

Prevalence of anxiety disorders in Latin America: a systematic review and meta-analysis



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Summary

Background The prevalence of anxiety disorders among the adult population in Latin America (LATAM) and its association with development indicators is insufficiently characterised. We estimated pooled regional, country, and sex-specific prevalence rates of anxiety disorders in LATAM based on International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. Additionally, we examined the association between its prevalence and four country-level development indicators: Human Development Index (HDI), income inequality (Gini coefficient), Gender Inequality Index (GII), and Intentional Homicide Rate (IHR).

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Methods We conducted a systematic review and meta-analysis of population-based studies on the prevalence of ICD/DSM anxiety disorders in LATAM from 1990 to 2024, irrespective of language. We searched PubMed, PsycINFO, Cochrane Library, SciELO, LILACS, and grey literature. Study quality was assessed using JBI's critical appraisal tools. Pooled estimates were generated using random-effects meta-analysis, and heterogeneity was evaluated using the I-squared (I^2) statistic. Meta-regression analyses were performed to examine the ecological association between anxiety disorders prevalence and four development indicators. The study was registered with PROSPERO (CRD42020190238).

Findings Using data from 36 studies in LATAM, we calculated the lifetime, 12-month, and current prevalence of ICD/DSM anxiety disorders at 14.55% (95% Confidence Interval 12.32%–17.11%; $I^2 = 97.9\%$); 6.61% (5.20–8.37; $I^2 = 98.1\%$), and 3.27% (2.34–4.56; $I^2 = 97.5\%$), respectively. Heterogeneity was high across prevalence periods, sexes, and countries (all $I^2 \geq 91.4\%$), warranting caution in interpreting pooled estimates. Elevated 12-month and current prevalence rates of anxiety disorders were associated with higher Gini coefficients ($p \leq 0.0013$). Additionally, higher current prevalence was associated with lower HDI ($p = 0.0103$) and higher GII ($p = 0.0023$), while elevated 12-month prevalence was associated with higher IHR ($p = 0.011$).

Interpretation This study shows that approximately one in seven people in LATAM experience anxiety disorders at some point in their lives. These findings highlight the need to strengthen mental health systems in the region, and evidence the association between prevalence of anxiety disorders and development indicators. Our results can serve as a baseline for tracking anxiety disorders and for informed decision-making at the national and regional levels. The substantial heterogeneity between studies and the underrepresentation of some countries underscore the imperative for enhancing regional mental health capacities.

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Abbreviations: CI, Confidence intervals; DSM, Diagnostic and statistical manual of mental disorders; GBD, Global burden of disease; GII, Gender inequality index; HDI, Human development index; ICD, International classification of diseases; IHR, Intentional homicide rate; LATAM, Latin America; OCD, Obsessive-compulsive disorder; OR, Odds ratio; PI, Prediction interval; PTSD, Post-traumatic stress disorder; SE, Standard error; WHO, World Health Organization

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Translation: For the translation of the abstract see the [Supplementary Materials](#) section.

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Keywords: Anxiety disorders; Prevalence; Latin America; Systematic review; Meta-analysis; Global mental health

Research in context

Evidence before this study

Anxiety disorders are the most common mental condition, imposing a substantial burden on individuals and society as one of the leading causes of disability worldwide. While the epidemiology of anxiety disorders is well-researched in high-income countries, it is insufficiently characterized in low- and middle-income countries, particularly in Latin America (LATAM). This region, characterized by high urbanization, large income and gender inequalities, and elevated violence rate, is believed to have notably high rates of anxiety disorders. However, existing data remains fragmented, and global studies often underrepresent the region. Moreover, we found no systematic reviews synthesizing the prevalence of these disorders in the region. To address this gap, we conducted a systematic review of population-based studies on the prevalence of ICD/DSM anxiety disorders in adults in LATAM, using a standardized and validated methodology.

Added value of this study

This article presents a comprehensive analysis of the prevalence of ICD/DSM anxiety disorders in LATAM and its association with four key development indicators: Human Development Index (HDI), income inequality (Gini), Gender Inequality Index (GII), and Intentional Homicide Rate (IHR). It provides: i) a systematic review of prevalence estimates in the region; ii) meta-analyses of regional, urban versus rural, country- and sex-specific lifetime, 12-month, and current estimates; and iii) evidence of associations between anxiety disorder prevalence and HDI, Gini, GII, and IHR. Our findings

indicate that anxiety disorders prevalence in LATAM is similar to global estimates, with women consistently exhibiting higher rates. Our review underscores the lack of studies in many Latin American countries, and a scarcity of studies on rural populations. We identified statistically significant positive associations between the anxiety disorder prevalence and Gini, GII, and IHR, while a negative association was observed with HDI, providing evidence of socio-economic factors related to anxiety in middle-income countries.

Implications of all the available evidence

Our findings offer valuable insights for evidence-based decision-making processes in LATAM, particularly in shaping healthcare policy, setting research agendas, allocating mental health resources and services, monitoring health-related outcomes, and assessing interventions to improve population mental health. The high prevalence of anxiety disorders in the region underscores the urgent need to prioritize accessible, high-quality care, particularly for women, and to expand population-based mental health research. Conducting research in unrepresented LATAM countries would allow governments to more effectively identify and address concentrated needs within their populations, enriching the understanding of the region's mental health epidemiology. Additionally, our findings on the association between anxiety disorders and inequality, violence, and human development provide cross-cultural evidence of the relationship between mental health and structural factors.

Introduction

Anxiety disorders share features of excess worry, counterproductive, and debilitating fear, and related behavioral disturbances.¹ They often co-occur with depressive disorders² and chronic physical illnesses,³ such as diabetes, cardiovascular conditions, stroke, and cancer, thereby significantly increasing mortality risk.⁴ As the most prevalent mental disorder,⁵ anxiety disorders pose a substantial economic burden on society.^{6,7} If left untreated, they often become chronic,⁸ imposing considerable costs, compromising quality of life and psychosocial functioning.⁹

The global prevalence of anxiety disorders among the general population varies, with lifetime prevalence estimated between 12.9% (11.3–14.7%)¹⁰ and 16.6% (12.7–21.1),¹¹ and 12-month prevalence between 6.7% (6.1–7.9%)¹⁰ and 11.6% (7.6–17.7%).¹² Additionally, the Global Burden of Disease (GBD) study estimates the current prevalence at 3.78% (3.18–4.47%),⁵ whereas a

systematic review analyzing 87 studies across 44 countries reports a current prevalence of 7.3% (4.8–10.9%).¹² Across studies, women consistently exhibit higher rates than men.^{3,5,10–12} Furthermore, the prevalence is notably higher in conflict-affected populations,^{12–14} and in regions characterized by high levels of income,^{11–13,15} human development,¹⁶ and urbanization.¹⁷ Research on the relationship between anxiety disorders and income inequality has yielded inconclusive results,¹⁸ with studies in high-income countries suggesting that the association depends on healthcare spending.¹⁹ Moreover, there is a scarcity of studies examining the association of other forms of inequality, such as gender inequality, with anxiety disorder prevalence.

Latin America (LATAM) is characterized by elevated rates of anxiety disorders,^{5,10,13,20} particularly in urban areas.²¹ In several of the region's most populous countries, including Mexico and Peru, government mental health spending is notably low. Furthermore, there

exists a significant imbalance between financial resources allocated to mental, neurological, and substance use disorders and the burden these conditions impose on the population.²² Despite the widespread impact of anxiety disorders across the region,²⁰ there has been a notable gap in systematically reviewing their prevalence. Available epidemiological data is highly fragmented and reported prevalence varies considerably.^{11,13} Existing regional syntheses are primarily descriptive, focusing on study characteristics rather than providing comprehensive prevalence estimates.^{23–25}

Global studies on the distribution of the prevalence of anxiety disorders have several limitations when trying to capture the LATAM landscape. Firstly, LATAM is consistently underrepresented in global systematic reviews,^{3,12} which often provide aggregate estimates for all age groups,¹² or focus exclusively on older adults.^{21,26} Additionally, LATAM countries are classified into three income categories as outlined in the World Health Organization (WHO) World Mental Health Survey Initiative,²⁷ which complicates efforts to draw conclusions about the region's mental health rates. Regional estimates from the GBD^{5,15,28} framework are useful, but present two main drawbacks: i) they do not provide data on lifetime or 12-month prevalence, or for specific anxiety disorders subtypes, ii) the current prevalence estimates are based on models using data from surveys of adults, children and older adults with varying quality.²⁸ These models combine period and point estimates adjusted for past-year recall and include studies with diverse assessment methods. These sources may not accurately reflect the true burden of anxiety disorders in LATAM and limit our understanding of prevalence among the adult population.

The present study aims to comprehensively evaluate and synthesize the best available evidence regarding the prevalence of anxiety disorders within the general adult population of LATAM. Our specific objectives are twofold: first, to synthesize the best available evidence regarding the prevalence of *any anxiety disorder*, as well as the prevalence of various disorders classified under this category; and second, to estimate the ecological association between the prevalence of *any anxiety disorder* in LATAM and four specific development indicators.

Methods

We conducted a systematic review and meta-analysis of population-based studies on the prevalence of anxiety disorders in LATAM published between 1990 and 2024. The methodology is consistent with our prior research on the prevalence of depressive disorder in LATAM,²⁹ and adheres to the GATHER³⁰ and PRISMA³¹ reporting standards ([Supplementary Method p 4](#)). Furthermore, the *a priori* review protocol was registered with PROSPERO (CRD42020190238).

Search strategy

We independently searched five databases—PubMed, PsycINFO, Cochrane Library, SciELO, and LILACS—from their inception up to April 19, 2024. We used the boolean operator AND with three search terms: i) anxiety condition; ii) context and population (i.e., LATAM region); and iii) epidemiological study design without language restrictions ([Supplementary Methods pp 5–11](#)). Additionally, we searched citations from international organisations, specialised repositories and LATAM governmental health and development agencies, and reference lists of selected citations to identify ongoing or unpublished research ([Supplementary Table S4](#)). No language restrictions were applied.

Study selection

A three-stage screening and selection process was conducted by two independent reviewers, with a third reviewer resolving disagreement. Citations were deemed eligible if they presented data from a community survey of general population (i.e., aged ≥ 15 years) in LATAM, focusing on the prevalence of *any anxiety disorder* or disorders grouped under *any anxiety disorder* (i.e., agoraphobia, generalized anxiety disorder, panic disorder, Obsessive-Compulsive Disorder (OCD), Post-traumatic Stress Disorder (PTSD), social anxiety disorder, specific phobia) according to validated diagnostic criteria (International Classification of Diseases [ICD] or Diagnostic and Statistical Manual of Mental Disorders [DSM]) and assessed using a structured clinical interview (i.e., Composite International Diagnostic Interview; Mini International Neuropsychiatric Interview). We excluded studies focusing on COVID-19 or older adults ([Supplementary Method S4](#)).

In the first stage, titles were screened to exclude citations unrelated to the topic. In the second stage, abstracts underwent screening against predefined inclusion criteria. The final stage involved a thorough full-text review using a decision matrix to identify citations that met all criteria ([Supplementary Method S4](#)).

Data extraction and management

Two independent reviewers extracted key information from each selected citation, including country, location, survey name, fieldwork date, study design, setting, response rate, sample size, proportion of women, participants' age range, outcome (i.e., *any anxiety disorder* or specific disorder), diagnostic criteria and clinical interview employed. For studies on *any anxiety disorder*, the number and disorders included were also extracted ([Supplementary Method S4](#)).

Overall and sex-specific case numbers and prevalence estimates were extracted for all studies. Additionally, age-stratified estimates were collected when available. To ensure accuracy and coherence, multiple citations associated with the same study were matched. The quality of each study was evaluated using the

Joanna Briggs Institute's (JBI) appraisal tool³² (Supplementary Method S4).

External data sources

We retrieved country-level data from external sources on the Human Development Index (HDI), income distribution (Gini Index), gender inequality (Gender Inequality Index [GII]), and interpersonal violence (Intentional Homicide Rate per 100,000 [IHR]) corresponding to the midpoint of the fieldwork period. The HDI and GII values (0–1) were converted to a percentage scale for ease of interpretation (Supplementary Method S4).

Data synthesis and statistical analysis

Firstly, we conducted a narrative synthesis of the characteristics of the included studies. Subsequently, we estimated the prevalence of *any anxiety disorder*, and disorders grouped under *any anxiety disorder*, based on the prevalence rates and standard errors (SE) reported in the studies. To address missing values in SE or 95% CI, alternate data sources were utilized (Supplementary Method S4).

For records without prevalence data, we calculated prevalence from the number of cases and sample size, assuming a simple random sample. SEs were derived from confidence intervals (CI); when CIs were absent, variance and SE were estimated using the number of cases and sample size (assuming a simple random sample). Missing 95% CI were obtained from the SE. Both the prevalence and SE were logit-transformed.

Overall, sex and country-specific pooled prevalence estimates for all outcomes were calculated across different prevalence periods (lifetime, 12-months, or current). This was achieved using random-effects meta-analysis via the restricted maximum likelihood method to account for between-study heterogeneity (Supplementary Method S4).³³ We analyzed of logit-transformed proportions, weighting each study by the inverse of the variance of the transformed proportion. Subsequently, pooled transformed proportions and corresponding SE were back-transformed to derive prevalence and corresponding 95% CI.

