Waterford Active Schools Programme
- An Evaluation

A report compiled by Waterford Sports Partnership and the
Centre for Health Behaviour Research, Department of Health,
Sport and Exercise Science, Waterford Institute of Technology

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Introduction

Waterford Sports Partnership (WSP) is committed to encouraging and supporting the people of Waterford to participate in sport and physical activity (PA).

“Our mission is to plan, coordinate, enable, assist and develop quality opportunities with the people of Waterford to facilitate their participation in sports and physical activities” (WSP Mission Statement, 2007).

The Waterford Active Schools Programme (WASP), or the WASP programme, as it is known, was designed and implemented by WSP with the aims of increasing awareness in families of the importance of being active and making activity a natural part of daily living resulting in families being more active, more often.

This research report describes the findings of an evaluation of the WASP Programme conducted by WSP in collaboration with the Centre for Health Behaviour Research at WIT.

The four-week programme was piloted in January 2007 in seven primary schools. In September/October 2007, 18 Waterford primary schools took part in the research project following an invite to all primary schools in County Waterford. More than 2,300 children and their parents/guardians took part in the WASP programme at that time.

Why promote PA in children?

It is well established that, in children, PA can lead to improvements in both long and short-term physical and mental health (Hallal et al, 2006; Parfitt and Eston, 2005) and there is good evidence that it is beneficial for academic and cognitive performance (Strong et al, 2005; CDC, 2004). The energy expenditure associated with PA is important in combating overweight and obesity. It is important to establish healthy patterns of PA during childhood and adolescence, as PA tracks through to adulthood (Kelder et al, 1994; Hallal et al, 2006).
It is universally recommended that children participate in at least 60 minutes of moderate-to-vigorous PA (MVPA) daily (CDC, 2004). MVPA is a combination of moderate and vigorous PA; moderate activity is defined as any activity that involves sweating lightly and breathing somewhat harder than normal while vigorous activity is defined as activity that makes you sweat more heavily and breathe much harder than normal.

Why promote PA amongst adults (parents/guardians)?
The benefits of PA for adults are similar to those defined earlier for children. National PA levels have not increased substantially amongst adults in Ireland (Morgan et al, 2008). Irish adults remain in the lower third of European countries with respect to participation in moderate and vigorous activities (TNS Opinion and Social, 2006). Current PA guidelines (US Dept. of Health and Human Services (USDHHS), 2008) suggest that adults should achieve 150 minutes of moderate intensity physical activity per week to attain the health benefits of PA. Most recent Irish data (Morgan et al., 2008) indicates that 29% of the adult population do not meet minimum PA recommendations.

Why target families to promote PA?
The school is seen as an ideal setting to access families for family health promotion programmes. No other institution has as much continuous and intense contact with children in the first two decades of life (Peterson and Fox, 2007). In a review of physical activity interventions in children, Van Sluijs et al (2007) found strong evidence for the development of school based interventions including family involvement and multi components. Indeed research has found that the most successful PA intervention programmes are those that have multiple components, including aspects of physical education, opportunities for active breaks and advocacy from the family environment (Salmon et al, 2007). There is considerable support for the involvement of parents in interventions to increase PA in adolescents although the evidence is less conclusive for children (Van Sluijs et al., 2007). It was recommended in that review that more research is needed in the area, validating this proposed intervention to target the family unit in an effort to increase PA in children.
**Research Questions**

This report will answer the following research questions:

1. How physically active are the children in the participating schools before the intervention (described as timepoint M1 in this report), after 4 weeks of the intervention (M2), and 4 weeks after cessation of the intervention (M3), compared to those children who did not receive the intervention (control group)?

2. How physically active are the parents in the participating schools at M1, M2 and M3 compared to those parents who did not receive the intervention (control group)?

3. What are the attitudes to PA of the children and did the WASP programme change these attitudes?

4. What are the attitudes to PA of the parents and did the WASP programme change these attitudes?

5. Is there a difference in self efficacy between M1, M2 and M3 in the children, in the intervention and control group?

6. Is there a relationship between perceived and reported levels of PA in children and parents, in the intervention and control group?

