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<tr>
<td>Alves et al, 2012</td>
<td>Consecutive sample of 7,381 puerperae from public maternity units, Porto (Generation XXI)</td>
<td>Exposures: marital status, income, occupation, education and working conditions. Outcomes: overweight/obesity, hypertension, dyslipidaemia and diabetes mellitus. Control: age.</td>
<td>Logistic regression</td>
<td>Being obese/overweight was strongly associated with being married, lower education, less differentiated occupations, being unemployed or a &quot;housewife&quot; and having a lower income. Hypertension was less likely in highly educated women and more likely in &quot;housewives&quot; relative to &quot;employed&quot;. Diabetes was inversely associated with income. Dyslipidaemia was not related to any SES indicator.</td>
<td>Probability sampling, large sample size.</td>
<td>Most outcome measures were self-reported, cross-sectional data.</td>
</tr>
<tr>
<td>Amaral et al, 2013</td>
<td>School-based sample of 6,899 adolescents, aged 12-18, Viseu</td>
<td>Exposure: gender. Outcome: insomnia. Control: age.</td>
<td>Logistic regression</td>
<td>Female gender was associated with insomnia symptoms in adolescents (OR=1.82, 95% CI=1.56–2.13).</td>
<td>Large sample size.</td>
<td>Use of a &quot;convenience sample&quot;, cross-sectional data.</td>
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<tr>
<td>Azevedo et al, 2012</td>
<td>Random stratified sample of 5,094 adults, over 18</td>
<td>Exposures: gender, marital status, occupation and education. Outcome: chronic pain. Control: age.</td>
<td>Logistic regression</td>
<td>Women were more likely to have chronic pain than men (OR=2.37, 95% CI=2.03–2.77). Unemployed (OR=1.64, 95% CI=1.14–2.38) and retired people (OR=1.67, 95% CI=1.28–2.17) were more likely to have chronic pain when compared to full time employees. Low educational level was associated with increased probability of chronic pain. Marital status was not associated with chronic pain.</td>
<td>Large sample size, probability sampling.</td>
<td>Cross-sectional data.</td>
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<tr>
<td>Bambara et al, 2009</td>
<td>No mention of sample size for Portugal, adults over 16 (EUROTHEINE/NHS)</td>
<td>Exposure: gender. Outcome: SRH. Control: age.</td>
<td>Logistic regression</td>
<td>Women had higher odds of reporting bad or very bad SRH (OR=2.01, 95% CI=1.87–2.15).</td>
<td>Probabilistic sampling procedure.</td>
<td>Cross-sectional data.</td>
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<tr>
<td>Bastos et al, 2013</td>
<td>Random sample of 2067 adults, over 18, Porto (EPI/Porto cohort)</td>
<td>Exposures: education, neighbourhood deprivation, occupation and gender. Outcome: H. pylori infection. Control: age and gender.</td>
<td>Poisson regression</td>
<td>Living in a deprived neighbourhood was associated with a higher prevalence of infection. The incidence rate of infection was lower among the more educated (≥10 vs ≤9: risk ratio = 0.25, 95%CI: 0.06–0.96). No evidence of gender or occupational differences.</td>
<td>Probability sampling, considerable sample size, longitudinal data.</td>
<td>Possibility of selection bias follow-up.</td>
</tr>
<tr>
<td>Bettencourt et al, 2013</td>
<td>Sample of 600 consecutive hospital admissions due to acute heart failure, 6 month follow-up</td>
<td>Exposure: socioeconomic deprivation index (income, educational level and living alone). Outcome: mortality. Control: age, gender and admission brain natriuretic peptide.</td>
<td>Cox regression analysis</td>
<td>Deprivation was not strongly associated with mortality (the hazard ratio of all-cause death was 1.48, 95% CI=0.77–2.82).</td>
<td>Longitudinal data, adequate control for confounders.</td>
<td>Used an uncommon SES measure, small sample size.</td>
</tr>
<tr>
<td>Bingham et al, 2013</td>
<td>Stratified random sample of 17,136 children, aged 3–10, mainland Portugal</td>
<td>Exposures: gender and parental education. Outcome: overweight/obesity. Control: age.</td>
<td>Logistic regression</td>
<td>Low paternal education was strongly related to the odds of being overweight or obese, while low maternal education was only related to the odds of being obese. Girls had higher odds of both obesity and overweight.</td>
<td>Trained technicians obtained anthropometric measures, probability sampling, large sample size.</td>
