Ontario's School-based HPV Immunization Program: School Board Assent and Parental Consent

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ABSTRACT

Objective: To evaluate the implementation of Ontario's publicly-funded, school-based HPV immunization program through a process evaluation.

Participants: The immunization program targets grade 8 females. Ontario vaccine-preventable disease managers were the key informants for this evaluation.

Setting: Ontario, Canada.

Intervention: Ontario's Public Health Units (HUs) are responsible for the local implementation of the immunization program. The process evaluation involved a telephone-based, semi-structured questionnaire which included questions on stakeholder engagement; school and school board participation; communication strategies; and processes for obtaining informed consent.

Outcomes: All 36 HUs participated; 16 (44%) reported difficulties receiving agreement from local school boards to administer HPV vaccine in schools. Two Catholic school boards have not permitted HPV vaccine clinics in their schools: 1 only during the first year and 1 in the second and third years. All HUs request parental consent for students to receive the HPV vaccine and 5/36 also request or encourage student consent; 14 HUs indicated they would immunize a grade 8 girl at a school clinic, in the absence of parental consent, if the student requested immunization and was judged capable of providing informed consent.

Conclusion: Many HUs reported challenges in receiving support from local school boards. Despite this, vaccine clinics have been offered in all but 2 public school boards since 2007. All HUs request parental consent before HPV immunization at school-based clinics; 39% would consider immunizing in absence of parental consent. The results of this process evaluation will inform the HPV immunization program evaluation that is currently underway in Ontario.

Key words: Human papillomavirus vaccines; school health services; adolescent health services; public health practice; vaccination

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2012;103(1):34-39.

Data from large clinical trials have shown that HPV vaccine can substantially reduce genital warts, cervical cytologic abnormalities and diagnostic and therapeutic cervical procedures when administered to pre-adolescent and adolescent girls.[1,2] Although modeling studies suggest that HPV immunization is cost-effective,[3-5] it remains a costly intervention. Given the expense of the vaccine series and its uniqueness, both in terms of a single gender approach and the availability of a secondary prevention strategy, it is essential that HPV immunization programs be evaluated in their local contexts.

In August 2007, the province of Ontario announced plans to implement a publicly-funded, school-based HPV immunization program using Gardasil® vaccine beginning in the 2007-2008 school year. The Ontario program is locally administered by its 36 public health departments (Health Units [HUs]). Grade 8 girls (approximately 13 years of age) are eligible for publicly-funded vaccine using a 3-dose schedule administered over a 4 to 6 month period. The provincial program targets a single grade cohort and a catch-up component was not included. However, if a grade 8 girl receives at least one dose, she may complete the vaccine series in grade 9. This is referred to as "extended eligibility".

Ontario is Canada's most populous province, with an ethnically diverse population of approximately 13 million.[6] Ontario's school boards are responsible for supervising the operation and financial management of publicly-funded schools.[7] There are 4 categories of publicly-funded school boards: English-language non-Catholic (31 boards), English-language Catholic (29 boards), French-language non-Catholic (4 boards), and French-language Catholic (8 boards) resulting in 2,851 public elementary schools; additionally there are 456 private schools.[8] In 2008, there were approximately 81,000 13-year-old girls in the province.[9]

The Health Care Consent Act[10] provides the legislative basis for the requirements of informed consent to treatment in Ontario. Although there is no minimum age for consent, traditionally schools request or require parental consent and parents expect to

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Acknowledgements: We thank the VPD managers of all 36 Ontario Health Units who provided the valuable feedback that comprises this evaluation; the members of the Ontario HPV Prevention Evaluation Committee for their helpful comments; Christine Heidebrecht for her helpful comments on the description of the study's methodology; Dr. Judy MacDonald for providing HPV vaccine coverage data from Calgary, Alberta; and Pam Sethi for her assistance with data entry.

