Are health fairs worth the time, effort, and money invested in them? A useful effort to arrive at an answer, and data on which an answer may be based are presented in this study. The authors raise a number of penetrating questions, of interest not only to those concerned with health education but even more broadly with the problem of medical care.

EVALUATION OF A DIABETES FAIR

Marjorie A. C. Young, Dr.P.H., F.A.P.H.A.; Owen Kiernan, D.Ed.; Grace Nangle, R.N., M.Sc.; and Leonid Snegireff, M.D., Dr.P.H.

Although there is considerable interest nation-wide in using the health fair to educate the public about health programs and problems, and although scores of communities have operated health fairs, the literature contains only a few references to evaluation studies in this field.3-6 If we are ever to know whether program goals are being achieved, then sound evaluation studies are essential. This report presents the results of an effort to evaluate several specific components of the Diabetes Fair held on November 15 and 16, 1960, in Boston. It is recognized that the study concerns itself with only one section of the United States, but the methods and findings probably are applicable to other sections of the nation.

On August 3, 1960, the president of the Metropolitan Diabetes Society appointed an Evaluation Committee to appraise the fair in relation to the two main objectives expressed by those who had been sponsoring the fair since its inception in 1951.1,2 These objectives were:

To educate and stimulate interest in the public concerning diabetes and its detection.
To stimulate the public at large to go to the family doctor and have a urine test for sugar and a blood test if necessary.

Since no funds or extra staff services were made available to the committee, the evaluation plan had to be one that could be carried out with minimal expenditure of time, materials, and personnel. The following three major areas were selected for concentrated study:

I. The important dimensions describing the people who attended the fair, namely:

A. Who comes to the fair?
1. Age distribution
2. Sex distribution
3. Geographical distribution
4. Diabetic history
5. Prior attendance at the fair
6. Occupational distribution

B. How did they learn about the fair?
C. Why did they come?

II. The nature and quality of the exhibits presented.

III. The nature and quality of the screening procedures offered.

In the following pages the committee members present a summary of their findings and a brief description of the procedures used in obtaining the data.
I. People Who Attended the Fair

To gather information about the audience reached by the fair, the committee devised a simple registration form (Appendix A) containing items related to the dimensions under consideration. The intent was to have every person who attended the fair fill out the form on entering the hall. In addition, a "checker" was assigned to obtain a count of total attendance at the fair so that we would know the percentage who took the time to register.

In round figures, 6,000 individuals were tallied and 3,000 filled out the registration form. We can assume that the 6,000 figure does not refer to 6,000 different individuals but that it includes a certain number of duplications, as of volunteers who serviced the exhibit booths throughout the two-day period of the fair. Therefore, we can say with assurance that more than 50 per cent of those who attended provided the information on which the findings are based and that this is a much larger percentage of returns than is usually obtained.

A. Who Comes to the Fair (Registered Group)

Data in all subsequent sections relate only to the 3,001 individuals who filled out the registration form in whole or in part.

1. Age Distribution—More than two-thirds of the group (2,166) were over 40 years of age—the group most important in terms of diabetes detection. Of those under 20 (309) the majority were students for whom attendance at the fair was an educational assignment; the rest were essentially young children whose parents had taken them to the fair "to be checked."

2. Sex Distribution—Women outnumbered men almost two to one (1,818 women, 1,001 men, 172 not given).

3. Geographical Distribution—Although more than half the group were residents of Boston (1,577) and another third came from cities and towns in close proximity to Boston proper, the others represented towns widely scattered not only throughout Massachusetts but also in several neighboring states.

4. Diabetic History—More than 40 per cent of those who registered (1,224) admitted that there was a history of diabetes in their family. Sixty-four individuals said, "I am diabetic." A variety of other comments given under question 8 in Appendix A—"What was your chief reason for coming to this fair?"—indicates that the number of diabetics in attendance was several times larger than 64.