<td>Cross-sectional data, low response rate (57%).</td>
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<td>Study</td>
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<tr>
<td>Borrell et al, 2014</td>
<td>207 small areas from the Lisbon metropolitan area.</td>
<td>Social deprivation and education</td>
<td>Proportion of unemployed people</td>
<td>Linear regression</td>
<td>Objective health outcome.</td>
<td>Low number of deaths can lead to low statistical power.</td>
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<tr>
<td>Bulhães et al, 2013</td>
<td>School based sample of 1,988 13 year-olds, Porto</td>
<td>Gender and parental education</td>
<td>Depressive symptoms</td>
<td>Logistic regression</td>
<td>Outcome was assessed with a validated instrument.</td>
<td>Cross-sectional data.</td>
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<tr>
<td>Camões et al, 2010</td>
<td>Random sample of 1,621 adults, 18 and over, Porto (EPIPorto cohort)</td>
<td>Gender and education</td>
<td>Depressive symptoms</td>
<td>Poisson regression</td>
<td>Longitudinal design, probability sampling, outcomes assessed by trained researchers.</td>
<td>High loss to follow-up (66% were followed)</td>
</tr>
<tr>
<td>Carvalho et al, 2010</td>
<td>Sample of 442 adults, 18 and over</td>
<td>Gender, age and education</td>
<td>Depressive symptoms</td>
<td>MANCOVA</td>
<td>Use of validated instruments to measure health outcomes.</td>
<td>Non-probabilistic sampling, cross sectional data.</td>
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<tr>
<td>Carvalho et al, 2014</td>
<td>Stratified school-based random sample of 17,911 adolescents, 10-17 years</td>
<td>Gender and perceptions of neighborhood safety</td>
<td>Depressive symptoms</td>
<td>Linear regression</td>
<td>Large sample size, probability sampling.</td>
<td>Not validated health measure, cross-sectional data.</td>
</tr>
<tr>
<td>Correia et al, 2015</td>
<td>Sample of 6,893 adult mothers of singletons, Porto (Generation XXI)</td>
<td>Grandparents’ education and social class, maternal education and marital status</td>
<td>Infertility</td>
<td>Logistic regression</td>
<td>Large sample size, high response rate.</td>
<td>Possibility of recall bias, cross sectional data.</td>
</tr>
<tr>
<td>Study</td>
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<tr>
<td>Dias et al, 2013</td>
<td>Snowball sample of 1,375 adult immigrants, over 18, Lisbon</td>
<td>Exposures: gender, nationality, education and perceived income. Outcome: SRH. Control: age, reported chronic disease, experienced mental illness, physical exercise and concern about eating habits.</td>
<td>Good SRH was reported by 66.7% of men and 56.6% of women (p &lt; 0.001). Good SRH was associated with African and Brazilian origin (compared to Eastern European) and secondary/higher education. Among women, good health was also associated with perceived sufficient income.</td>
<td>Logistic regression</td>
<td>Extensive control for confounders.</td>
<td>Cross-sectional data.</td>
</tr>
<tr>
<td>Eikemo et al, 2008</td>
<td>Random sample of 3,410 adults, 18 and over (ESS)</td>
<td>Exposure: education. Outcomes: SRH and limiting longstanding illness. Control: age.</td>
<td>All rate differences, for women, men, in SRH or limitations, were statistically significant, such that people with less education had worse health.</td>
<td>Rate differences</td>
<td>Large sample size, probability sampling.</td>
<td>Cross-sectional data.</td>
</tr>
<tr>
<td>Falcão et al, 2008</td>
<td>Random sample of 1,911 13-year-old urban adolescents (EPITeen).</td>
<td>Exposure: gender and maternal education. Outcomes: asthma and rhinitis. Control: age.</td>
<td>Boys were more likely to have had a rhinitis diagnose (prevalence was 0.120 versus 0.092, p=0.014). There was no difference in asthma prevalence. There were no differences in asthma or rhinitis diagnosis regarding maternal education.</td>
<td>Chi-square test</td>
<td>Probabilistic sampling procedure and objective measurement of outcome.</td>
<td>Cross-sectional data.</td>
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<tr>
<td>Ferrão et al, 2013</td>
<td>Sample of 2,690 children, aged 3-10, Porto</td>
<td>Exposure: parental perceptions of residential neighbourhood environments. Outcome: obesity. Control: age, gender, maternal education and school cluster.</td>