Conflict of Interest: None to declare.

provide consent for childhood and adolescent immunizations. Local HUs are responsible for developing the informed consent materials for school-based programs.

Prior to HPV vaccine introduction, both hepatitis B (since 1994) and meningococcal conjugate (since 2005) vaccines were offered to grade 7 students in Ontario through HU-delivered school-based programs. All three programs are voluntary. Ontario's coverage among its school-based hepatitis B and meningococcal conjugate vaccine programs is high at 80% and 86%, respectively, in the 2007-2008 school year.[11] Coverage for the HPV vaccine (series completion) for the first year of the program (2007-2008) was 51%.[12]

There were a number of important contextual considerations relevant to the program's initial implementation. There was considerable media interest surrounding Gardasil's® introduction, including a cover story in a popular national news magazine entitled "Our girls aren't guinea pigs" on August 27, 2007.[13] On September 13, 2007, a public letter was issued on behalf of the Ontario Conference of Bishops regarding "HPV inoculation in Catholic schools".[14] This letter stated that the "Bishops of Ontario regret its [HPV vaccine's] introduction without further opportunity for thorough study of all the effects of this program". It also requested that Catholic school board officials include the letter in any information package parents were to receive regarding the program. Finally, there was a provincial general election in October 2007, which delayed the provincial communications strategy to promote the new vaccine program. The Election Finances Act in Ontario prevents the promotion of public policies and programs once an election has been called.[15]

As part of a comprehensive HPV immunization program evaluation, a process evaluation was undertaken to examine the process of program planning, implementation and delivery and to provide important contextual information for future outcome evaluations. The objectives were to identify the strengths and challenges associated with the implementation of Ontario's school-based HPV immunization program, as expressed by managers of Ontario's HUs who are responsible for local program delivery. Highlights of the most salient findings from the comprehensive process evaluation are reviewed here.

METHODS

Development of the questionnaire

A semi-structured questionnaire was developed based on school-based immunization program logistics and operations in Ontario. The questionnaire consisted of a mix of open- and close-ended questions (Table 1). With the exception of a question that asked for managers' opinions about the program's strengths and challenges, the purpose of the open-ended questions was to ask about processes used in implementing specific aspects of the program. For example, HUs were asked about strategies used to address challenges with local school boards; processes for identifying non-mainstream school attendees; and processes for obtaining informed consent. The questionnaire was pilot tested with the first two respondents, resulting in only minor modifications to the language used in the telephone administration of the questionnaire; these interviews were included in the final analysis. The Alberta Research Ethics Community Consensus Initiative (ARECCI) ethics screening tool[16] was used but a formal ethics review was not sought as this project was judged to be a component of program evaluation rather than research.

Table 1. Selection of Questions From Process Evaluation Questionnaire

Stakeholder engagement prior to program rollout
- Did you engage local school boards prior to the rollout of the HPV immunization program?
- Did you experience any difficulties in receiving agreement from the school board(s) in your area to administer the HPV program in schools?
- If yes, with which school board(s) did these challenges arise?
- If yes, what were the reasons cited by the school board(s)?
- If yes, what process or strategy was used to address challenges with the school boards in your area?

Background on schools and school boards
- How many school boards fall within the area your HU serves?
- How many schools fall within the boundaries of your HU that have grade 8 girls enrolled?
- In how many schools do you implement your HPV immunization program?
- If you administer the program in fewer than 100% of schools, which schools do not participate?
- Does your HU send materials home to parents and guardians indicating how they can access publicly funded HPV vaccine, if you are not permitted into the school to administer a school-based HPV clinic?

Identifying the program's target population
- How does your HU identify non-mainstream school attendees in order to offer them publicly funded vaccines normally given in school-based clinics? For example, private and alternative schools, home schoolers, girls not attending school.
- How does your HU target non-mainstream school attendees to receive HPV immunization?