Our reporting includes both overall and sex-stratified pooled prevalence estimates, categorized by study period. Graphical representations show individual study prevalence and 95% CIs, alongside pooled analyses by country and sex. For *any anxiety disorder*, additional analyses were conducted based on: i) setting, ii) number and iii) included disorders, iv) classification system, and v) clinical interview employed. Prevalence estimates for disorders grouped under *any anxiety disorder* by setting were also calculated.

Heterogeneity between studies was assessed using χ^2 tests and the I^2 statistic, which quantifies the percentage of variability in prevalence prediction intervals (PI) due to heterogeneity rather than sampling error or chance,

with values $\geq 75\%$ indicating substantial heterogeneity.³⁴ Additionally, we present 95% PI for summary prevalence to provide a comprehensive understanding of estimation uncertainties.

To assess publication bias, we visually inspected funnel plots and applied the Harbord-Egger method,³⁵ supplemented by Doi plots, and the Luis Furuya-Kanamori index.³⁶ The Luis Furuya-Kanamori index quantifies plot asymmetry (i.e., presence of publication bias), with values within ± 1 suggesting no asymmetry, ± 1 to ± 2 indicating minor asymmetry, and above ± 2 signalling major asymmetry. All analyses were performed using R software with the metaphor package.³⁷

Meta-regression analyses were performed to assess the univariate association of each indicator (HDI, Gini, GII, IHR) with the 12-month and current prevalence of ICD/DSM *any anxiety disorder*. Random-effects models were applied, fitted via the restricted maximum likelihood method, and weights were estimated using the inverse-variance method.³⁸ Results are as odds ratios (OR) along with corresponding 95% CI.

Sensitivity analysis

We performed an influence analysis, systematically reevaluating the data by removing one observation at a time, to assess the impact of individual observations on the overall prevalence of *any anxiety disorder* and specific disorders. For current prevalence, sensitivity analyses also included recalculating summary estimates before and after the exclusion of three age-specific studies (Supplementary Method S4).

Role of the funding source

The study funders had no role in the design, data collection, analysis, data interpretation, or report writing of the study.

Results

Summary of search results

The database search yielded 20,233 citations. After removing duplicates, screening titles and abstracts, and reviewing 131 full texts, 32 citations^{39–70} from 18 studies met the inclusion criteria. An additional 27 citations, identified through alternative methods, were also deemed eligible, including nine published articles, chapters, or books from international organisations and repositories^{27,71–79} and 17 unpublished citations obtained from government agencies^{80–96} (Fig. 1; Supplementary Method S5). In total, our analysis included 59 citations, representing 36 studies that involved 110,527 individuals from seven LATAM countries. Thirty-one studies reported on *any anxiety disorder*,^{27,39–41,44–48,51,52,55–58,60,63–67,76–78,80–92,94–96} 30 on agoraphobia,^{39–41,44–47,51,52,54–56,62–67,72,76,80–92,94–96} 34 on generalized anxiety disorder,^{39–41,44–47,49–53,55–57,59,60,63,65–67,73,76,77,80–96} 27 on OCD,^{39–41,44–47,51–53,56,61,80–96} 32 on panic disorder,^{39–41,44–47,51–53,55–57,59,60,63,65–67,71,76,77,80–96} 30 on

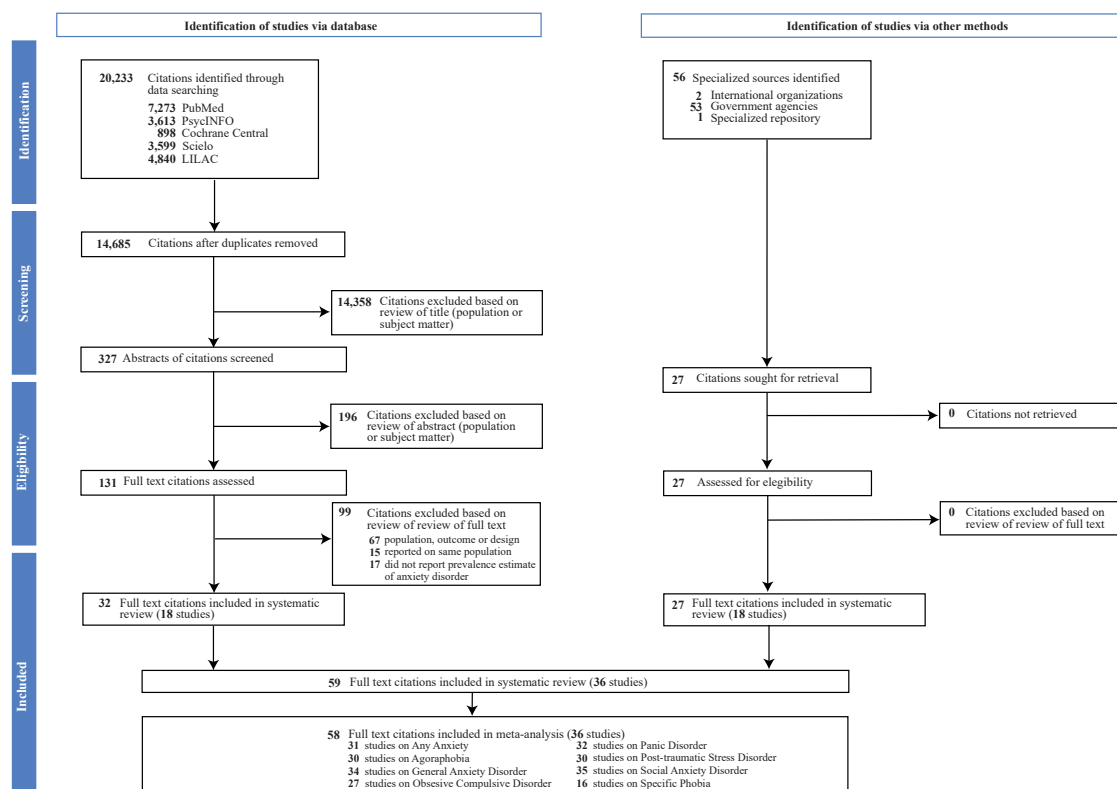


Fig. 1: Study selection and identification (PRISMA flow).

PTSD,^{39,40,44–47,49,51,52,55,56,58,63,65–67,69,70,77,79–96} 35 on social anxiety disorder,^{39–47,49–52,54–57,59,60,62–67,74,76,77,80–96} and 16 on specific phobia.^{39–41,44,45,47,51,52,54–56,62–67,75–77,94–96}

Characteristics of included studies

Table 1 summarizes the key characteristics of the included studies (Supplementary Method S5). Spanning from 1992 to 2019, most studies were conducted in three LATAM countries: 14 in Peru,^{66,67,71–75,79–92} eight in Colombia,^{27,55–57,71–75,77,79,93–96} and eight in Brazil.^{41–50,68,69,71–75,78,79} Additionally, we incorporated two studies from Mexico,^{59–65,71–76,79} two from Chile,^{51–54,70} and one study from Argentina,^{39,40} and Guatemala.⁵⁸

The median number of participants per study was 2536 (interquartile range 1544–3914). Among the 29 studies that provided prevalence breakdowns by sex,^{41,42,44,45,47,49–53,55,57,60,62,63,70,76,78,80–92,95,96} there were 41,191 men and 52,551 women. Seven studies did not report sex-specific estimates.^{27,39,40,43,56,58,66,67,71–75,93,94} Twenty-seven studies encompassed populations aged 18 or older,^{27,39–45,55–68,71–77,79–94} while six involved individuals aged 15 or 16 years and above.^{47,48,51–54,69,70,95,96} One study^{46,78} exclusively focused on individuals aged 18 to 24, and two birth cohort studies estimated the prevalence at ages 22,⁴⁹ and 30.⁵⁰

Thirty-two studies^{39,41–43,45,47,48,52,55–65,67,69–77,79,81–96} involving 97,774 individuals reported the lifetime prevalence. Twenty-nine studies inquired about prevalence in the last 12 months,^{27,40–44,47,48,52,55–57,61–66,69,70,72–77,79–92,94–96} covering 92,976 individuals. Additionally, 29 studies reported current^{41–43,46,49–51,53–55,57,63,66–68,70–75,78–93,95,96} prevalence involving 86,496 individuals (Table 2).

Prevalence of any anxiety disorder in the general adult population of LATAM

The pooled overall lifetime prevalence of *any anxiety disorder* in LATAM was 14.55% (95% CI: 12.32–17.11, PI: 5.70–32.45, 29 studies, $I^2 = 97.9\%$, $p < 0.0001$) (Fig. 2). The twelve-month prevalence was 6.61% (5.20–8.37, PI: 1.85–21.05, 27 studies, $I^2 = 98.1\%$, $p < 0.0001$) (Fig. 3) and the current prevalence 3.27% (2.34–4.56, PI: 0.69–14.12, 21 studies, $I^2 = 97.5\%$, $p < 0.0001$) (Fig. 4).

The estimated lifetime, 12-month, or current prevalence of *any anxiety disorder* was consistently higher among women compared to men. Specifically, it was 19.05% [15.78–22.81] for women versus 10.63% [8.66–12.98] for lifetime prevalence, 8.18% [6.11–10.87] versus 3.67% [2.71–4.94] in the past 12 months, and 4.42% [3.16–6.14] versus 1.96% [1.34–2.86] for current

Country Authors	Location (Survey)	Period	Design ^a / setting ^b	Sample size (Resp. rate %)	Diagnostic criteria/interview	Disorders grouped under any anxiety disorder (n) ^c
Argentina						
1. Cia et al. (2018) ³⁹ ; Stagnaro et al. (2018) ⁴⁰	National (AMHES) ^e	2015	CS/U	3927 (77.0)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SeAD, S (8)
Brazil						
2. Andrade et al. (2002) ⁴¹	Sao Paulo (ECAS-SP) ^d	1994–1996	CS/U	1464 (62.4)	DSM–III–R; ICD-10/CIDI	AG, GAD, OCD, PD, SAD, SP (6)
3. Vorcaro et al. (2004) ⁴² ; Rocha et al. (2005) ⁴³	Bambuí	1996–1997	CS/M	1041 (85.3)	DSM–III–R; ICD-10/CIDI	
4. Alonso et al. (2018) ⁷⁷ ; Andrade et al. (2012) ⁴⁴ ; de Jonge et al. (2018) ⁷¹ ; Ratanatharathorn et al. (2018) ⁷⁹ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Viana et al. (2012) ⁴⁵ ; Wardenaar et al. (2018) ⁷⁵	Sao Paulo (SPMHS) ^e	2005–2007	CS/U	5037 (81.3)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SeAD, SP (8)
5. Medeiros et al. (2015) ⁶⁸ ; Molina et al. (2014) ⁴⁶ ; Mondin et al. (2013) ⁷⁸	Pelotas	2007–2008	CS/U	1560 (NR)	DSM-IV/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
6. Longo et al. (2020) ⁶⁹ ; Ribeiro et al. (2013) ⁴⁷	Rio de Janeiro	2007–2008	CS/U	1208 (80.5)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SP (7)
7. Longo et al. (2020) ⁶⁹ ; Jaen-Varas et al. (2016) ^{48,f} ; Ribeiro et al. (2013) ⁴⁷	Sao Paulo	2007–2008	CS/U	2536 (84.5)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SP (7)
8. Loret de Mola et al. (2013) ⁵⁰	Pelotas (PBCS1982)	2012–2013	L (birth cohort)/U	3542 (68.1)	DSM-IV; ICD-10/MINI	
9. Gomes et al. (2019) ⁴⁹	Pelotas (PBCS1993)	2015	L (birth cohort)/U	3781 (72.1)	DSM-5/MINI	
Chile						
10. Vicente et al. (2004) ⁵¹ ; Vicente et al. (2006) ⁵² ; Zlotnick et al. (2006) ⁷⁰	National (CPPS) ^d	1992–1999	CS/M	2978 (90.3)	DSM–III–R/CIDI and DIS	AG, GAD, PD, PTSD (4)
11. Araya et al. (2001) ⁵³ ; Fritsch et al. (2010) ⁵⁴	Santiago (SMHS)	1996–1998	CS/U	3870 (90.0)	ICD-10/CIS-R	
Colombia						
12. de Jonge et al. (2018) ⁷¹ ; Posada-Villa et al. (2006) ⁵⁵ ; Posada-Villa et al. (2008) ⁷⁷ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	National (NSMH2003) ^e	2003	CS/U	4544 (87.7)	DSM-IV/CIDI	AG, GAD, PD, PTSD, SAD, SP (6)
13. Dirección Territorial Caldas (2010) ⁹³	Caldas	2009	CS/M	1269 (NR)	DSM-IV/MINI	
14. Alonso et al. (2018) ⁷⁷ ; de Jonge et al. (2018) ⁷¹ ; Ratanatharathorn et al. (2018) ⁷⁹ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	Medellín (MMHHS) ^e	2011–2012	CS/M	3261 (97.2)	DSM-IV/CIDI	AG, GAD, PD, PTSD, SAD, SeAD, SP (7)
15. Torres de Galvis et al. (2014) ⁵⁶	Itagüi (MHPSI)	2012	CS/U	642 (NR)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SeAD, SP (8)
16. Gómez-Restrepo et al. (2016) ⁵⁷	National (NSMH2015) ^e	2015	CS/M	10,870 (NR)	DSM-IV/CIDI	GAD, PD, SAD (3)
17. Torres de Galvis et al. (2018) ⁹⁶	Envigado ^e	2017	CS/M	2072 (NR)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SP (7)
18. Torres de Galvis et al. (2018) ⁹⁵	Sabaneta ^e	2018	CS/M	608 (NR)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SP (7)
19. Torres de Galvis et al. (2020) ⁹⁴	Medellín ^e	2019	CS/M	2304 (NR)	DSM-IV/CIDI	AG, GAD, OCD, PD, PTSD, SAD, SP (7)
Guatemala						
20. Puac-Polanco et al. (2015) ⁵⁸	National (GNMHS)	2009	CS/M	1452 (87.3)	DSM-IV/CIDI	AG, GAD, PD (3)
Mexico						
21. Caraveo-Anduaga et al. (1999) ⁵⁹ ; Caraveo-Anduaga et al. (2000) ⁶² ; Caraveo-Anduaga et al. (2002) ⁶⁰ ; Caraveo-Anduaga et al. (2004) ⁶¹	Mexico City (EPM) ^d	1995	CS/U	1734 (92.0)	DSM–III–R; ICD-10/CIDI	AG, GAD, PD, SAD, SP (5)
22. de Jonge et al. (2008) ⁷¹ ; Medina Mora et al. (2003) ⁶³ ; Medina Mora et al. (2005) ⁶⁴ ; Medina Mora et al. (2007) ⁶⁵ ; Medina Mora et al. (2008) ⁷⁶ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	National (M-NCS) ^e	2001–2002	CS/U	5826 (76.6)	DSM-IV; ICD-10/CIDI	AG, GAD, PD, PTSD, SAD, SP (6)