<td>The odds of obesity were lower in neighbourhoods that were perceived as safe, pleasant and with well-maintained sidewalks.</td>
<td>Logistic regression</td>
<td>Researchers took anthropometric measures, large sample size.</td>
<td>No information on sampling procedures, cross-sectional data.</td>
</tr>
<tr>
<td>Ferreira-Pinto et al, 2012</td>
<td>Aggregated statistics on 278 counties based on approx. 200,000 hospital admissions</td>
<td>Exposure: counties’ economic development. Outcome: mortality rates. Control: age, gender and health care resources.</td>
<td>Counties with higher economical development had significantly higher mortality rates (coefficient = 1.696, p&lt;0.001).</td>
<td>Linear regression</td>
<td>Objective health outcome, considerable sample size.</td>
<td>Ecological design, cross-sectional data.</td>
</tr>
<tr>
<td>Ferreira-Valente et al, 2014</td>
<td>Sample of 324 patients with chronic musculoskeletal pain from health institutions, 18 or over</td>
<td>Exposure: social support. Outcomes: pain intensity, physical functioning and psychological functioning. Control: age and gender</td>
<td>Social support was associated with physical functioning and psychological functioning but not pain intensity.</td>
<td>Linear regression</td>
<td>Use of validated instruments to measure the exposure and outcome.</td>
<td>Non-probabilistic sampling, sma sample size, cross-sectional data.</td>
</tr>
<tr>
<td>Fraga et al, 2015</td>
<td>Random sample of 1205 adults aged 35-75, Porto (EPIPorto cohort)</td>
<td>Exposures: education and occupation. Outcome: inflammatory markers. Control: age, gender, marital status, current smoking, heavy drinking, inactivity, BMI, chronic disease and anti-inflammatory medication</td>
<td>Both low education and undifferentiated occupation were associated with increased inflammatory markers.</td>
<td>Logistic regression</td>
<td>Large sample size, objective outcome measure, extensive control for confounders, data collection by trained interviewers, probability sampling.</td>
<td>Self-reported health behavior cut-offs used for health outcomes were depende on the distribution in the population, cross-sectional data.</td>
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<td>Study</td>
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<tr>
<td>Gotsens et al., 2013</td>
<td>207 small areas from the Lisbon metropolitan area.</td>
<td>Exposure: social deprivation (unemployment, manual workers, population aged 25–64 with primary education or lower, population aged 25–34 with a university degree and foreigners from low income countries).</td>
<td></td>
<td>Outcome: injury mortality. Control: age.</td>
<td>Relative risks of smoothed standardized mortality ratios. There were higher mortality rates due to transport injuries, falls, homicides and all injuries in neighbourhoods with lower socioeconomic index for men. For women, suicide mortality was lower in neighbourhoods with higher social deprivation. There were no other important associations.</td>
<td>Objective health outcome. Ecological design, low number of deaths can lead to low statistical power.</td>
</tr>
<tr>
<td>Goulão et al., 2015</td>
<td>Spatial random sample of 1,736 migrants, Lisbon and Setúbal.</td>
<td>Exposures: nationality, gender, time in Portugal and marital status.</td>
<td></td>
<td>Outcome: BMI. Control: gender, age, education, marital status and birthplace.</td>
<td>Linear regression Being married was associated with higher BMI, when compared to being single (β=0.55, p=0.019). Immigrants from São Tomé e Príncipe had higher BMI when compared to Brazilians (β=1.21, p=0.004). Living in Portugal for 10-14 years (β=1.15, p=0.004) or over 15 years (β=1.48, p&lt;0.001) was associated with higher BMI when compared to less than 5. Gender was not associated with BMI.</td>
<td>High response rate (97.9%). Weight and ethnic origin were self-reported, cross-sectional data.</td>
</tr>
<tr>
<td>Harding et al., 2006a</td>
<td>All births in a year in a hospital, 4,227 newborns, Amadora-Sintra.</td>
<td>Exposures: maternal migrant status, education and occupation.</td>
<td></td>
<td>Outcome: birth weight. Control: maternal age, education, mode of delivery, smoking, parity, gestational age and child gender.</td>