7. How do children, in the intervention and control group, perceive their parental support for PA?

8. Is there a relationship between parental support and PA of children, in the intervention and control group?

9. Did the children enjoy the WASP programme?

**Methods**

Ethical approval for the research project was obtained from the WIT Research Ethics Committee. While all pupils in the 18 schools took part in the research project, measurements were conducted only on 4th class pupils (9.3 (±0.5) years; n=288), as this age group can generally accurately self-report (Baranowski et al., 1986). They were randomly assigned to an intervention group (151 children; 60.3% male, 39.7% female) or control group (137 children; 27.7% male, 72.3% female). It is interesting to note that the random assignment of pupils to the two groups resulted in a substantial compositional difference by gender. This gender imbalance will be addressed further in the analysis of results. There were relatively equal numbers of males and females in the intervention and control groups for parents (Intervention group – 35% male, 65% female; control group – 29% male, 71% female).
Overview of WASP Intervention

The WASP Programme was a 4 week programme led by Wizzy, the WASP mascot. Children were encouraged to accumulate 60 minutes of PA for five days a week, and parents were encouraged to accumulate 30 minutes of PA for five days a week. This activity was recorded on a record card and stickers were awarded by the teacher for both the child and adult once the recommended amount of activity was met. Each class was supplied with support resources including:

- Record card and Wizzy stickers
- Teacher and Parent letters including FAQs
- General activity posters:
  - Rainy Day Ideas Poster
  - Activities you can do on your own/with others
  - Wizzy Motivational Poster
  - How Active is my Teacher? Poster

Measurements

Measurements were made via questionnaire, before the intervention (M1), immediately post-intervention i.e. after 4 weeks (M2), and 4 weeks after cessation of the intervention (M3). The timeline is shown in Appendix 2 and measurements commenced on the Monday of the weeks shown. PA in children at each stage was measured using a 24 hour previous day PA recall questionnaire (PDPAR; Weston et al, 1997). This is a validated tool but, as with all self-report questionnaires, a major limitation is the honesty and accuracy of responses (Robson, 2008). Three readings were taken during class time, one on Monday (to account for activity on Sunday) and on the two following week days. The children also completed a 19 item previously validated attitudinal questionnaire. Parental questionnaires, modified from the SLAN survey (Morgan et al, 2008) were taken home by students and returned completed within three days.
Results

1. How physically active were the children in the participating schools at M1, M2 and M3 compared to those children who did not receive the intervention (control group)?

At M1, the children, in both the intervention and control groups, were very active with high baseline levels of PA (>80 mins of moderate to vigorous PA(MVPA)/day). Notably the intervention group had an MVPA of 113.5 minutes versus an MVPA of 83.9 minutes for the control group. This difference in baseline MVPA may be due to the gender imbalance in the intervention and control group; there was a higher proportion of males in the intervention group. It has been shown that males are more active than females, throughout childhood and adolescence (Riddoch et al., 2004).

At both M2 and M3 there was a decrease in MVPA for both intervention and control groups. The observed decrease in PA over the measurement period may possibly be due to a seasonal effect (the intervention ran during September and October 2007). While the accumulated decline from M1 to M3 in % MVPA between the intervention and control groups was almost the same it is possible that the intervention delayed the inevitable decline in the intervention group due to seasonal factors - the decrease at M2 was considerably smaller in the intervention group (2.4%) than in the control group (16%).

Table 1:
Percentage changes in MVPA between the stages for intervention and control groups.