Consent
- What processes do you use to obtain consent for HPV immunization? Please describe.
- How does your HU deal with scenarios where an eligible grade 8 girl is interested in being immunized against HPV at a school clinic but where parental consent has not been obtained?

Communication strategies
- Does your HU translate any HPV communication materials into languages other than English?
- Are the girls who comprise the eligible cohort each year the target of any specific communication material from your HU sent through the school?
- Do grade 8 boys also receive material on HPV?

General
- Do you have any other comments on the strengths or challenges associated with the implementation of the school-based HPV immunization program that have not been covered in this questionnaire?

Telephone interviews

The Vaccine Preventable Disease (VPD) managers of Ontario's HUs were invited to participate in a telephone-based interview via an e-mailed letter of invitation. Non-responders were followed up by telephone. In large HUs with more than one VPD manager, the manager most involved in the program was asked to participate. Those who declined the telephone-based interview could complete a self-administered paper questionnaire. Interviews were completed between February and April 2010 by one interviewer (SW), who made notes throughout each interview; the interviews were not audio-recorded. Each respondent was provided with a copy of the completed questionnaire, populated with data and short quotations, and had an opportunity to provide corrections as a validation method. Only the revised questionnaires contributed to the analysis.

Relationship between authors and key informants

At the time of the survey, there were no direct employment or reporting relationships between the coauthors and the survey respondents.

Table 2. School Board Acceptance of the HPV Vaccine Program

Vaccine Program Characteristic	Ontario HUs n (%)
Difficulties in receiving agreement from local school board(s) to administer HPV vaccine in schools (n=36)	
Yes	16 (44%)
No, but encountered difficulties in implementation	8 (22%)
No	12 (33%)
School board(s) listed as reluctant to participate (n=16†)	
English-Catholic	12 (75%)
English-Public	1 (6%)
French-Catholic	1 (6%)
French-Public	0 (0%)
Multiple school boards	2 (12%)
Reasons cited by school boards if reluctant to participate* (n=16†)	
Belief that vaccine will lead to promiscuity	12 (75%)
Vaccine program contrary to religious beliefs	8 (50%)
Concerns regarding program's communication materials	2 (12%)
Confidentiality concerns	1 (6%)
Safety concerns	1 (6%)
Too little time to implement	1 (6%)
Strategies or events that may have positively influenced school board participation in the program* (n=14‡)	
Communication from Ontario Conference of Catholic Bishops	6 (43%)
Meetings between school board officials and Medical Officer of Health	3 (21%)
Revising content of informed consent materials	3 (21%)
Education on vaccine benefits and safety	2 (14%)
Emphasized requirement for parental consent	1 (7%)

* >1 response identified by respondents.
† The denominator (n=16) refers to HUs who encountered difficulties with local school boards.
‡ The denominator (n=14) refers to HUs who encountered difficulties with local school boards but who did not have the experience of an entire school board declining the program.

Table 3. Median Number of Schools Within Ontario's 36 HUs

School Category	Median (Range)
Non-Catholic public schools	33 (9-186)
Catholic public schools	18 (4-172)
Independent (private) schools	12 (0-72)
Total number of schools where program implemented	55 (15-430)

Table 4. School Participation and Methods to Reach Non-attendees Within Ontario's HUs

Vaccine Program Characteristic	Ontario HUs (N=36) n (%)
100% local school participation in program	
Yes	17 (47%)
No	19 (53%)
Formal mechanisms for identifying home-schooled students	
Yes	13 (36%)
No	23 (64%)
Mechanisms in place for identifying eligible girls not attending school	
Formal mechanism through social service agencies	13 (36%)
Formal mechanism through physicians in the case of chronic illness	2 (6%)
Informally through opportunistic visits at sexual health clinics	5 (14%)
Informally through client contacting the HU	3 (8%)
No formal or informal mechanism exists	12 (33%)
No response	1 (3%)
Opportunities for students attending non-participating schools to access vaccine*	
Immunization clinic at HU	33 (92%)
Referral to an immunization clinic at a nearby school	10 (28%)
Sexual health clinic operated by HU	19 (53%)
Release of vaccine to healthcare provider	6 (17%)
No response	3 (8%)

* >1 response identified by respondents.

