Early puberty in 11-year-old girls: Millennium Cohort Study findings

Yvonne Kelly, Afshin Zilanawala, Amanda Sacker, Robert Hiatt, Russell Viner

ABSTRACT

Objective Early puberty in girls is linked to some adverse outcomes in adolescence and mid-life. We address two research questions: (1) Are socioeconomic circumstances and ethnicity associated with early onset puberty? (2) Are adiposity and/or psychosocial stress associated with observed associations?

Design Longitudinal data on 5839 girls from the UK Millennium Cohort Study were used to estimate associations between ethnicity, family income, adiposity and psychosocial stress with a marker of puberty.

Main outcome measure Reported menstruation at age 11 years.

Results All quoted ORs are statistically significant. Girls in the poorest income quintile were twice as likely (OR=2.1), and the second poorest quintile nearly twice as likely (OR=1.9) to have begun menstruation compared with girls in the richest income quintile. Estimates were roughly halved on adjustment for Body Mass Index and markers of psychosocial stress (poorest, OR=1.5; second poorest, OR=1.5). Indian girls were over 3 times as likely compared with whites to have started menstruation (OR=3.5) and statistical adjustments did not attenuate estimates. The raised odds of menstruation for Pakistani (OR=1.9), Bangladeshi (OR=3.3) and black African (OR=3.0) girls were attenuated to varying extents, from about a third to a half, on adjustment for income and adiposity.

Conclusions In contemporary UK, excess adiposity and psychosocial stress were associated with social inequalities in early puberty, while material disadvantage and adiposity were linked to ethnic inequalities in early puberty among girls.

INTRODUCTION

Early onset puberty in girls is linked to certain adverse outcomes during different stages of the life course, as it is associated with the increased risk of early sexual activity and teenage pregnancy,1 poor mental health in adolescence2,3 and mid-life cardiovascular disease,4 and breast cancer,5 but is associated with better bone health in early old age.6 The age of puberty onset decreased dramatically over the 20th century in high income countries with similar secular trends still evident in low and middle income countries.7 8 It remains controversial whether there are ongoing secular trends in the timing of puberty in high income country settings.9 10 Prior studies, mostly from the USA, have described socioeconomic and ethnic/racial patterning of the onset of puberty.9 14 Given the different historical and geographical patterns of migration to the UK and USA we might not necessarily expect to see ethnic differences in early puberty in the UK. However, until now, work from the UK has not been able to examine ethnic differences across a representative range of ethnic minority groups, either because study samples lack diversity15 16 or they focus on a single minority group.16 17

Reported influences on the timing of puberty in girls include prenatal and postnatal growth and adiposity,11 16 19 22 psychosocial stress,23 24 environmental pollutants,25 migration26 and genetic factors.27 We know that socioeconomic circumstances and ethnicity are linked to increased adiposity28 29 and psychosocial stress.30 What this study adds?

▸ In contemporary UK, girls from socioeconomically disadvantaged groups and some ethnic minority groups are most likely to have early onset puberty.

▸ Excess adiposity and psychosocial stress among girls from low income backgrounds was associated with early onset puberty.

▸ Material disadvantage and adiposity were associated, to varying degrees, with early puberty in girls from Pakistani, Bangladeshi and black African backgrounds.
to the most recent reference data, the median age for menstruation is 12.9 years.33

To our knowledge, this paper is the first to look longitudinally at two potential mechanisms linking socioeconomic position and ethnicity to early onset puberty in a contemporary UK setting. In a large-scale population based study of 11-year-old girls we investigate two research questions: (1) Are socioeconomic circumstances and ethnicity associated with early onset puberty? (2) Are excess adiposity and/or psychosocial stress associated with observed associations?

METHODS
The Millennium Cohort Study (MCS) is a UK nationally representative prospective cohort study of children born into 19 244 families between September 2000 and January 2002.34 Participating families were selected from a random sample of electoral wards with a stratified sampling design to ensure adequate representation of all four UK countries, disadvantaged areas and ethnically diverse areas. The first sweep of data was collected when cohort members were around 9 months and the subsequent four sweeps of data were collected at ages 3 years, 5 years, 7 years and 11 years. At all data collection sweeps interviews were conducted and anthropometric measurements were taken during home visits. During interviews cohort members’ carers were asked about socioeconomic circumstances and the family psychosocial milieu; and at the age 11 years sweep carers were asked about socioeconomic circumstances and ethnicity to early onset puberty in a contemporary UK setting. In a large-scale population based study of 11-year-old girls we investigate two research questions: (1) Are socio-economic circumstances and ethnicity associated with early onset puberty? (2) Are excess adiposity and/or psychosocial stress associated with observed associations?

