Young Lives

March 2025

Health, Nutrition and Well-Being:

Preliminary Findings from the 2023–24 Young Lives Survey (Round 7): Ethiopia

Introduction

For more than 20 years, Young Lives has followed two cohorts, born seven years apart from infancy to early adulthood in Ethiopia, India, Peru and Vietnam.[1] This factsheet presents preliminary findings from Round 7 of the Young Lives survey conducted in Ethiopia in 2023–24, when the Younger Cohort was 22 years old and the Older Cohort was 29. It aims to provide an overview of the key nutrition, health and well-being indicators underlining changes over time by comparing the Younger Cohort at age 22 with the Older Cohort at the same age in 2016, and documenting the Younger Cohort's progression from age 12 to 22. The factsheet also reflects on the implications of the findings for achieving the Sustainable Development Goals (SDGs)

Headlines

- While the prevalence of underweight participants at age 22 has decreased across the two cohorts, underweight rates remain alarmingly high.
- The number of Young Lives households that are food insecure has remained persistently high over the last decade.
- Early-life inequalities are associated with food insecurity 20 years later.
- Subjective well-being has improved among the Younger Cohort since they were 12 years old, despite a notable decline during the COVID-19 pandemic.
- One in five of the Younger Cohort reported symptoms compatible with anxiety or depression, and levels of anxiety have increased since the pandemic.
- Stress is widespread, with six out of ten participants reporting symptoms indicative of at least moderate stress.
- Participants from regions directly affected by armed conflict reported worse nutrition, food security and mental health.

1 Round 7 took place in the Young Lives study sites in Ethiopia, India and Peru. On this occasion, data was not collected in Vietnam due to a change in government procedures for the international transfer of personal data.

Key Findings

- **While the prevalence of underweight participants at age 22 has decreased across the two cohorts, underweight rates remain alarmingly high**. The proportion of the Younger Cohort that is underweight at age 22 (23%) is lower than that of the Older Cohort at the same age (28%).
- **Food insecurity has remained persistently high over the last decade,** with seven out of ten Younger Cohort households being at least mildly food insecure in 2023.
- **Early-life inequalities are reflected in food insecurity 20 years later**. Participants from poorer households, living in rural areas, or with less educated childhood caregivers have higher levels of food insecurity. These results highlight the need for effective public policies to address early life socio-economic inequalities.
- **Subjective well-being has improved since the Younger Cohort were 12 years old**. There was a notable decline during the COVID-19 pandemic, however, by age 22 subjective well-being had begun to recover.
- **One in five of the Younger Cohort reported symptoms compatible with anxiety or depression, and levels of anxiety have increased since the pandemic**. The proportion of the Younger Cohort showing symptoms consistent with at least mild anxiety increased from 15% in 2020 (just before the Tigray armed conflict started in November) to 20% in 2023. In contrast, the prevalence of depression remained unchanged.
- **Six out of ten participants reported symptoms of at least moderate stress**, a much higher number than those reporting symptoms of anxiety and depression.
- **Participants originally from regions directly affected by the armed conflict reported worse nutrition, food security and mental health**[2]. Moreover, participants originally from the Amhara region, who were interviewed by phone due to ongoing conflict, reported the highest levels of food insecurity and mental health issues, including post-traumatic stress disorder. Urgent assistance in these regions is crucial to support vulnerable communities exposed to the armed conflict.

The policy context of nutrition and mental health in Ethiopia

Despite being a fast-growing economy with an annual GDP growth of 6.5% in 2023 (World Bank 2024), Ethiopia remains classified as a low-income country. According to the most recent official estimates, almost seven out of ten people lived in multidimensional poverty by 2019, and three out of ten were nutritionally deprived (UNDP 2023). The country has faced several adverse shocks over recent years. In addition to ongoing droughts and the COVID-19 pandemic, armed conflicts started in the Tigray region in November 2020, and in Amhara in September and October 2023. These events seem to be having a significant impact on levels of malnutrition. Ethiopia has a high prevalence of food insecurity – also linked to macro-economic challenges, such as unemployment and inflation – that have implications over the life course (Ocho et al. 2017; Concern Worldwide and Welthunger 2024; Hassen, Yimam and Awoke 2024).