(Table 1 continues on next page)

Country Authors	Location (Survey)	Period	Design ^a / setting ^b	Sample size (Resp. rate %)	Diagnostic criteria/interview	Disorders grouped under any anxiety disorder (n) ^c
(Continued from previous page)						
Peru						
23. NIMH (2002) ⁸⁰	Metropol. Lima	2002	CS/U	2077 (82.4)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
24. NIMH (2003) ⁸¹	Sierra	2003	CS/U	3895 (91.9)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
25. NIMH (2005) ⁸²	Amazon	2004	CS/U	3909 (92.2)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
26. Alonso et al. (2018) ²⁷ ; de Jonge et al. (2018) ⁷¹ ; Fiestas et al. (2014) ⁶⁷ ; Piazza et al. (2014) ⁶⁶ ; Ratanatharathorn et al. (2018) ⁷³ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	National (EMSMP) ^e	2004–2005	CS/U	3930 (90.2)	DSM-IV/CIDI	AG, GAD, PD, PTSD, SAD, SeAD, SP (7)
27. NIMH (2006) ⁸³	Fronteras	2005	CS/U	5857 (92.5)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
28. NIMH (2007) ⁸⁴	Costa	2006	CS/M	6555 (93.9)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
29. NIMH (2008) ⁸⁵	Rural Lima	2007	CS/R	2536 (96.5)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
30. NIMH (2009) ⁸⁶	Rural Sierra	2008	CS/R	3031 (94.8)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
31. NIMH (2012) ⁸⁸	Rural Amazon	2009	CS/R	2331 (99.9)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
32. NIMH (2011) ⁸⁷	Abancay	2010	CS/U	1746 (98.6)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
33. NIMH (2013) ⁸⁹	Metropol. Lima (R)	2012	CS/U	4445 (98.6)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
34. NIMH (2016) ⁹¹	Huánuco	2013	CS/U	1496 (94.7)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
35. NIMH (2016) ⁹⁰	Cerro de Pasco	2013	CS/U	1469 (85.6)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
36. NIMH (2019) ⁹²	Abancay (R)	2016	CS/U	1724 (92.6)	ICD-10/MINI	AG, GAD, OCD, PD, PTSD, SAD (6)
Abbreviations: Agoraphobia (AG); Argentina Mental Health Epidemiologic Survey (AMHES); Composite International Diagnostic Interview (CIDI); Revised Clinical Interview Schedule (CIS-R); Chile Psychiatric Prevalence Study (CPPS); Diagnostic Interview Schedule (DIS); Epidemiologic Catchment Area Study in the city of Sao Paulo (ECAS-SP); Encuesta Mundial de Salud Mental en el Peru (EMSMP); Epidemiology of Psychiatric Comorbidity Project (EPM); Generalized Anxiety Disorder (GAD); Guatemala National Mental Health Survey (GNMHS); Mexico National Comorbidity Survey (M-NCS); Mental Health Population Study Itagüí (MHPSI); Mini International Neuropsychiatric Interview (MINI); Medellín Mental Health Household Study (MMHHS); National Institute of Mental Health Peru (NIMH); Colombian National Study of Mental Health (NSMH); Not Reported (NR); Obsessive-Compulsive Disorder (OCD); Pelotas Birth Cohort Study 1982 (PBCS1982); Pelotas Birth Cohort Study 1993 (PBCS1993); Panic Disorder (PD); Post-Traumatic Stress Disorder (PTSD); Social Anxiety Disorder (SAD); Separation Anxiety Disorder (SeAD); Santiago Mental Disorders Survey (SMHS); Specific Phobia (SP); Sao Paulo Megacity Mental Health Survey (SPMHS). Studies are ordered alphabetically by country and then by year of survey. ^a CS (Cross-sectional); L (Longitudinal). ^b R (Rural); U(Urban); Mixed(M). ^c Number of disorders grouped under the "any anxiety disorder" aggregated category. ^d International Consortium of Psychiatric Epidemiology (ICPE) Surveys. ^e WHO World Mental Health Survey (WHO-WMHS) Consortium. ^f Citation not included in meta-analysis.						
Table 1: Characteristics of 36 studies included in the systematic review and meta-analysis.						

Country Authors	Location (survey)	% Prevalence [SE] ⁹							
		Any anxiety disorder	Disorders grouped under any anxiety disorder						
			Agoraphobia	General anxiety disorder	Obsessive-compulsive disorder	Panic disorder	Post-traumatic stress disorder	Social anxiety disorder	Specific phobia
Argentina									
1. Cia et al. (2018) ^{39,d} ; Stagnaro et al. (2018) ⁴⁰	National (AMHES) ^c	L: 16.4 [1.1] 12 m: 9.4 [0.5]	L: 0.5 [0.1] 12 m: 0.3 [0.1]	L: 3.9 [0.5] 12 m: 1.5 [0.2]	L: 2.9 [0.8] 12 m: 2.5 [0.8]	L: 1.5 [0.4] 12 m: 0.8 [0.2]	L: 2.8 [0.3] 12 m: 1.1 [0.2]	L: 2.6 [0.3] 12 m: 1.3 [0.2]	L: 6.8 [0.5] 12 m: 4.8 [0.3]
Brazil									
2. Andrade et al. (2002) ^{41,e}	Sao Paulo (ECAS-SP) ^b	L: 12.5 [1.0] 12 m: 7.7 [0.7] C: 6.0 [0.5]	L: 2.1 [0.4] 12 m: 1.2 [0.2] C: 0.8 [0.1]	L: 4.2 [0.6] 12 m: 1.7 [0.4] C: 1.3 [0.4]	L: 0.3 [0.1] 12 m: 0.3 [0.1] C: 0.3 [0.1]	L: 1.6 [0.3] 12 m: 1.0 [0.2] C: 0.4 [0.1]		L: 3.5 [0.4] 12 m: 2.2 [0.4] C: 1.7 [0.3]	L: 4.8 [0.5] 12 m: 3.5 [0.3] C: 2.9 [0.3]
3. Vorcaro et al. (2004) ^{42,e} ; Rocha et al. (2005) ⁴³	Bambui							L: 6.7 [0.8] ^a 12 m: 6.5 [0.7] ^a C: 6.0 [0.7] ^a	
4. Alonso et al. (2018) ²⁷ ; Andrade et al. (2012) ^{44,d,e} ; de Jonge et al. (2018) ⁷² ; Ratanatharathorn et al. (2018) ⁷⁹ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Viana et al. (2012) ^{45,d,e} ; Wardenaar et al. (2018) ⁷⁵	Sao Paulo (SPMHS) ^c	L: 28.1 [0.9] 12 m: 19.9 [0.8]	L: 2.5 [0.3] 12 m: 1.6 [0.3] C: 1.2 [0.2]	L: 3.7 [0.3] 12 m: 2.3 [0.2] C: 1.0 [0.1]	L: 6.7 [0.5] 12 m: 3.9 [0.4]	L: 1.7 [0.2] 12 m: 1.1 [0.2]	L: 3.2 [0.2] 12 m: 1.6 [0.2] C: 0.7 [0.2]	L: 5.6 [0.4] 12 m: 3.9 [0.3] C: 2.7 [0.3]	L: 12.4 [0.6] 12 m: 10.6 [0.5] C: 8.8 [0.5]
5. Medeiros et al. (2015) ⁶⁸ ; Molina et al. (2014) ⁴⁶ ; Mondin et al. (2013) ^{78,e}	Pelotas	C: 20.9 [1.0] ^a	C: 12.3 [0.8] ^a	C: 9.7 [0.8] ^a	C: 3.3 [0.5] ^a	C: 2.5 [0.4] ^a	C: 2.1 [0.4] ^a	C: 4.0 [0.5] ^a	
6. Longo et al. (2020) ⁶⁹ ; Ribeiro et al. (2013) ^{47,d,e}	Rio de Janeiro	L: 27.1 [1.2] ^a 12 m: 18.8 [1.3] ^a	L: 3.1 [0.5] ^a 12 m: 2.1 [0.4] ^a	L: 5.8 [0.7] ^a 12 m: 2.2 [0.5] ^a	L: 3.6 [0.6] ^a 12 m: 2.8 [0.6] ^a	L: 1.3 [0.4] ^a 12 m: 1.0 [0.4] ^a	L: 7.0 [0.2] ^a 12 m: 8.7 [0.9] ^a	L: 4.0 [0.6] ^a 12 m: 2.1 [0.4] ^a	L: 14.6 [1.1] ^a 12 m: 9.6 [0.9] ^a
7. Longo et al. (2020) ⁶⁹ ; Jaen-Varas et al. (2016) ^{48,d,f} ; Ribeiro et al. (2013) ^{47,d,e}	Sao Paulo	L: 30.8 [1.2] ^a 12 m: 20.8 [1.0] ^a	L: 4.0 [0.5] ^a 12 m: 2.7 [0.4] ^a	L: 6.0 [0.6] ^a 12 m: 3.5 [0.5] ^a	L: 4.1 [0.5] ^a 12 m: 3.3 [0.4] ^a	L: 0.7 [0.2] ^a 12 m: 0.1 [0.1] ^a	L: 10.2 [0.8] ^a 12 m: 8.7 [0.7] ^a	L: 5.7 [0.6] ^a 12 m: 3.3 [0.5] ^a	L: 16.8 [0.9] ^a 12 m: 10.2 [0.8] ^a
8. Loret de Mola et al. (2013) ^{50,d,e}	Pelotas (PBCS1982)			C: 12.7 [0.6] ^a		L: 1.6 [0.3] 12 m: 1.0 [0.2] C: 0.4 [0.1]		C: 3.7 [0.3] ^a	
9. Gomes et al. (2019) ^{49,d,e}	Pelotas (PBCS1993)			C: 10.4 [0.5] ^a			C: 4.5 [0.3] ^a	C: 5.0 [0.4] ^a	
Chile									
10. Vicente et al. (2004) ^{51,e} ; Vicente et al. (2006) ^{52,d,e} ; Zlotnick et al. (2006) ⁷⁰	National (CPPS) ^b	L: 16.2 [1.6] 12 m: 9.9 [1.0] 6 m: 7.9 [0.8] C: 6.8 [0.6]	L: 11.1 [1.4] 12 m: 6.3 [1.1] 6 m: 5.1 [0.8] C: 4.4 [0.7]	L: 2.6 [0.5] 12 m: 1.6 [0.3] 6 m: 1.2 [0.3] C: 0.9 [0.2]	L: 1.2 [0.6] 12 m: 1.2 [0.6] 6 m: 1.2 [0.6] C: 1.2 [0.6]	L: 1.6 [0.4] 12 m: 0.9 [0.4] 6 m: 0.7 [0.3] C: 0.6 [0.3]	L: 4.4 [0.5] 12 m: 2.4 [0.3] 6 m: 1.9 [0.3] C: 1.7 [0.3]	L: 10.2 [2.8] 12 m: 6.4 [1.6] 6 m: 5.9 [1.4] C: 4.5 [0.9]	L: 9.8 [1.8] 12 m: 8.0 [1.5] 6 m: 6.1 [1.3] C: 5.2 [1.2]
11. Araya et al. (2001) ^{53,e} ; Fritsch et al. (2010) ⁵⁴	Santiago (SMHS)		C: 1.0 [0.2] ^a	C: 5.1 [0.5] ^a	C: 1.3 [0.3] ^a	C: 1.3 [0.3] ^a		C: 1.1 [0.2] ^a	C: 1.9 [0.3] ^a
Colombia									
12. de Jonge et al. (2018) ⁷¹ ; Posada-Villa et al. (2006) ^{55,e} ; Posada-Villa et al. (2008) ⁷⁷ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	National (NSMH2003) ^c	L: 19.3 [1.1] 12 m: 11.7 [0.9] C: 5.1 [0.6]	L: 2.5 [0.3] 12 m: 1.7 [0.3] C: 0.7 [0.1]	L: 1.3 [0.3] 12 m: 0.6 [0.2] C: 0.3 [0.1]		L: 1.2 [0.2] 12 m: 0.7 [0.1] C: 0.3 [0.1]	L: 1.8 [0.4] 12 m: 0.6 [0.2] C: 0.2 [0.1]	L: 5.0 [0.5] 12 m: 2.8 [0.3] C: 1.6 [0.3]	L: 12.5 [0.8] 12 m: 8.0 [0.7] C: 5.7 [0.5]
13. Dirección Territorial Caldas (2010) ⁹³	Caldas			C: 3.2 [0.2] ^a	C: 0.9 [0.1] ^a	L: 6.8 [0.4] ^a C: 4.9 [0.3] ^a	C: 0.8 [0.1] ^a	C: 2.4 [0.2] ^a	
14. Alonso et al. (2018) ²⁷ ; de Jonge et al. (2018) ⁷¹ ; Ratanatharathorn et al. (2018) ⁷⁹ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	Medellín (MMHHS) ^c	12 m: 12.1 [1.0]	L: 1.6 [0.3] 12 m: 1.3 [0.2] C: 0.7 [0.2]	L: 2.6 [0.4] 12 m: 1.2 [0.3] C: 0.4 [0.1]		L: 1.3 [0.3]	L: 3.7 [0.6] 12 m: 1.0 [0.2] C: 0.3 [0.1]	L: 4.6 [0.5] 12 m: 3.8 [0.5] C: 2.2 [0.4]	L: 10.2 [0.8] 12 m: 8.3 [0.7] C: 6.4 [0.6]

