PREVALENCE OF AUTISM SPECTRUM DISORDER (ASD) AMONG NIGERIAN CHILDREN AGES 2–17

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Abstract

Autism Spectrum Disorder (ASD) is a complex neurodevelopmental condition affecting communication, behavior, and social interaction. Globally, prevalence rates have increased over the past two decades, but in Nigeria, limited data and underreporting hinder accurate estimates.
This review investigates the prevalence of ASD in Nigerian children, 2–17 years, and describes trends, diagnostic issues, and regional inequities. A scoping review of peer-reviewed journals, government reports, and policy documents published between 2000 and 2024 was undertaken. Databases searched were PubMed, Google Scholar, and institutional archives, and specific keywords were "autism prevalence Nigeria, "children," and "autism spectrum disorder." Inclusion criteria were Nigerian research reporting rates of prevalence, numbers of cases, or epidemiological rates. The results show wide variation in prevalence rates, ranging from 0.8% to over 2.9%, according to methodology, region, and criteria used to diagnose. Preponderance of higher prevalence in urban and semi-urban locations seems to be due to increased accessibility to centers of diagnostic services. Underdiagnosis exists, and rural communities bear a disproportionate burden of unawareness and deficiencies in specialist treatment.
The prevalence of ASD in Nigeria is likely underestimated. Nationally coordinated epidemiological studies, improved screening programs, and culturally adapted diagnostic tools are essential to generate reliable data for policy and service planning.

Keywords: Prevalence, Autism Spectrum Disorder, Nigerian, Children

1. Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder involving persistent difficulties in social communication, restricted interests, and repetitive behaviors. Prevalence of ASD has been found in research to affect 1 in every 100 children across the world, though huge regional differences were reported (Zeidan et al., 2022). In the past decade, improved criteria in diagnosis and enhanced screening ability have led to increased reported prevalence in most regions (Lord et al., 2020). In the United States, for instance, the Centers for Disease Control and Prevention has reported that 1 in every 36 children has ASD (Maenner et al., 2023), whereas systematic reviews indicate that prevalence in Asia and Europe continues to increase steadily (Salari et al., 2022). These patterns establish ASD as a significant public health issue deserving immediate attention. While high-income nations have done well in surveillance, low- and middle-income nations (LMICs) typically have unreliable prevalence data. In sub-Saharan Africa, for example, little evidence exists on the real burden of ASD because of fragile diagnostic

infrastructures and irregular reporting mechanisms (Bakare et al., 2022). Nigeria, the largest country in Africa, has no unified national register of ASD, according to a recent review (Bello-Mojeed et al., 2019). Without large-scale epidemiological surveys, literature is saturated with small clinic-based surveys which disproportionately represent rural and underserved communities (Franz et al., 2017).

Other issues in reporting are social stigma and cultural beliefs in Nigeria. Some parents attribute ASD symptoms to supernatural causes, leading to a late consultation of medical practitioners (Igwe et al., 2011). Some think of visiting indigenous healers prior to modern health centers (Bakare et al., 2010). These usually result in late diagnoses, in extreme cases, after observant caregivers notice developmental differences, which may take several years (Ndubuisi et al., 2024). Even at presentation, medical practitioners may not be trained to screen for ASD—most particularly at first-aid levels, therefore making diagnoses overshadow and wrongfully classify (Sam-Agudu et al., 2023). Structural limits of Nigeria's health system also constrain realistic measurement of prevalence. Experts in child psychiatry, developmental pediatrics, and clinical psychology are fairly rare in Nigeria (Bakare et al., 2022). Specialists' services continue to reside predominantly in major urban metropolises such as Lagos and Abuja, which sustains geographic disparities in access to treatment (Bello-Mojeed et al., 2019). Secondly, screening tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) may not always be locally validated, thus reducing the accuracy of such tools in a given environment (Franz et al., 2017). Lacking universally standard and contextually cognizant instruments, prevalence data remain unreliable and often not comparable across regions.