In 2021, the Ethiopian government established the Food and Nutrition Strategy (Federal Democratic Republic of Ethiopia 2021), with the aim to improve food security, and health and nutritional status, to benefit citizens' quality of life and longevity.

In 2021, the disability-adjusted life years (DALYs)[3] due to mental health conditions in Ethiopia was 1,784 per 100,000 inhabitants. While this figure is slightly lower than the overall estimate for low-income countries (1,830), a significant increase occurred in 2020, with DALYs from mental health conditions increasing by 7% compared to 2019 (WHO 2024b). The literature shows that the recent armed conflict in Tigray not only increased food insecurity (Araya and Lee 2024) but also worsened mental health (Favara et al. 2022). To improve mental health, the Ethiopian government has developed the National Mental Health Strategy (NMHSP) 2020–2025 (Federal Ministry of Health 2021). This government strategy aims to improve access to and quality of mental health services through a multisectoral approach.

2 When participants are referred to as being from a given region, this denotes their region of origin (Round 1).

3 A DALY is a measure of the overall burden of disease. One DALY represents the loss of one year of full health. It includes years lost due to premature mortality and due to disability.

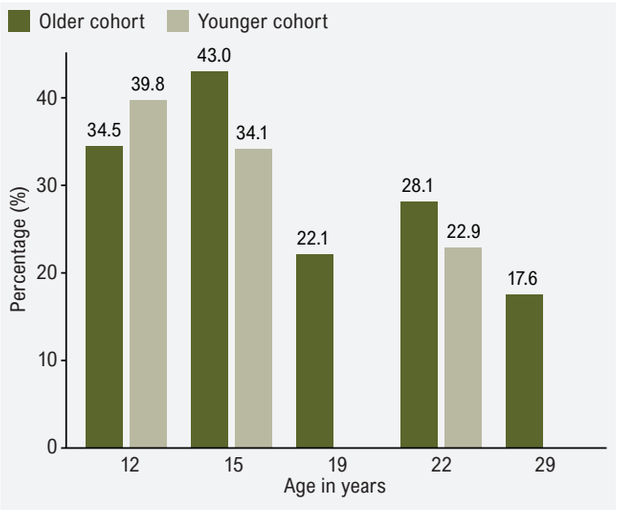
Methods

This factsheet uses preliminary data from the Young Lives Round 7 survey, which in Ethiopia was collected between October 2023 and April 2024. A total of 2,231 interviews were completed (1,535 from the Younger Cohort and 696 from the Older Cohort), which represents 74.4% of the original sample in Round 1 (Younger Cohort: 76.8%; Older Cohort: 69.6%) (Molina et al. 2025). Most of the interviews were carried out in person, but 9% of participants were interviewed using a phone survey due to the ongoing conflict in the Amhara region during the period of data collection. Participants from previous rounds who were not interviewed in Round 7 were excluded from the analysis. Participants are classified by gender, area of residence (urban or rural) at the time of data collection, household wealth (top, middle or bottom tercile in 2002) (Briones 2017), region of origin, and childhood caregiver's level of formal education.

Nutrition outcomes

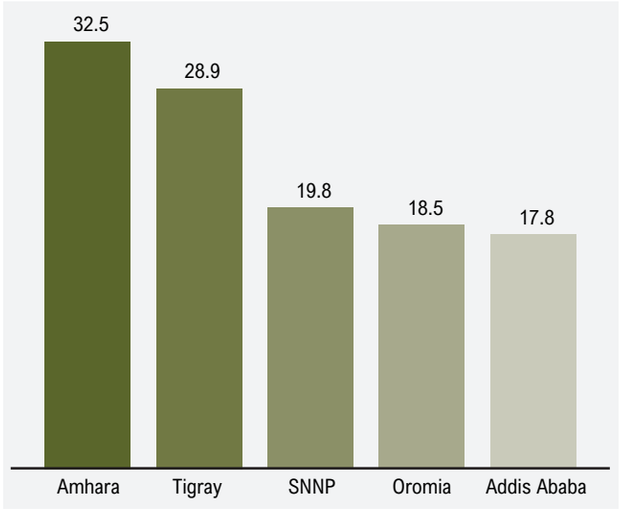
Almost one in four (23%) of the Younger Cohort were underweight at age 22, despite a decrease from age 15 (34%) and age 12 (40%). While fewer Younger Cohort participants were underweight at age 22 compared to the Older Cohort at the same age (28%) (Figure 1), this figure is still alarmingly high. In addition, there are substantial differences depending on participants' region of origin. While the percentage of underweight participants from SNNP, Oromia and Addis Ababa did not surpass 20%, the percentage of those from Tigray and Amhara was 29% and 33% respectively (Figure 2).[4] It is likely that this result is related to the famine that affected these regions as a result of the conflict.