5. Prior Attendance at the Fair—About one-third of the respondents said they had attended previous fairs. Almost half of this group had attended two or more previous fairs, with 138 individuals stating that they attend the fair yearly (Table 1).

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>a. Attendance at Previous Fairs</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>No answer</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>b. How Often</td>
</tr>
<tr>
<td>Once</td>
</tr>
<tr>
<td>Twice</td>
</tr>
<tr>
<td>Three or more</td>
</tr>
<tr>
<td>Yearly</td>
</tr>
<tr>
<td>No answer</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

6. Occupational Distribution—About 40 per cent of the group were composed of retired persons and housewives and 10 per cent were students for whom the fair was an educational assignment. If we exclude the students and add to the "retired-housewife" group those who
hold positions near the lower end of the economic scale (clerks, factory workers, laborers, bookkeepers, sales personnel, and restaurant workers), the total is 65 per cent. We can assume that this group is composed largely of those who are “medically indigent” and who will be responsive to any offer of free medical service.

It was interesting to note in tabulating the responses that more than 200 specific and highly specialized occupational and professional groups were represented by at least one attendant and these ran the gamut of all existing specialties.

B. How Did They Learn About the Fair?

Almost half of all responses (1,419) credited the newspapers as a chief source of information about the fair, and less than 15 per cent were attributed to television or posters. Almost 20 per cent gave word of mouth (friend, relative, school, hospital, and doctor) as the chief informational source. All told, about 60 per cent of the responses were assigned to the newspaper and word-of-mouth transfer of information. One might raise the question whether the high costs of using mass media—such as radio, television, posters, and flyers—are justified in terms of the results produced.

C. Why Did They Come?

About 70 per cent of the respondents came specifically to get a diabetes test or health checkup. Less than 2 per cent said they specifically to see the exhibits or listen to the talks. If we add to the 70 per cent mentioned above those who said “I have diabetes” or “Diabetes is in my family,” the total is raised to almost 80 per cent. Obviously, then, most people came to take advantage of the opportunity to get free service and many said they came to get more than one free test (Table 2).

Eighty individuals said they came especially to get a chest x-ray. Correla-

<table>
<thead>
<tr>
<th>Table 2—Why They Came</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons*</td>
</tr>
<tr>
<td>To get a test; health reasons; have symptoms, etc.</td>
</tr>
<tr>
<td>To learn more about diabetes</td>
</tr>
<tr>
<td>Diabetes in my family (or self)</td>
</tr>
<tr>
<td>Interest and curiosity</td>
</tr>
<tr>
<td>For a chest x-ray</td>
</tr>
<tr>
<td>School assignment</td>
</tr>
<tr>
<td>To see exhibits or hear the lectures</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

* Several gave more than one reason and some gave none at all.

II. Exhibits

During the preplanning sessions of the Evaluation Committee, it was decided that the criteria applied in evaluating the exhibits at the American Public Health Association annual meetings would be useful in obtaining some measure of the effectiveness of the exhibit material at the fair.7-11 The APHA criteria have been used to appraise hundreds of scientific exhibits over the past more than ten years and are the most widely accepted ones available (copy of these in Appendix B).

Three members of the Health Education Unit of the Harvard School of Public Health, all with considerable prior experience in applying the criteria, evaluated the fair exhibits independently. One week later they met and pooled their scores. (The scores given in Table 3 are the averages of these pooled scores.)

In addition, a Scandinavian expert on various aspects of diabetes viewed the exhibits and gave us the benefit of her
appraisals. In every case these were in complete agreement with the scores as reported by the Harvard staff.

Item 7 in Appendix B requires that a written statement giving the intended message of the exhibit be obtained from the exhibitor in advance. A letter was sent to all exhibitors requesting that “a statement of 25 words or less, giving the primary message that the exhibit is designed to impart” be sent to the president of the Diabetes Society by November 4. Ten exhibitors did not submit such a statement.

If one accepts a score of 60 per cent or better as indicative of exhibits with enough appeal to warrant the time and expense involved in producing and displaying them, then obviously, from these scores, half the fair exhibits were not particularly effective.