<td>Linear regression Among babies of Portuguese white mothers, manual occupations were associated with lower birth weight. Maternal education was not associated with birth weight in any group. There were no significant differences in birth weights between different ethnic groups.</td>
<td>Large sample size, controlled for most important possible confounders. Use of hospital records, with considerable missing information.</td>
</tr>
<tr>
<td>Harding et al., 2006b</td>
<td>All births registered in Portugal (1995 – 2002), 872,058 newborns.</td>
<td>Exposure: migration status.</td>
<td></td>
<td>Outcome: birth weight. Control: year of birth, gender, maternal age, gestational age, and parity</td>
<td>Polytomous logistic regression There was no difference in overall mean birth weights between Portuguese and African babies, but the percentage of small preterm births was higher among African (4.7%) than among Portuguese (2.9%) births.</td>
<td>Large sample size, analyses the whole population, not a sample. Exposure is nationality, not migration status.</td>
</tr>
<tr>
<td>Harding et al., 2008</td>
<td>Data from death registrations, 1998–2002, over 15,000 deaths.</td>
<td>Exposures: migration, marital status and occupational class (for men).</td>
<td></td>
<td>Outcome: cardiovascular mortality. Control: age.</td>
<td>Death rates African migrants had higher mortality for all causes, circulatory disease, coronary heart disease and stroke. There was considerable heterogeneity among Africans with Cape Verdeans having higher mortality than Angolans or Mozambicans. Occupation was associated with heart disease mortality rate for African but not for Portuguese men. Married individuals had lower mortality.</td>
<td>Analysis of all deaths in the time period, large sample size. Change in ICC codes in the middle of the period analyses.</td>
</tr>
<tr>
<td>Hoffman et al., 2014</td>
<td>207 small areas from the Lisbon metropolitan area.</td>
<td>Exposure: social deprivation (unemployment, manual workers, population aged 25–64 with primary education or lower, population aged 25–34 with a university degree and foreigners from low income countries).</td>
<td></td>
<td>Outcome: avoidable mortality. Control: age.</td>
<td>Relative risks of smoothed standardized mortality ratios. Deaths due to AIDS, cervical or uterine cancer, cerebro-vascular diseases and congenital heart diseases were higher in more deprived neighbourhoods. Mortality due to malignant colon illness was higher in less deprived neighbourhoods. There was no association between social deprivation and malignant diseases of the rectum, anal area or testes, or Hodgkin’s disease, rheumatic heart disease, hypertension, heart failure, peptic ulcer, renal failure or conditions from the perinatal period.</td>
<td>Objective health outcome. Ecological design, low number of deaths can lead to low statistical power.</td>
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<tr>
<td>Humboldt et al., 2014</td>
<td>Sample of 1,234 adults from life-long learning centers, over 75, Lisbon and the Algarve</td>
<td>Exposures: gender, education, marital and professional status, income, urban-rural residence, religion and nationality.</td>
<td>Control: age, recent disease, physical activity, medication.</td>
<td>Structural equation modelling</td>
<td>Adequate control for confounders.</td>
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<tr>
<td>Lawlor et al., 2005</td>
<td>School-based random sample of 1,153 children, aged 9 and 15, Madeira</td>
<td>Exposures: family income and parental education.</td>
<td>Outcome: age.</td>
<td>Linear regression</td>
<td>Probability sampling, extensive control for confounders.</td>
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<tr>
<td>Leurent et al., 2013</td>
<td>Consecutive sample of 1,005 adults, aged 18–75, from primary care, 6-12 months follow-up, Lisbon</td>
<td>Exposures: spiritual and religious beliefs.</td>
<td>Outcome: major depression.</td>
<td>Logistic regression</td>
<td>Probability sampling, extensive control for confounders.</td>
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<tr>
<td>Machado-Rodrigues et al, 2014</td>
<td>Stratified random sample of 1,886 girls aged 7–9 years.</td>
<td>Exposure: parental perceptions of neighbourhood environments.</td>
<td>Outcome: obesity and overweight.</td>
<td>Linear regression</td>
<td>Researchers objectively assessed CRF and BMI.</td>
<td></td>
