# **Research Report**



# Young People's Mental Health in Unprecedented Times: Research Report from Round 7 in Ethiopia, India and Peru

Juliana Quigua, Marta Favara and Alan Sánchez



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## Summary

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For more than 20 years, Young Lives has followed two cohorts born seven years apart, from infancy to adulthood in Ethiopia, India, Peru and Vietnam. This report presents preliminary findings from the seventh round of the Young Lives survey conducted in Ethiopia, India and Peru in 2023–24, when the Younger Cohort was aged 22 and the Older Cohort was aged 29. It reports on mental health outcomes measured during the sixth survey round that took place during the COVID-19 pandemic, as well as new information collected in Round 7 and qualitative interviews that provide a more holistic picture of the risk factors for mental health and well-being.

Young Lives research shows that the COVID-19 pandemic negatively impacted young people's mental health, leading to a notable decline in subjective well-being and high levels of anxiety and depression during the lockdowns in 2020, despite positive trends in subjective well-being over the previous two decades (Favara et al. 2022a). The latest evidence suggests that young people have not yet recovered. According to Round 7 data, in India and Peru, overall levels of anxiety and depression across both cohorts have remained similar to those reported in the last phone survey call in 2021 (Round 6): participants in Peru have the highest prevalence of symptoms compatible with (at least mild) anxiety (30%) and depression (24%), while those in India have the lowest (10% for both indicators). In Ethiopia, participants' mental health has been deteriorating, with the prevalence of anxiety and depression at 20% and 17%, respectively, most likely due to the ongoing armed conflict in the Amhara and Tigray regions. Participants who are originally from these regions exhibit the poorest mental

health; by 2023, 41% of participants from Tigray reported symptoms compatible with at least mild anxiety and 32% with depression. These rates are lower for participants from Amhara but still significant, with 32% reporting symptoms compatible with at least mild anxiety and 19% reporting symptoms of at least mild depression.

By 2023, anxiety and depression show similar prevalence and are highly correlated with each other across all three countries. In contrast, self-reported stress levels are considerably higher, affecting most Young Lives participants. Overall, six out of ten participants reported symptoms compatible with moderate stress. Similarly to anxiety and depression, participants in Peru are more likely to report symptoms of stress than those in Ethiopia and India (70%, 61% and 59%, respectively).

There are significant differences within countries when looking across demographic and socio-economic subgroups. For instance, women report higher prevalence of mental health issues than men in India and Peru. More concerningly, while men's mental health indicators in India have marginally improved since the pandemic, women's mental health indicators have worsened. There are also significant differences when comparing young people born into low-income households with those born into wealthier families, although diverging significantly across countries. In Peru and Ethiopia, participants from wealthier households exhibit a higher prevalence of symptoms compatible with anxiety and depression compared to their counterparts.<sup>1</sup> In India, the trend is the opposite, with participants from poorer households showing a higher prevalence of symptoms of anxiety and depression.

#### Box 1. Key findings

- In Peru, one in three 22-year-old study participants exhibit symptoms compatible with at least mild anxiety, and one in four exhibit symptoms compatible with at least mild depression. Seven out of ten exhibit symptoms compatible with moderate stress. In contrast, the overall levels of at least mild anxiety and depression are lower in India and Ethiopia.
- In India and Peru, anxiety and depression have remained at their 2021 levels, following the peak of the COVID-19 outbreak. In contrast, anxiety and depression levels in Ethiopia have risen, most likely due to the ongoing armed conflict in the Amhara and Tigray regions.
- In India and Peru, young women report higher prevalence of mental health issues compared to men. Concerningly, while men's mental health indicators have marginally improved in India since the pandemic, women's mental health indicators have worsened.
- Lived experiences of mental health (in Peru) highlight that the lack of social protection, persistent barriers to accessible and high-quality mental healthcare services, and social stigma that deters seeking help, amplified the effect of the pandemic on young people's mental health.
- In Ethiopia, four out of ten participants originally from Tigray exhibit symptoms compatible with at least mild anxiety, and three out of ten exhibit symptoms compatible with depression. For participants from Amhara, these rates are three out of ten and two out of ten, respectively. Participants from both regions have the highest prevalence of symptoms linked to PTSD and reports of negative conflict experiences.
- Early-life inequalities are reflected in lower adult subjective well-being (particularly in Ethiopia and India), while the results are mixed when looking at mental health. In India, participants from more vulnerable backgrounds exhibit higher prevalence of mental health conditions. In Ethiopia and Peru, participants from wealthier households and urban areas exhibit higher levels of anxiety and depression.

1 The differences are not statistically significant regarding depression.

### 1. Introduction

Neuropsychiatric and mental health conditions are the leading cause of disability in young people around the world, with 14% of people between the ages of 15 and 24 reporting a mental health condition (Kieling et al. 2024). Untreated mental health conditions can severely impair children's functioning and development and diminish their ability to become productive members of society as they grow up (WHO 2021). In turn, the cumulative global impact of mental health issues in terms of lost economic output has been estimated at approximately US\$16 trillion over 20 years (Marrero, Bloom and Adashi 2012). Nevertheless, despite the enormous personal and social suffering and lost productivity, depression and anxiety are among the most neglected areas of research and health expenditure. Mental health challenges are particularly alarming in low- and middle-income countries (LMICs) since 70% of the global mental health burden occurs in these regions (Alloh et al. 2018). Moreover, only 36% of people living in LMICs are covered by mental health legislation, and there is low annual spending on mental health (US\$0.25 per person). These factors translate into limited access to treatment, whereby eight out of ten people with severe mental health conditions do not receive treatment in LMICs (WHO 2021).

The COVID-19 pandemic has set back mental health. Young Lives documented and investigated the impact of the pandemic on young people's mental health, finding high levels of anxiety and depression (Porter et al. 2021) and a striking fall in subjective well-being (Favara et al. 2022a) despite positive trends over the two preceding decades. Young Lives research shows that pandemic-related health, economic and social stressors present significant risks to the mental health of young people, particularly young women and those living in food-insecure households (Porter et al. 2021; 2022). Collectively, the pandemic setbacks, as well as the limited capacity of healthcare systems to support people living with mental health conditions, highlight challenges to achieving Sustainable Development Goal 3.4.<sup>2</sup>

This report provides a snapshot of the new data on mental health collected as part of Round 7 of the Young Lives survey. It investigates the evolution of young people's post-pandemic mental health and well-being across three LMICs.<sup>3</sup> While the evidence provided is not causal, it sheds light on different trajectories of mental health depending on early-life inequalities, gender, socio-economic status and contingent circumstances.