An analysis of some of the individual criteria scores is also illuminating:

Nine of the 20 exhibits were scored 50 per cent or less on item 1 because the material printed on the exhibits could not be read from the point of observation.

Ten of the 20 exhibits were scored 50 per cent or less on item 2 because the charts, graphs, and other statistical presentations were not readily intelligible.

Eleven of the 20 exhibits were scored 50 per cent or less on item 3 because the vocabulary and style of writing were not applicable to the majority of the audience.

Thirteen of the 20 exhibits were scored 50 per cent or less on item 4 because they did not hold the viewer’s interest long enough to be read. Obviously, an exhibit cannot be an effective tool unless people look at it long enough to read the message printed on it.

Whether one refers to the total scores or to scores on the individual criteria, the conclusion reached is the same; namely, at least half the exhibits contributed little if anything of importance to the education of the viewers.

Since the exhibits were supplemented by talks and film showings, two of us sat through an entire afternoon session to obtain direct information on the content of the talk and film, the composition of the audience, the climate surrounding the experience, the types of questions asked, and the mechanics of operating the session. Our observations are summarized as follows:

1. Audience

This consisted mainly of two groups: a larger one composed of older diabetics and members of their families, and a smaller one composed of students. A total of about 150 people were in attendance at the beginning of the talk, but there was much moving in and out throughout the session causing considerable noise and distraction.

2. Mechanics

(a) The microphone was out of order during most of the session so it was almost impossible to hear clearly from the rear of the hall where we were sitting. The noise mentioned above added to this auditory difficulty.

(b) Since the physician who was answering questions from the audience did not repeat the questions, we heard only his answers, which were not meaningful apart from the questions raised.

(c) The film that was to be shown after the talk never was shown because the sound equipment attached to the projector was out of order. Although an effort was made to repair it, after considerable delay the

Table 3—Percentage Scores of Exhibits

<table>
<thead>
<tr>
<th>Scores</th>
<th>Number of Exhibits</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100</td>
<td>0</td>
</tr>
<tr>
<td>80-89</td>
<td>3</td>
</tr>
<tr>
<td>70-79</td>
<td>3</td>
</tr>
<tr>
<td>60-69</td>
<td>4</td>
</tr>
<tr>
<td>50-59</td>
<td>1</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
</tr>
<tr>
<td>20-29</td>
<td>1</td>
</tr>
<tr>
<td>10-19</td>
<td>1</td>
</tr>
<tr>
<td>0-9</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>
film showing was called off. (When the film was about to begin, the majority of the audience had left the hall anyway.)

3. Content

(a) The language used by the physician was highly technical much of the time, replete with jargon, initials of various drugs used by diabetic patients, and so on. Our analysis of the responses on the registration form leads us to believe that the material could not have been clearly understood except by those who were directly and intimately involved with diabetes and its treatment.

(b) The types of questions raised indicated that those who asked the questions had diagnosed diabetes; in fact, many questioners referred to themselves and their condition directly. Therefore, the answers given by the physician were also related to the technical aspects of diabetes and its treatment.

Positive attributes of these talks were the enthusiasm of the physicians, their superlative medical information and knowledge of the subject, and their patience with and understanding of the problems of the participants.

After a synthesis of these data and observations, the following questions come to mind:

Were the talks and film showings planned for diabetics and those involved in treatment of diabetes rather than for the public at large?
Were any efforts made to evaluate the effectiveness of the talks and films?
Are the diabetics who attend the talks trying to obtain free medical advice, reinforcement, or another medical opinion to compare with that of their attending physician?