(Table 2 continues on next page)

Country Authors	Location (survey)	% Prevalence [SE] ⁹							
		Any anxiety disorder	Disorders grouped under any anxiety disorder						
			Agoraphobia	General anxiety disorder	Obsessive-compulsive disorder	Panic disorder	Post-traumatic stress disorder	Social anxiety disorder	Specific phobia
(Continued from previous page)									
15. Torres de Galvis et al. (2014) ⁵⁶	Itagüi (MHPSI)	L: 15.5 [1.3] ^a 12 m: 9.1 [1.0] ^a	L: 0.5 [0.3] ^a 12 m: 0.3 [0.2] ^a	L: 2.1 [0.5] ^a 12 m: 1.0 [0.4] ^a	L: 1.9 [0.5] ^a 12 m: 1.9 [0.5] ^a	L: 0.3 [0.3] ^a 12 m: 0.3 [0.3] ^a	L: 11.0 [1.0] ^a 12 m: 2.6 [0.5] ^a	L: 2.2 [0.5] ^a 12 m: 1.7 [0.5] ^a	L: 7.5 [0.9] ^a 12 m: 4.8 [0.7] ^a
16. Gómez-Restrepo et al. (2016) ^{57,e}	National (NSMH 2015) ^c	L: 3.9 [0.7] ^a 12 m: 2.1 [0.2] ^a C: 1.1 [0.2] ^a	L: 1.3 [0.2] ^a 12 m: 0.5 [0.1] ^a C: 0.1 [0.1] ^a	L: 0.2 [0.1] ^a 12 m: 0.1 [0.0] ^a C: 0.0 [0.0] ^a	L: 0.2 [0.1] ^a 12 m: 0.1 [0.0] ^a C: 0.0 [0.0] ^a	L: 0.2 [0.1] ^a 12 m: 0.1 [0.0] ^a C: 0.0 [0.0] ^a	L: 0.2 [0.1] ^a 12 m: 0.1 [0.0] ^a C: 0.0 [0.0] ^a	L: 2.7 [0.2] ^a 12 m: 1.6 [0.2] ^a C: 0.9 [0.1] ^a	
17. Torres de Galvis et al. (2018) ^{96,d,e}	Envigado ^c	L: 9.7 [1.3] ^a 12 m: 4.4 [0.4] ^a C: 1.6 [0.3] ^a	L: 0.2 [0.1] ^a 12 m: 0.2 [0.1] ^a C: 0.0 [0.0] ^a	L: 0.9 [0.2] ^a 12 m: 0.3 [0.1] ^a C: 0.2 [0.1] ^a	L: 2.6 [0.9] ^a 12 m: 2.0 [0.8] ^a C: 0.8 [0.5] ^a	L: 1.3 [0.3] ^a 12 m: 0.7 [0.2] ^a C: 0.4 [0.1] ^a	L: 3.4 [0.6] ^a 12 m: 0.1 [0.1] ^a C: 0.1 [0.1] ^a	L: 2.6 [0.4] ^a 12 m: 1.5 [0.3] ^a C: 0.5 [0.2] ^a	L: 4.6 [0.5] ^a 12 m: 2.0 [0.3] ^a C: 0.5 [0.2] ^a
18. Torres de Galvis et al. (2018) ^{95,d,e}	Sabaneta ^c	L: 9.8 [0.7] ^a 12 m: 4.2 [0.8] ^a C: 2.3 [0.6] ^a	L: 0.4 [0.2] ^a 12 m: 0.2 [0.2] ^a C: 0.0 [0.0] ^a	L: 1.6 [0.5] ^a 12 m: 1.0 [0.4] ^a C: 0.8 [0.4] ^a	L: 1.2 [0.8] ^a 12 m: 1.2 [0.8] ^a C: 0.0 [0.0] ^a	L: 0.5 [0.2] ^a 12 m: 0.3 [0.2] ^a C: 0.1 [0.1] ^a	L: 4.7 [1.3] ^a 12 m: 0.6 [0.4] ^a C: 0.6 [0.4] ^a	L: 1.4 [0.5] ^a 12 m: 0.5 [0.2] ^a C: 0.0 [0.0] ^a	L: 4.1 [0.8] ^a 12 m: 2.0 [0.6] ^a C: 1.0 [0.4] ^a
19. Torres de Galvis et al. (2020) ^{94,d}	Medellin ^c	L: 19.8 [0.6] ^a 12 m: 9.8 [0.6] ^a [0.2] ^a	L: 1.0 [0.2] ^a 12 m: 0.6 [0.2] ^a [0.2] ^a	L: 1.8 [0.3] ^a 12 m: 1.0 [0.2] ^a [0.2] ^a	L: 2.8 [0.3] ^a 12 m: 2.8 [0.4] ^a [0.4] ^a	L: 1.3 [0.2] ^a 12 m: 1.0 [0.2] ^a [0.2] ^a	L: 8.6 [0.6] ^a 12 m: 1.9 [0.3] ^a [0.3] ^a	L: 4.7 [0.4] ^a 12 m: 2.4 [0.3] ^a [0.3] ^a	L: 9.8 [0.6] ^a 12 m: 5.4 [0.5] ^a [0.3] ^a
Guatemala									
20. Puac-Polanco et al. (2015) ⁵⁸	National (GNMHS)	L: 6.5 [0.7] ^a					L: 1.9 [0.4] ^a		
Mexico									
21. Caraveo-Anduaga et al. (1999) ⁵⁹ ; Caraveo-Anduaga et al. (2000) ^{62,e} ; Caraveo-Anduaga et al. (2002) ^{60,e} ; Caraveo-Anduaga et al. (2004) ⁶¹	Mexico City (EPM) ^b	L: 9.0 [1.2] ^a	L: 2.5 [0.4] ^a 12 m: 1.4 [0.3] ^a	L: 3.4 [0.4] ^a	L: 1.4 [0.2] ^a 12 m: 1.0 [0.2] ^a	L: 1.9 [0.3] ^a		L: 2.6 [0.4] ^a 12 m: 1.8 [0.3] ^a	L: 2.8 [0.4] ^a 12 m: 2.3 [0.3] ^a
22. de Jonge et al. (2008) ⁷¹ ; Medina Mora et al. (2003) ^{63,e} ; Medina Mora et al. (2005) ⁶⁴ ; Medina Mora et al. (2007) ^{65,d} ; Medina Mora et al. (2008) ^{76,e} ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	National (M-NCS) ^c	L: 14.3 [0.9] 12 m: 6.6 [0.6] C: 3.2 [0.3]	L: 2.5 [0.2] 12 m: 0.7 [0.1] C: 0.5 [0.1]	L: 1.2 [0.2] 12 m: 0.7 [0.2] C: 0.4 [0.2]		L: 2.1 [0.2] 12 m: 1.1 [0.2] C: 0.4 [0.1]	L: 1.5 [0.3] 12 m: 0.6 [0.1] C: 0.2 [0.1]	L: 4.7 [0.4] 12 m: 1.7 [0.2] C: 1.1 [0.2]	L: 7.0 [0.5] 12 m: 4.0 [0.5] C: 6.4 [0.6]
Peru									
23. NIMH (2002) ^{80,d,e}	Metropol. Lima	L: 25.3 [1.2] 6 m: 16.4 [1.1] C: 14.6 [1.0]	L: 4.5 [0.5] ^a 6 m: 2.7 [0.4] C: 1.6 [0.3] ^a	L: 9.9 [0.8] 6 m: 7.3 [0.8] C: 7.3 [0.8]	L: 1.6 [0.3] 6 m: 0.9 [0.2] C: 0.7 [0.2]	L: 3.7 [0.5] 6 m: 2.0 [0.4] C: 1.2 [0.3]	L: 6.0 [0.6] 6 m: 2.8 [0.5] C: 2.8 [0.4] ^a	L: 7.9 [0.8] 6 m: 3.7 [0.5] C: 2.8 [0.5]	
24. NIMH (2003) ^{81,d,e}	Sierra	L: 21.1 [1.0] 12 m: 6.6 [0.6] 6 m: 5.6 [0.5] C: 3.5 [0.4]	L: 1.8 [0.3] 12 m: 0.8 [0.2] 6 m: 0.6 [0.2] C: 0.5 [0.2]	L: 8.2 [0.6] 12 m: 3.2 [0.4] 6 m: 2.8 [0.4] C: 2.0 [0.4]	L: 0.4 [0.1] 12 m: 0.2 [0.1] 6 m: 0.1 [0.1] C: 0.0 [0.0]	L: 0.2 [0.0] 12 m: 0.1 [0.0] 6 m: 0.1 [0.0] C: 0.0 [0.0]	L: 12.8 [0.8] 12 m: 1.9 [0.3] 6 m: 1.6 [0.3] C: 0.7 [0.2]	L: 2.9 [0.5] 12 m: 0.9 [0.2] 6 m: 0.6 [0.2] C: 0.5 [0.1]	
25. NIMH (2005) ^{82,d,e}	Amazon	L: 18.3 [0.9] 12 m: 6.2 [0.6] 6 m: 5.5 [0.6] C: 3.7 [0.4]	L: 0.9 [0.2] 12 m: 0.4 [0.1] 6 m: 0.3 [0.1] C: 0.1 [0.1]	L: 8.2 [0.7] 12 m: 2.5 [0.3] 6 m: 2.6 [0.4] C: 2.0 [0.3]	L: 0.2 [0.1] 12 m: 0.1 [0.0] 6 m: 0.1 [0.0] C: 0.0 [0.0]	L: 1.0 [0.3] 12 m: 0.6 [0.2] 6 m: 0.5 [0.2] C: 0.2 [0.1]	L: 8.9 [0.6] 12 m: 2.3 [0.4] 6 m: 1.7 [0.3] C: 1.1 [0.3]	L: 1.5 [0.3] 12 m: 0.6 [0.2] 6 m: 0.5 [0.1] C: 0.4 [0.1]	
26. Alonso et al. (2018) ²⁷ ; de Jonge et al. (2018) ⁷¹ ; Fiestas et al. (2014) ^{67,d} ; Piazza et al. (2014) ⁶⁶ ; Ratanatharathorn et al. (2018) ⁷⁹ ; Roest et al. (2018) ⁷² ; Ruscio et al. (2018) ⁷³ ; Stein et al. (2018) ⁷⁴ ; Wardenaar et al. (2018) ⁷⁵	National (EMSMP) ^c	L: 14.9 [0.9] ^a 12 m: 7.9 [0.5]	L: 0.7 [0.1] ^a 12 m: 0.5 [0.1] C: 0.2 [0.1]	L: 0.7 [0.1] ^a 12 m: 0.2 [0.1] C: 0.1 [0.0]		L: 0.5 [0.1] 12 m: 0.3 [0.1]	L: 0.7 [0.1] 12 m: 0.2 [0.1] C: 0.1 [0.1]	L: 2.6 [0.3] ^a 12 m: 1.4 [0.1] C: 0.5 [0.1]	L: 6.6 [0.4] ^a 12 m: 4.6 [0.3] C: 2.5 [0.2]
(Table 2 continues on next page)									

(Table 2 continues on next page)