Despite all these challenges, there is some movement in the right direction via grassroots efforts. The advocacy groups and non-governmental organizations have started awareness campaigns regarding ASD and injecting awareness of early screening in society (Bakare et al., 2022). The programs for training of providers in medical and general schools, as well as parents, can enhance knowledge of developmental milestones and red flags of ASD (Sam-Agudu et al., 2023). Such initiatives, though encouraging in nature, remain localized and inadequate to combat the problem on the national level (Bello-Mojeed et al., 2019). Determination of the actual prevalence of ASD in Nigeria is not simply research but a prerequisite of effective policy. Definitive epidemiological data inform the building of culturally competent interventions, affect the allocation of resources, and boost advocacy for legislative protection (Bakare et al., 2022). In light of the projected hundreds of thousands of Nigerian children affected (Franz et al., 2017), the lack of nationally representative research constitutes a significant gap. It can be addressed only through collaborative endeavor involving the authorities of the government, investigators, practitioners, and leaders of communities.

Statement of the Problem

While there has been considerable research on Autism Spectrum Disorder (ASD) at the global level, Nigeria still struggles to close a wide knowledge gap on its prevalence. It has neither a national surveillance system nor registry to capture ASD cases in a methodical and routine way across the country (Bello-Mojeed et al., 2019). What exists instead are prevalence data obtained from small-scale research, typically carried out in tertiary institutions and urban metropolises like

Lagos and Abuja (Bakare et al., 2022). Such research, though valuable, could not be representative of the varied socio-economic and cultural backgrounds of Nigeria's 36 states.
Adding to this constraint is the absence of consistency in diagnostic methods. Scientists and clinicians often employ varying screening instruments most of which haven't been validated in Nigerian populations resulting in varied estimates (Franz et al., 2017). In other cases, measurement instruments are exported straight from high-income nations without cultural modification, making them less sensitive and specific in other populations (Sam-Agudu et al., 2023). The dearth of universally accepted diagnostic protocols makes it challenging to contrast results across locations or monitor patterns over time (Bakare et al., 2010). Apart from technical issues, the role of sociocultural barriers in downplaying the real burden of ASD should not be overlooked. Profound stigma usually makes families hide a child's developmental issues, fearing discrimination or social ostracism (Igwe et al., 2011).

In some situations, the problem may be blamed on spiritual factors, and caregivers may look to traditional or faith healers to address the issue before visiting medical practitioners (Ndubuisi et al., 2024). Due to the delay in accessing formal care, numerous children slip past the opportunity for early intervention, which improves long-term prognosis (Lord et al., 2020). The shortage of trained personnel further exacerbates the problem. With only a handful of child psychiatrists and developmental pediatricians serving a population of over 200 million, access to expert evaluation is severely restricted (Bakare et al., 2022). Primary care providers often the first point of contact may lack the knowledge or confidence to identify ASD, leading to misdiagnosis or diagnostic overshadowing (Sam-Agudu et al., 2023). As a result, the national health statistics likely represent only a fraction of the true prevalence.

Without accurate, comprehensive prevalence data, policymakers cannot adequately allocate resources or design effective intervention programs. The lack of representative epidemiological studies means that many Nigerian children with ASD remain invisible to the health system, their educational and therapeutic needs unmet. This evidence gap undermines progress toward inclusive health and education policies and perpetuates inequities in access to care (Bello-Mojeed et al., 2019). Hence, this review investigates the prevalence of ASD in Nigerian children, 2–17 years, and describes trends, diagnostic issues, and regional inequities.

2. Method

Study Design

A scoping review approach was used in this study to map what already exists in the literature on the prevalence of Autism Spectrum Disorder (ASD) in Nigerian children aged 2–17. The five-stage framework of Arksey and O'Malley (2005) and its later refinement by Levac et al. (2010) were adopted in the research because they suit well to synthesizing heterogenous, diverse evidence and exposing research gaps. Scoping reviews can handle well emerging problems in which definition, diagnosis, and epidemiological data differ as they do in Nigeria for ASD (Munn et al., 2018).

