



Health, Nutrition and Well-Being:

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

Introduction

For more than 20 years, Young Lives has followed two cohorts, born seven years apart, from infancy to young adulthood in Ethiopia, India, Peru and Vietnam.¹ This factsheet presents preliminary findings from Round 7 of the Young Lives survey conducted in Peru in 2023–24, when the Younger Cohort was 22 years old and the Older Cohort was 29. It provides an overview of the key nutrition, health and well-being indicators underlining changes across generations 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

- The prevalence of young people who are overweight or obese is high and has increased over time.
- Food insecurity rates are high for both cohorts.
- Subjective well-being has improved since the end of the COVID-19 pandemic.
- However, the burden of mental health has remained high since the pandemic.
- Women are worse off in terms of both nutrition and mental health, compared to men.
- Better early-life socio-economic conditions are associated with higher excess weight and lower food insecurity, as well as worse 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

- **The prevalence of young people who are overweight or obese is high and has increased over time.** There has been a marked increase in the prevalence of overweight or obesity among Older Cohort participants, from 36% at 22 years old to 61% at 29, indicating that excess weight is a growing public health issue.
- **Food insecurity rates are high for both cohorts.** Six out of ten households experience food insecurity, most of which are moderately or severely food insecure. Early-life inequalities are associated with a high food insecurity.
- **Subjective well-being has improved since the end of the COVID-19 pandemic.** The subjective well-being of both cohorts declined during the pandemic but has since recovered.
- **However, the burden of mental health has remained high since the pandemic.** Three out of ten participants exhibit symptoms associated with anxiety and depression, and this has not improved since the pandemic.
- **Women are worse off in terms of both nutrition and mental health, compared to men.** Within the Younger Cohort, women have simultaneously higher overweight prevalence and food insecurity, as well as higher prevalence of symptoms indicating stress, anxiety and depression.
- **Better early-life socio-economic conditions are associated with higher excess weight and lower food insecurity, as well as worse mental health.** Within the Younger Cohort, participants who were born in wealthier households have a higher prevalence of overweight or obesity and reported symptoms associated with at least mild anxiety and depression. In contrast, food insecurity is higher among participants who were born in poorer households.

The policy context of nutrition and mental health in Peru

At the national level, Peru has a high prevalence of both anaemia and being overweight (ENDES 2024). Being overweight is associated with increased mortality due to non-communicable illnesses such as cardiovascular disease, the second-highest cause of disability-adjusted life years (DALYs) in Peru, with 782 per 100,000 inhabitants in 2021.² Furthermore, half of Peru's households face moderate or severe food insecurity, reflecting low access to adequate food and a healthy diet, which are less affordable due to the economic crisis and accompanying increases in prices and poverty (Ministerio de Desarrollo e Inclusión Social 2024; World Bank 2023; INEI 2024). The poorest communities are disproportionately affected, leading to severe health consequences, reduced productivity, and a cycle of poverty hindering development. Policies have been launched recently to tackle these issues, such as the Law for the Promotion of Healthy Eating for Children and Adolescents (2017), the Multisectoral Plan for the Prevention and Reduction of Maternal and Child Anaemia (2024–30), and the Food and Nutritional Security Law, approved in 2024.

During the last decade, Peru has reformed its mental health services through Mental Health Law 29889, which includes a new community mental health service model that is integrated with the health insurance scheme for poor households (Marquez and Bayona Garcia 2019). Since 2015, community mental health centres, staffed by interdisciplinary teams of clinical and social workers, have expanded to all regions. However, during the COVID-19 pandemic, Peru faced a prolonged lockdown and had one of the highest mortality rates in the world (World Bank 2023), both affecting young people's mental health. Young people reported high levels of anxiety and depression during the pandemic (Ford and Freund 2022) and mental health conditions were the third-highest cause of DALYs, at 635.0 per 100,000 inhabitants in 2021, one of the largest increases worldwide compared to before the pandemic.