Data management and analysis

Quantitative and categorical data were summarized with descriptive statistics (medians, percentages) using Microsoft Excel software. Data from the open-ended questions were organized into categories using NVivo software. One author (SW) conducted the data analysis and several meetings were held with the coauthors to discuss the preliminary findings. The preliminary results were presented at a teleconference attended by all Ontario VPD managers, as a further method of validation. The structure of this validation exercise involved a presentation of preliminary findings followed by the opportunity for questions and discussion.

RESULTS

All 36 (100%) of Ontario's HUs participated; 33 (92%) were interviewed by telephone and 3 (8%) completed a self-administered questionnaire. Five managers (14%) provided minor corrections to their individual questionnaire. No changes were made to the evaluation's findings following the teleconference with key informants.

School board engagement

All HUs in Ontario reported engaging with local school boards in advance of the program's introduction. However, 13 (36%) qualified this by indicating their engagement was "limited" or "minimal" or that it did not occur through face-to-face meetings. Sixteen of 36 HUs (44%) reported difficulties in receiving agreement from local school board(s) to conduct the program in local schools (Table 2). There was no statistical association between HUs who reported limited engagement and those who experienced challenges receiving support for the program. Among the aforementioned 16 HUs reporting difficulties, the school board most commonly cited as the board that posed challenges was the local English-language Catholic school board (12/16, 75%). The most common responses cited by managers as the cause for school-board reluctance were: concerns that the vaccine would lead to promiscuity (12/16, 75%) and the perception that the vaccine program was in conflict with religious beliefs (8/16, 50%) (Table 2). Since the program's introduction, 2 HUs have each had an entire English-language Catholic school board refuse HPV immunization clinics within their schools. In the first year, a Catholic school board (23 schools) in one HU did not permit school-based HPV immunization clinics. The decision was reversed by the board and clinics have been held since year two. In another HU, a different English-language Catholic school board (40 schools) participated in year one but has not permitted school-based HPV immunization clinics in years two and three. Eight HUs (22%) described other challenges with school

boards in program implementation which related either to the letter that was sent to parents in the Catholic school system from the Ontario Conference of Catholic Bishops,[14] or the content of consent forms and supporting communication materials.

The HUs that described difficulties in receiving school board support described strategies used to address these challenges. Three HUs described making changes to the program's consent form and other communication materials, either by collaborating with local school boards, or by removing certain phrases that were of concern. For example, one manager described replacing the phrase "sexual transmission" with "person to person" transmission. Another manager described producing one informed consent form for the English-language Catholic school board and another for other boards in order to resolve issues about the content of the consent materials. Of the 14 HUs without the experience of having an entire school board not participate, 6 described the letter from the Ontario Conference of Catholic Bishops as the event with the largest impact on Catholic school boards' acceptance of the program (Table 2). The letter promoted participation by the boards because it emphasized that the decision to immunize is the responsibility of the parent and, by implication, not that of the school board.