<table>
<thead>
<tr>
<th></th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
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<tr>
<td><strong>Intervention Group –</strong></td>
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<tr>
<td>MVPA (mins/day)</td>
<td>113.5</td>
<td>110.8</td>
<td>88.9</td>
</tr>
<tr>
<td>% change between phases</td>
<td></td>
<td>-2.4%</td>
<td>-19.8%</td>
</tr>
<tr>
<td><strong>Control Group –</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MVPA (mins/day)</td>
<td>83.9</td>
<td>70.5</td>
<td>63.9</td>
</tr>
<tr>
<td>% change between phases</td>
<td></td>
<td>-16%</td>
<td>-9.4%</td>
</tr>
</tbody>
</table>

Note: 60 min/day is the recommended amount of PA/day for children (CDC, 2004)
This initial analysis would suggest the WASP programme had limited impact. However, a more detailed analysis involving categorising the children at M1 into least active, mid range and most active revealed a notable increase in the PA levels of the least active children between M1 and M2 in the intervention group (Figure 1). Within this study, children in this least active category are the primary target group as their baseline MVPA levels are less than the recommended guidelines. This increase, in the least active group, was not replicated in the control group (Figure 2).

**Figure 1:**

*Changes in Physical Activity in Baseline Physical Activity Groups in the Intervention Group*

*Indicates significance P<0.05 for M1 to M2

**Indicates significance P<0.05 M2 to M3*
As illustrated in Figure 3, the initial increase between M1 and M2 in the least active intervention group was not maintained between M2 and M3.

Figure 2:
Changes in Physical Activity in Baseline Activity Groups in the Control Group

Figure 3:
Changes in Physical Activity in the least active group—Intervention and Control
Gender analysis of changes of MVPA illustrates a slight increase in PA in boys in the intervention group (between M1 and M2) and a consistent decrease in PA of boys (*Figure 4*) in the control group, between M1 and M3. There was a consistent decrease in PA in girls in both the intervention and control group (*Figure 5*). The sharp decline in PA of girls in the intervention and control group may be due to the possibility that they might feel the seasonality effect more profoundly than boys. The intervention may have been successful in delaying this effect amongst boys in the intervention group.

**Figure 4:**
Boys MVPA at M1, M2 and M3 for the Intervention & Control Groups

*Indicate significance P<0.05 for M1 to M3
**Indicates significance P<0.05 M2 to M3*
The increase in MVPA, between M1 and M2, in the least active group is primarily due to the significant change in the boys group (Figure 6). There was a less substantial change in the girls group during the same time period. It is evident that boys, particularly the least active boys, demonstrated the greatest positive changes in PA after their involvement in the WASP programme.

Figure 6:
Change in MVPA in least active boys and girls group

*Indicates significance P<0.05 for M1 to M2
2. How physically active are the parents in the participating schools at M1, M2 and M3 compared to those parents who did not receive the intervention (control group)?

At M1, parental PA was high (between 65-70 MVPA) in both the intervention and control groups, i.e. greater than the recommended 30 minutes per day. There was little difference in baseline PA between the intervention and control group for parents perhaps due to the more equal gender distribution in each group. Parent’s PA (MVPA) did increase (+14.3%) during the programme for those in the intervention group (Figure 7). Four weeks following the programme (M3) these levels had dropped (-11.2%) but importantly, the MVPA of the intervention group was still noticeably higher than the control group.

**Figure 7:**
MVPA in parental Intervention and Control Groups

* Indicates significance P<0.05 M2 to M3
3. What were the attitudes to PA of the children and did the WASP programme change these attitudes?

At M1, approximately 95% of the intervention and control group enjoyed being physically active and less than 3% of both groups felt that PA was boring. Indeed, at M1, attitudes to PA were very positive in both the intervention and control group. For example, approximately 83% of both groups stated that they would like to try new sports and 60% indicated that they would be active as adults. Furthermore, 77% of both groups (intervention and control) indicated that they got sufficient exercise. At M1, there were no visible differences in attitudes to PA between the activity groups (least/mid/most). At M2 and M3, enjoyment of being active was consistent with M1, similar findings were noted for trying new sports, getting sufficient exercise and feeling PA is boring (intervention and control group). Among all children (intervention and control group), the belief that they would be active as adults increased between M1 to M2; 60% felt that they would be active as adults at M1, this increased to 67% at M2. In the intervention group at M3, 72% of the children felt they would be active as adults.