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<tr>
<td>Malmusi, 2014</td>
<td>Stratified random sample of approximately 12,000 adults (EU-SILC)</td>
<td>Exposure: migrant status.</td>
<td>Outcome: SRH.</td>
<td>Poisson regression</td>
<td>Large sample size, probability sampling.</td>
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<tr>
<td>Mari-Dell'Omo et al., 2015</td>
<td>207 small areas from the Lisbon metropolitan area.</td>
<td>Exposure: social deprivation (unemployment, manual workers, population aged 25–64 with primary education or lower, population aged 25–34 with a university degree and foreigners from low income countries). Outcome: mortality. Control: age.</td>
<td>Relative risks of smoothed standardized mortality ratios.</td>
<td>In men, higher mortality in more deprived areas was found for respiratory diseases, chronic liver diseases, cerebrovascular diseases, influenza and pneumonia and diabetes. In women, the same relationship was found for ischemic heart disease, chronic liver disease, cerebrovascular disease and diabetes. An opposite association was found for lung cancer and breast cancer in women. No associations were found for ischemic heart disease, lung cancer or prostatic cancer in men and for respiratory diseases and influenza and pneumonia in women.</td>
<td>Logistic regression</td>
<td>Objective health outcome.</td>
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<tr>
<td>Martins et al., 2012</td>
<td>Sample of 479 adults attending primary care in two metropolitan areas, over 50</td>
<td>Exposures: gender and education. Outcome: executive function. Control: age.</td>
<td>Linear regression</td>
<td>Lower educational levels were significantly associated with worse executive function. Gender was associated with some, but not all tests, and the direction of this association depended on the test.</td>
<td>Logistic regression</td>
<td>Assessment of outcome by trained researchers.</td>
</tr>
<tr>
<td>Mastekaasa, 2014</td>
<td>Random sample of adults, aged 20-59 (EULFS)</td>
<td>Exposure: gender. Outcome: sickness absence. Control: age, living with partner, children, level of education, working hours, occupation and industry.</td>
<td>Poisson regression</td>
<td>There were statistically significant gender gaps in sickness absence in Portugal, with OR that ranged from 1.27 to 2.22 in all the years analysed (women had higher odds).</td>
<td>Regression analysis</td>
<td>Very high response rate (91%) for Portugal.</td>
</tr>
<tr>
<td>Mello et al., 2008</td>
<td>School-based sample of 700 13 year olds, Porto.</td>
<td>Exposures: type of school, maternal education and gender. Outcome: dental caries. Control: soft drinks consumption.</td>
<td>Logistic regression</td>
<td>Attending a public school, being female and having parents with low educational attainment were identified as risk factors both for having dental caries and for having a high level of dental caries.</td>
<td>Logistic regression</td>
<td>Cross-sectional data, non-probabilistic sampling.</td>
</tr>
<tr>
<td>Miranda et al, 2014</td>
<td>18 municipalities, Lisbon metropolitan area</td>
<td>Exposures: illiteracy rate, deprivation, unemployment rate and proportion of precarious households. Outcome: pre-term births. Control: maternal age.</td>
<td>Relative risk &amp; Moran’s I</td>
<td>There was a global significant association between the relative risk of preterm births and illiteracy rate (Moran’s I=0.44), deprivation (Moran’s I=0.32) and the unemployment rate (Moran’s I=0.26). There was no association with precarious households.</td>
<td>Regression analysis</td>
<td>Adequate methods.</td>
</tr>
<tr>
<td>Neto, 2009</td>
<td>Sample of 1,055 adolescents (partially from ICSEY, Lisbon)</td>
<td>Exposures: migration status and gender. Outcome: mental health problems. Control: age and SES.</td>
<td>ANCOVA</td>
<td>Adolescents from immigrant families reported fewer mental health problems than their native Portuguese counterparts, and girls reported more mental health problems than boys.</td>
<td>ANCOVA</td>
<td>Large array of instruments to measure mental health problems.</td>
</tr>
<tr>
<td>Neto, 2010</td>
<td>Sample of 322 adolescents, aged 13-19, north of Portugal</td>
<td>Exposures: migration status and gender. Outcomes: depression, anxiety and psychosomatic symptoms. Control: age.</td>
<td>ANCOVA</td>
