

Module 3: Tables

This module focuses on tables as typically used to present results from a project or other activity involving data. It also addresses the issues pertinent to deciding when to use a table in a report and when to use a graph. Different types of graphs are considered in subsequent modules.

Tables and Graphs

- **Purpose:** To display data so that they can be readily understood.
- **Principle:** Tables and graphs should contain enough information to be self-sufficient without reliance on material within the text of the document of which they are a part.
- Tables and graphs share some common features, but for any specific situation, one is likely to be more suitable than the other.

Titles and Sources

- **Titles:** *What, How Classified, Where, and When*
 - Titles should specifically state what is being included in the cells of a table or the points plotted on a graph. With respect to a table cell, the title should clearly state what is in the cell, how the cells are classified, where the data were collected and when they were collected.
 - Titles should not state the purpose of the table or graph--a common mistake.
- **Source:** If a table or graph contains information from another published source, then that source should be indicated with a "source" statement.

Graphs and Tables

Graphs and tables should stand alone in a report. This means that the reader should not have to refer to the text in order to understand and interpret the information in them. In practice this means, they require descriptive titles and clear, meaningful labels.

Good Title

What, How Classified, Where, When

Number and Percent of Current Smokers for Jefferson County, AL, by Ethnicity, Gender and Age, Smoking Assessment Survey, 2001

Uninformative Title

What, How Classified, Where, When

Comparison of Criterion Standard Research and Bad Outcome—Focused Quality Assurance

AMERICAN JOURNAL OF PUBLIC HEALTH

Checklist for Preparing Tables

Delays in publication often occur because, in the final stages of acceptance of a paper, tables still need refinement. The page in every issue devoted to “What *AJPH* Authors Should Know” and our Annotation “Seven Fatal Flaws in Submitted Manuscripts” (*Am J Public Health* 1994;84(5):718-719) provide guidance on preparing tables for the Journal. Use of the following checklist will help assure that our requirements are met:

***AJPH* Checklist for Preparing Tables (contd.)**

- Each table stands alone; readers need not refer to the text for understanding.
- The titles fully explain the data displayed; they are comprehensible apart from the text.
- Displays are brief and clear with a minimum of statistical abbreviations.
- Where appropriate, tables provide measures of uncertainty along with point estimates (e.g., standard deviations with means).
- All but universal abbreviations are spelled out, except where explained in footnotes.

***AJPH* Checklist for Preparing Tables (contd.)**

- Overall sample sizes (N's) are presented at the top of each table or column. Percentages alone appear within individual cells if the N's can be reconstructed, except where numbers are small.
- Confidence intervals are provided rather than beta coefficients and p values (e.g., for logistic regression analyses).
- Redundancy is eliminated between text and tables.

***AJPH* Checklist for Preparing Tables (contd.)**

- Only results essential to the main thesis are presented. Appendices available upon request from the author or deposited with the National Auxiliary Publication Service (NAPS) can contain additional results and supplementary material. (Information on NAPS is available from AJPH.) An appropriate footnote will be added to the text.
- Once a paper is accepted, authors must obtain permission for the use of tables and parts of tables copyrighted elsewhere. The permission letter, in which the publisher grants the specific use requested, must be sent to the Journal office.

AJPH Table Format

**TABLE 1—Characteristics and Percentages of Participants:
June 22–October 30, 1998, and August 2001.**

Employment/Affiliation	First Phase of Study, No.	Second Phase of Study, No.
Civil servants	28	24
Private sector (except NGOs) ^a	24	3
Political parties	13	3
International organizations	8	...
Labor unions	7	2
University faculty	6	2
NGOs	2	3
Total	88 ^b	37 ^b

Note. NGOs = nongovernmental organizations.

^a Includes professional organizations such as medical associations, chambers of commerce, and professional practitioners.

^b Totals may be greater than the number of respondents because some respondents can be classified in 2 categories.