III. Screening Procedures

Since almost half the diabetics in the United States are currently unknown, obviously the first step in a well-planned community diabetes program must be the identification of these unknown cases. Public health and medical personnel have long accepted as fact that the detection of early diabetes is possible through well-established testing methods. Appropriate tests applied at random to apparently well individuals will screen out suspected diabetics and those who qualify for further testing.\(^12\)

In evaluating the screening procedures used at the fair, the committee attempted to relate them to the following basic questions:

A. Are the screening procedures consonant with the general objectives and purposes of the fair as stated earlier in this paper?
B. How successful are the screening procedures in finding previously unknown diabetics?
C. What are the physical and psychological conditions surrounding the screening procedures?
D. What are some of the reactions of those screened to the procedures used?
E. What follow-up procedures are instituted and how are these evaluated?

Several technics were utilized in obtaining data relevant to these questions:

1. Five trained professional workers, including two members of the Evaluation Committee, spent about two hours each, independently and at different times on different days, observing all aspects of the screening procedures at both the urine and blood testing stations. The following questions had been phrased in advance by the committee and were used by all observers as a frame of reference for the observations related to the surroundings:

(a) Are the arrangements attractive and inviting or unattractive and forbidding?
(b) Do those in attendance appear to be friendly or disinterested?
(c) Is testing done in the open or is there personal privacy?
(d) Is there privacy for consultation on the results?

2. After the initial observations, all the observers went through the screening procedures themselves to get a first-hand "feeling" for what was involved and to obtain data on the specific ways in which the attendants handled certain questions that arose in the course of the screening.

3. Four of the five trained observers conducted interviews, using a short interview schedule (see Appendix C), with a random sample of those who had
just left a screening test location. More than 50 interviews yielded the data on which the committee has based its answers to the basic questions posed.

4. Figures were obtained by written letter from the physician in charge of screening giving the total fair attendance, number who had urine tests, number with positive urine test results, number who had blood sugar tests, and number of new diabetics discovered. This physician also provided data on follow-up procedures.

5. Selected data tabulated from the registration forms were applied in answering questions.

The data derived from application of all five of these technics have been combined in various ways in arriving at the answers that follow.

A. Are Screening Procedures Consonant with the Objectives?

Objective 1: To educate and stimulate interest in the public concerning diabetes and its detection—If we define "the public" in the usual way as being composed of all classes and types of individuals comprising the general population in a given location, we can conclude that the group who attended the fair was not a representative cross-sectional sample of the public at large. Reference to the figures previously presented leads us to conclude that the fair attendance was skewed in the directions of more people over 40 and of a higher percentage of females than there are in the general population. The fair attendance was weighted on the side of those with a known history of diabetes in themselves or in their families, and about one-third of the audience were not new to the fair but were utilizing the fair probably as a means to obtain another free screening test or series of tests. Obviously, the fair attendance did not show as high a proportion of new, unselected individuals as one could expect from an organized attempt to "educate and stimulate interest in the public at large." We can raise the following questions:

Why were not those individuals with family histories of diabetes screened instead by their family physicians who are in a much better position to follow through with diagnostic and follow-up procedures?

If some of them had been screened previous to the fair by their family physicians, were they using the fair test results as a means of checking on their family physicians; in other words, were they seeking confirmation and reinforcement or were they not convinced of the accuracy of the results obtained from their family physicians?

Is not the fair audience largely composed of those who already are sensitized to diabetes and its detection rather than of those among whom the unknown cases are being sought? Would not some of those who went through the urine testing procedure offered at the fair be given a false sense of security, especially since the urine test when used alone without a blood test fails to identify a certain percentage of those with high renal thresholds for sugar? (Nobody was given a blood test unless the urine test was positive for sugar.)

Were the results of the screening tests interpreted in such a way as "to educate" those screened?

The National Health Council booklet states: "It is essential in any test program to make certain that the visitors to the fair know the significance of the tests before they take them. Results must also be properly interpreted. Technical language should never be used in interpreting the results to a nonprofessional person. For instance, a word like 'positive' which to the professional may mean presence of disease can mean just the opposite to the uninitiated."

The interviews and observations indicated to the committee that the interpretation of urine test results at the fair left much to be desired.