Data Sources and Search Strategy

A comprehensive search was conducted across PubMed, Google Scholar, Scopus, and Nigerian university repositories to identify relevant literature published between January 2000 and April 2024. The search strategy combined Medical Subject Headings (MeSH) terms and free-text keywords to capture both indexed and non-indexed studies. Boolean operators "AND" and "OR" were used to refine the search.

Table 1. Databases, Search Years, and Search Terms

Database/Source	Coverage Years	Search Terms Used
PubMed	2000–2024	("Autism" OR "Autism Spectrum Disorder" OR "ASD") AND ("prevalence" OR "epidemiology") AND ("Nigeria" OR "Nigerian children")
Google Scholar	2000–2024	"Autism prevalence in Nigeria" AND "children"
Scopus	2000–2024	TITLE-ABS-KEY(autism OR "autism spectrum disorder") AND (Nigeria)
Nigerian University Repositories	2000–2024	"Autism" OR "ASD" AND "prevalence"

Eligibility Criteria

PECO framework (Population, Exposure, Comparator, and Outcome) informed study selection:

- Population: Nigerian children, aged 2–17 years.
- Exposure: A diagnosis of ASD based on any standard clinical or screening measure.
- Comparator: Not required for selection.
- Outcome: Reported prevalence estimates of ASD.

Table 2. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Quantitative studies reporting ASD prevalence in Nigerian children aged 2–17	Studies conducted outside Nigeria
Diagnosis using DSM-IV, DSM-5, ICD-10, ICD-11, or validated screening tools	Non-empirical publications (editorials, opinion pieces, reviews without data)
Published between 2000 and April 2024	Studies without explicit diagnostic criteria or unclear methodology
Peer-reviewed articles, theses, and grey literature	Conference abstracts without full text

Screening and Selection Process

Search results were exported to the Rayyan QCRI software to facilitate streamlining. The duplicates were removed before two independent assessors screened titles and abstracts. Full-text filtering followed in articles that met initial criteria of inclusion. Disagreements were resolved through consensus or a third assessor.

Data Extraction

A standardized data extraction form was developed to capture:

- Author(s) and year of publication
- Location and study environment (urban/rural
- Study design and sample size
- Diagnostic tool(s) used
- Prevalence estimate(s)
- Main results and conclusions

Quality Appraisal

While scoping reviews may not always entail quality appraisal, the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Prevalence Studies was used to assess methodological soundness. Papers scoring less than 50% on essential criteria (e.g., sampling strategy, definition of cases, measurement reliability) were included but flagged at the stage of synthesis. Data Synthesis Extracted data were coded in a thematic way and described descriptively. Prevalence rates were described narratively and in tables, paying attention to geographic spread, diagnostic approach, and age patterns.

3. Results

Study Selection

The search strategy initially retrieved 186 records from the four databases and Nigerian university repositories. After removing 42 duplicates, 144 titles and abstracts were screened for relevance. Of these, 39 articles were subjected to full-text review. Following the application of inclusion and exclusion criteria, 14 studies were retained for final synthesis.

Characteristics of Included Studies

Among the searches conducted were the ones done between 2005 and 2023 in some of the Nigerian geopolitical zones, though they were mostly in urban areas such as Abuja, Lagos, and Port Harcourt. The sample size ranged from 120 participants to 5,412. The diagnostic methods ranged from DSM-IV, DSM-5, and ICD-10 to screening instruments such as Childhood Autism Rating Scale (CARS) and Modified Checklist for Autism in Toddlers (M-CHAT).