Figure 1. *Underweight prevalence by cohort and age (%)*



Note: The definition of underweight varies by age. We followed the World Health Organization (WHO) Child Growth Standards to classify children who are 5–19 years old (WHO 2024c). For adults over 19 years old, we used absolute thresholds, also defined by WHO (WHO 2024a). Regarding underweight, for children who are 5–19 years old, we calculated the prevalence of thinness, defined as children whose BMI-for age z-score is below two standard deviations below the median for a healthy reference child of the same age and gender; for adults over 19 years old, we calculated the percentage of underweight children, defined as having a BMI lower than 18.5kg/m^2. Overweight, for children who are 5–19 years old, is defined as those whose BMI-for age z-score is more than one standard deviation above the median for a healthy reference child of the same age and gender; for adults over 20 years old, it is defined as having a BMI higher than 25kg/m^2. Obesity, for children who are 5–19 years old, is defined as those who are more than two standard deviations above the median BMI for a healthy child of the same age and sex; for adults over 20 years old, it is defined as having a BMI greater than 30kg/m^2.

Figure 2. *Underweight prevalence among the Younger Cohort at age 22 by region of origin (%)*



Note: The definition of underweight varies by age. We followed the WHO Child Growth Standards to classify children who are 5–19 years old (WHO 2024c). For adults over 19 years old we used absolute thresholds, also defined by WHO (2024a). See Figure 1 for further details.

The low prevalence of overweight and obesity among participants indicates that these are not widespread problems in Ethiopia. While the percentage of the Younger Cohort who are overweight or obese at age 22 is low (5%), the percentage among the Older Cohort at age 29 is higher (14%), among whom 7% also have increased risk of cardiovascular disease. Notably, however, overweight participants among the Older Cohort participants at age 29 are primarily those living in urban areas and born in the wealthiest households (top wealth tercile), indicating that this is not a widespread problem in Ethiopia.

Food security

Most Young Lives households in Ethiopia are at least mildly food insecure (74% of both the Older Cohort and the Younger Cohort).[5] This percentage has remained consistently high for the Younger Cohort since they were 12 years old, indicating that measures to improve household food security are making slow progress. The persistence of high food insecurity is associated with droughts, armed conflict and macro-economic challenges (Ocho et al. 2017; Concern Worldwide and Welthunger 2024;

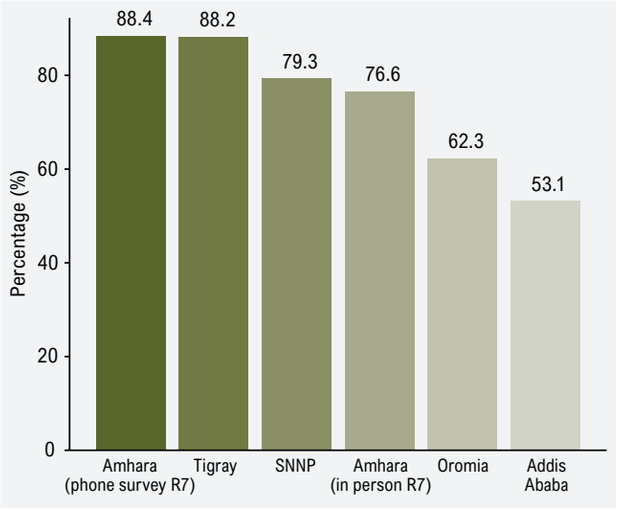
4 The sample of participants in the Amhara region only included those interviewed in person.

5 Food security is defined as physical and economic access to enough food to meet the dietary needs for a productive and healthy life (USAID 1992). At the household level, it was assessed using a modified version of the Household Food Insecurity Access Scale (HFIAS) (Coates, Swindale and Bilinsky 2007). Key changes included using a 12-month recall period instead of the standard 1-month and selecting six items from the original nine-item scale, with corresponding methodological adjustments.