Methods

This factsheet uses preliminary data from the Young Lives Round 7 survey, which in Peru was collected between June 2023 and January 2024. A total of 2,219 interviews were completed (1,702 from the Younger Cohort and 517 from the Older Cohort), which represents 80.2% of the original sample in Round 1 (Younger Cohort: 82.9%; Older Cohort: 72.4%) (Molina et al. 2025). The analysis used the sampling weights to emulate the original sampling design of the study (Escobal and Flores 2008). Participants from

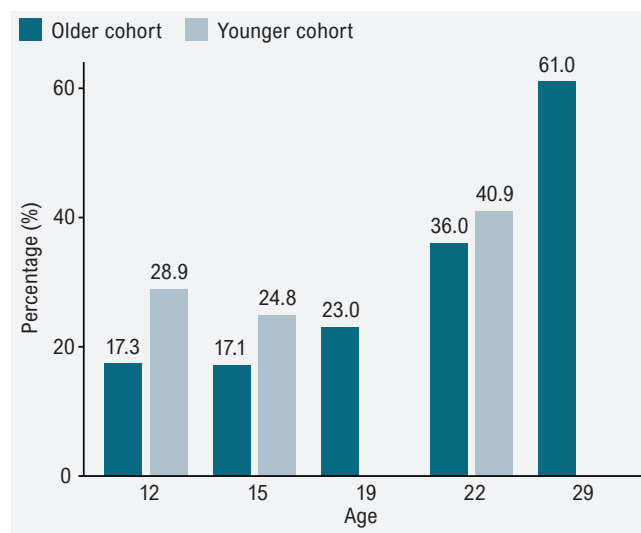
previous rounds who were not interviewed in Round 7 were excluded from the analysis. Participants are classified by area of residence (urban or rural) at the time of data collection, household wealth (top, middle or bottom tertile in 2002) (Briones, 2017), gender, maternal tongue (Spanish or Indigenous languages), mother's level of formal education, and whether they had children by age 19 or married before age 18.

Nutrition outcomes

The prevalence of young people who are overweight or obese is high and has increased over time, while the prevalence of those who are underweight is low. The percentage of participants who are overweight or obese is high for both cohorts, at 41% of the Younger Cohort at age 22 and 61% of the Older Cohort at age 29. The proportion who are overweight or obese has increased with age, from 36% at age 22 to 61% at age 29 for the Older Cohort, with the Younger Cohort following a similar pattern. In contrast, underweight prevalence is low for both cohorts, at only 2% for the Younger Cohort and 1% for the Older Cohort (Annex 1).

There is a higher prevalence of overweight or obese participants in the Younger Cohort (41%) compared to the Older Cohort (36%) at age 22. If Younger Cohort participants continue to exceed the trend of the Older Cohort, which has a prevalence of 61% by age 29, overweight and obesity will become an even more serious problem in the coming years.

Figure 1. Percentage of overweight or obese participants by cohort and age

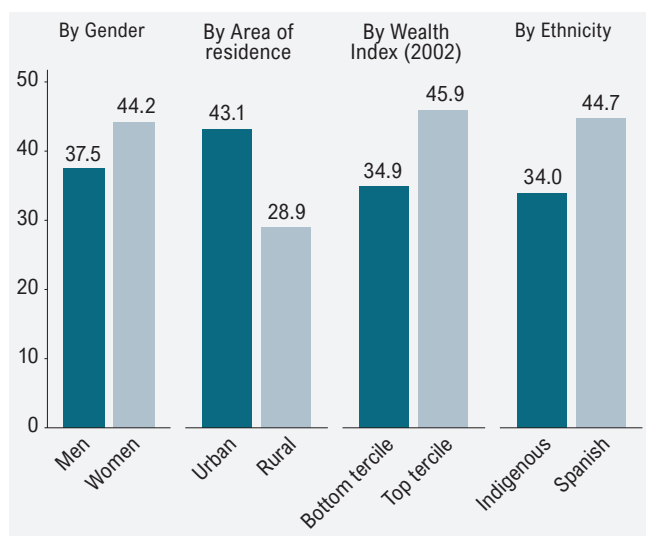


Notes: The definitions of underweight, overweight and obesity vary by age. We followed the World Health Organization (WHO) Child Growth Standards to classify children who are 5–19 years old (WHO 2024b). For adults aged over 19 years we used absolute thresholds, also defined by WHO (WHO 2024a).

² 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.

By age 22, there are significant differences in the prevalence of malnutrition in the Younger Cohort, depending on participants' early socio-economic conditions. Participants who were born in wealthier households and whose maternal tongue is Spanish are significantly more likely to be overweight or obese than their counterparts (Figure 2). This is consistent with national reports that show a positive relationship between the prevalence of being overweight and socio-economic status, explained by greater access to food and higher food intake among wealthier populations, in contrast to lower or moderate food intake and higher levels of physical activity typically seen among poorer communities (Dinsa et al. 2012; Curi-Quinto, Ortiz-Panozo and López de Romaña 2020).

