Prevalence and Diagnostic Discrepancies of Neurodevelopmental Disorders

A Cross-Regional Meta-Analysis from Infancy to Adolescence

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Abstract

This meta-analysis explores how common neurodevelopmental disorders (NDDs)—including autism spectrum disorder (ASD), Attention-Deficit/Hyperactivity Disorder (ADHD), Intellectual Disability (ID), and Learning Disabilities (LDs)—are among children and adolescents (ages 3 months to 18 years) in both South Asian and Western regions. Drawing from over 40 peer-reviewed studies published between 2000 and 2025, the research used rigorous search methods across major databases like PubMed, Scopus, PsycINFO, and regional health sources, ensuring at least 10 studies per disorder were included.

The analysis found significantly higher rates of these disorders in Western countries (ASD: 1–3%, ADHD: 5–10%, LDs: 5–15%, ID: ~1%) compared to South Asia, where reported rates were much lower (ASD: 0.1–1%, ADHD: 1–3%, LDs: 1–5%, ID: 0.5–2%). Stark differences were especially noted in areas like Jammu & Kashmir, India, where data suggests many cases go unreported due to limited screening and diagnostic resources.

Several factors appear to drive these regional differences, including variations in diagnostic standards (DSM-5 vs. ICD-10), healthcare access, public awareness, cultural stigma, and socioeconomic conditions. Service availability mapping shows a clear gap—South Asia faces critical shortages of child mental health professionals, early intervention centers, and inclusive education options compared to more developed systems in the U.S., Europe, and Australia.

This study highlights the pressing need for standardized diagnostic tools, nationwide prevalence surveys, and investment in support services for children with NDDs across South Asia. It calls for improved healthcare infrastructure, school-based screening programs, and culturally tailored intervention models.

Introduction

Background

Neurodevelopmental disorders (NDDs) are a group of lifelong conditions that begin in early childhood and affect how a child thinks, behaves, and interacts socially. Common types include autism spectrum disorder (ASD), Attention-Deficit/Hyperactivity Disorder (ADHD), Intellectual Disability (ID), and Learning Disabilities (LDs). If not identified and addressed early, these conditions can significantly hinder a child's academic performance, mental well-being, and overall quality of life.

Globally, NDDs represent a major public health concern, with an estimated 10–15% of children affected by some form of developmental challenge. However, the reported rates of these conditions vary widely from one region to another—often influenced by differences in diagnostic practices, cultural attitudes, and the healthcare infrastructure.

Why Prevalence Matters

Understanding how common these disorders are is crucial for several reasons:

- **Healthcare planning and policy**: Reliable data helps governments and institutions invest wisely in diagnostic centers, therapy programs, and inclusive education.
- **Resource allocation**: Ensures that support services and interventions are distributed fairly and reach those who need them most.
- **Research and advocacy**: Strong evidence base is essential for shaping child health policies at both national and global levels.

Despite its importance, there's a noticeable gap between regions. Western countries like the U.S., those in Europe, and Australia often report higher prevalence rates. In contrast, countries across South Asia such as India, Pakistan, Bangladesh, Nepal, Sri Lanka, and the Jammu & Kashmir region tend to report much lower rates. Whether this discrepancy reflects actual differences or results from underdiagnosis remains a critical question.

Study Objectives

This meta-analysis sets out to:

- Compare how common ASD, ADHD, ID, and LDs are among children (ages 3 months to 18 years) in South Asia versus Western countries.

- Investigate how differences in diagnostic criteria, assessment tools, and cultural perceptions influence reported rates.
- Explore the availability and accessibility of support services for children with NDDs across regions.
- Offer policy recommendations to improve early detection and intervention—especially in underserved areas like Jammu & Kashmir, India.

Literature Review

Global Context

In high-income countries, national health systems routinely conduct comprehensive epidemiological surveys to monitor neurodevelopmental disorders. For instance, the U.S. Centre for Disease Control and Prevention (CDC) reports that approximately 1 in 36 children is diagnosed with autism spectrum disorder (ASD), nearly 10% of children have Attention Deficit/Hyperactivity Disorder (ADHD), and 5–15% may experience Learning Disabilities (LDs). Intellectual Disability (ID) is estimated to affect about 1% of the general population. In contrast, prevalence data from South Asia remains fragmented, with estimates ranging between 0.1% and 3%, varying significantly based on disorder type and study methodology.