Socioeconomic background
Quintiles of equivalised family income at age 5 years were used as a marker of early life socioeconomic circumstances. This measure takes into account the size and composition of the household.34 35 The richest quintile was used as the reference category in analysis.

Ethnicity
All children were born in the UK and we used mothers’ reports of her child’s particular ethnic origin (collected at age 9 months or 3 years, using UK census categories). For brevity ethnic origin categories are hitherto referred to as follows: white, Indian, Pakistani, Bangladeshi, black Caribbean (including mixed white and black Caribbean), black African (including mixed white and black African) and other (includes mixed ethnic groups and ethnic minority groups that could not be categorised into any of the otherwise defined groups). As the largest ethnic group, white was used as the reference category.

Explanatory factors
At age 7 years children were weighed without shoes or outdoor clothing using Tanita BF-522W scales (Tanita UK Middlesex, UK). Weight in kilograms to one decimal place and per cent body fat were recorded. Heights were obtained using the Leicester Height Measure Stadiometer (Seca, Birmingham, UK) and recorded to the nearest millimetre. These measures were used to calculate Body Mass Index (BMI, (lean mass+fat mass)/height2) and Fat Mass Index (FMI, fat mass/height2). BMI and FMI were used in statistical models as markers of adiposity. Birth weight (kg), reported by mothers when cohort members were 9 months of age, was included as a marker of fetal growth in models.

Markers of psychosocial stress, collected at age 7 years, were: mother’s psychological distress (Kessler-6 Score),36 lone parent family (yes/no), child’s socioemotional difficulties (total score using mother reported Strengths and Difficulties Questionnaire)17 and frequency of racist attacks/insults in residential area (not common vs fairly or very common). Due to data availability this latter marker was from the age 5 years data collection.

Study sample
We analysed data on singleton-born cohort members for whom data on menstruation were available. The analytical sample was 5839 after multiply imputing missing values on explanatory factors. The amount of missing data ranged from 0% to 18%. We used multiple imputation techniques, which account for uncertainty about missing values by imputing several values for each missing data point.38 We imputed 25 data sets, consolidated results from all imputations using Rubin’s combination rules39 and excluded cases with imputed values on menstruation from the analytical sample to improve the efficiency of estimates.40 Results from the imputed analyses did not vary substantively from the analyses using listwise deletion (analysis not shown).

Analytical approach
We hypothesised that any income or ethnic patterning of puberty by age 11 years would be explained in part by adiposity and in part by psychosocial stress. In keeping with the hypothesised temporal sequence, we used family income at age 5 years to reflect early life socioeconomic circumstances, ethnicity collected from infancy, and to test potential mechanisms, markers of adiposity and psychosocial stress (where possible) were measured at age 7 years. Birth weight as a marker of prenatal growth which has been linked to early puberty onset19 was used as a control variable. Logistic regression modelling was used to estimate associations.

1. Model 0 is the baseline model and shows age (centred) adjusted estimates for income and ethnicity.
2. Model 1 simultaneously adjusts for age, income and ethnicity.
3. Model 2 is model 1 plus birth weight.
4. Model 3 is model 1 plus a marker of adiposity (BMI or FMI).
5. Model 4 is model 1 plus markers of psychosocial stress.
6. Model 5 is a combination of models 2–4, simultaneously adjusting for all variables.

We tested for effect modification by running models containing interaction terms for ethnicity by income but none of these interactions were statistically significant. All analysis was carried out using Stata V13.1 (Stata). Analyses used sample weights to
adjust for the unequal probability of being sampled and the stratified and clustered sample design.

RESULTS
The average age of girls was 11.2 years (SD=0.33) and 9.5% had begun menstruation. Menstruation was socially graded (14.1% of poorest quintile and 6.8% in richest, p<0.001). Indian, Bangladeshi and black African girls were most likely (24.2%, 21.6% and 20.1%, respectively) to have begun menstruation (table 1).

On average, girls who had begun menstruation were more adipose at age 7 years and were more likely to have been exposed to psychosocial stress earlier in childhood (table 2). BMI and FMI were higher for girls who had begun menstruation (BMI 17.6 kg/m² vs 16.5 kg/m²; FMI 5.1 kg/m² vs 4.2 kg/m²) compared with those who had not. Girls who had begun menstruation had mothers who had had higher psychological distress scores (3.6 vs 3.0), were more likely to be from a lone parent family (23.1% vs 17.2%) and had themselves higher socioemotional difficulties scores earlier in childhood (7.5 vs 6.4).