Country Authors	Location (survey)	% Prevalence [SE] ⁹						
		Any anxiety disorder	Disorders grouped under any anxiety disorder					
			Agoraphobia	General anxiety disorder	Obsessive-compulsive disorder	Panic disorder	Post-traumatic stress disorder	Social anxiety disorder
(Continued from previous page)								
27. NIMH (2006) ^{83,d,e}	Fronteras	L: 17.5 [0.7] 12 m: 7.7 [0.5] 6 m: 6.8 [0.5] C: 4.7 [0.4]	L: 2.7 [0.3] 12 m: 1.3 [0.2] 6 m: 1.1 [0.2] C: 0.6 [0.1]	L: 7.4 [0.5] 12 m: 3.0 [0.5] 6 m: 2.7 [0.3] C: 2.5 [0.4]	L: 0.3 [0.1] 12 m: 0.2 [0.1] 6 m: 0.2 [0.1] C: 0.1 [0.1]	L: 0.4 [0.1] 12 m: 0.3 [0.1] 6 m: 0.3 [0.1] C: 0.1 [0.0]	L: 6.7 [0.4] 12 m: 1.9 [0.2] 6 m: 1.5 [0.2] C: 0.7 [0.1]	L: 3.6 [0.4] 12 m: 1.9 [0.3] 6 m: 1.7 [0.3] C: 1.2 [0.2]
28. NIMH (2007) ^{84,d,e}	Costa	L: 9.3 [0.6] 12 m: 3.1 [0.4] 6 m: 2.8 [0.4] C: 1.8 [0.4]	L: 1.3 [0.2] 12 m: 0.6 [0.1] 6 m: 1.4 [0.1] C: 0.2 [0.1]	L: 4.2 [0.4] 12 m: 1.1 [0.2] 6 m: 1.1 [0.2] C: 0.8 [0.2]	L: 0.1 [0.1] 12 m: 0.1 [0.0] 6 m: 0.1 [0.0] C: 0.0 [0.0]	L: 0.2 [0.0] 12 m: 0.1 [0.1] 6 m: 0.1 [0.1] C: 0.1 [0.0]	L: 3.7 [0.3] 12 m: 0.8 [0.2] 6 m: 0.7 [0.2] C: 0.3 [0.1]	L: 1.3 [0.2] 12 m: 0.7 [0.2] 6 m: 0.6 [0.2] C: 0.5 [0.1]
29. NIMH (2008) ^{85,d,e}	Rural Lima	L: 16.6 [1.7] 12 m: 5.8 [0.7] 6 m: 5.2 [0.7] C: 2.6 [0.6]	L: 0.6 [0.2] 12 m: 0.2 [0.1] 6 m: 0.2 [0.1] C: 0.1 [0.1]	L: 6.6 [1.0] 12 m: 1.4 [0v3] 6 m: 1.3 [0.4] C: 1.2 [0.4]	L: 0.1 [0.0] 12 m: 0.0 [0.0] 6 m: 0.0 [0.0] C: 0.0 [0.0]	L: 0.4 [0.2] 12 m: 0.1 [0.1] 6 m: 0.1 [0.1] C: 0.1 [0.1]	L: 9.1 [1.2] 12 m: 3.5 [0.6] 6 m: 3.1 [0.5] C: 0.9 [0.3]	L: 3.0 [0.6] 12 m: 0.6 [0.2] 6 m: 0.5 [0.1] C: 0.3 [0.1]
30. NIMH (2009) ^{86,d,e}	Rural Sierra	L: 16.9 [1.1] 12 m: 3.3 [0.4] 6 m: 2.6 [0.4] C: 1.7 [0.3]	L: 1.0 [0.2] 12 m: 0.3 [0.1] 6 m: 0.3 [0.1] C: 0.3 [0.1]	L: 5.0 [0.5] 12 m: 1.2 [0.2] 6 m: 1.0 [0.2] C: 0.4 [0.1]	L: 0.0 [0.0] 12 m: 0.0 [0.0] 6 m: 0.0 [0.0] C: 0.0 [0.0]	L: 0.4 [0.1] 12 m: 0.1 [0.1] 6 m: 0.1 [0.1] C: 0.0 [0.0]	L: 12.0 [1.0] 12 m: 1.2 [0.3] 6 m: 0.7 [0.2] C: 0.5 [0.2]	L: 1.8 [0.3] 12 m: 0.7 [0.2] 6 m: 0.6 [0.2] C: 0.6 [0.2]
31. NIMH (2012) ^{88,d,e}	Rural Amazon	L: 13.1 [1.0] 12 m: 3.4 [0.5] 6 m: 2.7 [0.5] C: 1.5 [0.3]	L: 1.0 [0.2] 12 m: 0.3 [0.1] 6 m: 0.3 [0.1] C: 0.2 [0.1]	L: 2.5 [0.4] 12 m: 0.6 [0.2] 6 m: 0.6 [0.2] C: 0.3 [0.1]	L: 0.1 [0.0] 12 m: 0.0 [0.0] 6 m: 0.0 [0.0] C: 0.0 [0.0]	L: 0.7 [0.2] 12 m: 0.4 [0.1] 6 m: 0.3 [0.1] C: 0.3 [0.0]	L: 7.8 [0.8] 12 m: 1.3 [0.3] 6 m: 0.8 [0.2] C: 0.3 [0.1]	L: 3.2 [0.5] 12 m: 0.9 [0.3] 6 m: 0.8 [0.3] C: 0.7 [0.3]
32. NIMH (2011) ^{87,d,e}	Abancay	L: 15.0 [1.1] 12 m: 4.3 [0.6] 6 m: 3.6 [0.6] C: 2.5 [0.5]	L: 0.2 [0.1] 12 m: 0.1 [0.1] 6 m: 0.1 [0.1] C: 0.1 [0.1]	L: 2.0 [0.3] 12 m: 0.5 [0.2] 6 m: 0.4 [0.1] C: 0.4 [0.1]	L: 0.1 [0.1] 12 m: 0.1 [0.1] 6 m: 0.1 [0.1] C: 0.0 [0.0]	L: 0.3 [0.1] 12 m: 0.1 [0.1] 6 m: 0.0 [0.0] C: 0.0 [0.0]	L: 10.4 [0.9] 12 m: 1.3 [0.3] 6 m: 0.8 [0.3] C: 0.0 [0.0]	L: 4.4 [0.6] 12 m: 2.4 [0.5] 6 m: 2.3 [0.5] C: 2.0 [0.4]
33. NIMH (2013) ^{89,d,e}	Metropol. Lima (R)	L: 10.5 [0.6] 12 m: 2.9 [0.3] 6 m: 2.4 [0.3] C: 1.9 [0.2]	L: 1.2 [0.2] 12 m: 0.5 [0.1] 6 m: 0.3 [0.1] C: 0.3 [0.1]	L: 3.0 [0.3] 12 m: 0.7 [0.1] 6 m: 0.7 [0.1] C: 0.6 [0.1]	L: 0.2 [0.1] 12 m: 0.1 [0.0] 6 m: 0.1 [0.0] C: 0.1 [0.0]	L: 0.5 [0.1] 12 m: 0.1 [0.0] 6 m: 0.1 [0.0] C: 0.0 [0.0]	L: 5.1 [0.4] 12 m: 0.7 [0.1] 6 m: 0.5 [0.1] C: 0.3 [0.1]	L: 2.2 [0.3] 12 m: 0.9 [0.2] 6 m: 0.9 [0.2] C: 0.8 [0.2]
34. NIMH (2016) ^{91,d,e}	Huánuco	L: 9.1 [1.0] 12 m: 3.1 [0.5] 6 m: 2.6 [0.5] C: 2.1 [0.4]	L: 1.4 [0.4] 12 m: 0.7 [0.3] 6 m: 0.7 [0.3] C: 0.6 [0.2]	L: 2.8 [0.6] 12 m: 0.7 [0.2] 6 m: 0.6 [0.2] C: 0.8 [0.3]	L: 0.4 [0.2] 12 m: 0.3 [0.2] 6 m: 0.3 [0.2] C: 0.3 [0.2]	L: 0.9 [0.3] 12 m: 0.2 [0.1] 6 m: 0.1 [0.1] C: 0.1 [0.1]	L: 4.4 [0.6] 12 m: 0.9 [0.3] 6 m: 0.7 [0.2] C: 0.3 [0.1]	L: 1.3 [0.3] 12 m: 0.5 [0.2] 6 m: 0.4 [0.1] C: 0.1 [0.1]
35. NIMH (2016) ^{90,e}	Cerro de Pasco	L: 16.5 [1.7] 12 m: 5.4 [0.9] 6 m: 4.0 [0.6] C: 2.7 [0.4]	L: 1.4 [0.2] 12 m: 0.3 [0.1] 6 m: 0.3 [0.1] C: 0.3 [0.1]	L: 4.3 [0.7] 12 m: 0.8 [0.2] 6 m: 0.6 [0.2] C: 0.6 [0.2]	L: 0.3 [0.3] 12 m: 0.1 [0.1] 6 m: 0.1 [0.1] C: 0.1 [0.1]	L: 0.7 [0.2] 12 m: 0.3 [0.2] 6 m: 0.2 [0.1] C: 0.1 [0.1]	L: 6.6 [0.8] 12 m: 1.4 [0.4] 6 m: 1.0 [0.3] C: 0.4 [0.2]	L: 7.1 [1.2] 12 m: 2.9 [0.8] 6 m: 2.1 [0.5] C: 1.5 [0.3]
36. NIMH (2019) ^{92,e}	Abancay (R)	L: 11.2 [0.3] ^a 12 m: 4.1 [0.3] ^a 6 m: 3.8 [0.7] ^a C: 2.3 [0.5]	12 m: 0.6 [0.3] ^a C: 0.3 [0.0] ^a	12 m: 1.2 [0.4] ^a C: 1.1 [0.3] ^a	12 m: 0.5 [0.3] ^a C: 0.3 [0.2] ^a	12 m: 0.2 [0.1] ^a C: 0.1 [0.1] ^a	12 m: 1.2 [0.3] ^a C: 0.2 [0.1] ^a	12 m: 1.1 [0.4] ^a C: 0.6 [0.3] ^a

Abbreviations: Argentina Mental Health Epidemiologic Survey (AMHES); Chile Psychiatric Prevalence Study (CPPS); Epidemiologic Catchment Area Study in the city of Sao Paulo (ECAS-SP); Encuesta Mundial de Salud Mental en el Peru (EMSMP); Epidemiology of Psychiatric Comorbidity Project (EPM); Guatemala National Mental Health Survey (GNMHS); Mexico National Comorbidity Survey (M-NCS); Mental Health Population Study Itagüi (MHPSI); Medellín Mental Health Household Study (MMHHS); National Institute of Mental Health Peru (NIMH); Colombian National Study of Mental Health (NSMH); Pelotas Birth Cohort Study 1982 (PBCS1982); Pelotas Birth Cohort Study 1993 (PBCS1993); Standard Error (SE); Santiago Mental Disorders Survey (SMHS); Sao Paulo Megacity Mental Health Survey (SPMHS). Studies are ordered alphabetically by country and then by year of survey. ^aSE calculated from CI. ^bInternational Consortium of Psychiatric Epidemiology (ICPE) Surveys. ^cWHO World Mental Health Survey (WHO-WMHS) Consortium. ^dCitation reporting age-stratified estimates. ^eCitation reporting sex-stratified estimates. ^fCitation not included in meta-analysis. ⁹Lifetime(L); 12 months (12 m); 6 months (6 m); Current (C): period prevalence from 1-month to 1-week or point prevalence.

Table 2: Prevalence estimates of any anxiety disorder and disorders grouped under any anxiety disorder reported in the 36 studies included in the systematic review and meta-analysis.

Study	(Location)	n (N)	Prevalence [95% CI]
Argentina			
Cia et al, 2018		644 (3,927)	16.40 (14.36–18.67)
Brazil			
Andrade et al, 2002		183 (1,464)	12.50 (10.67–14.60)
Viana et al, 2012	(Rio de Janeiro)	827 (2,942)	28.10 (26.37–29.90)
Ribeiro et al, 2013		327 (1,208)	27.10 (24.90–30.10)
Ribeiro et al, 2013	(Sao Paulo)	781 (2,536)	30.80 (28.50–33.10)
Chile			
Vicente et al, 2006		482 (2,978)	16.20 (13.30–19.59)
Colombia			
Posada-Villa et al, 2006		877 (4,544)	19.30 (17.24–21.55)
Torres De Galvis et al, 2014		139 (896)	15.50 (13.28–18.02)
Gomez-Restrepo et al, 2016	(Envigado)	424 (10,870)	3.90 (3.40–4.60)
Torres de Galvis et al, 2018		200 (2,072)	9.65 (8.40–10.90)
Torres de Galvis et al, 2018	(Sabaneta)	59 (608)	9.78 (7.40–12.10)
Torres de Galvis et al, 2020		456 (2,304)	19.80 (18.22–21.48)
Guatemala			
Puac-Polanco et al, 2015		93 (1,425)	6.50 (5.20–7.90)
Mexico			
Caraveo-Anduaga et al, 2002		156 (1,734)	9.00 (7.74–10.44)
Medina-Mora et al, 2003		833 (5,826)	14.30 (12.62–16.16)
Peru			
NIMH, 2002		525 (2,077)	25.30 (13.10–27.80)
NIMH, 2003		822 (3,895)	21.10 (19.20–23.10)
Fiestas et al, 2014		586 (3,930)	14.90 (13.10–16.70)
NIMH, 2005		715 (3,909)	18.30 (16.60–20.20)
NIMH, 2006		1025 (5,857)	17.50 (16.10–19.00)
NIMH, 2007		610 (6,555)	9.30 (8.10–10.60)
NIMH, 2008		421 (2,536)	16.60 (13.50–20.20)
NIMH, 2009		512 (3,031)	16.90 (15.00–19.10)
NIMH, 2012		305 (2,331)	13.10 (11.20–15.30)
NIMH, 2011		262 (1,746)	15.00 (13.10–17.30)
NIMH, 2013		467 (4,445)	10.50 (9.40–11.60)
NIMH, 2016	(Huánuco)	136 (1,496)	9.10 (7.40–11.20)
NIMH, 2016	(C. de Pasco)	242 (1,469)	16.50 (13.50–20.10)
NIMH, 2019		193 (1,724)	11.20 (8.90–14.00)
Random-effects model			
Heterogeneity: $I^2=97.9\%$, $T^2=0.27$, $Q=1452.84$, $df=28$ ($p<0.0001$)			14.55 (12.32–17.11)
Test of Moderators QM ($df=6$) = 8.7614, $p=0.1874$			PI: 5.70–32.45

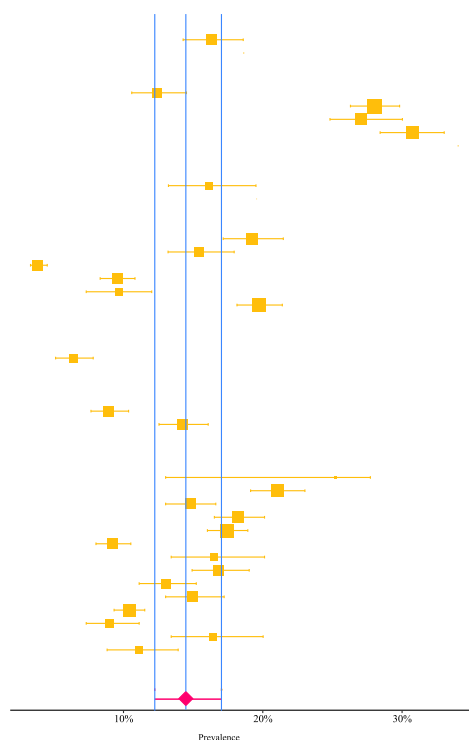


Fig. 2: Lifetime prevalence of any anxiety disorder in LATAM.

prevalence (Supplementary Figures S7–S9). Age-specific estimates were not pooled due to the diverse range of age groups included (Supplementary Figures S2–S4).