Objective 2: To stimulate the public at large to go to the family doctor and have a urine test for sugar and a blood test if necessary—In Table 2 we note that about 70 per cent of the respondents came to the fair specifically to get a
diabetes test or checkup. Obviously this group did not go to their family physicians but used the services of the fair instead.

From the physician’s letter as well as from the interview responses and our own observations, we know that many people were eager to have a blood test performed as well as a urine test. Experts in the field of diabetes have advocated the use of the blood test alone or the two tests in combination.13-17

“Blood tests have greater validity and reproductibility and are to be preferred over urine tests under most circumstances; urine testing is, however, usually the simpler and less expensive of the two methods.

“It has been found that roughly one-half of the previously unknown diabetics found through screening with a blood test were missed by a urine test performed at the same time. Since twice as many people must be tested to yield a given number of cases, and since a larger number of false positive screenees must be retested, the economy of urine testing would seem more apparent than real.”12

To sum up, the committee is of the opinion that the fair, as it was operated, did not focus on the stated objectives of “stimulating the public at large to go to the family doctor and to have a urine test for sugar and a blood test if necessary,” and of “educating the public concerning diabetes and its detection.” It did motivate more than 3,000 people to have a simple routine urine test, the results of which were quite “loosely” interpreted, leaving most screenees to form their own opinions of the values and meanings associated with the procedure and its results.

B. How Successful Are the Screening Procedures in Finding Previously Unknown Diabetics?

Data received from the physician are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number who had urine tests</td>
<td>3,200</td>
</tr>
<tr>
<td>Number with positive urine tests</td>
<td>180</td>
</tr>
<tr>
<td>Number who had blood sugar tests</td>
<td>310</td>
</tr>
<tr>
<td>Of these, known diabetics totaled</td>
<td>180</td>
</tr>
<tr>
<td>New diabetics discovered</td>
<td>41</td>
</tr>
</tbody>
</table>

From these figures we cannot tell whether the 180 known diabetics are the same individuals as the 180 with positive urines, nor do we know anything about the 130 individuals who presumably either obtained a blood test only or had a negative urine test. In the light of the preceding quotation that if one-half of the unknown diabetics found later with a blood test were missed by a urine test, we can say that some of the 3,000 plus individuals who were given a “clean slate” at the urine screening station were unknown diabetics who did not have the benefit of a follow-up blood sugar test.

If we subtract the 180 known diabetics from the 310 total who had blood sugar tests and use the resulting figure (130) as our denominator, then about 32 per cent of all those who had blood tests were found to be “new diabetics.”

From these data we can raise the following questions:

Why were 180 known diabetics given follow-up blood sugar tests at the fair rather than in the offices of their attending physicians? Is this encouraging the patient to go to his family physician and assisting in the search for previously unknown diabetics?

Why were not blood tests made available to all those who desired them? Should not the blood test have been made a routine part of the screening, especially since such a large percentage of those attending the fair are related to known diabetics and are therefore a high prevalence group?

For the 41 “new diabetics” was a definite diagnosis as such made at the fair? If so, by whom, and why was the person not referred to his family physician or to a clinic for more extensive diagnostic workup?

Furthermore, if 32 per cent of those (without diagnosed diabetes) given blood sugar tests were found to be “new diabetics,” does not this indicate that the fair population is a highly selected one and not representative of the “public at large”?

Would more previously unknown diabetics have been found if all persons with a known history of diabetes in the family had been urged to have both a urine and a blood test?
From a study of the limited data available to us, the committee feels that the screening procedures used were not as effective as some others might have been in finding previously unknown diabetics.

C. What Are the Physical and Psychological Conditions Surrounding the Procedures?

It was agreed by all observers that the urine testing arrangements were unattractive, that they provided no privacy either for testing or consultation, and that the attendants were indifferent to or unconcerned about the people being screened. The attendants chatted among themselves and showed no interest in soliciting or answering questions about the test, diabetes, or related subjects.