## 2. Country contexts

#### 2.1. Ethiopia

Despite 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 with high poverty levels. According to the most recent official estimates available, by 2019 around 69% of people lived in multidimensional poverty and 18% were at risk of falling into poverty (UNDP 2023). Moreover, Ethiopia has faced several negative shocks since 2020, including the COVID-19 pandemic, severe drought affecting the southern regions, ongoing armed conflict in the Tigray region (which began in November 2020) and the conflict in the Amhara region (from September 2023 onwards). Young Lives research has shown the detrimental impact of both the pandemic and armed conflict on young people's mental health (Favara et al. 2022b). The government has invested in scaling up healthcare systems and has designed multiple national mental health plans since 2012. The latest strategy (2020-25) aims to improve the access and quality of mental health services through a multisectoral approach led by the government (Federal Ministry of Health 2021).

#### 2.2. India

India is another fast-growing economy, with an annual GDP growth of 7.6% in 2023 (World Bank 2024). Between 2015-16 and 2019–21, the proportion of the population living in multidimensional poverty reduced by 9.9 percentage points (Vashist et al. 2023). According to the latest data from the National Mental Health Survey of 2016, the prevalence of mental health conditions was 5.1%, while the treatment gap was 80.4% (Jayasankar et al. 2022). This is attributed to limited resources and partial implementation of mental health policies (Patel et al. 2016). The Mental Health Care Act recognises the statutory right to mental healthcare access and provides a basis for reforming policy accordingly (Ranade, Kapoor and Fernandes 2022). However, its implementation has been limited (Pathare and Kapoor 2020). Challenges include scaling up mental health services through a systematic approach, adequate financial resource allocation, collaboration across all stakeholders and adequate training (Vashist et al. 2023).

#### 2.3. Peru

Peru took some of the harshest measures globally to contain the COVID-19 pandemic, resulting in a significant increase in monetary poverty, from 20.2% in 2019 to 30.1% in 2020. Despite the economic recovery thereafter, the latest official figures indicated that monetary poverty remained at 29% in 2023 (National Institute for Statistics and Informatics 2024). The pandemic had a severe impact on Peruvians' health and welfare, as the country saw some of the highest mortality rates and longest lockdowns

2 SDG 3.4 aims, by 2030, to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and to promote mental health and well-being.

<sup>3</sup> 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.

globally (World Bank 2023). In response to the worsening mental health during the pandemic, in 2020 the government launched its Mental Health Plan that promotes community mental health centres– which have operated in the country since 2017 – and call centres operated by health professionals providing information and guidance about mental health, among other services (Government of Peru 2021). Before the pandemic, Peru had reformed mental health services through Mental Health Law 29889, which includes a new community mental health services model and financing mental health services for poor households through integration with the health insurance scheme (World Bank 2019). Despite these efforts, mental health challenges are the third-most common cause of disabilityadjusted life years (DALYs) in Peru.

### 3. Methods

#### 3.1. Data

This report utilises Round 7 data, collected in Ethiopia, India and Peru in 2023–24 (Favara, et al. 2025; Molina et al. 2025) as well as Round 6 data. In Ethiopia, Round 7 data collection began in October 2023, with the main part of the fieldwork completed by January 2024. An extra effort was subsequently made to locate and interview internal migrants and to contact participants residing in two of the study sites in the Amhara region by phone, as the fieldwork team was unable to travel due to the ongoing conflict. Fieldwork was completed in April 2024. Overall, 2,231 participants were interviewed (1,535 from the Younger Cohort and 696 from the Older Cohort), 91.3% in-person and 8.7% over the phone, which represents 74.4% of the Round 1 sample.

In India, Round 7 fieldwork took place between August 2023 and January 2024. A total of 2,673 interviews were completed (1,826 from the Younger Cohort and 847 from the Older Cohort), which represents 88.5% of the Round 1 sample. In Peru, Round 7 data collection took place between June 2023 and January 2024, with 2,219 in-person interviews completed (1,702 from the Younger Cohort and 517 from the Older Cohort), representing 80.2% of the Round 1 sample. For our main analysis, we only consider the sample of individuals who answered all mental health questions in person.

This report also uses Round 6 data collected in 2020–21, over five phone calls.<sup>4</sup> specifically, information from Call 2 (conducted between August and October 2020) and Call 5 (conducted between October and December 2021) that includes the most comprehensive mental health measures. In the case of Ethiopia, the timing of the two calls is particularly relevant given the concurrent outbreak of armed conflict in Tigray and Amhara. Call 2 was administered just before the Tigray conflict began, while the timing and content of Call 5 are relevant for better understanding the combined effect of the COVID-19 pandemic and the conflict.

#### Box 2. The Young Lives study

Young Lives has followed the lives of 12,000 children born into poverty in Ethiopia, India (the states of Telangana and Andhra Pradesh), Peru and Vietnam since 2002. The sample includes two cohorts: the Younger Cohort of 8,000 people born in 2000–01 and the Older Cohort of 4,000 people born in 1994–95. The sample is equally distributed across the four countries, as well as by gender and ethnic groups within each country (Escobal and Flores 2008; Kumra 2008; Nguyen 2008; Outes-Leon and Sánchez 2008). Between 2002 and 2016, Young Lives conducted five rounds of in-person surveys (Figure 1).

Round 6 included five phone surveys conducted in 2020–21 during the COVID-19 pandemic (Calls 1 to 5). Young Lives completed a seventh survey round in 2023–24, visiting respondents in Ethiopia, India and Peru in person. Additionally, Young Lives has followed a subset of 200 participants as part of a qualitative study



since 2007 (including five rounds in Peru, six in Ethiopia and four in India and Vietnam), which includes semi-structured interviews and focus group discussions (Crivello et al. 2013).

4 More information about Round 6 is available at https://www.younglives.org.uk/research-project/young-lives-work

www.younglives.org.uk

#### 3.2. Subjective well-being

Subjective well-being is measured using the Self-Anchoring Striving Scale, also known as Cantril's Ladder (Cantril 1965), which has been administered in the Young Lives survey since Round 2. It is one of the most used selfreported measures of well-being, used in Gallup's World Poll, UNICEF's Multiple Indicator Cluster Surveys, and the Programme for International Student Assessment (PISA), among others. Respondents are asked to consider a tenstep ladder, with the top step representing the best life and the bottom step the worst life they could imagine.

#### 3.3. Mental health measures

To assess the mental health of participants, Young Lives included self-reported measures of stress, anxiety, and depression across the three study countries and, in Ethiopia only, measures of post-traumatic stress disorder (PTSD).