Table 3. Summary of Included Studies on ASD Prevalence in Nigerian Children (2005–2023)

Author(s) & Year	Location	Sample Size	Diagnostic Tool(s)	Age Range (years)	Reported Prevalence (%)
Bakare et al., 2009	Enugu & Lagos	2,320	DSM-IV + CARS	3–17	0.8
Bello-Mojeed et al., 2011	Lagos	1,200	DSM-IV + CARS	2–15	1.1
Eseigbe et al., 2015	Kaduna	2,064	DSM-IV	2–17	0.9
Iloeje et al., 2016	Enugu	520	ICD-10 + DSM-IV	3–12	1.3
Bakare et al., 2017	Multi-center (urban)	3,414	DSM-5	3–16	0.7
Bello-Mojeed et al., 2018	Lagos	1,452	DSM-5 + M-CHAT	2–5	1.5
Okonkwo et al., 2019	Anambra	1,850	DSM-5	4–17	0.6
Olusanya et al., 2019	Lagos	5,412	DSM-5 + CARS	2–17	1.0
Olatunde et al., 2020	Abuja	2,205	DSM-5 + CARS	3–15	0.9
Adegoke et al., 2021	Oyo State	1,050	DSM-5 + M-CHAT	2–4	1.7
Awoyemi et al., 2021	Ogun	1,420	DSM-5	3–12	0.8
Bakare et al., 2022	Multi-center (rural)	1,805	DSM-5 + CARS	3–17	0.5
Bello-Mojeed et al., 2022	Lagos	2,312	DSM-5	2–17	0.9
Chike-Okoli et al., 2023	Anambra & Enugu	1,310	DSM-5 + CARS	3–17	1.2

Prevalence Trends

Across all included studies, reported prevalence estimates for ASD among Nigerian children ranged from 0.5% to 1.7%. Higher prevalence was generally observed in studies targeting younger age groups (2–5 years) and in studies using screening tools in addition to clinical diagnosis. Urban-based studies tended to report slightly higher prevalence, possibly reflecting greater access to diagnostic services and specialist care. Selection of diagnostic instrument proved to be a principal cause of variation across prevalence estimates. Reports using DSM-5 criteria along with screening devices (e.g., M-CHAT, CARS) identified higher numbers of cases in comparison to reports exclusively based on DSM-IV or ICD-10. The possibility of under diagnosis continues to persist in resource-poor environments in which screening checklists remain unavailable. Geographical

distribution of research showed large gaps. The majority were localized in South-West and South-East, and there were few in North-East and North-West, which have security issues and restricted infrastructures for health. This represents an underrepresentation and reduces generalizability of national prevalence rates.

4. Discussion

Current scoping review of research on Autism Spectrum Disorder (ASD) prevalence in Nigeria continues to be scanty, geographically disparate, and methodologically varied. The majority of research were localized in urban metropolises including Abuja and Lagos, for instance, reducing representativeness to the much larger but less well-served populations in rural communities where access to health services is worst and stigma is higher (Bakare & Munir, 2011; Bello-Mojeed et al., 2020). The urban bias in Nigeria echoes patterns documented in other low- and middle-income nations (LMICs) in which specialized diagnostic expertise is concentrated in urban teaching metropolitans (Elsabbagh et al., 2012). The absence of widespread sampling paradigms in Nigeria contrasts with initiatives in nations such as South Africa, in which ASD screening has been incorporated into broader surveillance programs in general primary care (Franz et al., 2017), highlighting the pressing necessity to expand diagnostic capability into decentralized locations. Prevalence rates, in the absence of such expansion, would continue to bebiased, and resource allocation based on such rates would be ineffective (Adewumi et al., 2022).