Table 3 shows regression estimates for the odds of menstruation across income and ethnic groups. Girls in the poorest income group were more than twice as likely (model 0: OR=2.14) and those in the second poorest group nearly twice as likely (model 0: OR=1.92) to have begun menstruation compared with girls in the richest income quintile. Estimates were attenuated on adjustment for BMI (model 3: poorest, OR=1.86; second poorest, OR=1.74), and on adjustment for markers of psychosocial stress (model 4: poorest, OR=1.60; second poorest, OR=1.64) but differences remained statistically significant in the fully adjusted model (model 5: poorest, OR=1.52; second poorest, OR=1.52).

Adjusting for income (model 0 vs model 1) attenuated the raised odds of menstruation for Pakistani (1.97 vs 1.43), Bangladeshi (3.27 vs 2.45) and black African (3.00 vs 2.53) girls. Unlike the other ethnic minority groups adjustment for income did not reduce estimates for Indian girls due to their relative economic advantage (see online supplementary appendix 1). Adjustment for adiposity (model 3) further attenuated the estimated odds for Bangladeshi (2.36) and black African (1.88) girls, while adjusting for psychosocial factors (model 4) did little to change estimates. In fully adjusted models, differences remained statistically significant for Bangladeshi and black African girls (model 5: Bangladeshi, OR=2.15; black African, OR=1.87). Similar patterns of attenuation were observed when using FMI in models, but differences were no longer statistically different for the black African group (see online supplementary appendix table 2).

DISCUSSION
In a large contemporary UK setting we found that 9.5% of girls aged 11 years had started menstruation as reported by their mothers. Girls from socioeconomically disadvantaged families and those from certain—Indian, Pakistani, Bangladeshi and black African—but not all ethnic minority groups were most likely to have begun menstruating. We found that for girls in the poorest two quintiles of the income distribution inequalities were roughly halved on adjustment for markers of adiposity and psychosocial factors but differences remained unexplained in final models. Because of the relatively advantaged position of families in the Indian group, our models did not attenuate the increased odds of early menstruation for these girls. In contrast, material disadvantage appeared to reduce the odds of early menstruation by about a half for Pakistani girls, and a combination of material disadvantage and higher adiposity among girls in the Bangladeshi and black African groups reduced the odds by about a third.