<td>Adolescents from immigrant families reported fewer mental health problems than Portuguese adolescents who have never migrated. There were no gender differences.</td>
<td>ANCOVA</td>
<td>Use of a control group.</td>
</tr>
<tr>
<td>Nogueira et al, 2013a</td>
<td>School-based sample of 1,885 children, 5–10 years, Coimbra</td>
<td>Exposure: parents' perceptions of social and built residential environment. Outcome: obesity. Control: age and parental education.</td>
<td>Logistic regression</td>
<td>Girls living in neighbourhoods perceived as having poorly built environmental conditions and as being unsafe had increased odds of being obese (OR=1.47 and 1.34, respectively, p&lt;0.005). These relationships were not evident for boys.</td>
<td>Logistic regression</td>
<td>Researchers measured weight and height.</td>
</tr>
<tr>
<td>Study</td>
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<tr>
<td>Nogueira et al, 2013b</td>
<td>Sample of 1,885 Portuguese children, aged 3–10, Coimbra</td>
<td>Exposure: parental education. Outcome: obesity. Control: gender, age and clustering of children in schools.</td>
<td>Logistic regression</td>
<td>Children whose parents had low (OR = 51.76, 95% CI=1.25–1.99) and medium (OR=1.57, 95% CI=1.34–2.33) education were more likely to be obese than their high-education peers.</td>
<td>Large sample size.</td>
<td></td>
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<tr>
<td>Nunes et al, 2010</td>
<td>Random sample of approximately 1,000 adults, aged 55–79, primary care registries, Northern Portugal</td>
<td>Exposures: urban-rural residence and education. Outcomes: cognitive impairment and dementia. Control: age, gender, vascular risk factors, cardiovascular disease, depression and other diseases.</td>
<td>Logistic regression</td>
<td>Lower education was associated with cognitive impairment (OR = 1.54, 95% CI=1.02-2.33), whereas residence was not. There were no significant associations with dementia.</td>
<td>Probabilistic sampling.</td>
<td></td>
</tr>
<tr>
<td>Oliveira et al, 2012</td>
<td>Sample of 146 homeless adults, over 18, and matched controls (on sex, age and education) from the general population, Porto</td>
<td>Exposure: homelessness. Outcomes: overweight/obesity, abdominal obesity, hypertension, dyslipidaemia and diabetes. Control: age and education.</td>
<td>Poisson and linear regression</td>
<td>Overweight/obesity (prevalence ratio=0.66, 95% CI=0.45-0.95) and self-reported dyslipidaemia (prevalence ratio=0.21, 95% CI=0.10-0.43) were less common among homeless participants than in non-homeless. There were no differences in the other health outcomes.</td>
<td>Some anthropometric measures taken by researchers, use of matched control group.</td>
<td></td>
</tr>
<tr>
<td>Oliveira et al, 2015</td>
<td>Sample of 96,905 hospital patients with hip fracture, 50 and over, within 278 municipalities of continental Portugal</td>
<td>Exposure: municipal deprivation. Outcome: hip fracture. Control: age and gender.</td>
<td>Hierarchical regression model</td>
<td>In women, there was a lower risk associated with more affluent municipalities: relative risk=0.83 (95% CrI 0.65–1.00). In older ages (≥75 years) affluent municipalities had higher risk of hip fracture.</td>
<td>Large sample size, use of multilevel data and methods.</td>
<td></td>
</tr>
<tr>
<td>Pereira et al, 2013</td>
<td>Sample of 146 homeless adults, over 18, Porto</td>
<td>Exposures: gender, education, nationality and duration of homelessness. Outcome: oral caries. Control: age.</td>
<td>Linear regression</td>
<td>Having decayed teeth was significantly associated with nationality (‘other’ vs. ‘Portuguese’), β = 2.7, 95% CI=0.4-5.2) and years of homelessness (‘≥6’ vs ‘&lt;1 month’, β=2.8, 95% CI=0.4-5.2) but not associated with gender or education. Having missing teeth was not associated with any of these variables.</td>
<td>A single dentist assessed outcome.</td>
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</tr>
<tr>
<td>Perelman et al, 2012</td>
<td>Random sample of 33,662 adults, over 18 (NHS)</td>
<td>Exposure: gender. Outcomes: SRH, restricted-activity days, bed days and chronic diseases. Control: age, education, employment status, income, insurance status, marital status, occupation.</td>
<td>Logistic regression</td>
<td>Women were more likely to have poor SRH, more days lost to disability, and 6 out of 8 chronic diseases. Men experienced more bed days.</td>