4. What were the attitudes to PA of the parents and did the WASP Programme change these attitudes?

Parental attitudes to PA were generally positive at all stages, with similar responses for the intervention and control groups. Parents in both groups were visibly aware of the benefits of being physically active; at M1, 84% of the intervention and 86% of the control group stated that more PA would improve their health. These statistics were replicated at M2 and M3. Similarly, high rates (88% approx) of parents, in both groups, reported that they could do more PA if they wanted to at M1, M2 and M3. There were no significant changes in attitudes between the different stages. The most commonly cited barriers to PA reported by parents were demands of a young family and lack of time (>40% of parents). This is consistent with the results of the latest SLAN survey where 39% of men and 44% of women reported “no time” as the main reason for their inactivity (Morgan et al., 2008). Post intervention, significantly fewer parents in the intervention group compared to the control group (i.e. 45.1% versus 66%) reported lack of time as a barrier to them being physically active.
5. **Is there a difference in self efficacy between M1, M2 and M3 in the children, in the intervention and control group?**

Self efficacy is defined as the belief or confidence in one’s ability to be active in different situations (Marcus et al, 1992). Following the intervention, children felt more confident in their ability to exercise, i.e. their self-efficacy increased from M1 to M2 to M3 in the intervention group while the trend was less consistent in the control group. The least active children benefited most from the programme, according to the self efficacy scale. Self efficacy increased by nearly 4% in the least active group over the first measurement period and a further 15% thereafter. This is a very important finding although it was not translated into an increase in physical activity between M2 and M3.

6. **Is there a relationship between perceived and reported levels of PA in children and parents, in the intervention and control group?**

At M2, 89% of children stated that they did more activity to get Wizzy stickers. This was not manifested in actual PA levels as there was a minimal (approximately 2 minute) increase in PA among these children, at M2. This represents a lack of consistency between reported and perceived levels of PA. Analysis of the least active group at M2 does show a more positive relationship between perceived and actual PA levels. The least active children in the intervention group who felt that they increased their PA levels did show an approximate 30 minute increase in actual PA. This relationship was not sustained at M3. Indeed at M2, over 70% of children indicated that they would still be active in six months but all groups reported a subsequent decrease in actual PA levels.

Forty-eight percent of parents in the intervention group reported doing more activity as a result of the programme and did demonstrate an increase in actual PA of 18 minutes, between M1 and M2. Furthermore, parents who stated that they did not increase their PA levels showed no change in their actual PA, indicating uniformity between reported and perceived levels of PA. Of those who did do more activity, 54.2% intended to keep up that level, at M2.
Analysis of reported PA levels indicated that this intention was not transferred to actual PA between M2 and M3; actual PA decreased in this group by approximately five minutes. Parents who indicated or perceived that they did maintain their PA levels at a high level at M3, demonstrated an overall increase in actual reported PA levels (9.5 minute increase) between M1 and M3. This increase in PA, in minutes, was not apparent amongst parents who felt they did not maintain higher PA levels at M3.

Overall, this suggests that both parents and children do perceive that they have increased their own PA levels and are confident that that they will be able to keep it up although this is not always manifested in actual PA levels.

7. How do children, in the intervention and control group perceive their parental support for PA?

Children reported increased support from parents for PA after the intervention. For example, at M1, 47% of children in the intervention group felt their parents encouraged them to be active, this increased to 55% at M2 and 51% at M3; an overall increase that was also apparent in the control group. Also, at M1, 29% of children stated that they were active with their parents, this increased to 40% at M2 and 43% at M3; this was not replicated in the control group. Lastly, at M1, 38% of children reported that their parents watched them being active, this increased to 43% at M2 and 47% at M3. A less substantial increase was also evident in the control group. The increase in parental support apparent in the intervention and control group may be due to parents becoming more aware and sensitive to their position as role models for PA as they answered questions related to this concept at three different intervals. It is also common for participants to provide answers that they feel are morally correct when completing questionnaires (Dale et al., 2002).
8. **Is there a relationship between parental support and PA of children, in the intervention and control group?**