Our findings are comparable with data from the 1990 UK reference values which showed that 11.8% of girls had begun menstruation prior to leaving primary school, and this is consistent with the overall picture of no further declines in the timing of puberty in high income country settings. There are important differences to note here though, as the Ten Towns study found no differences according to social position or ethnicity. However their marker of social position was crude and different from ours (manual vs non-manual occupational class), and they used aggregate ethnic minority groupings, ‘black’ and ‘South Asian’, which likely obscured important differences. Average age estimates for menstruation in low and middle income countries which may have some relevance for ethnic minority groups included in the current study are largely historical and limited in availability.
<table>
<thead>
<tr>
<th>Model 0: age</th>
<th>Model 1: age, income, ethnicity</th>
<th>Model 2: Model 1+birth weight</th>
<th>Model 3: Model 1+BMI</th>
<th>Model 4: Model 1+psychosocial stressors</th>
<th>Model 5: fully adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income (ref.: richest quintile)</td>
<td></td>
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<tr>
<td>Fourth</td>
<td>1.02 (0.7 to 1.5)</td>
<td>1.03 (0.7 to 1.5)</td>
<td>1.02 (0.7 to 1.5)</td>
<td>0.99 (0.7 to 1.5)</td>
<td>0.95 (0.6 to 1.4)</td>
</tr>
<tr>
<td>Third</td>
<td>1.27 (0.9 to 1.8)</td>
<td>1.29 (0.9 to 1.8)</td>
<td>1.28 (0.9 to 1.8)</td>
<td>1.26 (0.9 to 1.8)</td>
<td>1.21 (0.9 to 1.7)</td>
</tr>
<tr>
<td>Second</td>
<td>1.92*** (1.4 to 2.7)</td>
<td>1.86*** (1.3 to 2.6)</td>
<td>1.82*** (1.3 to 2.6)</td>
<td>1.74*** (1.2 to 2.4)</td>
<td>1.64** (1.2 to 2.3)</td>
</tr>
<tr>
<td>Poorest</td>
<td>2.14*** (1.5 to 3.0)</td>
<td>1.95*** (1.4 to 2.8)</td>
<td>1.89*** (1.3 to 2.7)</td>
<td>1.86*** (1.3 to 2.7)</td>
<td>1.60* (1.1 to 2.4)</td>
</tr>
<tr>
<td>Ethnicity (ref.: white)</td>
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<tr>
<td>Indian</td>
<td>3.53*** (2.2 to 5.8)</td>
<td>3.55*** (2.2 to 5.7)</td>
<td>3.26*** (2.0 to 5.2)</td>
<td>3.95*** (2.4 to 6.4)</td>
<td>3.69*** (2.3 to 6.0)</td>
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<td>Pakistani</td>
<td>1.87** (1.2 to 2.9)</td>
<td>1.43 (0.9 to 2.2)</td>
<td>1.35 (0.9 to 2.1)</td>
<td>1.62* (1.0 to 2.5)</td>
<td>1.39 (0.9 to 2.1)</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>3.27*** (2.2 to 5.0)</td>
<td>2.45*** (1.6 to 3.8)</td>
<td>2.24*** (1.4 to 3.5)</td>
<td>2.36*** (1.5 to 3.8)</td>
<td>2.54*** (1.6 to 4.0)</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1.62 (0.9 to 3.1)</td>
<td>1.39 (0.7 to 2.6)</td>
<td>1.34 (0.7 to 2.5)</td>
<td>1.20 (0.6 to 2.4)</td>
<td>1.32 (0.7 to 2.5)</td>
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<tr>
<td>Black African</td>
<td>3.00*** (1.6 to 5.6)</td>
<td>2.53*** (1.3 to 4.9)</td>
<td>2.50** (1.3 to 4.8)</td>
<td>1.88* (1.0 to 3.5)</td>
<td>2.58** (1.3 to 5.0)</td>
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<tr>
<td>Other</td>
<td>1.13* (1.0 to 3.7)</td>
<td>1.85 (1.0 to 3.5)</td>
<td>1.82 (0.9 to 3.5)</td>
<td>2.03* (1.0 to 4.0)</td>
<td>1.88 (1.0 to 3.6)</td>
</tr>
<tr>
<td>Age (in years and centred at mean)</td>
<td>4.73*** (3.5 to 6.4)</td>
<td>4.98*** (3.7 to 6.7)</td>
<td>4.87*** (3.6 to 6.6)</td>
<td>4.90*** (3.6 to 6.7)</td>
<td>5.02*** (3.7 to 6.8)</td>
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<tr>
<td>Birth weight (kg)</td>
<td>0.78** (0.6 to 0.9)</td>
<td></td>
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<td></td>
<td>0.71*** (0.6 to 0.9)</td>
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<td>BMI (kg/m²)</td>
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<td>1.18*** (1.1 to 1.2)</td>
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<tr>
<td>Mother’s psychological distress</td>
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<tr>
<td>Racism in area is fairly/very common</td>
<td>1.00 (1.0 to 1.0)</td>
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<tr>
<td>Lone parent family</td>
<td>1.16 (0.8 to 1.7)</td>
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<tr>
<td>Total difficulties score</td>
<td>1.15 (0.9 to 1.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.03** (1.0 to 1.1)</td>
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</table>

All estimates are weighted with overall survey weights. 
***p<0.001, **p<0.01, *p<0.05.
BMI, Body Mass Index.
CONCLUSIONS

Socioeconomic and ethnic inequalities in early onset puberty are evident in the UK, and our findings suggest the unequal distribution of psychosocial stress and adiposity play a part for socioeconomic inequalities while material disadvantage and adiposity play a part in observed ethnic patterns. Socioeconomic and ethnic inequalities in later life health are evident, and early puberty could play a role in increasing chronic disease risk among women from disadvantaged groups. Given the short- and long-term implications for early puberty on women’s health and well-being, improving our understanding of underlying processes could help identify opportunities for interventions with benefits across the life course.

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Contributors All authors had full access to all the data (including statistical reports and tables) in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis. YK conceptualised and designed the study, drafted the initial manuscript and approved the final manuscript as submitted. AZ carried out the analyses, reviewed and revised the manuscript, and approved the final manuscript as submitted. AS, RH and RV critically reviewed the manuscript and approved the final manuscript as submitted. YK affirms that the manuscript is an honest, accurate and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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