As expected, there was a notable increase in the lifetime ($p = 0.0039$) and 12-month ($p = 0.0083$) prevalence of any anxiety disorder when a greater number of disorders was included under any anxiety disorder. However, no association was observed between the number of included disorders and current prevalence ($p = 0.720$) (Supplementary Table S16). Subgroup analyses revealed that the prevalence of 12-month any anxiety disorder was higher when specific phobia (9.93% [7.47–13.09] vs 4.47% [3.53–5.65], $p < 0.0001$) and separation anxiety disorder (10.64% [7.94–14.12] vs 5.84% [4.50–7.56], $p = 0.0176$) were included. Nevertheless, the association with specific phobia was not apparent for lifetime or current prevalence, and no association with separation anxiety disorder was observed for lifetime prevalence. Furthermore, the lifetime prevalence of any anxiety disorder was higher when OCD (15.97% [13.61–18.66] vs 10.79% [6.99–16.29], $p = 0.032$) and PTSD (16.15% [14.04–18.50] vs 7.36% [4.48–11.86], $p < 0.0001$) were included. However, these associations were not observed for 12-month or current prevalence (Supplementary Table S17).

Subgroup analyses also revealed that the prevalence of 12-month any anxiety disorder was higher when

assessed using DSM compared to ICD criteria ($p = 0.0032$), and the Composite International Diagnostic Interview instead of the Mini International Neuropsychiatric Interview ($p = 0.0009$). However, these associations were not evident for lifetime or current prevalence (Supplementary Tables S19–S20). Interestingly, no significant association was found between urban setting and the prevalence of any anxiety disorder across different prevalence periods (Supplementary Table S18).

Across prevalence periods, we observed high heterogeneity between any anxiety disorder studies (overall: $I^2 \geq 91.4\%$; sex-specific: $I^2 \geq 94.8\%$; within-countries: $I^2 \geq 91.4\%$), leading to wide 95% PI (Figs. 2–4; Supplementary Figures S7–S9). Substantial inter-study heterogeneity persisted even after excluding age-specific studies or specific disorders such as OCD, PTSD and specific phobias. This variability was evident across subanalyses, by factors such as country, sex, the number of included disorders, classification system, and clinical interviews (Supplementary Figures S7–S9; Supplementary Tables S15–S21).

Prevalence of disorders grouped under any anxiety disorder in the general adult population of LATAM

The pooled overall lifetime prevalence of the disorders categorized under any anxiety disorder ranged from

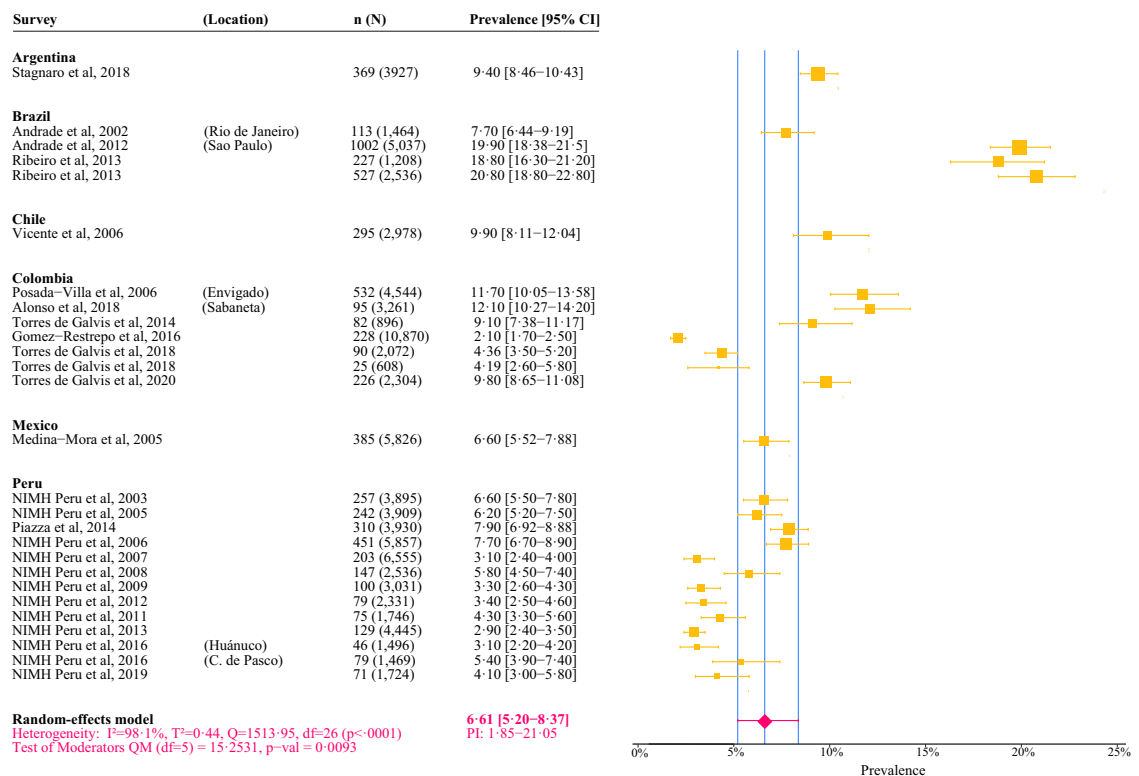


Fig. 3: 12-month prevalence of any anxiety disorder in LATAM.

0.72% (95% CI: 0.39–1.29, PI: 0.05–9.88, 23 studies, $I^2 = 97.1\%$, $p < 0.0001$) for OCD (Supplementary Figure S16) to 7.90% (95% CI: 6.10–10.18, PI: 2.80–20.35, 15 studies, $I^2 = 97.5\%$, $p < 0.0001$) for specific phobia (Supplementary Figure S28). The 12-month prevalence of disorders varied from 0.37% (95% CI: 0.26–0.54, PI: 0.07–1.94, 26 studies, $I^2 = 87.3\%$, $p < 0.0001$) for panic disorder (Supplementary Figure S20) to 5.21% (95% CI: 3.91–6.92, PI: 1.67–15.14, 15 studies, $I^2 = 97.4\%$, $p < 0.0001$) for specific phobia (Supplementary Figure S30). Similarly, the current prevalence ranged from 0.23% (95% CI: 0.12–0.45, PI: 0.01–4.23, 23 studies, $I^2 = 96.0\%$, $p < 0.0001$) for panic disorder (Supplementary Figure S21) to 3.20% (95% CI: 1.83–5.54, PI: 0.51–17.52, 10 studies, $I^2 = 98.5\%$, $p < 0.0001$) for specific phobia (Supplementary Figure S31). Supplementary Figures S10, S13, S19, S22 and S25 present the pooled lifetime prevalence of additional disorders grouped under *any anxiety disorder*. Supplementary Figures S11–S12, S14–S15, S17–S18, S23–S24 and S26–S27 provide additional 12-month and current estimates.

The lifetime, 12-month, and current prevalence of agoraphobia, generalized anxiety disorder, panic

disorder, PTSD, social anxiety disorder, and specific phobia was consistently higher among women than men (Table 3; Supplementary Figures S34–S36, S40–S51). Additionally, the 12-month prevalence of OCD was higher among women than men, although no sex differences were observed for the lifetime and current prevalence of OCD (Supplementary Figures S37–S39). Subgroup analyses revealed that the prevalence of specific disorders did not vary by study setting. However, the prevalence of OCD was consistently higher in urban versus mixed (all $p \leq 0.026$) and rural (all $p \leq 0.009$) settings, across prevalence periods (Supplementary Table S22).

Across disorders, we found substantial heterogeneity within studies ($I^2 \geq 92.3\%$ overall; $I^2 \geq 80.1\%$ women; $I^2 \geq 51.4\%$ men; Table 3). With a few exceptions, high heterogeneity was also evident within countries, and in urban and mixed settings (Supplementary Table S21–S22).

Publication bias across studies

The Doi plots revealing publication bias displayed major asymmetry in the meta-analyses of 12-month (Luis Furuya-Kanamori index = -2.54) and current (Luis Furuya-Kanamori index = -2.87) prevalence of *any*

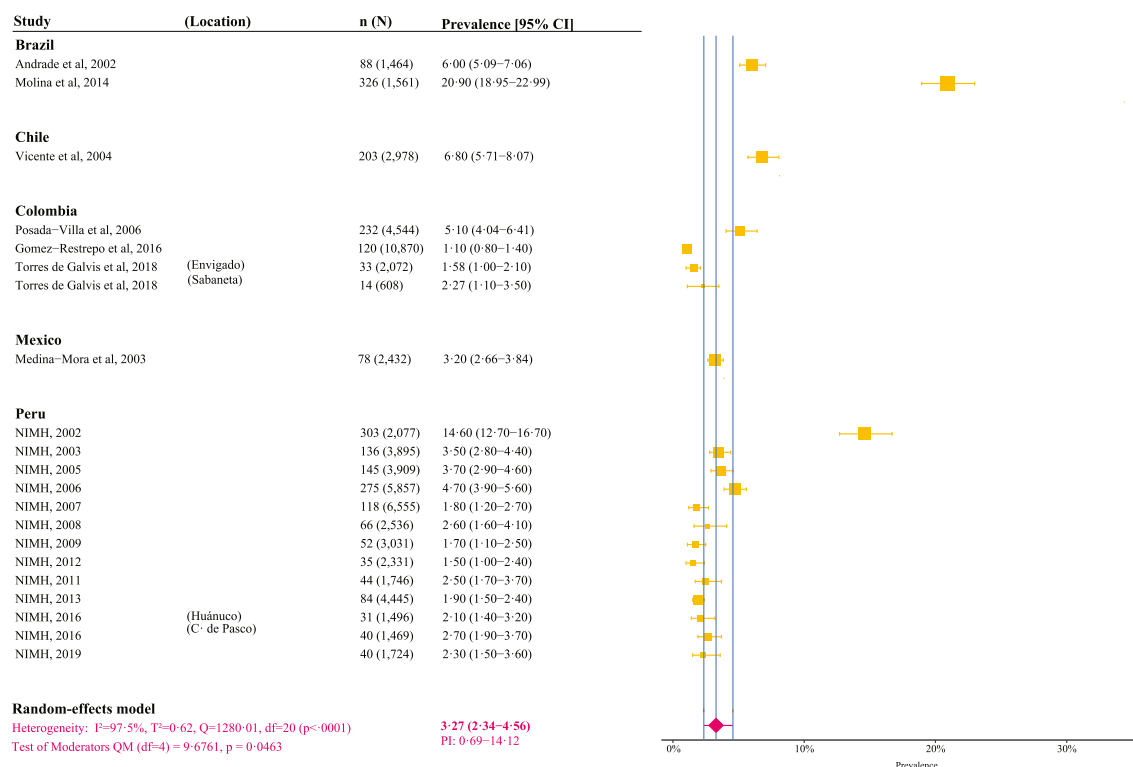


Fig. 4: Current prevalence of any anxiety disorder in LATAM.

anxiety disorder, suggesting substantial publication bias (Fig. 5). Additionally, minor asymmetry (Luis Furuya-Kanamori = -1.51) was observed in the meta-analyses of lifetime *any anxiety disorder* prevalence. Notably, major asymmetries with Luis Furuya-Kanamori indices larger than ± 2.07 were consistently noted across prevalence periods for all disorders grouped under *any anxiety disorder* (Supplementary Figures S52–S58).

Ecological association between macro-level indicators and prevalence of any anxiety disorder in LATAM

The bubble plots displayed in Fig. 6 show the statistically significant associations between the prevalence of *any anxiety disorder* and development indicators; non-significant associations and sex-stratified analyses are reported in the Supplementary Tables S24–S25. Meta-regression analyses revealed a negative association between HDI and the current prevalence of *any anxiety disorder* (OR = 0.88 [95% CI 0.79–0.97], $p = 0.010$, Fig. 6A). This finding suggests that the odds of having an anxiety disorder decreased by 12% for each one-percentage-point increase in HDI. However, we found no statistically significant association between HDI and the 12-month prevalence ($p = 0.103$) (Supplementary Table S24).