Hassen et al. 2024). Participants' early life socio-economic conditions are also strong predictors of food insecurity; those whose mother had no formal education were almost twice as likely to live in food insecure households compared to those whose mother had eight years or more of formal education. Conversely, participants born in the wealthiest households (top wealth tercile) and those who currently live in urban areas are less likely to live in food insecure households than their counterparts (Annex 1).

As expected, participants from areas affected by the armed conflict are more likely to live in food insecure households. Among the Younger Cohort, 88% from Tigray and 77% from Amhara who were interviewed in person (and 88% from Amhara who were interviewed by phone), were at least mildly food insecure (Figure 3). Among those from SNNP, the percentage of food insecure participants was also high (79%). Similar results were documented previously, with 75% of participants from SNNP being mildly food insecure during the pandemic (Freund et al. 2022). In contrast, food insecurity was considerably lower among participants from Oromia (62%) and Addis Ababa (53%). To gain a broader understanding throughout the armed conflict, participants were asked about food security during the first 12 months of the conflict using a shorter version of the Household Food Insecurity Scale (HFIAS) scale.[6] This showed high food insecurity among those from Tigray (91%) and Amhara (71% of those interviewed in person and 80% of those interviewed by phone).[7]

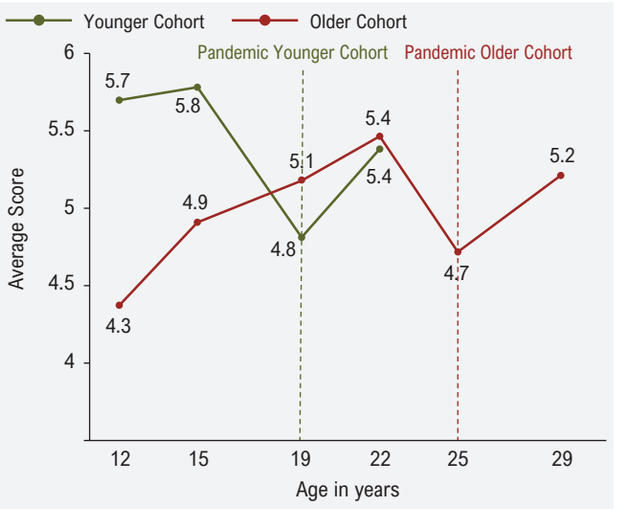
Figure 3. *Food-insecure households among the Younger Cohort at age 22 by region of origin (%)*



Subjective well-being

Over the course of the study, participants have been asked about their subjective well-being on a scale from one to nine, with nine being the best possible life. **The average score for the Younger Cohort at age 22 was 5.4, the same as for the Older Cohort at a similar age in 2016** (Figure 4). However, we recorded a decrease in subjective well-being during the pandemic (age 25 for the Older Cohort and age 19 for the Younger Cohort) and before the armed conflict in Tigray had started.[8] By 2023, there are visible signs of recovery. However, significant differences were found, with participants whose childhood caregiver has a higher level of education and those from areas not affected by conflict (SNNP, Addis Ababa and Oromia) reporting higher subjective well-being than their counterparts.

Figure 4. *Subjective well-being – average score by cohort and age*



Mental health

By 2023, one in five of the Younger Cohort reported symptoms compatible with anxiety or depression, and levels of anxiety had increased since the pandemic. Stress is widespread, with six out of ten participants reporting symptoms compatible with at least moderate stress. The prevalence of at least mild anxiety was 20% among the Younger Cohort and 23% among the Older Cohort. Compared to 2020, levels of anxiety have increased by 4 percentage points for the Younger Cohort, but dropped by the same amount for the Older Cohort. The percentage of participants with symptoms reflecting at least mild depression was slightly lower (16% for the Younger Cohort and 19% for the Older Cohort), which were

6 We used a shorter version of the HFIAS that is not comparable with the other percentages presented in this section. To calculate the percentage of participants at least mildly insecure, we calculated the percentage of households who reported worrying about running out of food or actually ran out of food over the relevant time period.