Table 5. Representative Quotations Regarding Program Challenges

Theme 1: Rapid program implementation (n=12)
"If we go back to the beginning-it wasn't something that we were expecting and weren't prepared to implement the program when it was announced."
"It is extremely difficult to implement a program in 6 weeks."
"Now doing a lot of damage control—because of the rushed implementation in the first year."
"Difficulty with the provincial campaign is not getting things in a timely matter... "The first year it was so political it was hard for Health Units to respond without Ministry supporting materials."
Theme 2: Challenges inherent to school-based immunization programs (n=10)
"We get clinics cancelled because of other school activities without receiving notices, for example, sometimes we go into the school and the group is gone on a field trip, or arrive at the school and the school realizes that they haven't sent out a consent form and so we can't proceed with immunization."
"It's challenging to have to return to a school three times in one year. Although the schools have been very cooperative—it is a challenge for them as well… to schedule these clinics for us to come in… and to take over a gym etc. for the clinic."
"You can only give so many immunizations in the janitor's closet….. We have advocated for appropriate space within schools… otherwise we will not immunize at the school."
"We use the schools too much to implement immunization programs…..we take quite a bit of time from the schools without giving anything back."
Theme 3: Program's eligibility requirements (n=8)
"Parents in the Catholic system tend to wait until the student has transferred to the high school level before calling us to arrange for the HPV series."
"It's difficult to say no to students who have missed out on the vaccine because they did not accept in grade 8 and are no longer eligible."
"It seems unfair to many in the community that the program doesn't allow girls to still access the vaccine if parents change their mind about the vaccine."
"We frequently receive calls from parents who want the vaccine for their grade 9 daughter but unfortunately many are not eligible because they didn't begin in grade 8."

Schools and methods to reach non-attendees

There is considerable variability among HUs; the number of schools with eligible students within a HU varied substantially from 15 to 430 (Table 3). In 22 HUs (61%), local schools are represented by at least 4 publicly-funded school boards; private or independent schools are in addition to this. HUs also vary widely in geography and population density.

In 19/36 HUs (53%), fewer than 100% of schools agree to have the local HU immunize students against HPV through school-based immunization clinics, including the one HU where the Catholic board currently does not participate (Table 4). The schools that declined HPV immunization clinics were described as small independent schools; these often had a religious affiliation. Many managers remarked that most non-participating schools allowed other school-based immunization programs. Seven (37%) HUs indicated they were not permitted to send their usual program materials indicating eligibility for publicly-funded HPV vaccine home through non-participating schools. Two of the seven addressed this by mailing information to students' home addresses. Two others, in consultation with non-participating schools, drafted alternate communication products that were distributed to students. Within Ontario's sole non-participating school board, materials regarding HPV vaccine eligibility and material prepared by the board on the importance of sexual abstinence are given to eligible students to take home in a sealed envelope. All HUs responding to the question (n=33) indicated that girls attending non-participating schools can access the vaccine through the HU's clinic location(s).

HUs described how they identify eligible girls not attending school, including home-schooled students, in order to reach this population. Thirteen HUs (36%) had mechanisms to send materials indicating HPV vaccine eligibility to home-schooled students through either schools or school boards (Table 4). The remaining HUs rely on parents of home-schooled students to arrange for their daughter to be immunized at the HU's immunization clinic. Thirteen (36%) HUs described formal partnerships with social service organizations or youth correctional facilities as methods for identifying eligible girls not attending school. Twelve (33%) said they either had no mechanism to reach this group or that they specifically do not attempt to reach this group. One HU indicated that due to the program's eligibility criteria, attempts to actively seek out girls not attending school through youth clinics or shelters are not made because they would "also find older girls who are not eligible for the vaccine".

Procedures for consent and communication strategies

All 36 HUs request written parental consent before HPV immunization in schools. Five (14%) also encourage student consent (i.e., a consent form that requests both parent and student signatures). Fourteen HUs (39%) indicated they would consider immunizing a grade 8 girl at a school clinic in the absence of parental consent if the student requested the vaccine and was judged capable of providing informed consent.

Two HUs, representing 24% of Ontario's population, send home communication materials that are translated into languages other than English or French; four use other strategies to address language barriers. The Ontario Ministry of Health and Long-Term Care website provides HPV vaccine fact sheets, but not informed consent forms, in 24 languages. Nineteen HUs (53%) described sending HPV communication materials to grade 7 female students and their families, often at the time of the final dose of the hepatitis B vaccine. The majority of HUs (33/36, 92%) do not target grade 8 boys with

any HPV-related communication products or strategy. Providing in-class HPV education is not a program requirement, however 8 HUs (22%) hold these sessions; only 1 indicated that boys also attend.