The meta-regressions uncovered positive associations between a country's Gini coefficient and the

prevalence of 12-month (OR = 1.08 [1.03–1.14], $p = 0.0013$) and current (OR = 1.13 [1.06–1.21], $p = 0.0004$) prevalence of *any anxiety disorder*. This suggests that the odds of 12-month and current prevalence increased by 8% and 13%, respectively, for each one-percentage-point rise in Gini (Fig. 6B and C). GII also showed a positive association with the current prevalence of *any anxiety disorder* (OR = 1.11 [95% CI 1.04–1.19], $p = 0.0023$, Fig. 6D), suggesting that the odds increased by 11% for each one-percentage-point increase in GII. However, no association was observed between GII and 12-month prevalence ($p = 0.22$) (Supplementary Table S24).

A positive association between IHR and the prevalence of 12-month *any anxiety disorder* was also observed (OR 1.02 [1.00–1.03], $p = 0.011$; Fig. 6E), suggesting that the odds of 12-month prevalence increased by 2% for each one percentage point increase in IHR. However, the current prevalence of *any anxiety disorder* was not found to be associated with IHR.

Discussion

This systematic review presents a comprehensive synthesis of the prevalence of ICD/DSM anxiety disorders among adults in LATAM. Drawing on data from 36 studies, our analysis reveals that a substantial proportion of the surveyed populations experienced *any anxiety*

Outcome period	Women					Men					p-value between sex
	Number of studies	N	% (95% CI)	PI	I ²	Number of studies	N	% (95% CI)	PI	I ²	
Agoraphobia											
Lifetime	22	36,108	2.19 (1.46–3.28)	0.33–13.12	97.0	22	28,444	1.07 (0.77–1.48)	0.28–4.04	82.9	<0.0001
12-month	22	35,839	1.00 (0.65–1.54)	0.14–6.22	93.4	22	28,360	0.47 (0.32–0.68)	0.11–1.90	70.1	<0.0001
Current	19	31,010	0.54 (0.32–0.90)	0.07–4.05	90.0	19	24,554	0.26 (0.16–0.42)	0.06–1.26	64.2	<0.0001
General anxiety disorder											
Lifetime	23	42,484	4.26 (3.12–5.79)	0.95–17.14	97.8	23	32,740	2.31 (1.67–3.20)	0.51–9.87	97.3	<0.0001
12-month	22	41,230	1.49 (1.05–2.12)	0.30–7.18	95.0	22	31,907	0.87 (0.65–1.18)	0.27–2.76	77.5	<0.0001
Current	23	38,378	1.39 (0.79–2.45)	0.09–17.81	98.7	23	29,220	0.79 (0.46–1.35)	0.07–8.15	98.1	<0.0001
Obsessive-compulsive disorder											
Lifetime	20	32,254	0.58 (0.28–1.20)	0.03–10.99	95.6	20	24,930	0.51 (0.27–0.98)	0.04–6.50	90.8	0.0509
12-month	20	31,987	0.41 (0.19–0.88)	0.02–8.54	94.4	20	24,847	0.33 (0.16–0.67)	0.02–4.58	84.2	0.0255
Current	17	27,722	0.14 (0.06–0.31)	0.01–1.92	74.8	17	22,879	0.22 (0.10–0.46)	0.02–2.36	74.3	0.3177
Panic disorder											
Lifetime	22	39,031	1.02 (0.71–1.46)	0.20–4.98	92.0	22	30,010	0.57 (0.40–0.80)	0.16–2.01	73.5	<0.0001
12-month	22	41,230	0.50 (0.34–0.74)	0.10–2.46	84.1	22	31,907	0.27 (0.19–0.38)	0.09–0.77	51.4	<0.0001
Current	20	36,750	0.36 (0.23–0.58)	0.07–1.97	80.1	19	27,763	0.18 (0.10–0.33)	0.03–1.07	52.5	0.0009
Post-traumatic stress disorder											
Lifetime	20	33,695	7.60 (6.02–9.56)	2.64–19.97	97.0	20	26,692	4.13 (3.16–5.38)	1.30–12.38	93.9	<0.0001
12-month	20	33,765	1.91 (1.38–2.65)	0.46–7.57	94.0	20	26,363	0.85 (0.63–1.14)	0.31–2.31	66.9	<0.0001
Current	20	32,928	0.87 (0.55–1.38)	0.13–5.70	93.6	20	26,119	0.35 (0.19–0.64)	0.04–2.98	85.3	<0.0001
Social anxiety disorder											
Lifetime	24	43,072	4.25 (3.36–5.37)	1.35–12.57	94.9	24	33,189	2.73 (2.08–3.56)	0.78–9.11	91.6	<0.0001
12-month	24	42,913	2.05 (1.51–2.79)	0.47–8.47	93.6	24	33,193	1.18 (0.85–1.65)	0.27–5.05	88.1	<0.0001
Current	23	41,895	1.39 (0.91–2.10)	0.20–9.12	95.9	23	32,810	0.75 (0.49–1.15)	0.12–4.66	91.4	<0.0001
Specific phobia											
Lifetime	10	14,035	10.34 (7.01–15.00)	2.80–31.58	97.8	10	11,170	4.77 (3.12–7.23)	1.23–16.82	94.3	<0.0001
12-month	10	14,035	7.03 (4.63–10.53)	1.77–24.12	97.4	10	11,170	2.95 (1.96–4.41)	0.87–9.49	88.1	<0.0001
Current	6	6965	2.65 (1.46–4.76)	0.58–11.20	93.3	6	6527	0.86 (0.33–2.22)	0.09–7.77	86.6	0.0002
Any anxiety disorder											
Lifetime	23	42,473	19.05 (15.78–22.81)	7.26–41.44	98.3	23	32,347	10.63 (8.66–12.98)	3.90–25.85	96.6	<0.0001
12-month	22	41,233	8.18 (6.11–10.87)	1.98–28.26	98.2	22	31,510	3.67 (2.71–4.94)	0.90–13.72	97.4	<0.0001
Current	21	38,378	4.42 (3.16–6.14)	0.93–18.53	97.6	21	29,220	1.96 (1.34–2.86)	0.36–10.03	94.8	<0.0001

Confidence Interval (CI), Prediction Intervals (PI). I² indicates the level of heterogeneity.

Table 3: Pooled sex-specific prevalence estimates of any anxiety disorder and disorders grouped under any anxiety disorder in Latin America.

Confidence Interval (CI), Prediction Intervals (PI). I^2 indicates the level of heterogeneity.

Table 3: Pooled sex-specific prevalence estimates of any anxiety disorder and disorders grouped under any anxiety disorder in Latin America.

disorder. Specifically, approximately one in seven individuals met the criteria for *any anxiety disorder* at some point in their lives, while one in fifteen, and one in thirty experienced one in the 12 months and one month prior to assessment, respectively.

To the best of our understanding, this is the first systematic review to present estimates of lifetime, 12-month, and current prevalence of *any anxiety disorder* and disorders grouped under *any anxiety disorder* in LATAM. Our findings regarding the lifetime (14.55% [12.32–17.11]) and 12-month (6.61% [5.20–8.37]) prevalence of *any anxiety disorder* are remarkably similar to estimates derived from a comparable global systematic review of 70 adult studies by Steel et al.¹⁰ (lifetime: 12.9% [11.3–14.7] and 12-month: 6.7% [6.1–7.9]). These results also fall within the confidence intervals of the

lifetime prevalence estimates documented in a prior global systematic review by Somers et al.¹¹ (lifetime: 16.6% [12.7–21.1] and 12-month: 10.6% [7.5–14.9]). It is noteworthy that the slightly higher 12-month prevalence reported by Somers et al. may be attributed to their inclusion of wealthier countries, as research suggests that higher income is associated with an increased prevalence of anxiety disorders.^{15,27}

Our 12-month *any anxiety disorder* prevalence estimate appears to be lower than figures reported in the WHO World Mental Health Surveys,²⁷ the most comparable cross-national study, which found a global prevalence of 9.8%. This survey indicated rates of 10.3%, 10.6% and 7.9% for high, upper-middle, and lower-middle-income countries, respectively. However, it is important to note that the WHO-World Mental

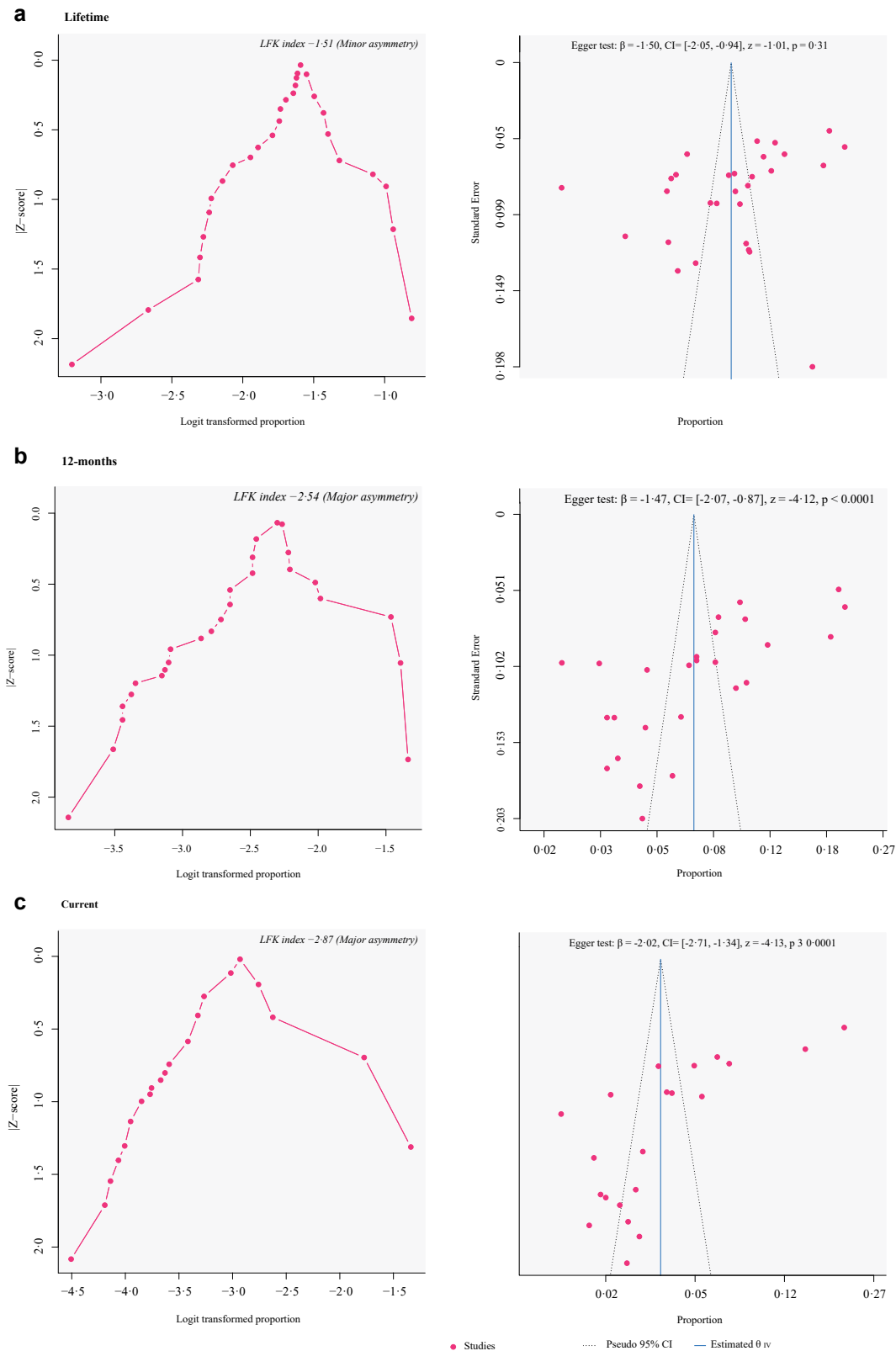


Fig. 5: Publication bias any anxiety disorder in LATAM.