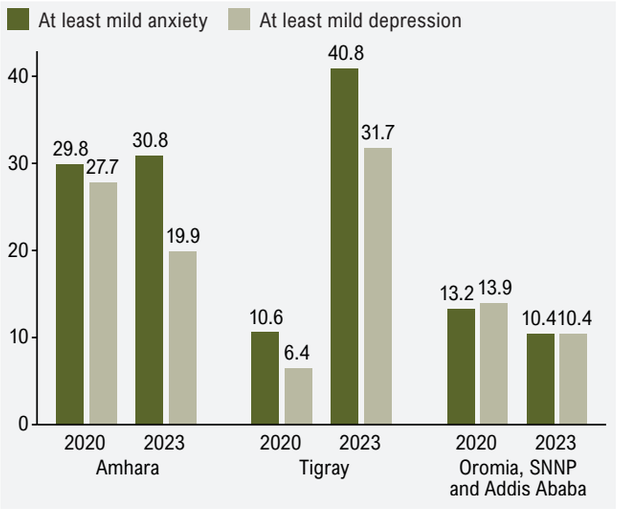
7 While evidence shows that participants who are originally from areas affected by the conflict exhibit a high percentage of underweight and food insecurity, it is worth noting that the two samples are different, as the nutrition statistics exclude participants interviewed by phone.

8 Data on subjective well-being was collected between August and October 2020, before the conflict in Tigray and Amhara started.

similar during the pandemic.[9] In contrast, a higher number of participants self-reported symptoms associated with at least moderate stress (61% for the Younger Cohort and 63% for the Older Cohort).[10]

Among the Younger Cohort, those from areas affected by armed conflict (Amhara and Tigray), have the highest prevalence of symptoms compatible with (at least moderate) stress, (at least mild) anxiety and depression and post-traumatic stress disorder (PTSD). While no more than 3% of participants from Addis Ababa, Oromia and SNNP reported one or more symptoms of PTSD, this increased to 19% and 7% for participants from Tigray and Amhara, respectively. Comparing mental health indicators before and after the start of the conflict in Amhara and Tigray, using data from August–October 2020 (Call 2 from Round 6), reveals that participants from conflict-affected areas have consistently experienced a high prevalence of mental health conditions since the conflict began in Amhara, while those in Tigray have shown even higher prevalence (Figure 5). In contrast, participants from areas not directly exposed to the armed conflict reported better indicators of mental health in 2020 and 2023.

Figure 5. *Anxiety and depression among the Younger Cohort over time and by region (%)*



Participants living in areas of ongoing conflict reported the highest prevalence of symptoms indicative of stress, anxiety and depression. Shorter versions of full scales were used to assess participants' stress and depression though interviews conducted over the phone. As a result, the findings are not directly comparable to the results shown in Annex 2 or Figure 5, which were gathered through face-to-face interviews using the full scales. Using an adjusted method for comparison,[11] we find that Younger Cohort participants from the Amhara region, interviewed over the phone, showed a significantly higher prevalence of symptoms compatible with stress (99%) and depression (28%), compared to those interviewed in person. For the anxiety indicators, the same scale was used for participants interviewed in person and over the phone. Similar to stress and depression, Younger Cohort participants from Amhara interviewed over the phone had the highest prevalence of at least mild anxiety (49%), followed by those from Tigray (41%) and those from Amhara interviewed in person (31%). The poor mental health reported among phone survey participants from Amhara was expected, as they were living in active conflict zones at the time of the interview.

Conclusions

The overall level of underweight participants remains alarmingly high in Ethiopia, despite the overall decrease over time. In addition, the high prevalence of food insecurity among participants highlights major challenges in addressing malnutrition in Ethiopia, achieving SDG Target 2.1, and ensuring a productive and healthy life for citizens.[12] Subjective well-being has generally improved over the last decade, despite a notable decline during the pandemic and before the armed conflict started. Regarding the potential impact of the conflict, participants originally from Amhara and Tigray reported worse nutrition, food security and mental health. Moreover, young people from the Amhara region who were living in active conflict zones reported the highest food insecurity and incidence of mental health conditions. Urgent assistance in these regions is crucial. Further research is vital to assess the impact of the conflict in Ethiopia, including how it has affected young people's migration patterns.

9 Participants interviewed in Amhara via the phone survey were excluded from most of the analysis in this section since a shorter scale was used to assess depression and stress levels for the sake of brevity.