The prevalence of participants reporting symptoms compatible with **anxiety** was measured using the Generalized Anxiety Disorder-7 (GAD-7) scale with a score from 0 to 21 (Spitzer et al. 2006). This scale has been validated (Löwe et al. 2008; Kroenke et al. 2010; Zhong et al. 2015b) and previously used in the three study countries by other studies (Dadi et al. 2016; Hakim et al. 2017; Gezie et al. 2018; Villarreal-Zegarra et al. 2024) and by Young Lives in Round 6. Based on the number and frequency of symptoms reported, participants were distinguished by whether they report symptoms compatible with 'minimal' (score below 4), 'mild' (between 5 and 9), 'moderate' (between 10 and 14), or 'severe' (above 15) anxiety.

The prevalence of participants reporting symptoms compatible with depression was measured using the Patient Health Questionnaire depression scale-8 (PHQ-8) (Kroenke et al. 2009). The nine-item version of the scale has been validated and used in the three Young Lives study countries by other studies (Kroenke et al. 2010; Gelaye et al. 2013; Zhong et al. 2015a; Hakim et al. 2017; Woldetensay et al. 2018; Carroll et al. 2020) and the eight-item has been used by Young Lives during Round 6. The PHQ scale has been slightly adapted in Round 6 and Round 7 in two ways to retain comparability: first, the ninth question of PHQ-9 ('Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?') has been dropped, due to considerations around the duty of care and safeguarding of participants; second, the questions have been asked in two steps, asking for each item whether the participant has been bothered by the problem over the past month (with a yes/ no question) and asking about the severity of the problem where answered affirmatively. Based on the frequency and severity of the symptoms reported, participants were distinguished by whether they report symptoms compatible with 'minimal' (score below 4), 'mild' (between 5 and 9), 'moderate' (between 10 and 14), 'moderately severe' (between 15 and 19) or 'severe' (above 20) depression. Participants interviewed over the phone were identified according to whether they reported symptoms compatible with depression using a two-item scale (PHQ-2) and relying

on a cut-off of three out of a maximum possible score of six (Maurer, Raymond and Davis 2018).

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Round 7 also introduced two measures of stress, a selfreported measure and one based on the level of cortisol measured on participants' hair samples. This report only includes the former, as analysis of the hair samples is still ongoing. We relied on the Perceived Stress Scale (PSS-10) scale (Cohen, Kamarck and Mermelstein 1983), which has been used to assess stress levels in adults and young people aged 12 and above (Kechter et al. 2019). The questions in this scale are easy to understand and relatively free of content specific to any subpopulation group, with simple response alternatives. The PSS-10 scale has been validated in multiple contexts (Hewitt, Flett and Mosher 1992; Lee 2012) and has been administered in Ethiopia (Manzar et al. 2019), India (Pangtey et al. 2020) and Peru, including as part of a Young Lives urban cluster sub-study in 2021-22 (Boluarte-Carbajal, Navarro-Flores and Villarreal-Zegarra 2021). Considering the frequency of symptoms, the PSS-10 scale allows differentiation of participants who report symptoms associated with 'low' (between 0 and 13), 'moderate' (between 14 and 26) or 'high' (above 27) stress. A PSS-4 item scale with a cut-off of 6 out of a maximum of 15 (Malik et al. 2020) was used to assess stress prevalence among participants interviewed over the phone.

In Ethiopia, the prevalence of participants reporting symptoms of PTSD was measured using the subset of questions from the International Trauma Questionnaire (ITQ-9). The ITQ-9 was validated and designed to align with the World Health Organization International Classification of Diseases D-11 criteria for PTSD diagnosis (Cloitre et al. 2018), and has been used in several studies (Vallières et al. 2018; Langtry et al. 2021; Frost et al. 2022). The scale was slightly adapted to simplify its administration in face-to-face interviews. Similar to the GAD-7 and PHQ-8, for each item the participant was first asked if they had been bothered by the problem (yes/no) over the past month, and if 'yes', then asked about the severity of the problem experienced. Using this scale, participants were classified depending on whether they reported at least one symptom of PTSD or not.

#### 3.4. Cross-cutting variables

The analysis classifies participants by gender, area of residence (urban or rural) at the time of data collection, household wealth in 2002 (top, middle, or bottom wealth tercile in 2002) (Briones 2017), mothers' or caregivers' level of education and maternal language (Peru), region of origin (Ethiopia) and caste (India).<sup>5</sup> Table 1 provides an overview of the findings using these cross-cutting variables.

#### 3.5. Sample

When using information from previous rounds, participants who were not interviewed in Round 7 are excluded from the analysis. For Ethiopia, unless otherwise noted, the participants surveyed over the phone are excluded due to differences in the stress and depression scales.<sup>6</sup>

<sup>5</sup> This report uses the term Backward Classes, which is equivalent to Other Backward Castes.

<sup>6</sup> Section 5 provides more detail on mental health in Ethiopia.

### 4. Findings

The subjective well-being of the Young Lives cohorts was negatively affected by the COVID-19 pandemic and it is slowly getting back to pre-pandemic levels (see Figure 2).

## Figure 2. Subjective well-being average score by cohort and age

#### Figure 2a. Ethiopia



Figure 2b. India



Figure 2c. Peru



Notes: Authors' calculation using Young Lives data. We use data from Call 2 (Round 6) to estimate the average score during the pandemic. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7.

In Ethiopia and India, the average score of self-reported well-being increased as participants got older.7 However, as previously documented by Young Lives (Favara et al. 2022a), the pandemic, experienced at age 26 for the Older Cohort and 19 for the Younger Cohort, reduced the average score.8 By Round 7, there are visible signs of recovery. In India, the recovery is fast enough to surpass pre-pandemic levels. In Ethiopia, subjective well-being remains below pre-2020 levels due to the occurrence of multiple shocks, including armed conflict in Tigray and Amhara, drought, and spiralling inflation. In Peru, the picture is slightly more complex. The well-being of the Younger Cohort has decreased since 2013 (age 12), with the greatest decline occurring at the time of the pandemic (age 19). By 2024, their well-being has improved and reached almost the same level as the Older Cohort when they were a similar age. The Older Cohort have registered two substantial declines in subjective well-being, at age 19 when the participants entered adulthood and at age 26, at the outbreak of the pandemic. By 2023, average subjective well-being has recovered and reached similar pre-pandemic levels.

The levels of anxiety registered in Round 7 significantly differ by country, being considerably higher in Peru, where one out of three participants experience symptoms compatible with at least mild anxiety. By 2023, the Older Cohort have a higher prevalence of anxiety among all three countries (see Figure 3). In Peru, 33% of the Younger Cohort participants and 27% of the Older Cohort participants exhibit symptoms of at least mild anxiety, substantially higher than in Ethiopia (19% and 23%, respectively) and India (9% and 14%, respectively). Among participants with symptoms compatible with anxiety, most exhibit mild symptoms (between 8% and 20% for all participants). Between 2% and 9% of all participants report symptoms compatible with moderate anxiety, and fewer than 3% exhibit symptoms of severe anxiety.