Autism Spectrum Disorder (ASD)

Western Data

- **United States**: 2.8% prevalence (Maenner et al., 2023)
- **Europe**: 1–2% (Elsabbagh et al., 2012)
- **Australia**: 1.4% (Australian Bureau of Statistics, 2021)

South Asian Data

- **India**: 1–1.5% (Arora et al., 2018), with notably lower rates reported in rural areas
- **Bangladesh**: 0.15–0.8% (Hossain et al., 2017)
- **Pakistan**: 0.9% (Minhas et al., 2015)
- **Sri Lanka**: ~1.1% (Perera et al., 2016)
- **Nepal**: 1–2% (Poudel et al., 2020)
- **Jammu & Kashmir**: Limited data; a school-based study indicates 0.9% prevalence (Bhat et al., 2019)

Diagnosis in South Asia is often complicated by over-reliance on ICD-10 criteria, limited availability of gold-standard tools such as ADOS and ADI-R, and persistent stigma that may prevent families from seeking help.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Western Data

- **United States**: 9.8% in children aged 3–17 (Danielson et al., 2018)
- **Europe**: 5–7% (Polanczyk et al., 2015)
- **Australia**: 7.4% (Sciberras et al., 2017)

South Asian Data

- **India**: 1.6–4% (Garg et al., 2017)
- **Pakistan**: 2.4% (Syed et al., 2019)
- **Bangladesh**: 1.5–3% (Alam et al., 2020)
- **Sri Lanka**: ~2.5% (Fernando et al., 2018)
- **Nepal**: 2–3% (Koirala et al., 2019)
- **Jammu & Kashmir**: No population-level data; clinical observations suggest around 2% prevalence

Challenges in accurate ADHD diagnosis in the region include a lack of standardized assessment tools such as the Conners or Vanderbilt rating scales, combined with cultural tendencies to downplay symptoms like hyperactivity or inattentiveness.

Intellectual Disability (ID)

Western Data

- **Global prevalence**: ~1% (WHO, 2019)
- Rates are consistent across the U.S., Europe, and Australia

South Asian Data

- **India**: 1–2% (Sharma et al., 2018)
- **Bangladesh**: 0.5–1.5% (UNICEF, 2016)
- **Pakistan**: 1.4% (Mirza et al., 2017)
- **Sri Lanka**: 0.8–1% (Wickramasinghe et al., 2016)
- **Nepal**: 1–1.5% (Acharya et al., 2019)

- **Jammu & Kashmir**: No large-scale surveys; clinical accounts suggest ~1% prevalence

Learning Disabilities (LDs)

Western Data

- **United States**: 5–15% among school-aged children (Cortiella & Horowitz, 2014)
- **Europe**: 7–10% (Snowling, 2019)
- **Australia**: 7–9% (McArthur et al., 2020)

South Asian Data

- **India**: 2–5% (Karande et al., 2018)
- **Pakistan**: 2–4% (Jameel et al., 2019)
- **Bangladesh**: 1.5–3% (Hasan et al., 2016)
- **Nepal**: ~2% (Poudel et al., 2021)
- **Jammu & Kashmir**: Data remains limited; anecdotal evidence points to underdiagnosis, likely due to the absence of routine school-based screening

Research Methods Applied

Study Design

This study followed a systematic meta-analytic approach, reviewing peer-reviewed research published from 2000 to 2025. The aim was to estimate the prevalence of four major neurodevelopmental disorders, autism spectrum disorder (ASD), Attention Deficit/Hyperactivity Disorder (ADHD), Intellectual Disability (ID), and Learning Disabilities (LDs) in children and adolescents aged 3 months to 18 years. The study was conducted in accordance with PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines.

Search Strategy

Researcher searched through several major academic and regional databases:

- **PubMed**
- **Scopus**
- **PsycINFO**
- **Google Scholar**
- **Regional Databases**: IndMED, PakMediNet, Bangladesh Health Journals

Keywords used were combinations of:

- "Neurodevelopmental disorders"
- "ASD prevalence South Asia/Western countries"
- "ADHD epidemiology"
- "Intellectual disability in children"
- "Learning disabilities in schools"
- "Jammu and Kashmir autism prevalence"

Inclusion Criteria

Studies were included if they met the following:

- Peer-reviewed and published between 2000 and 2025
- Involved children aged 3 months to 18 years
- Reported prevalence for ASD, ADHD, ID, or LDs
- Conducted in either South Asian countries (India, Pakistan, Bangladesh, Nepal, Sri Lanka, and Jammu & Kashmir separately) or Western countries (US, Europe, Australia)

Exclusion Criteria

Studies were excluded if they:

- Focused on adult populations
- Were not peer-reviewed (e.g., grey literature, conference abstracts)
- Had sample sizes under 200 participants

Data Extraction

From each eligible study, the following information was extracted:

- Geographic location, publication year, sample size, age group
- Reported prevalence rates by disorder
- Diagnostic tools used (DSM-IV, DSM-5, ICD-10, ICD-11, or standardized scales)
- Service-related metrics (e.g., psychiatrists per 100k, availability of therapy centers, inclusive education)

Statistical Analysis

- A random-effects model was used to pool prevalence estimates.
- Heterogeneity was assessed using I^2 statistics.
- Subgroup analyses were conducted by region, age group, and diagnostic criteria.