AJPH Table Format

TABLE 3—Regression of Performance Scores for Smoking Cessation Counseling With Selected Provider Characteristics, Perceptions, and Knowledge Measures: Boston, Mass. Community Health Centers, 1996–1997

	Scales			
	Mean (SD)	<i>b</i>	<i>P</i> ^a	<i>r</i>
Knowledge (summary scale) ^b	3.50 (1.90)	9.0	.001	0.24
Perceptions (continuous scale)				
Role ^c	4.14 (0.95)	0.22	.0001	0.30
Effectiveness of counseling ^c	3.12 (0.99)	0.19	.0002	0.27
Self-efficacy ^c	2.73 (0.97)	0.27	.0001	0.38
Difficulty (barriers) ^d	1.76 (0.49)	−0.0076	.95	−0.0054
Motivation ^c	3.24 (0.45)	0.30	.01	0.19
Leadership (organizational facilitators) ^e	2.12 (0.46)	−0.2683	.02	−0.1774
System (organizational facilitators) ^c	1.87 (0.51)	−0.08	.46	−0.0576

Perceptions	Single Items		
	No. (%)	Mean Performance Score (SD)	<i>P</i> ^f
a. Mothers we see in our practice have so many other problems in their lives that stopping smoking is a very low priority for them.			.005
Agree	125 (75)	1.34 (0.66)	
Disagree	42 (25)	1.68 (0.73)	
b. Mothers have so many problems in their lives that intervening about smoking is a very low priority for me.			.0001
Agree	28 (17)	0.94 (0.50)	
Disagree	136 (83)	1.52 (0.69)	
c. Most mothers want us to provide them with smoking cessation counseling.			.02
Agree	71 (43)	1.56 (0.69)	
Disagree	95 (57)	1.31 (0.69)	

^a*P* for test that correlation is zero. ^bRange 0–10. ^cFive-point response scale.

^dThree-point response scale. ^eFour-point response scale. ^f*P* for test of equality of means.

Typical *JAMA* Table Format

Characteristics	No. (%) of Lesbians (n = 550)	No. (%) of Heterosexuals (n = 279)
Age, y		
< 30	53 (10)	44 (16)
31 – 40	187 (34)	89 (32)
41 – 50	186 (34)	82 (30)
51 – 60	88 (16)	36 (13)
> 60	31 (6)	25 (9)
Education		
High School or less	79 (15)	46 (17)
Some College	263 (48)	132 (48)
Advanced Degree	204 (37)	98 (9)
Ethnicity		
African American	75 (14)	42 (15)
Caucasian	418 (76)	200 (72)
Other	57 (10)	29 (10)
Relationship Status		
Single	102 (24)	55 (25)
In a committed Relationship	280 (66)	39 (18)
Married	37 (9)	118 (53)
Employment Status		
Full time	409 (75)	202 (72)
Part time	88 (16)	46 (17)
Unemployed	37 (7)	16 (6)
Retired	14 (3)	8 (3)
Disabled	11 (2)	4 (1)
Annual Income, \$		
< 10 000	35 (6)	20 (7)
10 000 – 20 999	77 (14)	27 (10)
30 000 – 35 999	160 (29)	72 (26)
36 000 – 50 999	121 (22)	55 (20)
51 000 – 75 999	89 (16)	47 (17)
> 76 000	66 (12)	56 (20)

Note: Numbers on which percentages were based vary because of missing data on some variables.

MMWR Table Format

Vol. 44/ No. 33

MMWR

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Vaccination Coverage Levels — Continued

TABLE 1. Vaccination coverage levels among children aged 19–35 months, by selected vaccines — United States, 1994

Vaccine/Dose	1996 Goal	NHIS*		NHIS provider†		NIS‡	
		%	(95% CI)†	%	(95% CI)	%	(95% CI)
DTP/DT**							
≥3 Doses	90%	89	(±2.4)	93	(±2.2)	93	(±0.7)
≥4 Doses	—	69	(±3.0)	76	(±3.4)	77	(±1.1)
Poliovirus							
≥3 Doses	90%	78	(±2.7)	83	(±3.0)	83	(±1.0)
Haemophilus influenzae type b							
≥3 Doses	90%	73	(±3.1)	89	(±2.6)	86	(±0.9)
Measles-containing (MCV)							
≥3 Doses	90%	91	(±1.8)	88	(±3.8)	89	(±0.9)
Hepatitis B††							
≥3 Doses	70%	27	(±3.5)	17	(±2.8)	37	(±1.2)
Combined series							
4 DTP/3 Polio/1 MCV§§	—	67	(±3.1)	72	(±3.4)	75	(±1.2)

* 1994 National Health Interview Survey, January–June.

† 1994 National Health Interview Survey, January–June, with provider data.

‡ 1994 National Immunization Survey, April–December.

§ Confidence interval.

** Diphtheria and tetanus toxoids and pertussis vaccine/Diphtheria and tetanus toxoids.

†† The difference between the NIS and NHIS provider estimates for hepatitis B is primarily because of different time periods for the surveys and the rapid improvement in hepatitis B coverage during 1994.

§§ Four doses of DTP/DT, three doses of poliovirus vaccine, and one dose of MCV.