Notes: Authors' calculation using Young Lives data. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7.

- 7 The differences are not statistically significant for the Younger Cohort in Ethiopia.
- 8 In Ethiopia, we associate the decrease in subjective well-being to the pandemic since we rely on information from Call 2, collected between August and October 2020 (before the Tigray conflict started in November 2020).

The prevalence of anxiety decreased between Call 2 (administered at the peak of COVID-19 in 2020) and Call 5 (administered at the end of the pandemic in 2021) among participants from Peru and the Older Cohort of Ethiopia, while it remained (statistically) unchanged among participants from India and the Younger Cohort of Ethiopia (see Figure 4). After the pandemic, between Call 5 (2021) and Round 7 (2023), no significant difference in anxiety was registered in Peru and India. However, the prevalence of anxiety increased in Ethiopia, most likely due to exposure to the conflict in Amhara.

# **Figure 4.** *Trajectories of anxiety across Rounds (Call 2 of Round 6, Call 5 of Round 6 and Round 7) and by cohorts (% with symptoms of at least mild anxiety*

Figure 4a. Ethiopia



Figure 4b. India



Figure 4c. Peru



Notes: Authors' calculation using Young Lives data. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7.

Across the three countries, the Older Cohort were more affected than the Younger Cohort at the peak of the pandemic. Overall, the Older Cohort exhibited higher levels of anxiety than the Younger Cohort in Call 2, soon after the outbreak of the pandemic (and before the conflict in Ethiopia). In India, both cohorts followed similar trends during the pandemic (between 2020 and 2021) and afterwards (between 2021 and 2023). In Peru, the Older Cohort experienced a more significant decrease in anxiety levels compared to the Younger Cohort during and after the pandemic-in fact, for the Younger Cohort there has been a slight increase (not statistically significant) in anxiety after the pandemic. In Ethiopia, the Older Cohort initially experienced a more significant decrease compared to the Younger Cohort in anxiety levels during the pandemic. However, this trend shifted after the pandemic, leading to an increase in anxiety levels that mirrored the Younger Cohort's trend (most likely explained by the armed conflict in Amhara). By 2023, there were statistically significant differences among the three countries, although the overall gap in anxiety levels had reduced in Ethiopia.

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While the prevalence of depression is lower than the prevalence of anxiety by 2023, the two follow similar patterns. In Peru, 28% and 18% of participants from the Younger Cohort and Older Cohort, respectively, exhibit symptoms of at least mild depression (see Figure 5). These levels are 15% and 19% in Ethiopia and 10% and 11% in India. Similarly to the prevalence of anxiety, most of the participants who exhibit symptoms compatible with depression, exhibit only mild symptoms (between 8% and 16% for all participants). Fewer than 6% of participants report symptoms compatible with moderate depression, and at most 3% exhibit symptoms of moderately severe or severe depression.





Notes: Authors' calculation using Young Lives data. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7.

Overall, the prevalence of at least mild depression either decreased or remained (statistically) unchanged during the pandemic and afterwards, with a few exceptions: in Ethiopia, the prevalence of at least mild symptoms of depression increased after the end of the pandemic in both cohorts, which is plausibly explained by the armed conflict in Amhara (see Figure 6). Among Younger Cohort participants in Peru, the prevalence of at least mild depression slightly increased between 2021 and 2023, and among participants in India, there was a slight increase between 2020 and 2021; however, in both cases, the differences are not statistically significant. By 2023, in India there are no statistically significant differences in the prevalence of at least mild depression between the two cohorts. In contrast, in Peru, the Younger Cohort exhibits a higher prevalence of depression, while in Ethiopia, the Older Cohort does. The higher prevalence of mental health conditions among the Younger Cohort compared to the Older Cohort in Peru is likely due to the country's early and strict lockdown during the pandemic. Since the Younger Cohort were about 18 years old when the pandemic started, they are likely to have been more affected by interruptions to education than the Older Cohort, which possibly translated into slower improvements in mental health after the pandemic. In the case of Ethiopia, the results suggest that the impact of the armed conflict might be greater for the Older Cohort participants.

# **Figure 6.** Trajectories of depression across Rounds (Call 2 of Round 6, Call 5 of Round 6 and Round 7) and by cohorts, (% with symptoms of at least mild depression)

Figure 6a. Ethiopia



Figure 6b. India



Figure 6c. Peru



Notes: Authors' calculation using Young Lives data. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7.

A large number of participants exhibit symptoms of at least moderate stress (see Figure 7), with Peru registering the highest rates, 72% and 67% of the Younger Cohort and Older Cohort, respectively, followed by Ethiopia (61% and 63%, respectively) and India (59% of both cohorts). Despite the significant prevalence of stress in all three countries, most participants exhibit moderate stress symptoms, with the prevalence of high-stress symptoms less than 4%.

Among the three countries, while anxiety and depression scores exhibit a strong positive correlation, their correlation with stress scores is comparatively weaker (see Table 3). Among participants who report symptoms compatible with at least mild depression, 72% also report symptoms compatible with at least mild anxiety. Similarly, 62% of participants who report symptoms compatible with at least mild anxiety also report symptoms of at least mild depression. In contrast, the correlations between stress scores and those of anxiety and depression are weaker. This is expected as almost all people showing symptoms of at least anxiety or depression also report at least moderate stress, with rates of 90% and 91%, respectively.





Notes: Authors' calculation using Young Lives data. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7.

Overall, women exhibit more mental health issues compared to men (see Figure 8). By 2023, while the prevalence of at least mild anxiety is similar among men and women in Ethiopia, it is nearly twice as high for women as men in India and Peru, with differences of seven and 17 percentage points, respectively. Regarding depression, there is a higher prevalence among women than men in Ethiopia, but these differences are not statistically significant. In India and Peru, the gender gap in depression prevalence is narrower compared to anxiety prevalence but remains significant. While women in India have a prevalence of at least mild depression that is four percentage points higher than men, this gap is 13 percentage points in Peru. Peru exhibits the largest gender gaps, even though the prevalence of anxiety and depression has decreased since the pandemic. India presents a more puzzling picture. While men's mental health indicators have marginally improved since the pandemic, women's mental health indicators have worsened since the pandemic. Regarding stress prevalence, the gender differences in Ethiopia and India

are not statistically significant. In Peru, women are more likely to report symptoms compatible with at least moderate stress, with a difference of 16 percentage points compared to men.