Figure 2. Percentage of overweight or obese Younger Cohort participants in 2023 by gender, area of residence, ethnicity and wealth index (2002)



Notes: The definitions of overweight and obesity vary by age. We followed the World Health Organization (WHO) Child Growth Standards to classify children who are 5–19 years old (WHO 2024b). For adults aged over 19 years we used absolute thresholds, also defined by WHO (WHO 2024a).

Without effective policies, cardiovascular disease risk could worsen for the Younger Cohort. Cardiovascular risk was assessed using abdominal obesity as an indicator, which is strongly associated with being overweight and having higher levels of metabolic impairment – both established predictors (Xue et al. 2021). Given the high prevalence of overweight or obesity in both cohorts, along with nearly 20% of the Older Cohort having cardiovascular disease risk by age 29, without effective policies it can be expected that these issues will only worsen for the Younger Cohort as they approach the same age. Similar to the distribution of overweight and obesity, cardiovascular disease risk is higher among women compared to men (by 12 percentage points), among those born in the

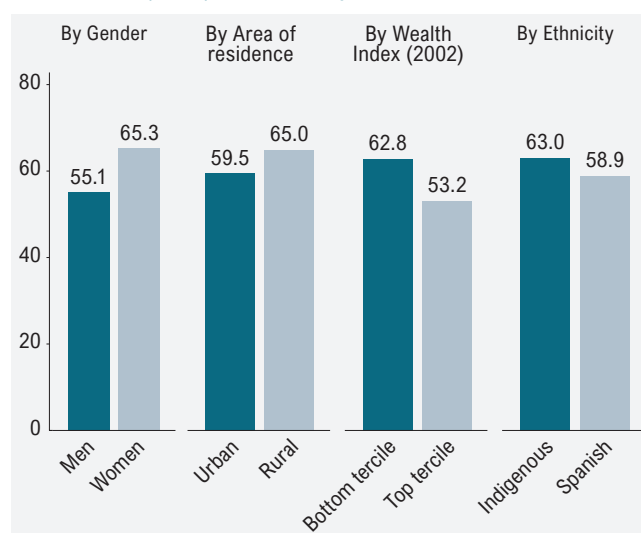
wealthier households compared to the poorest households (by 10 percentage points) and among non-Indigenous participants (by 6 percentage points) compared to Indigenous participants.

Food security

60% of Young Lives households are food insecure, with most being moderately or severely insecure.³ This can be primarily explained by the ongoing economic crisis and increase in poverty, coupled with the economic impacts of the COVID-19 pandemic, which have yet to be reversed. In 2023, monetary poverty reached 29%, an increase of 1.5 percentage points compared to 2022, with 5.7% of the population living in extreme poverty (1.92 million people) (INEI 2024). Additionally, climate shocks, such as the El Niño phenomenon, are affecting access to food because of their negative impact on food production and the rise in food prices, as well as the insufficient capacity of the state to mitigate these impacts.

Being a woman, as well as being born in a poorer household, are both risk factors for food insecurity at age 22. In the Younger Cohort, around 65% of women and 55% of men are living in food-insecure households, with these percentages being higher for participants from poorer households and those whose mother had less education (Figure 3). As previous studies have indicated, poverty and low education are linked to higher vulnerability to food insecurity due to the limited capacity to cope with these challenges (Curi-Quinto et al. 2021; Santos et al. 2022).

Figure 3. Percentage of food-insecure households in the Younger Cohort at age 22 by gender, area of residence, wealth index (2002) and ethnicity

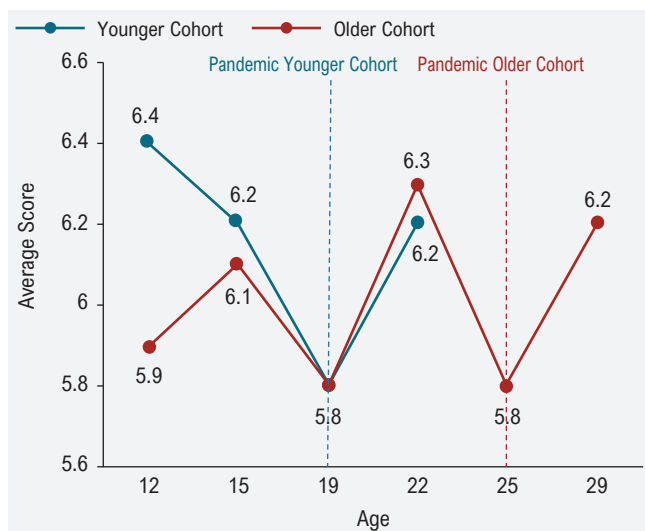


³ Food security is defined as the physical and economic access to enough food to meet the dietary need for a productive and healthy life (USAID 1992). At the household level, it was assessed using a modified version of the Household Food Insecurity Scale (HFIS) (Coates, Swindale and Bilinsky 2007). Key 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.