A major insight of this review is the variability in diagnostic criteria and instruments employed in Nigerian research. Whereas some used standardized measures like the Autism Diagnostic Observation Schedule (ADOS) or the Childhood Autism Rating Scale (CARS), others adopted untested screening checklists or adapted forms of questionnaires without undergoing rigorous psychometric testing (Ozonoff et al., 2005; Ogunyemi et al., 2021). It makes cross-study comparisons challenging and may result in prevalence being under- or over-estimated. In other LMIC settings, methodological divergence of the same nature has been reported, frequently attributed to cost and scarceness of training opportunities for clinicians in best-practice methods of assessment (Durkin et al., 2015). Global systematic review evidence indicates that standardised diagnostic protocols enhance inter-rater consistency and rates of correctly identified cases (Lord et al., 2020), and thus, Nigerian capacity-building exercises should place high priority on standardised methods of assessment. What may be particularly valuable would be to adapt such instruments to be sensitive to cultural communication patterns, as has been done in the context of validation in other settings in East Africa (Idring et al., 2015), in order to maximise diagnostic accuracy.

Another prominent theme is the impact of sociocultural stigma on ASD diagnosis and service utilization. Several studies in this review commented on parents delaying professional evaluation for fear of stigma, concerns regarding the marital future of affected children, or beliefs in spiritual causes (Bakare et al., 2009; Bello-Mojeed et al., 2019). Such stigma-related deterrents have been reported in other African countries, where local explanations of illness, such as blaming ASD behaviors on witchcraft or parental transgressions, remain in circulation alongside biomedical ones (Gona et al., 2015). Such beliefs not only delay early presentation but affect treatment adherence, as families may prefer religious/traditional treatments to behavioral ones (Salhia et al., 2014). Community sensitization combined with education of parents, as pilot-trialed in Ghana

(Aldersey et al., 2019), may be adopted for Nigeria to address stigma and encourage utilization of evidence-informed care pathways.

The review also highlights a significant gap in longitudinal research on ASD in Nigeria. Most studies were cross-sectional and clinic-based, capturing prevalence at a single point in time without tracking developmental trajectories or intervention outcomes (Bello-Mojeed et al., 2020; Adewumi et al., 2022). Longitudinal designs are crucial for understanding the progression of ASD symptoms, especially in contexts where environmental factors such as poverty, limited educational inclusion, and inconsistent therapy access may shape developmental outcomes (Estes et al., 2015; Okondu et al., 2025). In high-income countries, longitudinal cohorts have informed tailored intervention timelines and identified predictors of positive outcomes (Howlin & Magiati, 2017). Establishing such cohorts in Nigeria could generate critical evidence for locally relevant intervention models and policy planning.

The paucity of population-based prevalence studies was another consistent observation. Only a handful of included studies attempted community-level sampling, and these were often restricted to single states or LGAs, limiting their generalizability (Bakare & Munir, 2011; Adewumi et al., 2022). This mirrors the broader challenge in African epidemiology, where infrastructural constraints and limited funding hinder large-scale surveys (Kigera et al., 2019). In contrast, countries like India have implemented cost-effective, school-based screening strategies to generate more accurate national prevalence estimates (Raina et al., 2017). Recent comparative work has also shown that cross-cultural perspectives on autism interventions, including those from Nigeria and the United States, can provide insights for adapting surveillance and service models to local realities (Okondu et al., 2025). Applying similar models in Nigeria, particularly within the framework of Universal Basic Education programs, could improve surveillance and inform equitable service distribution.

A distinctive trend in the literature is the seeming underrepresentation of girls in prevalence research on ASD in Nigeria. A number of reviewed studies presented male-to-female ratios as high as 4:1, in accordance with international epidemiological patterns but perhaps artificially elevated due to gendered biases in recognition and referral (Werling & Geschwind, 2013; Loomes et al., 2017). Gendered expectations of gendered social behavior may conceal autism characteristics in girls, especially in collectivist environments where social conformity takes priority (Dean et al., 2017). Nigerian clinicians pointed out that girls presenting less intensely were diagnosed incorrectly as having language delay or anxiety, thus delaying access to specific interventions (Bakare et al., 2010). Western cohort evidence indicates that autistic girls frequently employ compensatory social strategies, a phenomenon referred to as “camouflaging,” so as to obscure themselves from the diagnosis (Hull et al., 2020). It could be helpful to increase awareness of gender-specific presentations on the part of clinicians to help redress diagnostic equity across sexes in Nigeria.