Social support was found to have a positive influence on the children’s PA levels. Children who enjoyed PA also received higher levels of parental encouragement and tended to have more active families than those who did not. For example, 53% of the intervention group reported doing PA with a parent almost or every day at M1. This was maintained at M2 (52%) and increased to 60% at M3. At M2, being active with parents was complimented by an increase in actual PA levels in the least and mid active group; this was not maintained at M3. Similarly, at M2, least active children who stated that they did activities with their parents reported an approximate 30 minute increase in PA. However, in the control group these responses were 31% at M1, declining to 26% at M2 and 27% at M3. Immediately after the intervention (M2) 50% of parents reported being active with their child more than three times a week. Four weeks following the intervention (M3) this figure fell to 34.5%. These results suggest that the intervention had an immediate effect (at M2), in increasing PA and parental support for PA. However, these changes were not maintained at M3.

9. **Did the children enjoy the WASP programme?**

Results from the process evaluation of the programme were very positive; over two-thirds of children said they definitely enjoyed WASP, and 58% said they would definitely like to do another programme like WASP. Almost two-thirds of parents felt that they benefited from the programme. A majority of parents (89%) thought their children were more active as a result of the programme. When asked to rate the programme 43.3% of parents said excellent and 43.3% rated it good. It was also noted that only 5% of children in the intervention group stated that they didn’t enjoy the programme, 19% stated that they would prefer to watch TV or play computer games and only 10% reported that their parents did not want to participate in PA with them.
Summary
The WASP programme aimed to increase awareness in families of the importance of being active and make activity a natural part of daily living resulting in families being more active, more often.

The main findings from the research were...

1. Overall the evaluation found that there was a decrease in the PA levels of children in both the intervention and control group from M1 to M2 to M3. There are a number of factors that may have impacted on this result including:
   - High M1 MPVA - it should be noted that the children’s M1 levels of PA were very high. For all but the least active tertile of children, PA levels were above recommended levels at all time points.
   - Seasonality - the darker evenings from September to November may have impeded opportunities for children to be active outdoors.
   - Gender Split – the random assignment of pupils to intervention and control groups resulted in a substantial compositional difference in the two groups. There was a higher proportion of males in the intervention group, leading to higher levels of MVPA in this group at M1.

2. The least active children in the intervention group increased their PA levels between M1 and M2 suggesting that the WASP programme was successful in increasing PA levels in the least active children for the duration of the programme; this was particularly apparent amongst the least active boys. This is a very important finding, as this is the group of children most in need of intervention, and the group which is traditionally hardest to reach in interventions of this type.

3. Parent’s PA increased during the programme for those in the intervention group. Four weeks following the programme these levels had dropped but the MVPA of the intervention group were still noticeably higher than the control group.
4. Another important finding was that the children's self efficacy for PA increased in the least active group from M1 to M2 to M3. This suggests that the programme was successful in increasing the confidence to be active in this particular group.

5. Parental support was found to have a positive influence on the children’s PA levels. Children who enjoyed PA also received higher levels of parental encouragement and tended to have more active families than those who did not. At M2, the least active children in the intervention group who stated that they did activities with their parents reported an approximate 30 minute increase in PA.

6. The role of parents is vitally important. The WASP programme indicated that parental PA can be positively influenced via the child, as well as vice versa. This is evidence to support this family approach and suggests scope to possibly develop the programme in schools and communities in Ireland.

7. Although parents and children commonly perceived that they had increased or maintained their PA levels, this was not always consistent with actual changes in PA. However, once more in the least active group, their perceived increase in PA was consistent with a 30 minute increase in actual PA.

8. Children did enjoy the programme; over two-thirds of children said they definitely enjoyed WASP, and 58% said they would definitely like to do another programme like WASP. Parents also were complimentary about the programme; over 90% rated the programme as excellent or very good.
Recommendations

Following the WASP Programme evaluation and the analysis of national and international data on physical activity interventions, the following recommendations are proposed:

- The current 4 week WASP Programme was successful on many levels and should be used again for future interventions. Of particular interest is the fact that the programme was particularly successful with children who were least active and this group are the most important target group for interventions of this type.