Although the blood testing station was also unattractive and lacking in privacy, the technicians in attendance appeared friendly and cordial. Patients at this table received cards giving brief instructions. The proximity of this testing area to the social service workers was considered to be very helpful in coordinating the test results with competent consultation services.

The need for descending a long flight of stairs to reach the urine testing stations was considered unfortunate in view of the large number of elderly and handicapped persons in attendance.

In summary, the committee members feel that the testing routines were not conducive either to the creation of positive attitudes toward screening procedures in general or to the development of increased functional and accurate knowledge about diabetes and its detection.

D. What Are Some of the Reactions of Those Screened to the Procedures Used?

Appendix C contains the brief interview schedule used in obtaining reactions to the screening procedures from more than 50 people; this is about a 1 per cent sample of all who attended the fair and about a 2 per cent sample of all who were screened for diabetes.

The majority of those interviewed had taken advantage not only of the urine test but also of the chest x-ray and eye tests. Many of these had had urine tests done previous to the current visit to the fair. Several believed they should have been allowed to have a blood test as well and spoke strongly about this. Several did not know what the test really indicated and one person thought the x-ray mobile was used to "take a picture of my pancreas to see if I have diabetes." This type of response confirms the need mentioned on page 766 of "making certain that the visitors to the fair know the significance of the tests before they take them." There were similar misconceptions about the eye test and its significance.

More than half of the respondents replied that they did not have an opportunity to ask questions or to get adequate answers to the questions they raised.

The answers to the question "What do you think you should do next?" were varied. Some comments were: "Cut down on smoking," "Cut down on food," "Keep doing what the doctor says," "Get a chest x-ray," "Keep weight at present level."

These kinds of comments are indicative of an interest in and concern about health even if the expected reply, "See my own doctor," was not verbalized even once.

Some questions we should like to raise are:

Why were people not given some definite information about the tests, their limitations, and significance?

Why were the eye tests included? Was the eye photography a means of gathering facts for a research project related to prediabetic conditions? If so, was this clearly enough presented to those screened? Did each person receive a report on the condition of his eyes following the processing of the photographs?

Why was the chest x-ray included? Although
EVALUATION OF A DIABETES FAIR

this is a useful screening device, what is its connection with diabetes detection?

E. What Follow-Up Procedures Are Instituted and How Are These Evaluated?

No case finding or screening program can be considered successful unless there is adequate follow-up that leads to diagnosis and treatment when necessary, and seeees should be informed at the time of initial screening that this is only a first step and that further tests by a physician may be needed. In fact, it should be emphasized strongly that fair tests do not replace individual examination by a physician. Furthermore, a long time lapse between taking the screening test and report on the results should be avoided.

The letters received from the Metropolitan Diabetes Society indicate that two months were allowed to elapse after the screening before any attempt at follow-up was made and that a second follow-up effort was made three months after the fair. No figures were made available to the committee on the results of these follow-up efforts from previous years, so that we have no basis for specific evaluation of this part of the program.

Questions that we should like to raise about the follow-up program are:

To whom are the letters sent: To the 310 individuals who had blood sugar tests made at the fair? To the 41 “new diabetics” only?

To those with positive urine?

Why is there a two-month lag between the fair and the first follow-up attempt?

Is the letter to the individual the only type of follow-up? Has there been any attempt to use the telephone or home visits by a public health nurse?

How have follow-up efforts been evaluated in the past?

What provisions if any are made for those who are medically indigent and who need various kinds of follow-up treatment services?

Summary

After prolonged consideration of all the data obtained from the many sources and technics described herein, the committee members feel that the pivotal question to be answered by the agency sponsoring the fair is this:

Would the stated objectives of the fair be achieved with better results (both quantitative and qualitative) if the money spent in all aspects of planning and operating the fair were utilized instead to employ an additional, full-time staff member with competence in health education and community organization? From the figures we have received on the amounts of staff and secretarial time devoted to fair activities and on other costs for flyers, posters, public relations services, and the like, it appears that for a comparable sum a well-qualified professional person could be employed to work on a year-round basis with the cities and towns serviced by the agency, assisting them to organize and operate diabetes detection programs at the local level.