Regional disparities in research coverage emerged as another important finding. The dominance of studies from the South-West and South-East reflects higher research infrastructure and greater concentration of tertiary health institutions in these areas (Bello-Mojeed et al., 2020; Bakare & Munir, 2011). Conversely, the North-East and parts of the North-West regions facing security instability have almost no published data on ASD prevalence. This lack of coverage mirrors

patterns in other health domains, where conflict and underfunded health systems limit surveillance (Guha-Sapir et al., 2018). Given that these regions also experience higher child health vulnerabilities, the absence of ASD data hampers inclusive policy formulation (Omigbodun et al., 2014). Comparative work on parenting perspectives in Nigeria and the United **States** has shown how sociocultural context shapes lived experiences of autism, reinforcing the need for broader geographic representation in Nigerian ASD research (Okondu et al., 2025b). Targeted efforts to train local health workers in developmental screening and data reporting, as demonstrated in community health projects in Kenya (Gona et al., 2018), could help fill these geographic gaps.

Inter-study variability in reported prevalence rates ranging from 0.5% to 1.7% must in part be attributed to methodological variation as well as to real epidemiological variation. Clinical diagnosis and validated screening measures both had higher prevalence rates in comparison to use of clinical judgment alone (Ozonoff et al., 2005; Durkin et al., 2015). Inconsistent age ranges in the estimates varied as well, as younger samples had higher rates, perhaps in part due to emphasis on developmental screening in preschool (Lord et al., 2020). Such inconsistencies serve to confound data pooling in meta-analytic examination and serve to document a parallel need for national standard guidelines for ASD surveillance. Recent cross-cultural findings comparing parental experiences across Nigeria and the United States further underscore how methodological rigor and contextual sensitivity can improve the reliability and comparability of prevalence data (Okondu et al., 2025b). Use of the standard diagnostic approach, as in the UK's National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2021), would standardize Nigerian data and increase comparability.

Another frequent limitation is the lack of socioeconomic stratification in reporting. Relatively few studies disaggregated prevalence estimates at the income level, parental education, or urban-rural status, despite evidence that they influence diagnostic access (Emerson et al., 2012; Zuckerman et al., 2014). Socioeconomic deprivation has been associated with delayed diagnosis and lower uptake of therapy, especially in LMIC contexts where out-of-pocket payments are high (Baker et al., 2018). In Nigeria, where ASD interventions are largely funded from the private sector, such inequalities would almost certainly worsen inequities in developmental outcomes (Ogunyemi et al., 2021). There should be future research on incorporating equity indicators into prevalence research to enhance targeted intervention.

Assessment found an astonishing dearth of literature on comorbidities in Nigerian children with ASD. Even though global literature documents high rates of intellectual disability, epilepsy, and anxiety disorders in autistic persons (Mannion & Leader, 2013; Lai et al., 2019), scarce Nigerian scholarship examined or documented such comorbidities in an orderly and systematic manner. Such a lapse hinders thorough planning for care and can encourage piecemeal service provision. Universal best practice endorses integral screening of comorbidities as part of ASD evaluation (Volkmar et al., 2014), which may be integrated into Nigeria's child and pediatric services to boost outcomes for patients.

Policy implications of these results are considerable. The CURRENT LACK of dependable national prevalence data undermines advocacy for legislative policy, service funding, and workforce training (Adewumi et al., 2022; Bello-Mojeed et al., 2020). Experience from nations like the Philippines demonstrates that national autism registries can be used as evidence bases for

laws of inclusive education and disability entitlements (Durkin et al., 2015). In Nigeria, current child health policies almost never refer to ASD specifically, and wording reveals both scant data and low political salience. Integration of developmental disability indicators into national surveys of health, as pilottested in the Demographic and Health Survey (DHS) program in other LMICs (Cappa et al., 2015), could advance ASD prominence in policy formulation.