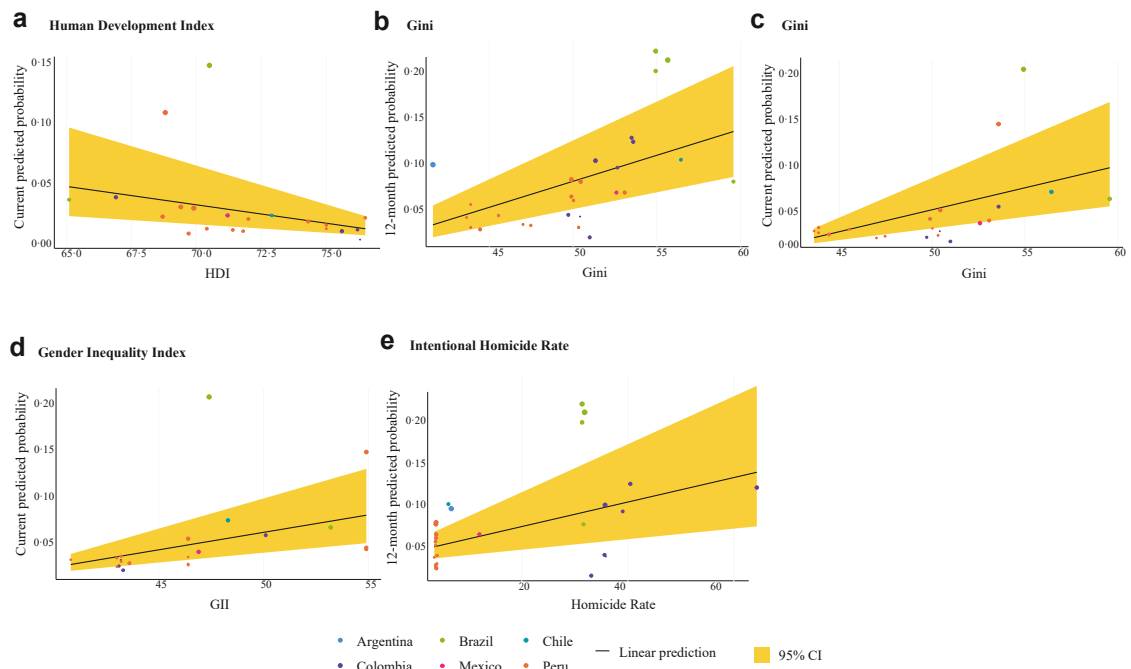


Fig. 6: Prevalence any anxiety disorder in LATAM modulated by indicators.

Health Surveys employ both the Composite International Diagnostic Interview and the DSM-IV classification system, which yield higher pooled prevalence estimates in our sub-group analyses. This finding highlights the importance of accounting for methodological differences when comparing prevalence rates as there is a close alignment between our 12-month DSM (9.07%) and Composite International Diagnostic Interview (8.97%) prevalence estimates and the WHO-World Mental Health Survey estimates.

When comparing our *any anxiety disorder* results with findings from Baxter et al.'s global systematic review,¹² we observe some overlap in the 12-month prevalence and a notably lower current prevalence estimate (3.27% [2.34–4.56]) in our study versus their reported figure (7.3% [4.8–10.9]). As with the WHO-World Mental Health Surveys, the comparison with Baxter's results is complicated by methodological differences between the two reviews. Specifically, the Baxter review includes studies involving both children and adults, employs a range of clinical interview methodologies, and combines six- and one-month prevalence estimates into its current prevalence.

Our current prevalence estimate of *any anxiety disorder* closely aligns with the global figures reported in the GBD 2010 (4.0% [3.7–4.2]), and 2019 (3.78% [3.18–4.47]) reviews, and with the data pertaining to the Central LATAM subregion in the GBD 2019 review (3.93% [3.25–4.78]).^{5,98} Nonetheless, our estimate is lower than GBD 2019 estimates for three out of the four

other LATAM subregions: Southern (5.13% [4.46–5.89]); Andean (5.50% [4.47–6.89]); and Tropical (7.38% [6.30–8.61]). It is important to acknowledge that comparisons between our findings and GBD results are not straightforward, given that the GBD framework covers all age groups, and includes studies that combine annual and point prevalence with varying levels of quality, potentially leading to a prevalence overestimation.¹⁴

Despite regions of LATAM being ranked among the highest in prevalence of anxiety disorders,^{5,13,28} our prevalence estimates of *any anxiety disorder* closely align with global figures reported across narrative reviews,⁹⁹ and cross-national,^{27,100} and cross-cultural²¹ studies. They suggest that when using similar inclusion criteria, assessment methods, and income adjustment, and despite the higher rates of violence in the region, the prevalence of ICD/DSM anxiety disorders in LATAM is not particularly elevated. However, this comparison should take into account our strict data criteria, the higher number and quality of our studies, their uneven distribution per GBD region, as well as the absence of studies from three countries included in GBD's Tropical, Southern and Central LATAM regions: Bolivia, Ecuador and Venezuela.

As expected,¹² our findings indicate that expanding the number of disorders grouped under *any anxiety disorder* was associated with higher lifetime and 12-month prevalence, although not with current prevalence. Furthermore, including OCD and PTSD was

associated with elevated lifetime but not 12-month or current prevalence. Conversely, including specific phobia was associated with increased 12-month, but not lifetime or current prevalence. The inconsistent association between including specific disorders and the prevalence of *any anxiety disorder* across different prevalence periods is challenging to interpret and may be due to variations of what different studies consider *any anxiety disorder*. Further research is needed to better understand comorbidity between disorders.

Regarding the specific disorders grouped under *any anxiety disorder*, their distribution in our study is consistent with prominent international population surveys, such as United States' National Comorbidity Survey-Replication,¹⁰¹ the European Study of the Epidemiology of Mental Disorders,⁹⁷ and the WHO-World Mental Health Surveys.⁷⁵ Consistent with these large-scale studies, specific phobia emerged as the most common of the disorders grouped under *any anxiety disorder* in our study. Similarly, in accordance with previous research,^{73,74,97,101,102} PTSD, social anxiety disorder, and generalized anxiety disorder were among the second most prevalent lifetime disorders. Moreover, social anxiety disorder and generalized anxiety disorder also ranked among the second most prevalent disorders over the past 12 months and currently, showing consistency across sexes and prevalence periods.

Our prevalence estimates for specific phobia, social anxiety disorder, generalized anxiety disorder and PTSD closely align with values reported in systematic reviews, and the WHO-World Mental Health Surveys.^{73–75,102} However, our agoraphobia, panic disorder, and OCD estimates are lower than documented in the WHO-World Mental Health Surveys,^{71,72} and in cross-national research.¹⁰³ These variations may be influenced by various factors, including methodological and cultural differences, highlighting the need for further analysis.

Our study finds that women in Latin America are approximately twice as likely as men to experience *any anxiety disorder*, agoraphobia, panic disorder, PTSD, social anxiety disorder and specific phobias, across various prevalence periods. This finding is consistent with evidence from other global studies^{28,104} and underscores the role of biological factors. Additionally, we identified a significant association between the prevalence of *any anxiety disorder* and country-level indicators such as HDI, Gini coefficient, and GII, particularly for women, suggesting the influence of social and environmental factors.

Our meta-analyses identified substantial heterogeneity among prevalence studies of *any anxiety disorder*, as well as disorders grouped under *any anxiety disorder*, across different methodological factors such as prevalence period, diagnostic criteria, and clinical interview method. Notably, within-country heterogeneity was consistently high for *any anxiety disorder* and all disorders, with the exception of OCD. Similar patterns of

elevated heterogeneity have been reported in meta-analyses examining the global and regional prevalence of anxiety disorders within the general population,^{10–12} as well as PTSD among populations affected by mass conflict and displacement.¹⁰⁵ Our previous research on the prevalence of depressive disorders across LATAM also indicated significant heterogeneity.²⁹ This variability, combined with strict inclusion criteria, and the lower within-study heterogeneity observed in the pooled male prevalence estimates, suggests that the between-study variations may partially reflect the diverse contexts within the region.¹⁰⁶ These contexts include disparities in healthcare access, psychosocial factor, cultural influences, and regional differences. To address the observed heterogeneity and improve the reliability of prevalence estimates across LATAM, future research should take into account existing regional and contextual differences, employ consistent diagnostic methodologies, and aim to generate more robust data.

Exposure to various factors such as disrupted family environments, childhood sexual abuse, multiple traumatic events, bullying, interpersonal violence, and crime increases the risk of anxiety disorders.^{12,14,28,107,108} Socio-economic factors, including income,^{72–75,79,109} education,^{72–75,79,109} employment status,^{72–75,79,109} urban residence,^{109,110} and age,^{72–75,79,109} significantly influence prevalence. Additionally, cultural norms, societal beliefs, and healthcare inequalities may shape how anxiety disorders are viewed and treated.²⁷ Unfortunately, data limitations prevented us from systematically testing most of these factors, except for urban setting and IHR.

Urban settings showed consistently higher prevalence estimates of OCD in this study. Additionally, urbanicity was associated with higher rates of two disorders in some prevalence periods: generalized anxiety disorder and social anxiety disorder. However, the association was not evident for *any anxiety disorder*, or for other disorders grouped under *any anxiety disorder*. These findings partially align with research^{17,21,109,110} reporting higher prevalence of anxiety disorders in urban areas. However, when interpreting our findings, it is essential to consider two characteristics of our review: i) the limited number of included rural studies; ii) the classification of settings into urban, mixed, or rural was based on the authors' descriptions of the catchment areas.

We observed a positive association between IHR and 12-month prevalence of *any anxiety disorder*, but not current prevalence. This finding is consistent with higher anxiety disorder rates observed in conflict^{12,14} and crime-affected areas¹⁰⁷ and offers insights into an underrepresented region in the global literature. However, the lack of consistency across prevalence periods should be interpreted cautiously and consider that IHR is an objective measure of violence, and perceived crime may show a stronger association with anxiety prevalence.¹⁰⁷

Our findings reveal a strong association between Gini levels and the prevalence of anxiety disorders in the region. Similarly, we found a comparable association between HDI and GII with current, but not 12-month prevalence. Differences between our Gini and HDI results and previous research that either did not identify an association,¹⁷ presented inconclusive results¹⁸ or reported a reverse pattern¹⁶ could be explained by differences in research methodologies and statistical power. Nevertheless, the consistent association of Gini across sex and prevalence periods, and the alignment of our GII and HDI findings with our prior work on depressive disorders²⁹ highlights a distinct economic inequality trend in LATAM over the last three decades, and suggests a nuanced pattern of inequality within the region that may not have been captured in broader global analyses.

This study has some limitations. First and foremost, despite efforts to standardize methodologies, substantial heterogeneity remains across meta-analyses negatively affecting their interpretability. Secondly, the research is concentrated in seven wealthier LATAM countries, primarily in urban settings, which may limit the generalizability of findings to the broader region (Supplementary Figure S5). The included countries tend to be more violent, and exhibit higher HDI and Gini scores, and lower GII scores compared to those not included. Additionally, urban areas often have more mental health resources, and unique stressors, which can influence the prevalence. These disparities emphasize regional differences (Supplementary Table S5 and Supplementary Figure S6) and underscore the need for strengthening mental health research capacities in the region. Incorporating rural communities and marginalized populations into research studies could provide a more comprehensive understanding of anxiety disorders in the region.

Third, the current review excludes studies focusing on children, adolescents, or older adults, making the findings relevant only to the general adult population in LATAM. Fourth, the classification of anxiety disorders differs across various systems, with some disorders included in the present study not categorized as anxiety disorders in the DSM-5 or ICD-11. Fifth, our analysis uses national-level development indicators, although many of the included studies are based on regional or subnational data. This scale discrepancy may lead to ecological fallacy, where national-level associations may not accurately reflect subnational relationships, potentially affecting the generalizability of our results. Finally, while the study presets useful hypotheses regarding the ecological association between exposure to human development, inequalities, and violence and prevalence of anxiety disorders, it does not establish causal relationships, warranting cautious interpretation at the individual level.

This review addresses a significant knowledge gap regarding the prevalence of anxiety disorders, and their association with development indicators in LATAM, the most urbanized region in the world,¹¹¹ which also has the highest intentional homicide rate—four times the global average.¹¹² By integrating a thorough search strategy, strict inclusion criteria, rigorous quality appraisal, and advanced meta-analytic methods, our study offers estimations for LATAM derived from a larger number of population-based studies than previously available. Our findings provide an up-to-date analysis of the epidemiological landscape of anxiety disorders in the region. They offer a valuable framework for conducting systematic cross-country comparisons and intra-regional assessments. They can assist governments in defining research priorities and guiding the formulation of health-related policies, for example, by leveraging tools such as the WHO Mental Health Global Action Program¹¹³ intervention guide for common mental health issues. Ultimately, these findings can serve as a resource for the development and assessment of programs and services aimed at improving population mental health. A particular strength of the current review lies in the analytical approach employed to estimate the association between regional prevalence and development indicators. The study sheds light on the significance of how changes in HDI, Gini, GII and IHR in LATAM are associated with the prevalence of anxiety disorders between 1990 and 2024.

Contributors

AE and PBJ conceived and designed the project. PBJ, NAC and EAU provided supervision to AE. AE designed the regional grey literature search, carried out the database searches and the screening process, prepared data for analyses, provided supervision to DA, and research assistants, drafted the manuscript, administrated the project, and acquired the funding. DA carried out the grey literature search, provided supervision to research assistants, quality scored all citations, and produced figures. APS carried out statistical analyses. APS, DA, EAU, FB, NAC and RT contributed to the interpretation of the data for the manuscript. PBJ and AE resolved conflicts regarding the inclusion of studies. All authors reviewed the study findings, critically revised the manuscript at all stages, and approved the final version before submission.

AE and DA accessed and verified the data, and AE was responsible for the decision to submit the manuscript.

Data sharing statement

The study protocol is publicly available at PROSPERO, CRD42020190238. The data used for this meta-analysis is available in the Harvard Dataverse online repository, and can be accessed via the following link: <https://dataverse.harvard.edu/dataset.xhtml?persistentId=doi:10.7910/DVN/2UYNND>.

Use of generative artificial intelligence

OpenAI's GPT-4 (2023) [Computer software] was utilized for the purpose of reviewing the English language quality of the manuscript.

Declaration of interests

AE has received funding from Pfizer Global Medical Grants (Independent Medical Education Grant 69879319). PBJ has received an honorarium from MSD for participating in a scientific advisory board. APS, DA, EAU, FB, NAC, and RT declare no competing interests.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.lana.2025.101057>.

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