Results

Comparative Prevalence of NDDs

Table 1: Regional Prevalence of Neurodevelopmental Disorders (Ages 3 months – 18 years)

Disorder	South Asia (%)	Western Countries (%)	Key Observations
ASD	0.1 – 1.5	1 – 3	Western rates are higher, reflecting more structured screening processes
ADHD	1.5 – 4	5 – 10	School-based screening is common in the West, unlike in South Asia
ID	0.5 – 2	~1	Rates are similar, though likely underreported in South Asia
LDs	1 – 5	5 – 15	Underdiagnosed in South Asian schools due to lack of formal assessments

The global prevalence of neurodevelopmental disorders (NDDs) varies significantly, with notably lower reported rates in South Asia compared to Western countries. For instance, autism spectrum disorder (ASD) is estimated to affect between 0.1% and 1.5% of the South Asian population, whereas in Western nations, prevalence rates range from 1% to 3%. This disparity is largely attributed to the presence of comprehensive and routine screening initiatives in the West. A similar trend is observed in Attention-Deficit/Hyperactivity Disorder (ADHD), with South Asian figures between 1.5% and 4%, compared to 5%–10% in Western settings, where school systems actively participate in early detection. In contrast, prevalence rates for Intellectual Disability (ID) demonstrate greater consistency across regions approximately 0.5% to 2% in South Asia and around 1% in Western countries, though underreporting remains a notable issue in South Asia. Learning Disabilities (LDs), however, are considerably underrecognized in South Asia, where reported rates fall between 1% and 5%, as opposed to 5%–15% in the West. This is primarily due to more robust diagnostic protocols and regular school assessments in Western educational systems. Overall, the lower incidence figures in South Asia are more likely reflective of systemic challenges such as limited public awareness, insufficient diagnostic infrastructure, and less comprehensive school-based support rather than true regional differences in prevalence.

Country-Specific Data

Table 2: Country-Wise Prevalence of NDDs

Country/Region	ASD (%)	ADHD (%)	ID (%)	LDs (%)
United States	2.8	9.8	1	10–15
Europe	1–2	5–7	1	7–10
Australia	1.4	7.4	1	7–9
India	0.9–1.5	1.6–3.5	1–2	2–5
Jammu & Kashmir	0.9	~2	~1	Sparse data
Pakistan	0.9	2.4	1.4	2–4
Bangladesh	0.15–0.8	1.5–3	0.5–1.5	1.5–3
Nepal	1–2	2–3	1–1.5	~2
Sri Lanka	1.1	2.5	0.8–1	2–3

Neurodevelopmental disorders show significant regional variation in prevalence. In the United States, rates are among the highest globally, with autism spectrum disorder (ASD) at 2.8%, ADHD at 9.8%, Intellectual Disability (ID) around 1%, and Learning Disabilities (LDs) between 10–15%. Europe reports slightly lower figures: ASD 1–2%, ADHD 5–7%, ID 1%, and LDs 7–10%. Australia shows similar trends, with ASD at 1.4%, ADHD at 7.4%, ID at 1%, and LDs 7–9%.

In contrast, South Asian countries report lower prevalence. In India, ASD is 0.9–1.5%, ADHD 1.6–3.5%, ID 1–2%, and LDs 2–5%. Jammu & Kashmir reflects similar figures: ASD 0.9%, ADHD ~2%, ID ~1%, with limited LD data. In Pakistan, ASD is 0.9%, ADHD 2.4%, ID 1.4%, and LDs 2–4%. Bangladesh reports even lower rates: ASD 0.15–0.8%, ADHD 1.5–3%, ID 0.5–1.5%, and LDs 1.5–3%. Nepal estimates ASD at 1–2%, ADHD 2–3%, ID 1–1.5%, and LDs around 2%. Sri Lanka reports ASD 1.1%, ADHD 2.5%, ID 0.8–1%, and LDs 2–3%.

Overall, Western countries report higher diagnostic rates, especially for ADHD and LDs, while South Asia shows consistently lower figures, possibly due to underdiagnosis or differing healthcare infrastructure

Diagnostic Disparities

Western Countries:

- Rely heavily on DSM-5 and ICD-11.
- Use standardized assessment tools such as ADOS-2, ADI-R, Conners, and Vanderbilt scales.
- Pediatricians and child psychologists often diagnose children early.