10 We do not provide a comparison since the pandemic, as stress was only assessed in 2023.

11 To measure whether a participant exhibits symptoms of stress using the shorter scale, we used a cut-off of six out of a maximum possible score of 16 (Malik et al. 2020). To measure if a participant exhibits depressive symptoms, we used a cut-off of three out of a maximum possible score of six (Maurer, Raymond and Davis 2018). To compare the prevalence of anxiety and PTSD, we used the same scale as for the in-person interviews.

12 SDG Target 2.1 aims, by 2030, to end hunger and ensure access by all people, particularly poor people and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.

Annex 1. *Nutrition and food security indicators*

	Underweight (%)			Overweight and obesity (%)			High cardiovascular risk (%)		Food-insecure households (%)	
	OC (age 22)	OC (age 29)	YC (age 22)	OC (age 22)	OC (age 29)	YC (age 22)	OC (age 29)	YC (2023)	OC (age 29)	YC (age 22)
Average of full sample	28.14	17.55	22.89	3.56	13.65	4.55	7.44	1.66	74.53	74.13
Gender										
Men	27.83	15.86	21.11	1.62	12.62	3.33	3.00	0.69	73.08	74.31
Women	28.47	19.61	24.81	5.69	14.90	5.86	12.87	2.71	76.13	73.95
Difference (t-test)	0.64	3.75	3.70	4.08**	2.28	2.53	9.86***	2.02**	3.06	-0.36
Area of residence (Round 1)										
Urban	27.62	13.37	25.00	4.97	22.09	7.40	11.29	2.40	64.00	64.55
Rural	28.36	19.39	21.69	2.93	9.95	2.94	5.73	1.24	78.79	78.85
Difference (t-test)	0.74	6.02	-3.31	-2.04	-12.14***	-4.46***	-5.56	-1.16	14.79***	14.30***
Current area of residence										
Urban	28.94	13.48	24.06	4.40	17.79	6.24	9.36	2.08	70.45	68.25
Rural	27.71	25.79	21.30	2.87	5.26	2.44	3.57	1.14	78.43	78.55
Difference (t-test)	-1.23	12.31***	-2.76	-1.53	-12.53***	-3.80***	-5.79	-0.94	7.98	10.30***
Wealth index (Round 1)										
Bottom tercile	30.00	22.40	19.83	3.00	5.73	2.83	4.46	1.53	77.97	78.24
Middle tercile	29.03	20.00	26.61	2.76	9.76	3.21	4.13	0.68	81.51	80.84
Top tercile	25.00	9.04	22.41	5.23	27.71	6.98	14.67	2.54	60.62	63.05
Difference (bottom vs top tercile) (t-test)	-5.00	-13.36***	2.58	2.23	21.98***	4.14**	10.22***	1.01	-17.34***	-15.19***
Region (Round 1)										
Addis Ababa	25.71	5.97	17.79	5.71	29.85	7.69	12.86	2.88	52.00	53.14
Amhara (in person)	42.53	13.41	32.50	2.30	9.76	3.00	3.41	1.50	82.80	76.62
Amhara (phone survey)	.	.	.	.	.	.	.	.	90.48	88.37
Oromia	28.57	21.90	18.54	1.43	6.57	2.43	6.04	0.91	61.84	62.28
SNNP	16.15	10.39	19.84	4.97	19.48	6.52	11.52	2.45	77.19	79.30
Tigray	34.09	30.65	28.93	3.79	8.06	3.21	3.76	0.71	84.40	88.19
Childhood caregivers' education										
None	29.11	20.07	24.58	2.74	9.32	3.67	4.39	0.99	80.80	81.48
1 to 4 years	25.14	14.61	23.60	2.19	16.85	4.97	7.73	2.48	70.37	74.86
5 to 8 years	29.87	9.86	17.04	7.79	18.31	7.17	9.21	2.69	68.97	63.48
More than 8 years	31.58	27.78	21.97	7.89	22.22	3.79	25.64	1.52	55.81	47.06
Difference (none vs more than 8 years) (t-test)	2.47	7.71	-2.61	5.16	12.90	0.12	21.25***	0.53	-24.99***	-34.42***
Number of participants	590	564	1385	590	564	1385	605	1386	695	1531

Notes: Differences are significant at ***1%, **5% and *10%. Differences are percentage points. Information on caregiver's education was taken from 2006 (Round 2). Area of residence refers to the household location in 2002 (Round 1) as well as 2023 (Round 7). Region uses information from 2002 (Round 1). Household wealth terciles were calculated separately for each cohort using the household wealth index of 2002 (Round 1). The indicators of malnutrition (height, underweight, overweight, obesity, high cardiovascular risk) exclude participants who were interviewed via a phone survey.