- There may be a need for changes in the community and/or school environment to help maintain initial increases in PA that have been detected in this study. While WASP is a useful short term intervention, multiple and regular reminders and prompts are likely to be necessary to maintain PA habits. For sustained behaviour change, schools and communities must create and maintain environments that support health behaviour otherwise impacts could be lost. As well as curricular exposure to sport and PE in schools the physical environment of both schools and communities is also very important. Alternative activities and resources could also be identified for times of the year when PA levels are lowest.

- The evaluation raised a number of interesting questions suitable for further research including:
  - What is the effect of seasonality on short term PA programmes such as WASP?
  - Does the gender of the participant have an impact on the response to a programme such as the WASP?
  - How great is the effect of Parental PA levels on levels of PA of their children?
References


Appendix 1

WASP Control Schools

1. **Faithlegg N.S.**, Faithlegg, Co. Waterford
2. **Glenbeg N.S.**, Glenbeg, Dungarvan, Co. Waterford
3. **Our Lady of Mercy N.S.**, Military Road, Waterford
4. **S.N. Baile Mhic Airt**, Baile Mhic Airt, An Sean Phobal, Dún Garbhán, Co. Phort Lairge
5. **Scoil An Bhaile Nua**, Newtown, Kilmacthomas, Co. Waterford
6. **Scoil na bhFíodh**, Fews, Kilmacthomas, Co. Waterford
7. **Villierstown N.S.**, Villierstown, Cappoquin, Co. Waterford
8. **Whitechurch N.S.**, Cappagh, Co. Waterford

WASP Intervention Schools

1. **Ballycurrane N.S.**, Clashmore, Co. Waterford
2. **Kill N.S.**, Kill, Kilmacthomas, Co. Waterford
3. **Kilmacthomas Primary School**, Kilmacthomas, Co. Waterford
4. **Knockmahon N.S.**, Bunmahon, Co. Waterford
5. **Mount Sion Primary School**, Barrack Street, Waterford
6. **Our Lady of Mercy N.S.**, Stradbally, Co. Waterford
7. **Passage East N.S.**, Crooke, Passage East, Co. Waterford
8. **Rathgormack N.S.**, Carrick-on-Suir, Co. Waterford
9. **Scoil Gharbháin**, Clais na Lachan, Dún na Mainistreach, Dún Garbhán, Co. Phort Lairge
10. **St Mary’s N.S.**, Grange, Via Youghal, Co. Waterford
Appendix 2

Intervention Timeline

January 2007
Pilot conducted in 7 Waterford schools

June 2007
Invitation Letter to all 78 schools in Waterford City and County to participate in the WASP programme

September 2007
Random selection of schools to intervention or control group. (10 intervention; 8 control groups)
Explanatory meetings held with nominated schools co-ordinators

M1
Collection of baseline data (M1):
Fourth Class Questionnaires
Parental Questionnaires

October 22nd 2007
M2
Post-intervention data collection (M2)

November 19th 2007
M3
Four week post intervention data collection (M3)
Appendix 3

List of Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CDC</td>
<td>Centre for Disease Control and Health Promotion</td>
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<td>CHBR</td>
<td>Centre for Health Behaviour Research</td>
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<tr>
<td>FAQ</td>
<td>Frequently Asked Questions</td>
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<td>HSE</td>
<td>Health Service Executive</td>
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<td>ISC</td>
<td>Irish Sports Council</td>
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<tr>
<td>MVPA</td>
<td>Moderate &amp; Vigorous Physical Activity</td>
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<td>PA</td>
<td>Physical Activity</td>
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<td>PDPAR</td>
<td>Previous Day Physical Activity Recall</td>
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<td>PE</td>
<td>Physical Education</td>
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<td>SLAN</td>
<td>Survey of Lifestyle, Attitudes and Nutrition in Ireland</td>
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<td>Taylor Nelson Sofres</td>
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<td>United States Department of Health and Human Services</td>
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