<td>Probability sampling, large and representative sample.</td>
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<tr>
<td>Researcher(s)</td>
<td>Sample Description</td>
<td>Exposure</td>
<td>Outcomes</td>
<td>Methodology</td>
<td>Data Collection</td>
<td>Study Design</td>
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<tr>
<td>Perelman, 2014</td>
<td>Random sample of 28,433 adults, aged 25-79 (NHS)</td>
<td>Height (as an indicator of early-life SES)</td>
<td>Obesity, smoking, employment</td>
<td>Logistic regression</td>
<td>Probability sampling, large and representative sample</td>
<td>Cross-sectional data and self-reported information on height and health conditions.</td>
</tr>
<tr>
<td>Pimenta et al, 2011</td>
<td>Sample of 243 women with vasomotor symptoms, aged 42-60, Lisbon</td>
<td>Marital status, professional status, income and education</td>
<td>Hot flashes and night sweats, therapy for menopausal symptoms, psychological problems, alcohol and coffee intake, smoking, physical exercise and BMI</td>
<td>Structural equation modelling</td>
<td>Extensive control for potential confounders</td>
<td>Recruitment and sampling procedures are not described, cross-sectional data, small sample size.</td>
</tr>
<tr>
<td>Ramos et al, 2007</td>
<td>Random sample of 2,161 13-year-old urban adolescents (EPITeen)</td>
<td>Parental education</td>
<td>Overweight</td>
<td>Logistic regression</td>
<td>Weight and height were collected by trained researchers</td>
<td>Cross-sectional data.</td>
</tr>
<tr>
<td>Ribeiro et al, 2014</td>
<td>Sample of 97 centenarians, Porto and Beira Interior</td>
<td>Gender</td>
<td>Anxiety symptoms</td>
<td>Logistic regression</td>
<td>Use of validated instruments to measure outcome.</td>
<td>No information selection or sampling procedures, cross-sectional small sample size.</td>
</tr>
<tr>
<td>Rodrigues et al, 2008</td>
<td>Sample of 1,822 consecutive births from public maternities.</td>
<td>Maternal employment</td>
<td>Pre-term delivery, maternal age, marital status, education and obstetric characteristics</td>
<td>Logistic regression</td>
<td>Use of control group, controlled for most important confounders.</td>
<td>Possibility of b due to health selection, non-probabilistic sampling.</td>
</tr>
<tr>
<td>Ruiz et al, 2015</td>
<td>Consecutive sample of 8,330 births from public maternities, Porto (Generation XXI)</td>
<td>Maternal education</td>
<td>Pre-term birth, small for gestational age, child sex, maternal age and ethnicity</td>
<td>Relative index of inequality and slope index of inequality</td>
<td>Probability sampling and large sample size.</td>
<td>Missing data very common among mother with low education – possibility of b ecological design, cross-sectional data.</td>
</tr>
<tr>
<td>Santana et al, 2014</td>
<td>All diabetes deaths per municipality in Portugal, covering 278 municipalities.</td>
<td>Index of sociomaterial deprivation</td>
<td>Diabetes mortality</td>
<td>Bayesian hierarchical model</td>
<td>Observes all population (all deaths), objective outcome.</td>
<td>Ecological design, cross-sectional data.</td>
</tr>
<tr>
<td>Santos et al, 2003</td>
<td>Random sample of 1,436 adults, aged 18–90, Porto</td>
<td>Education, occupation and marital status</td>
<td>Obesity, smoking status, physical activity and energy intake</td>
<td>Logistic regression</td>
<td>Outcome was measured by researchers, probability sampling.</td>
<td>Cross-sectional data.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Sample Description</td>
<td>Exposures</td>
<td>Outcome</td>
<td>Statistical Methods</td>
<td>Key Findings</td>
<td>Study Design</td>
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<tr>
<td>Santos et al, 2008</td>
<td>Random sample of 1,962 adults over 40 years, Porto.</td>
<td>Marital status, education, occupation, social class.</td>
<td>Metabolic syndrome.</td>
<td>Logistic regression</td>
<td>Among women, lower education, more differentiated occupation and lower social class, but not marital status, were associated with higher odds of metabolic syndrome. There were no significant associations among men.</td>
<td>Anthropometric measures were taken by trained researchers, probability sampling and large sample size.</td>
</tr>
<tr>
<td>Santos et al, 2010</td>
<td>Random sample of 1,093 adults, over 18, Porto (EPIPorto cohort).</td>