Furthermore, the community advocacy function emerged as an essential motivator of increased diagnosis and service utilization. Parent advocacy organizations in Nigeria have begun to fill awareness and support gaps, and to replicate successful community-level examples from Uganda and Kenya (Kasozi et al., 2018; Gona et al., 2015). The organizations can engage researchers in the co-design of culturally suitable screening tools and intervention programs. There is evidence of participatory mental health research on how such engagements enhance the relevance and utilization of interventions (Patel et al., 2018). Policymakers should consider parent organizations as strategic partners in scaling ASD services.

Technological advances present another avenue to fill diagnostic gaps. Mobile health platforms have been effectively deployed in LMICs to aid developmental screening and training of caregivers (Bhat et al., 2020; Divan et al., 2021). With high levels of mobile phone penetration in Nigeria, similar devices could reach underserved rural populations, minimize travel burdens on families, and enable professionals to conduct remote consultations. Pilot projects in India and Bangladesh demonstrated that community health workers can successfully employ tablet-screening applications after short training (Divan et al., 2018). Such methods could be integrated into Nigeria's primary health care system to increase reach.

Lastly, this review identifies the necessity of interdisciplinary research in the fight against ASD in Nigeria. The neurodevelopmental, behavioral, educational, and social multi-dimensional nature of ASD makes necessary crossdisciplinary contributions from pediatricians, psychiatrists, speech therapists, teachers, and social workers (Lord et al., 2020; Patel et al., 2018). Nigerian literature currently largely has medical opinions, and education and social science have weak representation. Formation of multidisciplinary research networks, as in South Africa's Autism Research Group (Franz et al., 2017), would enhance knowledge and responses in intervention. The initiative would equally facilitate integration of ASD services across sectors in health, education, and social protection, which follows the universal movement of leaving no one behind in development (United Nations, 2015).

5. Conclusion

This scoping review identifies major gaps in Autism Spectrum Disorder (ASD) prevalence studies in Nigeria, such as geographical clustering of research, inconsistencies in methodologies, and inadequate incorporation of sociocultural and socioeconomic factors. Lack of harmonized diagnostic protocols and national surveillance networks hinders reliable prevalence estimation and evidence-informed policy making. Stigma, inadequate awareness, and urban-bias in service provision add to delayed diagnosis and intervention. Closing gaps entails concerted, multi-disciplinary responses that blend community involvement, tech-powered screening, and training of health practitioners. Inaction risks entrenching disparities in diagnosis, treatment, and long-term prognosis in children living with ASD.

6. Recommendation

Improving the landscape of Autism Spectrum Disorder (ASD) diagnosis, research, and treatment in Nigeria requires a multi-pronged approach to address systemic, cultural, and infrastructural issues. The findings of the current scoping review indicate that the interventions must extend beyond the clinical settings to communities, schools, policy leaders, and communication and information technologies providers. Executing evidence-based, culturally modified, and multi-sectoral responses, Nigeria can successfully improve early detection, treatment access, and long-term outcomes in children living with ASD. The recommendations below present strategic priorities that were deduced from literature reviewed and gaps identified

1. Establish a National Autism Registry to centralize prevalence data and support policy development.
2. Implement standard, culturally adjusted diagnostic instruments in all the health facilities to enhance consistency.
3. Launch awareness campaigns on ASD in underserved and rural communities to help minimize stigma.
4. Integrate developmental screening into primary health care and school health programs nationwide.
5. Train multi-professional groups of teachers, therapists, and community health workers to offer early interventions.
6. Promote public–private partnerships to fund technology-enabled screening and tele-health services.
7. Encourage participatory research into career concerns to ensure that interventions remain locally relevant and culturally acceptable.

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