Annex 2. *Mental health indicators (excluding phone survey)*

	At least moderate stress (PSS-10) (%)		At least mild anxiety (GAD-7) (%)		At least mild depression (PHQ-8) (%)		PTSD (ITQ-9) (%)	
	OC (age 29)	YC (age 22)	OC (age 29)	YC (age 22)	OC (age 29)	YC (age 22)	OC (age 29)	YC (age 22)
Average of full sample	62.50	61.08	22.70	19.51	18.73	16.11	8.07	6.05
Gender								
Men	59.16	60.19	21.69	19.47	17.82	14.92	9.31	6.09
Women	66.22	62.02	23.83	19.56	19.73	17.35	6.69	5.99
Difference (t-test)	7.06	1.83	2.14	0.09	1.91	2.43	-2.62	-0.10
Area of residence (Round 1)								
Urban	56.63	55.86	30.61	23.26	24.49	15.90	8.16	5.56
Rural	65.14	64.00	19.12	17.41	16.13	16.22	8.03	6.32
Difference (t-test)	8.50	8.14**	-11.49**	-5.85**	-8.36	0.31	-0.14	0.76
Current area of residence								
Urban	62.03	59.54	23.58	24.62	19.81	20.13	8.49	7.03
Rural	63.73	63.12	19.80	13.11	16.83	11.04	7.35	4.82
Difference (t-test)	1.70	3.58	-3.78	-11.51***	-2.98	-9.09***	-1.14	-2.22
Wealth index (Round 1)								
Bottom tercile	62.38	62.02	15.38	14.66	14.83	13.15	5.71	4.72
Middle tercile	67.39	65.16	27.83	22.27	20.96	18.26	10.43	8.31
Top tercile	56.54	56.07	24.61	21.13	20.42	16.53	7.85	5.02
Difference (bottom vs top tercile) (t-test)	-5.84	-5.95	9.22	6.47**	5.59	3.38	2.14	0.30
Region (Round 1)								
Addis Ababa	51.35	53.37	17.57	15.38	18.92	12.50	1.35	2.88
Amhara (in person)	68.82	77.11	37.63	30.85	20.43	19.90	11.83	7.46
Amhara (phone survey)	.	.	.	.	.	.	.	.
Oromia	58.55	56.89	13.25	5.42	11.33	5.15	3.29	1.50
SNNP	56.98	56.27	7.60	12.03	9.88	13.90	0.00	1.33
Tigray	75.18	66.67	43.97	40.85	36.17	31.69	24.11	18.75
Childhood caregivers'education								
None	68.93	64.80	26.62	22.82	22.73	20.17	12.94	8.66
1 to 4 years	58.00	62.65	19.10	17.77	14.57	13.90	3.50	3.61
5 to 8 years	52.44	48.88	20.73	12.61	15.85	8.56	3.66	2.69
More than 8 years	56.10	57.78	14.63	17.78	14.63	12.59	2.44	3.70
Difference (none vs ore than 8 years) (t-test)	-12.83	-7.02	-11.99	-5.04	-8.09	-7.58	-10.51	-4.96
Number of participants	632	1403	630	1399	630	1397	632	1406

Notes: Differences are significant at ***1%, **5% and *10%. Differences are percentage points. Information on caregiver's education was taken from 2006 (Round 2). Area of residence refers to the household location in 2002 (Round 1) as well as 2023 (Round 7). Region uses information from 2002 (Round 1). Household wealth terciles were calculated separately for each cohort using the household wealth index of 2002 (Round 1). This table exclude participants who were interviewed using via a phone survey.

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Young Lives is a longitudinal study of poverty and inequality, following the lives of 12,000 children into adulthood in four countries (Ethiopia, India, Peru and Vietnam).

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