Perceived program strengths and challenges

Seven HUs provided views on the program's strengths; 3 mentioned the provincial communications campaign, 2 indicated the extension of vaccine eligibility into grade 9, and a further 2 described the ability to coordinate with other school-based immunization programs.

Twenty-five VPD managers described challenges they perceived were significant. The most common responses fell into one of three themes: rapid program implementation (n=12, 48%); challenges associated with school-based immunization programs (n=10, 40%); and the program's finite eligibility requirements (n=8, 32%) (Table 5).

DISCUSSION

School-based vaccine delivery, in contrast to physician delivery, is regarded as the optimal platform to achieve high coverage for adolescent immunization.[17-19] Benefits of school-based programs include peer support at the time of immunization[20] and reductions in socio-economic gradients in vaccine coverage.[19] Canada has a history of voluntary school-based adolescent programs for hepatitis B and meningococcal vaccines, which have been successful in achieving high coverage.[11,17] Unsurprisingly, preliminary reports from other provinces have revealed that HPV vaccine coverage varies markedly between participating and non-participating school boards, even if students attending non-participating schools can access free vaccine in alternate sites. The Calgary Health Region has reported that, depending on grade, HPV vaccine series coverage was 18-22% for eligible students attending schools or school boards where school-based HPV immunization clinics were not provided even though they could access vaccine through community-based clinics. This is as compared to vaccine coverage of 70-72% among eligible girls attending participating schools (ref. 21, and personal communication, Dr. Judy MacDonald, Medical Officer of Health for Calgary, December 29, 2010).

The decision of multiple publicly-funded Catholic school boards within Canada to decline participation in school-based HPV immunization programs is concerning. To our knowledge, Catholic school boards have refused to allow school-based clinics in Ontario,[22] Alberta[21] and the Northwest Territories.[23] Although the media have followed with interest the decisions of local Catholic school boards to decline participation in school-based HPV immunization programs, there has been little public debate about whether publicly-funded school boards should be 'entitled' to refuse admission to public health officials administering publicly-funded immunization programs. We found that many Ontario HUs reported difficulties in receiving agreement from local school boards, yet despite these difficulties, they were able to offer school-based HPV clinics in all but two public school boards since 2007. Because VPD managers constituted the only stakeholder group surveyed, a detailed understanding of the factors associated with the decisions of publicly-funded Catholic school boards and privately-funded, independent schools to decline school-based HPV immunization clinics as part of Ontario's program was not possible.

Interestingly, we found that 39% of HUs would consider immunizing an eligible student against HPV in the absence of parental consent. This is consistent with a recently published environmental scan of HPV vaccine policies in Health Departments of the Northeastern United States[24] which found that 9 to 67% would provide vaccine to women under the age of 18 without "parental permission". Informed consent to treatment, including immunization, is grounded in biomedical ethical principles which include respect for individual autonomy, and adolescence is a time of emerging autonomy.[25] Variability in the extent to which 13 year-olds will have the capacity to fully understand the risks and benefits of HPV immunization and its refusal is to be expected. This heterogeneity in capacity is acknowledged in Ontario's Health Care Consent Act,[10] which requires an assessment of capacity rather than specifying a minimum age. Other investigators have explored the views of nurse immunizers,[26] parents of adolescent girls,[27] and adolescent girls themselves[28] on consent to HPV immunization in England where the legal context of adolescent consent is similar to that of Ontario. Stretch and co-authors[26] interviewed school nurses in England, who had immunized 12- and 13-year-old girls against HPV as part of a feasibility study, on their attitudes towards immunizing adolescents in practice, as opposed to within the study's environment. The nurses knew how to assess competency to consent to immunization but would be unwilling to immunize if parents had refused consent, even if the student were assessed as competent.[26] Among the adolescent girls who participated in the feasibility study, 70% of the immunized and 41% of the unimmunized thought that girls of their age should be able to consent to the vaccine without parental consent.[28] A qualitative study engaging parents for their views on immunizing adolescents against HPV without parental consent found that parents were almost equally divided between those insisting on being involved in decision-making versus those supportive of adolescent autonomy in providing consent.[27] It appears from our evaluation that the views of at least some managers in Ontario may differ from those of public health staff in the United Kingdom.