Subjective well-being

The COVID-19 pandemic had a negative impact on young people's subjective well-being, but is now back to pre-pandemic levels for both cohorts. Over the course of the study, Young Lives participants have been asked about their subjective well-being using a scale from one to nine, with nine being the best possible life. Both cohorts saw a decline in subjective well-being associated with the pandemic, as measured during the Round 6 phone survey in 2020, followed by a recovery in Round 7 in 2023 (Figure 4). Although this decline may also be associated with entering adulthood, as happened in the Older Cohort at age 19, the average score for the Younger Cohort in Round 7 is 6.2, which is not statistically different from the Older Cohort at the same age. Subjective well-being does not significantly vary across sub-groups.

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



Mental health

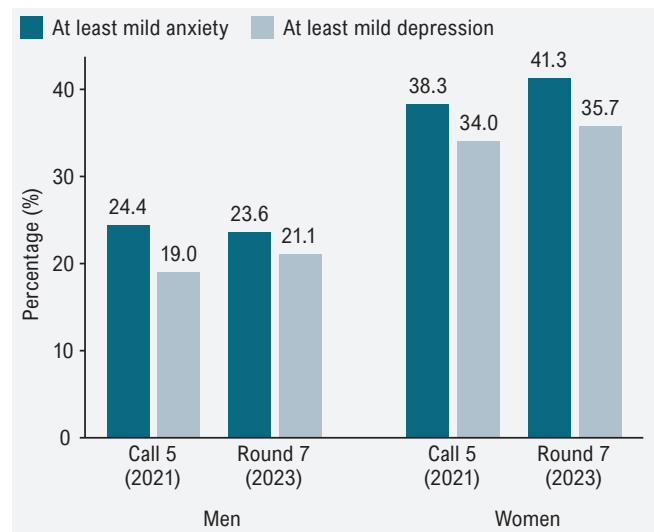
Three out of ten participants exhibit symptoms associated with anxiety and depression, while seven out of ten exhibit stress symptoms. Many participants exhibit symptoms associated with at least moderate stress: 72% in the Younger Cohort and 67% in the Older Cohort. Moreover, 33% of Younger Cohort participants and 29% of Older Cohort participants reported symptoms indicative of at least mild anxiety, with symptoms indicative of at least mild depression being present in 29% of the Younger Cohort and 19% of the Older Cohort.

Mental health has not improved following the pandemic. During the first year of the pandemic, Peru experienced one of the highest death rates in the world and strong lockdown policies (World Bank 2023): depression and anxiety were highly prevalent but showed some improvement a year later in 2021 (Ford and Freund 2022). Two years later, the prevalence of depression and anxiety remained unchanged. For the Younger Cohort, the proportion of at least mild

anxiety (depression) slightly increased from 32% (27%) in 2021 to 33% (29%) in Round 7 (Figure 5). These results might be due to persistent consequences of the pandemic, as well as political instability, being reflected in higher poverty levels and economic instability (Rojas Arangoitia and Alván León 2024).

For Younger Cohort participants, mental health is persistently poorer among 22-year-old women, who have a higher prevalence of symptoms associated with (at least mild) stress, anxiety and depression. Anxiety and depression are higher in participants who live in urban areas and who have more advantageous backgrounds, such as those born in wealthier households and from households with more-educated mothers (Annex 2).

Figure 5. Mental health indicators in the Younger Cohort by gender (%)



Conclusions and looking forward

Our Round 7 findings highlight food insecurity, being overweight, and poor mental health as key issues, with significant differences across socio-economic groups and by gender. Women, non-Indigenous and wealthier participants are more vulnerable to being overweight or obese compared to their counterparts, while Indigenous communities and those with lower socio-economic status are more likely to be food insecure. Policies must address these challenges to achieve SDG 2 (Zero hunger) by strengthening multi-purpose strategies to tackle malnutrition – especially excess weight – and food insecurity. Key aspects should include having a national regulatory framework, but most importantly, clear mechanisms for effective implementation and evaluation, considering the diverse and sociodemographic heterogeneities within the country. Effective regulations to improve access to healthy foods, increase physical activity, enhance food quality and improve school food environments are a key opportunity to strengthen food policies and tackle malnutrition among the Peruvian population.