The fact that approximately half of the people who attended the fair traveled some distance to take advantage of the services offered is an indication that there is considerable interest in diabetes detection and that unmet needs exist in the many communities from which they came. Diabetes programs carried on at the local level should provide valuable data on unmet needs and assist the agency to plan realistic ways of meeting these needs on a broader, firmer basis than that afforded by the annual fair.

Does the annual two-day fair of this type justify the expense involved, in terms of both short- and long-range results, as well as a full-time paid staff worker would?

To us this is the crucial question to be answered by those categorical agencies sponsoring such endeavors.

REFERENCES


Dr. Young is assistant professor in health education and in charge of the Health Education Unit, and Dr. Snegireff is director of the Chronic Disease and Gerontology Unit, Department of Public Health Practice, Harvard University School of Public Health, Boston, Mass.; Dr. Kiernan is commissioner of education, Commonwealth of Massachusetts, Boston; and Miss Nangle is supervisor of practical nurse education, Massachusetts State Department of Education, Boston.

APPENDIX A

Boston Diabetes Fair
Registration Form (No Signature Required)

Check the appropriate items

1. Age: Under 20 □ 20-39 □ 40-59 □ 60 or over □
2. Sex: Male □ Female □
3. Occupation (please list) __________________________
4. Town or City where you live __________________________
5. Has diabetes ever been found in any member of your family or in you? Yes □ No □
6(a) Have you ever attended the Boston Diabetes Fair before? Yes □ No □
6(b) If yes, how often? __________________________
7. How did you learn about this fair? (Check all those items that apply.)
   Newspaper □ Television □ From a friend or relative □
   Radio □ Posters □ Other (please specify) □
8. What was your chief reason for coming to this fair?

770   VOL. 53, NO. 5, A.J.P.H.
### APPENDIX B

#### Summary of Evaluation of APHA Exhibits*

**Exhibit sponsored by** ____________________________

<table>
<thead>
<tr>
<th>Value Not to Exceed</th>
<th>Evaluator’s Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Is it physically possible to read the exhibit from the point of observation?</strong></td>
<td>10</td>
</tr>
<tr>
<td>2. <strong>Will all graphs, charts, and diagrams be clearly understood by the intended audience? Has the use of statistical presentations been kept to a minimum?</strong></td>
<td>10</td>
</tr>
<tr>
<td>3. <strong>Is the vocabulary and style of writing used such that the intended audience can comfortably follow and understand the exhibit?</strong></td>
<td>10</td>
</tr>
<tr>
<td>4. <strong>Does the exhibit sustain interest long enough to read completely?</strong></td>
<td>10</td>
</tr>
<tr>
<td>5. <strong>Supplementary items (qualified attendant present; visual aid used; visitor-operated devices used and contributing to exhibit; literature supporting the exhibit objectives)</strong></td>
<td>10</td>
</tr>
<tr>
<td>6(a) <strong>Does the exhibit tie in with the interests of the visitor?</strong></td>
<td>10</td>
</tr>
<tr>
<td>(b) <strong>Does the exhibit offer the visitor a chance to participate in satisfying a personal purpose?</strong></td>
<td>15</td>
</tr>
<tr>
<td>7. <strong>Does the exhibit impart the message that it is designed to impart?</strong></td>
<td>25</td>
</tr>
<tr>
<td><strong>100 Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Revised October, 1956.

### APPENDIX C

#### Boston Diabetes Fair

1. **(A) What test(s) did you have?** _____________________________________________

   **(B) What does this mean to you?** ____________________________________________

   **(C) Have you had this test before?** _______Yes _______No

2. **Did you have an opportunity to ask questions and to get answers to your questions?** _______Yes _______No

3. **What do you think you should do next?** _______________________________________

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**MAY, 1963**