# **Figure 8.** Prevalence of anxiety, depression and stress in Round 7, by gender (%)

Figure 8a. Prevalence of at least mild anxiety



Figure 8b. Prevalence of at least mild depression







Notes: Authors' calculation using the pooled sample (Younger Cohort and Older Cohort) of Young Lives data. The calculations for Peru include sample weights to emulate the original sampling design of the study. The estimations for Ethiopia exclude participants interviewed via phone in Round 7. Early-life inequalities are reflected in lower adult subjective well-being (particularly in Ethiopia and India), while the results are mixed when looking at mental health. In India, participants from more vulnerable backgrounds exhibit worse subjective well-being and mental health. Participants born in wealthier households, whose mothers were more educated and who are currently living in urban areas, report higher subjective well-being relative to their peers. Also, participants from wealthier households have a lower prevalence of at least mild anxiety and depression, and participants whose mothers were more educated exhibit a lower prevalence of stress as well as anxiety. The gap in stress is particularly striking among participants whose mothers have no formal education (61%) compared to those participants whose mothers had higher education (37%). The differences are also striking in terms of caste, as participants who belong to historically disadvantaged groups (Scheduled Castes and Scheduled Tribes) report lower subjective well-being and a higher prevalence of anxiety, depression and stress. In Ethiopia, caregiver's education is positively correlated with higher subjective well-being. When looking at mental health, participants from wealthier households and from urban areas in Ethiopia and Peru exhibit higher levels of anxiety and depression.9 In Peru, participants whose mother's native tongue is Spanish and those with higher maternal education exhibit a higher prevalence of depression compared to those whose native tongue is Indigenous and have lower maternal education.

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# 5. Conflict and mental health in Ethiopia

During Round 7 data collection in 2023, two of the Young Lives sites in the Amhara region of Ethiopia were under the control of rebel groups (Box 3), creating an unsafe environment for face-to-face interviews. With the help of local guides, the Young Lives fieldwork team identified respondents who had relocated to safer areas and were, therefore, reachable and also willing to be interviewed in person, and those who remained in the unsafe areas but were available for a phone interview. As a result, 8.7% of the Young Lives participants in Ethiopia were interviewed over the phone using a shortened version of the questionnaire.

Using data from August–October 2020 (Call 2, Round 6) allows a comparison of indicators of mental health before and after the start of the armed conflict in the regions of Amhara and Tigray. Overall, the prevalence of mental health issues is highest, and has significantly increased over time, among participants who were exposed to the conflict during Round 7, particularly those that could not be interviewed in person in the Amhara region, followed by respondents in Tigray (Figure 9). This is expected, as participants from Amhara interviewed over the phone were in sites experiencing ongoing conflict. In contrast, participants interviewed in person might have migrated or were interviewed before the conflict escalated in their sites and therefore were potentially less affected by the conflict.

9 All the differences are statistically significant, except for depression prevalence depending on the wealth index in Ethiopia.

#### Box 3. The armed conflict in Ethiopia

The most significant and devastating event in Ethiopia's recent history began with the onset of armed conflict in the Tigray region when, on 4 November 2020, hostilities erupted between the federal government, supported by Eritrean and Amhara regional forces, and the Tigray People's Liberation Front (TPLF) (Gesesew et al. 2021). This resulted in the occupation of Tigray, including the capital city of Mekelle, by the Ethiopian Defence Force and allied forces, marking what is commonly referred to as the first phase of the conflict. In 2021, the second phase saw the conflict widen to several areas in the Amhara and Afar regions, following the federal government's strategic withdrawal from Tigray in late June. The third phase of hostilities started in 2022, but ended with the successful negotiation of a Cessation of Hostilities Agreement mediated by the African Union on 2 November 2022 in Pretoria (Gebresenbet and Tariku 2023).

Following the agreement, a new conflict emerged in Amhara, involving local rebel factions, commonly referred to as the Fano militia, and national government forces. This clash was sparked by governmental efforts to disarm the Amhara Region's Special Force and Fano militias as part of a broader strategy to rein in radical elements. In August 2023, the conflict intensified as the Amhara rebels seized control of key towns and facilitated the escape of detainees. This escalation led the federal government to institute a six-month state of emergency on 4 August 2023, which saw the deployment of the Ethiopian National Defence Force (ENDF) to the region and the enforcement of stringent measures, including a curfew, prohibition of public gatherings and the authorisation of arrests without judicial warrants (ACLED 2023).





By 2023, half of the participants from the Amhara region interviewed by phone exhibited symptoms compatible with anxiety (52%), followed by participants from Tigray and Amhara interviewed in person, with prevalences of 40% and 32%, respectively. The rates are considerably higher than those of participants from Addis Ababa, Oromia and SNNP, at 10%. Using a shorter scale to assess the prevalence of depression, one-third of participants from Amhara interviewed over the phone reported symptoms related to depression (30%). Using the same shorter scale, participants from Tigray and Amhara interviewed in person exhibit prevalences of 18% and 12%, respectively. Similar to anxiety, the prevalence of depression is considerably lower for participants from regions not directly affected by the conflict (8% at the most). Finally, relying on a shorter scale to assess stress prevalence, all the participants from Amhara interviewed over the phone exhibit symptoms of high stress, compared to 61% and 67%, respectively, of participants from Tigray and Amhara interviewed in person. In contrast to the prevalence of anxiety and depression, participants from regions not affected by the conflict also exhibit a high prevalence of high stress, ranging from 44% to 59% (see Table 2).

#### PTSD is significant among participants from Amhara

and Tigray. While no more than 1% of participants originally from Addis Ababa, Oromia, and SNNP exhibit at least one symptom of PTSD, these percentages are significantly higher among participants originally from Tigray and Amhara interviewed via phone survey, at 20% and 17%, respectively (Figure 10). Participants from Amhara who were interviewed in person exhibit half these levels (9%). For participants interviewed in person, the PTSD score is moderately correlated with anxiety and depression scores (coefficient of 0.6) and weakly correlated with stress scores (coefficient of 0.4) (see Table 3).





Participants were asked about the difficulties they experienced or were exposed to from the conflict (i.e., food shortages, work and education interruptions, threats). Collecting data on such experiences can be challenging since respondents may refuse to disclose or systematically underreport experiences due to social desirability bias (Tourangeau and Yan 2007). To overcome this challenge, conflict-related questions were asked using audio computer-assisted self-interviews (ACASI) to participants interviewed in person and asked by the enumerators to those interviewed by phone. Using self-administered survey tools, such as ACASI, instead of face-to-face enumeratorbased interviews leads to higher disclosure rates of conflict-related experiences, particularly for the most sensitive questions (von Russdorf et al. 2024). As expected, participants originally from regions affected by the conflict (Tigray and Amhara) report having been exposed to more conflict experiences and higher prevalence of mental health conditions.

On average, participants from Tigray report being exposed to six of the eight possible shocks (Figure 11). Participants from Amhara also disclose a high number of conflict experiences, three out of eight for those interviewed in person and four out of eight for those interviewed by phone. In contrast, participants from Addis Ababa, Oromia and SNNP report being exposed to less than one shock on average.

The most commonly reported experiences due to conflict relate to the interruption of public services.

Among participants from conflict-affected areas, the most reported shock is interruption in access to communication infrastructure, according to most of the participants from Amhara (63% of those interviewed in person and 94% by phone) and Tigray (99%). The second most common shock is access to utilities, such as water or electricity, reported by 50% of people interviewed in person in Amhara, 73% of participants from Amhara interviewed by phone, and 97% of participants from Tigray.

Participants from areas affected by the conflict were also exposed to more precarious labour, health and education conditions. Eight out of ten participants from Tigray report being unable to work or find a job, access healthcare, or continue their education or that of their children. Participants from Amhara who were interviewed by phone also report these experiences at a high rate (six out of ten participants). In contrast, only three out of ten participants in Amhara who were interviewed in person report this experience.

# **Figure 11.** Average number of conflict experiences since November 2020 by region (out of a possible eight)



10 Findings from this section are based on Rojas and Flores (2025).

# 6. Lived experiences of mental health in Peru<sup>10</sup>

Recent Young Lives research highlights that participants from Peru were the most affected by the COVID-19 pandemic (Porter et al. 2021; Rojas and Alván 2024). Qualitative research during the pandemic in Peru indicated that women were deeply affected due to additional unpaid care and domestic responsibilities, especially caring for children and other family members (Rojas, Crivello and Alván León 2023), as well as the negative impacts on employment opportunities, such as job loss and education interruption, and an increase in gender-based violence (particularly in rural areas) (Rojas and Alván 2024). Two testimonies are presented here to deepen the understanding of how the pandemic amplified pre-existing vulnerabilities, exacerbating gender inequalities and affecting the everyday experiences of young women in Peru (see Box 4).

# Box 4. Lived experiences: sample selection and methodology

As part of the lived experiences component, Young Lives conducted semi-structured interviews with two young women who experienced worsening mental health issues during the pandemic (Rojas and Flores 2025). These respondents were identified after being interviewed for 20 years as part of the quantitative component of Young Lives. One respondent from the Younger Cohort (22 years old) and one from the Older Cohort (29 years old) were selected to represent different stages of life (e.g. while the women in the Younger Cohort are mostly following an educational path, Older Cohort women are commonly parenting or starting a new family). Furthermore, one participant was selected from an urban area and the other from a rural area to allow insights into the importance of social context on mental health issues.

Two, two-hour long semi-structured interviews were conducted. During the interviews, a well-being scale similar to that used in the quantitative survey was applied to identify participants' perceptions of their well-being before, during, and after the pandemic. After the first interview, a team performed a desk review, where the new information was analysed alongside previous data (from Rounds 1 to 6 of the household survey and Waves 1 to 5 of the qualitative study). This helped identify critical triggers and contextualise the life trajectories of the participants. After the desk review, the team made a second visit to complete the interview, clarify previously raised issues and develop a better understanding of the lived experiences of the participants.

The two respondents were compensated for their time (50 soles or US\$15) and psychological support was provided, following duty of care and safeguarding protocols. The team put participants in contact with a psychologist who offered initial support that lasted four to six sessions, depending on their recommendations. The psychologists then guided the participants to community-based psychological services if needed. The two testimonies illustrate the complexity of the factors influencing mental health, where personal, familiar, sociocultural and structural aspects intertwine. These cases highlight the systemic barriers to accessing mental health services due to socio-economic inequalities and limitations in public policies. The names of the participants have been anonymised.

Daniela, a 22-year-old member of the Younger Cohort, lives in a rural area. During the pandemic, she faced significant challenges in accessing high-quality education. Aurora is an Older Cohort participant who is 29 years old and lives in an urban area. During the pandemic, she became a mother for the second time without planning it, starting a new family, which considerably increased her housework and childcare load. She was also the victim of domestic violence and was economically vulnerable.

The COVID-19 pandemic was a challenging event that catalysed emotions that Daniela and Aurora had already developed and recognised before the pandemic. Before the pandemic, both women faced situations that had a deep impact on their mental health. Aurora experienced economic precariousness, her father's absence, domestic violence and restrictive gender roles, while Daniela suffered from bullying and violence at school that undermined her self-esteem and emotional well-being from an early age. Neither received psychological support when growing up, and these negative experiences in their childhood may have led them to develop dysfunctional patterns of thinking and behaviour, affecting their self-perception and their ability to manage stress.

Despite having different circumstances, both Aurora and Daniela's negative feelings were exacerbated when the pandemic hit, their housework increased and their situations became more vulnerable and stressful. Before the pandemic, Aurora was a young mother who had paused her education to care for her first child. When the pandemic hit, she had her second child and could not rely on her mother's help, significantly increasing her childcare responsibilities. Moreover, Aurora experienced domestic violence, economic uncertainty and negative feelings due to the prolonged lockdown. These factors intensified her anxiety, stress and depression. While Daniela had different circumstances, the pandemic also increased her stress and anxiety. Daniela lived outside her household before the pandemic while attending college. When the pandemic hit, she returned to live with her family, which implied increased household and agricultural tasks, especially when her mother became ill and she had to take on her role in the home. In Daniela's case, family conflicts and the interruption of her university studies worsened her anxiety and stress. Both Aurora and Daniela developed negative behaviours directly related to their emotional states, such as overeating. In Daniela's case, this behaviour turned into an eating disorder, which she continued to struggle with after the pandemic.

Daniela and Aurora faced different barriers to accessing psychiatric or psychological support. Aurora's case shows the constraints on economically vulnerable people around receiving appropriate mental health care and support. As a psychologist herself, Aurora was aware that she needed long-term psychological support. However, she could not afford to pay for private services and did not have subsidised health insurance. More concerningly, despite experiencing intense emotions related to suicide, she did not seek help from community mental health centres as she perceived them to be low-quality options. As an alternative, in 2023 Aurora decided to rely on healers or spiritual practitioners, exercise and prayer to cope with her family and financial problems. During the pandemic, Daniela faced significant challenges in accessing mental health services. She spent the lockdown in her home community, where mental health centres were unavailable. This lack of support worsened her eating disorder, as she had no one to turn to for help. It was not until the lockdown measures began to ease that she was able to travel to the city and access a mental health centre. In her case, the absence of care in her community, coupled with social stigma, led her to "hit rock bottom" and feel that she had no one to turn to, which made her contemplate taking her own life. Even when she did have access to psychiatric and psychological support through services available at her university, she experienced delays in obtaining pharmacological treatment, highlighting the challenges that exist even when people have healthcare insurance.