Although subjective well-being has recovered since the pandemic, mental health issues remain widespread, particularly for women. Whilst the reform of Peru's mental health services has been positive in a number of respects, it has been challenging to implement, and is insufficient on its own to reduce mental health conditions and mitigate their causes and consequences. Mental health is a

complex issue that requires strategic multisectoral action to achieve further progress towards SDG 3 (Good health and well-being). Key activities should include continuing the expansion of community mental health services and the use of new technologies to reduce access costs and time, as well as reinforcing mental health education to improve the timely prevention and management of mental health issues.

Annex 1. Nutrition and food security indicators

	Underweight (%)			Overweight and obesity (%)			High cardiovascular risk (%)			Food-insecure households (%)	
	OC (2016)	OC (2023)	YC (2023)	OC (2016)	OC (2023)	YC (2023)	OC (2016)	OC (2023)	YC (2023)	OC (2023)	YC (2023)
Average of full sample	2.2	1.0	1.9	36.0	61.0	41.0	14.9	19.8	11.2	60.0	60.4
Gender											
Women	0.4	1.2	1.5	29.4	60.3	37.5	3.4	5.9	5.1	57.6	55.1
Men	3.9	0.9	2.2	42.6	61.8	44.2	26.7	34.6	17.0	62.5	65.3
Difference (t-test)	3.5	-0.3	0.7	13.2	1.5	6.8**	23.3***	28.7***	11.8***	4.9	10.1***
Area of residence (Round 1)											
Rural	1.7	0.6	2.4	43.0	69.5	44.4	19.1	26.2	13.5	60.5	60.8
Urban	2.7	1.6	1.0	27.5	50.9	34.9	9.9	12.3	7.2	59.3	59.7
Difference (t-test)	0.9	1.0	-1.4	-15.5**	-18.6**	-9.6***	-9.2	-13.8**	-6.3***	-1.2	-1.1
Current area of residence											
Rural	2.4	0.4	1.7	38.9	64.0	43.1	15.8	21.1	12.0	59.4	59.5
Urban	1.3	3.3	2.7	26.4	50.8	28.9	11.9	15.3	7.1	62.0	65.0
Difference (t-test)	-1.2	2.9	1.0	-12.5	-13.2	-14.2***	-3.9	-5.8	-4.9	2.6	5.4
Wealth index (Round 1)											
Bottom tercile	0.7	1.6	1.9	32.7	55.4	34.9	15.2	16.6	6.3	64.6	62.8
Middle tercile	3.6	0.9	1.6	36.3	64.8	44.4	15.9	22.1	13.5	64.1	63.6
Top tercile	2.7	0.0	2.1	42.2	66.4	45.9	11.8	23.1	15.8	42.4	53.2
Difference (t-test)	2.0	-1.6	0.2	9.5	11.0	11.0***	-3.4	6.6	9.5***	-22.1***	-9.7**
Maternal language											
New Andhra Pradesh	2.3	1.7	2.1	41.7	67.8	44.7	15.8	24.5	13.1	58.4	58.9
Telangana	2.1	0.2	1.3	26.6	51.8	34.0	13.6	14.2	7.6	61.0	63.0
Difference (t-test)	-0.1	-1.5	-0.8	-15.1**	-15.9**	-10.8***	-2.2	-10.3	-5.6***	2.6	4.1
Maternal education											
Primary incomplete or less	2.3	1.0	1.6	34.8	57.3	38.4	17.2	18.2	8.9	61.9	63.8
Complete primary or secondary	2.1	0.6	1.9	36.9	66.1	42.1	13.1	23.7	12.2	58.4	61.7
Higher education	3.1	0.0	1.5	29.9	55.3	46.0	2.6	8.3	14.9	46.0	42.5
Difference (primary incomplete or less vs higher education) (t-test)	0.8	-1.0	-0.1	-4.9	-1.9	7.6	-14.6***	-9.9	6.1	-15.9	-21.3***
Number of participants	497	508	1669	497	508	1669	487	508	1670	517	1700

Notes: Differences are significant at ***1%, **5% and *10%. Differences are percentage points. Information on maternal education and language were taken from 2006 (Round 2). Area of residence refers to the household location in 2002 (Round 1). Household wealth terciles were calculated separately for each cohort using the household wealth index of 2002 (Round 1).