<td>Gender and education.</td>
<td>Metabolic syndrome.</td>
<td>Poisson regression</td>
<td>Low education was associated with 1.53 higher odds of developing metabolic syndrome (p&lt;0.05). There were no gender differences.</td>
<td>Longitudinal data, extensive control for confounders, probability sampling.</td>
</tr>
<tr>
<td>Santos et al, 2011</td>
<td>School based sample of 266 adolescents, aged 12-18, Lisbon.</td>
<td>Gender and ethnicity.</td>
<td>Cardiovascular risk factors.</td>
<td>Linear regression</td>
<td>Interactions between age and ethnicity and between age and gender showed negative associations with CRF, such that Caucasian adolescents and girls had lower cardiorespiratory fitness.</td>
<td>Researchers objectively assessed CRF.</td>
</tr>
<tr>
<td>Santos et al, 2014a</td>
<td>Random sample of 1,051 adults, 50 and over, from health registries, Guimarães and Vizela.</td>
<td>Education and gender.</td>
<td>Self-reported health.</td>
<td>Linear regression and structural equation modelling</td>
<td>Gender showed different associations with cognitive ability, depending on the test used. Women tended to show more depressive mood. Education was positively associated with cognitive ability.</td>
<td>Probability sampling, measures are confirmed by medical records.</td>
</tr>
<tr>
<td>Santos et al, 2014b</td>
<td>School-based sample of 517 adolescents, aged 15-18, Azoars.</td>
<td>Parental education.</td>
<td>Systolic blood pressure and metabolic risk score.</td>
<td>Z-scores</td>
<td>Systolic blood pressure and metabolic risk score were higher in adolescents whose parents had lower education. The other outcomes were not associated with parental education.</td>
<td>Outcomes were objectively tested.</td>
</tr>
<tr>
<td>Schutte et al, 2013</td>
<td>Stratified random sample of approximately 1,000 adults (EQLS).</td>
<td>Education.</td>
<td>SRH.</td>
<td>RII</td>
<td>Only women showed significant education-related inequality in SRH (RII for men = 1.4 (0.3, 3.3) and women = 5.9 (2.6, 13.4)).</td>
<td>Adequate methods.</td>
</tr>
<tr>
<td>Silva, 2014</td>
<td>Randomized stratified sample of 1,000 adults over 50, continental Portugal.</td>
<td>Gender, occupation, employment, income, education, individual social capital indicators (characterization of social network, characterization of social activities).</td>
<td>SRH.</td>
<td>Linear regression</td>
<td>Being male, with more education, more differentiated occupation, employed, with higher income and higher number of activities outside the home were all associated with better SRH. Other social capital indicators had no association with SRH.</td>
<td>Probability sampling, extensive control for potential confounders.</td>
</tr>
<tr>
<td>Sousa-Ribeiro et al, 2014</td>
<td>Sample of 300 adults aged between 40 and 65, Porto.</td>
<td>Employment, psychological well-being.</td>
<td>Employment.</td>
<td>MANOVA</td>
<td>The employed reported better well-being than the other groups, and the unemployed in training showed lower distress than those who were not.</td>
<td>Used validated instruments to measure the health outcome.</td>
</tr>
<tr>
<td>Stewart-Knox et al, 2012</td>
<td>Stratified cluster sample of 540 adults, aged 43-93.</td>
<td>Employment, gender and education.</td>
<td>Waist circumference and BMI.</td>
<td>Linear regression</td>
<td>BMI was not predicted by any SES variable. Being male, not working and having lower education were associated with higher waist circumference.</td>
<td>Researchers took anthropometric measures, probability sampling.</td>
</tr>
<tr>
<td>Authors</td>
<td>Sample/Exposures/Outcomes/Control</td>
<td>Methodology</td>
<td>Data Notes</td>
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<tr>
<td>Vilhena et al., 2014</td>
<td>Sample of 774 chronic disease patients, over 17, from hospitals. Exposures: spirituality and social support. Outcomes: quality of life and subjective well-being. Control: gender, education, age, time since diagnosis and severity of disease perception.</td>
<td>MANCOVA</td>
<td>Spirituality and social support were significant predictors of quality of life and subjective well-being. Used validated instruments to measure health outcome, extensive control for potential confounders. Unclear sampling procedures, cross-sectional data.</td>
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Legend: