer is  
203 undoubtedly an issue for harmonisation too. In the longer term, this would be solved by  
204 manufacturers making raw data counts available or at least allowing researchers to apply to  
205 access this information. However, due to the proprietary nature of data processing, it is  
206 unclear if raw data or only processed data are available. In the short-term however,  
207 comparative validation between devices should enable statistical techniques that allow for  
208 between device data pooling without compromising data quality. Finally, it is also worth  
209 noting that there is a small but growing sector of 'hackable' wearables. These devices are  
210 usually based on small form factor processing boards (e.g., small Raspberry Pi or Arduino  
211 boards) which include tri-axial accelerometers, heart rate measurement, WIFI and Bluetooth.  
212 These devices also support the remote storage of raw data signals, which would overcome  
213 the limitations of unknown and proprietary algorithms. Although useful for research studies,  
214 it seems unlikely that such devices will achieve the market penetration of larger  
215 manufacturers.

216

217 **The issue of representativeness**

218 Given the widespread use of smartphones and the growing use of activity trackers, we should  
219 not ignore the possibility that in the near future wearable activity tracker data could also be  
220 used as a population PA surveillance tool. However, at present the primary challenge relating  
221 to such data is that it likely over-represents individuals who are more physically active and  
222 more proactive in setting and meeting activity goals relative to the general population who  
223 may not be tracking their activity level (Omura et al., 2017; Strain et al., 2019). Therefore, any  
224 cohort or surveillance research exclusively involving participants who own, and wear, activity  
225 trackers will introduce selection bias. The issue of representativeness is, however, not  
226 necessarily limited to wearable activity trackers. Selection bias might also occur in data  
227 derived from public calls to self-report PA or participate in cohort studies involving self-report  
228 or device-based measures of PA. Indeed, it has previously been suggested that selection bias  
229 is a significant issue in many cohort studies including those with objective assessments  
230 (Barreto et al., 2013; Folley et al., 2018; Stamatakis et al., 2021). Nevertheless, in such cohort  
231 and surveillance studies it is possible to use weighting to adjust for non-responders. This is  
232 not currently possible for data from wearable activity tracker and future research should  
233 focus on statistical approaches to estimate the population effect, and the effect in those with  
234 trackers, to help overcome this limitation.

235

236 While activity tracker sales and usage are increasing, the demographic reach appears, so far,  
237 to be constrained to young adults from more affluent backgrounds (Omura et al., 2017; Strain  
238 et al., 2019). Nevertheless, the cost of activity trackers has decreased significantly in recent  
239 years making them more affordable and accessible. This, combined with the increasing  
240 interest in activity trackers as behaviour change tools, may reduce this constrained

241 demographic reach over time. For example, recent initiatives to provide activity trackers as  
242 part of health care (NHS England, 2019), health improvement (Yao et al., 2020) or health  
243 insurance (Buckle et al., 2020) may serve to increase the breadth of the population using the  
244 devices. The more initiatives and interventions utilising activity trackers, the more they could  
245 be adopted by individuals from underserved populations, such as older adults and those with  
246 lower incomes.

247

#### 248 **The issue of data access**

249 Finally, it is worth noting some of the challenges inherent in accessing data from consumer-  
250 grade activity trackers. To access data, researchers can establish an industry agreement with  
251 a relevant company (e.g. Fitbit or Garmin) whose terms of service for collecting research data  
252 are different from those governing commercial access (Hicks et al., 2019). While the specific  
253 manufacturers control access to the data repositories, the data remains the property of the  
254 individual user, therefore to access any data collected by the device, each individual user must  
255 consent and agree to share the data. Managing thousands, and possibly tens of thousands, of  
256 data sharing requests to individual users, and subsequently also having to manage their  
257 authorisation and access details, brings its own logistic challenges. The most effective  
258 approach is for participants to be directed to a project website which manages participant  
259 information, consent, and authorisation requests via the specific manufacturers API.  
260 Following successful authorisation, access codes for each user can be securely sent to the  
261 research team for subsequent processing. It is worth noting that, even with successful  
262 authorisation, there remain additional challenges. Authorisation is usually limited to a  
263 maximum of 12 months before the user must re-approve access, which may limit follow-up  
264 assessments in very large cohorts where direct contact with participants is limited. In

265 addition, it is users, not researchers, who define the scope of the data that can be accessed;  
266 therefore, users may allow access to all or only some of their data (e.g. only pulse rate, or  
267 step count, or some combination thereof), resulting in incomplete data sets. Additionally,  
268 most devices allow users to manually add activity to account for any activity not passively  
269 detected by the device (e.g. swimming or cycling). At present, it is unclear if such self-reported  
270 estimates affect validity. Most databases separate device collected (passive) data from user  
271 added (self-reported) data, meaning the research team have to make a decision regarding  
272 which should be regarded as the 'canonical' source of users' PA.

273

274 Clearly, these challenges are not trivial, and future research teams will require multi-  
275 disciplinary skills, including specialists in behavioural science, PA, data science, and software  
276 and web development to successfully manage such projects. Nevertheless, if accessed and  
277 interpreted appropriately, these data may allow understanding of PA behaviour at a scale  
278 previously unimaginable. We are in the process of using this method at a national level to  
279 understand the impact of coronavirus, but future research using this technique could examine  
280 worldwide PA patterns, both prospectively and retrospectively, using multi-site and multi-  
281 lingual research teams.

282

## 283 **CONCLUSIONS**

284 As with other device-based and self-report methods, we propose that consumer-grade  
285 activity tracker data be considered with their limitations in mind rather than dismissed as a  
286 flawed approach, particularly when the feasibility of large-scale accelerometry is prohibitive.  
287 Given the rising popularity of wearable activity trackers, the volume of data collected, and  
288 the possibilities in analysing data retrospectively, we believe data from wearable activity

289 trackers should be considered a viable PA measurement tool. To be clear, we are not  
290 advocating that other tools, particularly self-report methods, should be consigned to history  
291 or replaced by wearable activity tracker 'big data'. Quite the contrary, despite their limitations  
292 self-report methods have provided critical insights into PA behaviour and are likely to remain  
293 important in the future. Rather, our view is that if physical activity researchers, practitioners,  
294 and public health professionals can use and interpret self-report data in light of their  
295 limitations, the same should be possible for activity tracker data.

296

297

## 298 **LIST OF ABBREVIATIONS**

299	AAQ	Active Australia Questionnaire
300	API	Application Programming Interface
301	CHAMPS	Community Health Activities Model Program for Seniors
302	IPAQ	International Physical Activity Questionnaire
303	PA	Physical Activity
304	USNHIS	US National Health Interview Survey

305

## 306 **DECLARATIONS**

### 307 **Ethical Approval**

308 Not Applicable

309

### 310 **Consent for Publication**

311 Not Applicable

312



313 **Competing Interests**

314 None to declare.

315

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321 All authors contributed equally to the writing of this manuscript.

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