Annex 2. Subjective well-being and mental health indicators

	Subjective well-being score (0–10)		At least moderate stress (PSS-10) (%)		At least mild anxiety (GAD-7) (%)		At least mild depression (PHQ-8) (%)	
	OC (2023)	YC (2023)	OC (2023)	YC (2023)	OC (2023)	YC (2023)	OC (2023)	YC (2023)
Average of full sample	6.2	6.2	66.7	72.1	28.9	32.8	19.0	28.7
Gender								
Men	6.1	6.2	60.2	62.8	21.9	23.6	13.6	21.1
Women	6.3	6.2	73.4	80.6	36.1	41.3	24.6	35.7
Difference (t-test)	0.2	0.0	13.2	17.8***	14.1**	17.7***	11.1	14.6***
Area of residence (Round 1)								
Urban	6.3	6.2	65.7	71.6	36.3	35.5	25.6	31.9
Rural	6.1	6.1	67.9	72.9	19.9	28.0	11.1	23.3
Difference (t-test)	-0.2	-0.1	2.3	1.3	-16.3**	-7.5**	-14.5***	-8.6***
Current area of residence								
Urban	6.3	6.2	67.6	71.6	34.4	34.8	22.6	30.3
Rural	6.2	6.1	63.3	75.0	9.3	21.7	6.3	19.7
Difference (t-test)	-0.1	-0.2	-4.3	3.4	-25.2***	-13.1***	-16.4***	-10.6***
Wealth index (Round 1)								
Bottom tercile	6.2	6.2	67.3	74.2	25.1	27.3	17.4	23.2
Middle tercile	6.2	6.2	69.6	70.5	31.4	34.4	19.2	29.3
Top tercile	6.4	6.3	60.6	70.9	33.3	38.8	22.7	36.0
Difference (bottom vs top tercile) (t-test)	0.2	0.1	-6.7	-3.3	8.3	11.5***	5.3	12.8***
Maternal language								
Spanish	6.4	6.3	62.2	71.1	32.0	34.5	19.3	31.3
Indigenous language	6.1	6.1	72.9	73.2	25.2	29.1	17.4	23.0
Difference (t-test)	-0.3	-0.2	10.7	2.1	-6.9	-5.4	-1.9	-8.3***
Maternal education								
Primary incomplete or less	6.1	6.2	69.5	72.8	27.4	28.4	15.1	24.2
Complete primary or secondary	6.4	6.2	64.0	72.2	32.7	35.0	22.9	29.5
Higher education	6.4	6.3	63.5	65.4	27.9	36.7	24.8	36.9
Difference (primary incomplete or less vs higher education) (t-test)	0.3	0.1	-6.0	-7.4	0.6	8.4	9.7	12.7***
Number of participants	514	1685	514	1685	514	1685	514	1685

Notes: Differences are significant at ***1%, **5% and *10%. Differences are percentage points. Information on maternal education and language were taken from 2006 (Round 2). Area of residence refers to the household location in 2002 (Round 1). Household wealth terciles were calculated separately for each cohort using the household wealth index of 2002 (Round 1).

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Acknowledgements and credits

This factsheet is part of a series giving a preliminary overview of key data from Round 7 of the Young Lives survey, covering education and learning; health, nutrition and well-being; and labour markets and family lives. It was written by Katherine Curi and Antonio Campos, with support from Dianela Espinoza and Anthony Aquino. Thanks to Marta Favara, Alan Sánchez, Juliana Quigua and Vanessa Rojas for their comments and suggestions. We are grateful to Sofia Madrid, who coordinated the survey fieldwork, Mónica Lizama, Peru Data Manager, and to our fieldwork teams for their dedication and enthusiasm.

We particularly wish to thank the Young Lives respondents and families for generously given us their time and cooperation. Thanks to Adam Houlbrook for copyediting, Garth Stewart for design and Julia Tilford for oversight of the publication of Young Lives' summative reports.

Special thanks to Old Dart Foundation and the UK's Foreign, Commonwealth & Development Office (FCDO) for funding Young Lives at Work and enabling this research. We also wish to thank Wellcome Trust for funding Young Lives research into health and well-being.

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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).