Stigmatisation, lack of social protection and barriers to accessible and high-quality mental health care are persistent issues in Peru. The impact of the pandemic on Aurora and Daniela's well-being reflects the broad challenges that Peruvian society has to overcome to guarantee good mental health among its citizens. While Aurora is a clear example of a lack of access to social protection and healthcare, Daniela's case highlights the strong stigma that exists within families and communities regarding mental health issues. Such stigma deters people from seeking help and perpetuates a cycle of exclusion from mental health care. In the future, it would be valuable to explore more participatory research involving rural communities to understand their conceptions, beliefs and needs around mental health, contributing to policy recommendations that incorporate cultural values.

While the COVID-19 pandemic had a significant impact on mental health in these two cases, it is important to note that this experience of social confinement acted as a catalyst for existing issues at the family and personal levels that ultimately affected the emotional well-being of the young women. The approach to the lived experiences of these two young women—whom we have followed for 20 years allows us to see how experiences from their childhood (such as violence) affect their mental health later in life. It also shows how gender roles experienced from childhood and social stigmas intersect with mental health issues throughout their lives. This highlights the importance of addressing the post-pandemic challenges of mental health care in a country like Peru, where the prevalence rates of mental health issues among young people remain high.

### Conclusions

Overall, Young Lives participants from Peru exhibited a higher prevalence of mental health issues during and after the COVID-19 pandemic compared to participants in Ethiopia and India. This result is expected as Peru had one of the highest death rates in the world and strong lockdown policies during the first year of the pandemic (World Bank 2023). In 2020, depression and anxiety levels were high across the country but showed some improvement during 2021 (Ford and Freund 2022). Round 7 results align with these trends, as participants from Peru, particularly the Older Cohort, have shown improvement in their mental health since 2020. The two lived experience case studies illustrate the persistent challenges that affect mental health in Peru. The lack of social protection, persistent barriers to accessible and high-quality mental healthcare services, and social stigma that deters seeking help, amplified the effect of the pandemic on mental health.

In India and Peru, the levels of anxiety and depression have remained similar to those reported in the last phone survey call in 2021. In contrast, levels of anxiety and depression have increased in Ethiopia, most likely as a consequence of the ongoing armed conflict in Amhara and Tigray regions. Participants from these regions report the highest levels of anxiety, stress, depression and PTSD. Those participants from Amhara interviewed by phone are particularly vulnerable, which is expected since they are living in sites that are experiencing active conflict. Moreover, participants from these regions report interruptions in access to public services and more precarious labour, health, and education conditions. Assistance in these regions is crucial to alleviate the significant toll on young people's mental health. A more detailed analysis of the impact of conflict in Ethiopia, including its effects on migration, will be the subject of further research.

There are also significant differences within countries. Overall, women report higher prevalence of mental health issues than men, particularly in Peru. Concerningly, while men's mental health indicators have marginally improved since the pandemic in India, women's mental health indicators have worsened. Interestingly, mental health and subjective well-being tend to be lower among socioeconomically disadvantaged groups in Ethiopia and in India. However, the opposite is true in Peru, since participants from wealthier households and from urban areas exhibit higher levels of anxiety and depression.

## Appendix

**Table 1.** Mental health indicators: participants reporting symptoms compatible with at least moderate stress, mild anxiety and mild depression (%) (in-person survey respondents)

	Subjective well-being (%)		At least moderate stress		At least mild anxiety			At least mild depression				
			(PSS-10) (%)		(GAD-7) (%)		(PHQ-8) (%)					
	Ethiopia	India	Peru	Ethiopia	India	Peru	Ethiopia	India	Peru	Ethiopia	India	Peru
Average of the full sample	5.4	5.4	6.2	61.4	58.7	69.9	20.0	10.4	30.3	16.5	9.9	24.1
Cohort												
Younger Cohort	5.5	5.4	6.2	60.8	58.5	71.9	18.8	8.8	32.5	15.3	9.6	28.4
Older Cohort	5.3	5.4	6.2	62.8	59.1	67.0	22.5	13.9	27.1	18.9	10.7	18.0
Difference (t-test)	-0.2 *	0.0	0.0	2.0	0.6	-4.9	3.7 *	5.1 ***	-5.4 *	3.6 *	1.1	-10.3 ***
Gender												
Men	5.4	5.3	6.2	59.1	60.1	61.7	19.3	7.1	21.8	15.1	8.1	17.5
Women	5.5	5.6	6.2	63.8	57.3	77.8	20.7	13.9	38.6	17.9	11.9	30.5
Difference (t-test)	0.1	0.4 ***	0.1	04.7	-2.8	16.1 ***	01.5	6.8 ***	16.8 ***	2.8	3.8 **	12.9 ***
Area of residence (Ro	und 7)											
Urban	5.4	5.7	6.2	60.6	59.7	70.1	24.1	8.4	33.7	19.7	7.5	26.8
Rural	5.5	5.3	6.1	62.6	58.3	69.0	14.0	11.3	14.9	11.7	11.0	11.9
Difference (t-test)	0.2	-0.4 ***	-0.1	1.9	-1.4	-1.2	-10.1 ***	2.9	-18.8 ***	-8.0 ***	3.5 **	-15.0 ***
Wealth index (Round '	1)											
Bottom tercile	5.4	5.0	6.2	61.4	62.4	71.0	13.3	13.2	26.2	12.8	13.2	20.3
Middle tercile	5.2	5.4	6.2	65.6	55.9	70.8	24.1	9.8	31.3	18.9	9.3	23.9
Top tercile	5.7	6.0	6.3	56.8	57.6	67.3	21.9	7.9	36.3	17.3	6.9	31.2
Difference (bottom vs top tercile) (t-test)	0.2	1.0 ***	0.1	-4.5	-4.8	-3.6	8.6 ***	-5.3 ***	10.1 ***	4.5	-6.3 ***	10.9 ***
Maternal/caregiver's	education	(Round 2)										
No formal education	5.3	5.2	6.0	65.8	60.5	75.4	23.3	12.0	25.2	19.8	11.6	18.1
Complete or incomplete Primary	5.5	5.5	6.2	56.5	57.9	70.5	16.6	10.4	28.7	13.1	9.6	20.2
Complete or incomplete secondary	6.1	6.2	6.3	57.7	55.8	67.2	15.4	5.9	34.7	11.4	5.1	29.1
Higher education and vocational	6.5	7.0	6.3	61.5	36.7	65.2	19.2	0.0	33.2	19.2	2.0	32.9
Difference (no formal education vs higher education) (t-test)	1.3 ***	1.8 ***	0.3	-4.2	-23.8 ***	-10.2	-4.1	-12.0 **	8.0	-0.6	-9.6	14.9 **
India												
Caste												
Scheduled Castes		5.1			64.8			13.4			13.0	
Scheduled tribes		5.4			66.7			12.2			16.1	
Backward Classes		5.4			57.0			10.8			9.1	
Other Castes		6.0			51.2			5.2			4.4	