There are some important limitations of this evaluation. The first is the use of self-report of VPD managers to describe the program's implementation. Difficulties in recall, or changes in HU staff since program introduction, may have resulted in an incomplete program description. Second, this evaluation documented program implementation by interviewing only one group of stakeholders – VPD managers – and it did not solicit the opinions and experiences of other important program stakeholders, including other health unit staff members, school board officials, parents or eligible students. Third, the interviews were not audio-taped for transcription and one person conducted the analysis. This limitation was mitigated by two methods for validation: providing the completed questionnaire to each manager to allow for corrections, and the presentation of preliminary findings for discussion and feedback at a teleconference with all participants. Finally, the experiences of each HU were not correlated with their HPV vaccine coverage data. Conversely, the strengths of this evaluation include a 100% response rate and rich contextual information provided by respondents on their program's local history.

CONCLUSIONS

To our knowledge, this process evaluation is the first investigation to have formally documented the experiences of front-line public health managers in Canada involved in the local implementation

of school-based HPV immunization programs. These findings will provide important contextual information to guide an HPV immunization program evaluation currently underway in Ontario.

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Received: March 18, 2011
Accepted: August 12, 2011

RÉSUMÉ

Objectif : Évaluer la mise en œuvre du programme ontarien de vaccination en milieu scolaire contre le VPH (un programme subventionné par l'État) au moyen d'une évaluation en cours d'exécution.

Participants : Le programme cible les filles en 8e année. Nos informateurs pour cette évaluation étaient les gestionnaires ontariens des maladies évitables par la vaccination.

Lieu : Ontario (Canada).

Intervention : Les bureaux de santé publique (BSP) de l'Ontario sont chargés de la mise en œuvre du programme de vaccination sur le terrain. Notre évaluation en cours d'exécution comportait un questionnaire téléphonique semi-structuré avec des questions sur la mobilisation des intervenants; la participation des écoles et des conseils scolaires; des stratégies de communication; et un processus d'obtention d'un consentement éclairé.

Résultats : Les 36 BSP ont participé à l'étude; 16 d'entre eux (44 %) ont fait état de difficultés à obtenir l'accord des conseils scolaires locaux pour administrer le vaccin anti-VPH dans les écoles. Deux conseils scolaires catholiques n'ont pas autorisé la présence de cliniques de vaccination contre le VPH dans leurs écoles : un la première année seulement et un autre la deuxième et la troisième année. Tous les BSP demandent le consentement parental à ce que l'élève reçoive le vaccin anti-VPH, et 5 sur 36 demandent et encouragent aussi le consentement de l'élève; 14 BSP ont dit qu'ils vaccineraient une élève de 8e année à la clinique de l'école en l'absence de consentement parental si l'élève elle-même demandait à être vaccinée et qu'elle était jugée capable de donner un consentement éclairé.

Conclusion : De nombreux BSP ont fait état de difficultés à obtenir l'appui des conseils scolaires locaux. Malgré cela, les cliniques de vaccination ont été tenues dans tous les conseils scolaires sauf deux depuis 2007. Tous les BSP demandent le consentement parental à la vaccination contre le VPH à l'école; 39 % des BSP songeraient à vacciner une élève en l'absence de consentement parental. Nos résultats viendront étayer l'évaluation du programme de vaccination contre le VPH en cours d'exécution en Ontario.

Mots clés : vaccins contre le virus du papillome humain; service hygiène scolaire; service santé adolescent; pratique en santé publique; vaccination