South Asia:

- Commonly use older systems like ICD-10 and locally adapted checklists.
- There is a significant shortage of qualified clinicians.
- Social stigma, particularly toward girls, often delays or prevents diagnosis.

Service Availability

Table 3: Service Infrastructure for Children with NDDs

Region	Child Psychiatrists per 100k	Early Intervention Centers	% Inclusive Schools	Therapy Access
United States	9.7	Widely available	80%+	Widespread
Europe	8–10	Strong coverage	75%+	Strong
Australia	8.5	Good coverage	~70%	Strong
India	0.3	Very limited	~30%	Low
Jammu & Kashmir	<0.2	Minimal	<15%	Very low
Pakistan	0.2	Minimal	~20%	Very low
Bangladesh	0.1	Poor	10–15%	Very low
Nepal	0.15	Poor	~15%	Low
Sri Lanka	0.4	Limited	20–25%	Low

Comparative Summary of Child Mental Health Infrastructure Across Selected Regions

A global comparison of child and adolescent mental health infrastructure reveals stark disparities in psychiatric workforce availability, early intervention coverage, inclusive education, and access to therapy services.

The United States leads among the surveyed regions, with approximately 9.7 child psychiatrists per 100,000 children. The country also boasts widespread availability of early intervention programs, over 80% of schools classified as inclusive, and broad access to therapeutic services. Similarly, European countries report between 8 to 10 child psychiatrists per 100,000 children, coupled with strong intervention coverage, over 75% inclusion in mainstream education, and robust therapy support systems.

Australia presents comparable figures, with 8.5 psychiatrists per 100,000, good early intervention coverage, approximately 70% inclusive schools, and strong access to therapy.

In contrast, South Asian countries, particularly India and its neighboring regions, demonstrate significantly lower metrics. India reports only 0.3 child psychiatrists per 100,000 children, with very limited access to early intervention centers, around 30% of schools being inclusive, and low levels of therapy access. The situation is even more concerning in the Union Territory of Jammu & Kashmir, which falls below 0.2 psychiatrists per 100,000, with minimal early intervention availability, less than 15% inclusion in schools, and very low therapy access.

Neighboring countries such as Pakistan (0.2), Bangladesh (0.1), and Nepal (0.15) exhibit minimal to poor coverage of early intervention, only 10–20% of schools being inclusive, and very low to low levels of therapy accessibility. Among these, Sri Lanka shows marginally better outcomes, with 0.4 psychiatrists per 100,000, limited intervention infrastructure, 20–25% inclusive schools, and low therapy access.

These figures reflect a significant mental health resource gap between high-income and low- to middle-income countries. While Western nations invest in systemic support for early diagnosis, school integration, and therapeutic care, South Asian countries face acute shortages in professional availability and systemic support, highlighting an urgent need for targeted mental health policy interventions and infrastructure development in the region.

Discussion

This meta-analysis highlights several important findings:

Prevalence Gaps

- Western countries report significantly higher prevalence rates likely due to better diagnostic practices, not necessarily higher incidence.
- South Asia's low figures likely stem from underdiagnosis, stigma, and insufficient data.

Diagnostic Variability

- Use of outdated diagnostic systems (ICD-10) and non-standard tools in South Asia contributes to inconsistencies.
- Many diagnoses in South Asia are based on clinician judgment without structured scales.

Service Inequality

- South Asia faces a severe shortage of child mental health professionals (e.g., fewer than 0.5 psychiatrists per 100,000 children).
- Early intervention centers and inclusive schooling are scarce.
- Jammu & Kashmir has minimal research data and virtually no service infrastructure.

Cultural and Economic Barriers

- Stigma surrounding neurodevelopmental disorders is particularly strong in South Asia, often leading to delayed diagnosis.
- Economic hardship limits families' ability to access private care.
- Schools are typically unequipped, lacking special educators and trained school psychologists.

Limitations

- There is a lack of comprehensive, population-based studies in many South Asian regions.
- Variations in diagnostic methods, tools, and age ranges across studies introduce inconsistency.
- Rural and tribal populations are significantly underrepresented.
- Much of the service data relies on NGO/government sources rather than peer-reviewed publications.

Conclusion

This review reveals substantial disparities in the diagnosis and support of neurodevelopmental disorders between South Asian and Western countries. While Western nations report higher prevalence, these figures more accurately reflect active identification rather than true incidence. For South Asia, urgent action is needed in several areas:

- Adopt standardized diagnostic criteria (DSM-5/ICD-11)
- Conduct large scale population studies especially in underserved areas like Jammu & Kashmir
- Expand investment in early intervention and mental health training
- Launch public awareness campaigns to challenge stigma
- Integrate NDDs screening into primary health centers and school systems

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