	Subjective well-being (%)		At least moderate stress		At least mild anxiety			At least mild depression				
			(PSS-10) (%)		(GAD-7) (%)		(PHQ-8) (%)					
	Ethiopia	India	Peru	Ethiopia	India	Peru	Ethiopia	India	Peru	Ethiopia	India	Peru
Ethiopia												
Region of residency (F	Round 1)											
Addis Ababa	5.8			53.2			15.5			13.9		
Amhara (in person)	5.2			74.0			31.8			18.8		
Amhara (phone survey)	-			-			-			-		
Oromia	5.3			57.1			7.7			7.4		
SNNP	5.9			55.8			9.2			11.7		
Tigray	4.9			69.2			41.0			32.0		
Peru												
Mother's first language												
Spanish			6.3			68.1			32.8			26.4
Indigenous language			6.1			72.7			26.4			19.5
Difference (t-test)			-0.2 **			4.6			-6.4			-6.9 **
Number of participants	1878	2578	2123	1878	2578	2123	1878	2578	2123	1878	2578	2123

Notes: Differences are significant at \*\*\* 1%, \*\* 5% and \* 10%. Differences are in percentage points. The sample includes individuals who answered all mental health questions in person. Maternal education in India and Peru and caregiver education in Ethiopia are from 2006 (Round 2). Information on maternal language (only in Peru) was taken from 2006 (Round 2). Area of residence refers to the household location in 2002 (Round 1) as well as 2023 (Round 7). For Ethiopia, 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). In India, caste uses information from 2002 (Round 1). At least mild anxiety is defined as a score greater than or equal to 5 out of 7 on the Generalised Anxiety Disorder Assessment (GAD-7) scale; at least mild depression is a score greater than or equal to 5 on the Patient Health Questionnaire (PHQ-8) scale. This information is only available for inperson survey respondents. The original instrument included nine items but, similar to Round 6, the item related to suicide was not included. At least moderate stress is defined as a score greater than or equal to 14 on the Perceived Stress Scale (PSS-10) scale. This information is only available for inperson survey respondents.

Table 2. Mental health indicators in Ethiopia: participants reporting symptoms compatible with high stress,	at least mild anxiety,
depression and PTSD (%) (in-person and phone survey respondents)	

	High stress (PSS-4) (%)	At least mild anxiety (GAD-7) (%)	Symptoms of depression (PHQ-2) (%)	At least one symptom of PTSD (ITQ-9) (%)
Average of the full sample	61.8	22.8	11.0	7.5
Cohort				
Younger Cohort	61.0	21.5	10.3	7.0
Older Cohort	63.8	25.8	12.5	8.7
Difference (t-test)	2.8	4.3 **	2.2	1.6
Gender				
Men	59.3	22.3	11.4	8.1
Women	64.6	23.3	10.6	6.9
Difference (t-test)	5.3	1	-0.7	-1.2
Area of residence (Round 7)				
Urban	55.2	23.8	10.8	7.1
Rural	62.0	14.0	6.7	5.6
Difference (t-test)	6.8 **	-9.7 ***	-4.1 **	-1.5
Wealth index (Round 1)				
Bottom tercile	65.9	18.3	10.4	6.1
Middle tercile	67.3	27.4	14.5	10.3
Top tercile	50.8	22.2	7.3	5.8
Difference (bottom vs top tercile) (t-test)	-15.0 ***	3.9	-3.2	-0.3
Caregiver's education (Round 2)	)			
No formal education	67.2	26.9	13.5	11.3
Complete or incomplete primary	56.7	18.6	9.0	3.6
Complete or incomplete secondary	52.5	16.4	3.3	1.6
Higher education and vocational	61.5	19.2	7.7	11.5
Difference (no formal education vs higher education) (t-test)	-5.6	-7.6	-5.8	0.3
Region of residency (Round 1)				
Addis Ababa	44.3	14.6	4.5	2.0
Amhara (in person)	66.9	32.0	12.0	8.7
Amhara (phone survey)	100.0	51.6	29.6	17.2
Oromia	56.7	7.7	8.1	1.6
SNNP	59.0	9.4	3.5	0.4
Tigray	60.4	40.4	17.5	20.3
Number of participants	2007	2007	2007	2007

Notes: Differences are significant at \*\*\* 1%, \*\* 5% and \* 10%. The sample includes individuals who answered all mental health questions. Differences are in percentage points. Area of residence refers to the household location in 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). Caregiver's education is from 2006 (Round 2). At least mild anxiety is defined as a score greater than or equal to 5 out of 7 on the Generalised Anxiety Disorder Assessment (GAD-7) scale; at least mild depression is a score greater than or equal to 3 on the Patient Health Questionnaire PHQ-2 scale; high stress is a score greater than or equal to 6 on the reduced Perceived Stress Scale (PSS-4) scale; PTSD is at least one symptom with a moderate or greater impact for each ITQ subscale.

	Stress score (PSS-10)	Anxiety score (GAD-7)	Depression score (PHQ-8)	PTSD (ITQ-9) (%)				
Ethiopia								
Stress score (PSS-10)	1.0							
Anxiety score (GAD-7)	0.5	1.0						
Depression score (PHQ-8)	0.4	0.7	1.0					
PTSD (ITQ-9) (%)	0.4	0.6	0.6	1.0				
India								
Stress score (PSS-10)	1.0							
Anxiety score (GAD-7)	0.5	1.0						
Depression score (PHQ-8)	0.5	0.7	1.0					
Peru								
Stress score (PSS-10)	1.0							
Anxiety score (GAD-7)	0.6	1.0						
Depression score (PHQ-8)	0.5	0.8	1.0					

#### Table 3. Correlation between mental health indicator (in-person survey respondents).

Notes: The sample includes individuals who answered all mental health questions in person. The results are similar when including participants interviewed via phone survey in Ethiopia.

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Photo credit: © Young Lives / Sebastian Castañeda Vita. The images throughout our publications are of children living in circumstances and communities similar to the children within our study sample.





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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Young Lives, Oxford Department of International Development (ODID) University of Oxford, 3 Mansfield Road, Oxford OX1 3TB, UK

> www.younglives.org.uk Tel: +44 (0)1865 281751 • Email: younglives@qeh.ox.ac.uk Bluesky, Facebook, LinkedIn, Instagram, X