Original Article

Translation and Contextualisation of the Substance Use Disorders Module of the WHO mhGAP Intervention Guide for Primary Care Settings in Pakistan

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Abstract

Background: **Substance use disorders (SUDs) are a leading public health concern worldwide, particularly in low- and middle-income countries (LMICs), with an estimated 75% treatment gap. To bridge this gap, the World Health Organization (WHO) launched the Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) to scale up mental health services globally and strengthen the capacity of non-specialists equipped with skills to deal with SUDs. However, its implementation in Pakistan remains limited due to the lack of an accessible Urdu-language version for frontline healthcare workers. This study describes the process of translating and contextualising the mhGAP-IG SUD module to address treatment and implementation gaps within low-resource primary healthcare settings.**

Methods: **We used a qualitative research design within a participatory approach. The mhGAP-IG SUD module was first translated into Urdu using the MAPI guidelines. Focus group discussions (*N* = 23) with key stakeholders—primary care physicians (PCPs), mental health professionals, and social workers—were conducted, along with five cognitive debriefing interviews with PCPs. A six-step framework thematic analysis informed the contextualisation and comprehension of the Urdu version of the mhGAP-IG SUD module.**

Results: **During contextualisation, multiple linguistic and conceptual adaptations were made without altering clinical algorithms (e.g., defining terminologies). These adaptations also featured contextually familiar expressions to improve comprehension and relevance (e.g., adding brief descriptions of technical terms) and the use of dual-language terminologies.**

Conclusion: **This study presents a systematic translation and contextualisation of the mhGAP-IG SUD module. The resulting Urdu version, currently published on the WHO website, is culturally appropriate and offers support to primary healthcare workers. This work demonstrates that successful contextualisation requires a culturally grounded and participatory approach. We recommend the inclusion of this guide in pre-service training and its integration into Pakistan's primary healthcare system to ensure long-term policy support.**

Keywords: *translation, contextualisation, mhGAP-IG SUD-Urdu, primary healthcare, MAPI, WHO*

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Introduction

Low- and middle-income countries (LMICs) bear a disproportionate burden of mental health disorders (90%), with massive treatment gaps (1, 2). To bridge this gap, the World Health Organization (WHO) launched in 2008 the Mental Health Gap Action Programme Intervention Guide (mhGAP-IG), including the substance use disorder (SUD) module, to transform healthcare services in LMICs by integrating mental health into primary healthcare and facilitating service availability, delivery, and uptake (3). Since then, the WHO has released version 2.0 (mhGAP-IG v2) in 2016 and an operational manual in 2018 as additional tools to support capacity building in primary healthcare and community-based settings (3). As part of a broader initiative to develop nation-specific mental health action plans (4), the mhGAP-IG has been implemented in over 80 countries, including India, Sri Lanka, Afghanistan, Nepal, and Iran, and translated into more than 20 languages (4).

Among various mental health issues, the prevalence of SUDs has become a major public health concern, particularly in Pakistan (5). This burden is exacerbated by a lack of available evidence-based treatment options (6). Despite the strengthening of mental health policy and planning, service availability, healthcare delivery, and uptake elements still require significant transformation to effectively reduce mental health issues, such as SUDs (1). Furthermore, in Pakistan, the adaptation and implementation of the mhGAP-IG remain limited primarily due to contextual challenges, such as linguistic barriers and other systemic constraints (7). While most primary healthcare providers (PHCPs) in Pakistan are fluent in both English and Urdu, clinical practice and communication are predominantly in Urdu (8). Therefore, an accurate translation of the mhGAP-IG SUD module is urgently required to enhance usability, improve comprehension, and facilitate implementation at the primary healthcare level in Pakistan (9).

SUDs are a silent endemic, with estimated rates of 8.9 million substance users, of whom 4.25 million are drug-dependent and in dire need of professional treatment (10). The number of drug users is rising at an alarming rate of 40,000 annually, thereby placing Pakistan among the most severely drug-affected countries in the world (11). This ever-increasing trend of SUDs, coupled with a lack of access to evidence-based treatments, has resulted in devastating public health consequences (12). For instance, only 1 in 6 individuals living with SUDs (approximately 30,000) receive care annually (13). Such a significant gap in treatment can largely be attributed to factors such as availability, accessibility, sustainable treatment options, scarcity of mental health practitioners, overburdened healthcare systems, economic constraints, and paucity of referral pathways (14–16).

In Pakistan, existing structural and financial barriers have increased the need to integrate culturally contextualised, accessible, and scalable interventions, such as the mhGAP-IG SUD module, into the country's primary healthcare system (17), specifically for non-specialists in primary healthcare. Doing so can effectively maximise outreach and optimise limited resources. Likewise, comparable approaches have been successfully implemented in maternal mental healthcare and their infants (18) and subsequently scaled to community volunteers (19). Thus, the SUD treatment gap can be better addressed by initiating the adaptation and implementation of evidence-based guidelines contextualised to local healthcare infrastructure (6).

The WHO's mhGAP-IG SUD module v2 (hereafter "mhGAP-IG SUD module") is an evidence-based intervention that aims to address priority mental, neurological, and substance use disorders and to scale up mental healthcare by improving the skills of non-specialists in primary healthcare settings (3). The SUD module, in particular, consists of step-by-step clinical guidelines across three domains, namely SUB-1: Assessment (identification, intoxication, overdose, withdrawal, harmful use, and dependence), SUB-2: Management (psychoeducation, psychosocial, and pharmacological interventions), and SUB-3: Follow-up and continuity of care. The module addresses a wide range of SUDs, including those related to alcohol, opioids, benzodiazepines, cannabis, stimulants, khat, and tobacco, as well as provides comprehensive guidance for primary healthcare, such as emergency presentation,

assessment, management, and follow-up (20). Hence, the module empowers PHCPs with the knowledge, skills, and tools to identify, manage, and refer cases appropriately. It also has the potential to reduce the overwhelming demand on tertiary care facilities and promote equitable access to quality healthcare at primary-care facilities (9).

However, to date, no contextualised Urdu version of the mhGAP-IG SUD module has been produced. Given that Urdu is the national language of Pakistan (8), integrating its culturally contextualised version into the country's healthcare system is essential in facilitating timely intervention by PHCPs and enhancing treatment outcomes. Therefore, the present study aimed to translate and contextualise the SUD module for the Pakistani context, with the aim of strengthening its primary healthcare system and addressing the specific needs of people with SUDs. This study not only fills a critical gap in the healthcare system but also provides a model for adapting evidence-based scalable interventions across cultural settings, thereby promoting sustainable primary care practices.

Methods

Study Design

We used a qualitative iterative research design within a participatory approach (21) to translate and contextualise the mhGAP-IG SUD module (Figure 1). This study employed gold-standard MAPI guidelines (22), ensuring conceptual, semantic, and cultural equivalence. Contextualisation was further informed by a dual-stage qualitative validation comprising focus group discussions (FGDs) and cognitive debriefing interviews.

Preparation and Ethical Considerations

The study, conducted between October 2024 and March 2025, obtained ethics approval from the National Bioethics Committee for Research (NBCR-1020/23/970). Permission from WHO officials for translation and contextualisation was obtained in October 2024. Administrative approvals for stakeholder engagement were secured from relevant provincial healthcare departments.

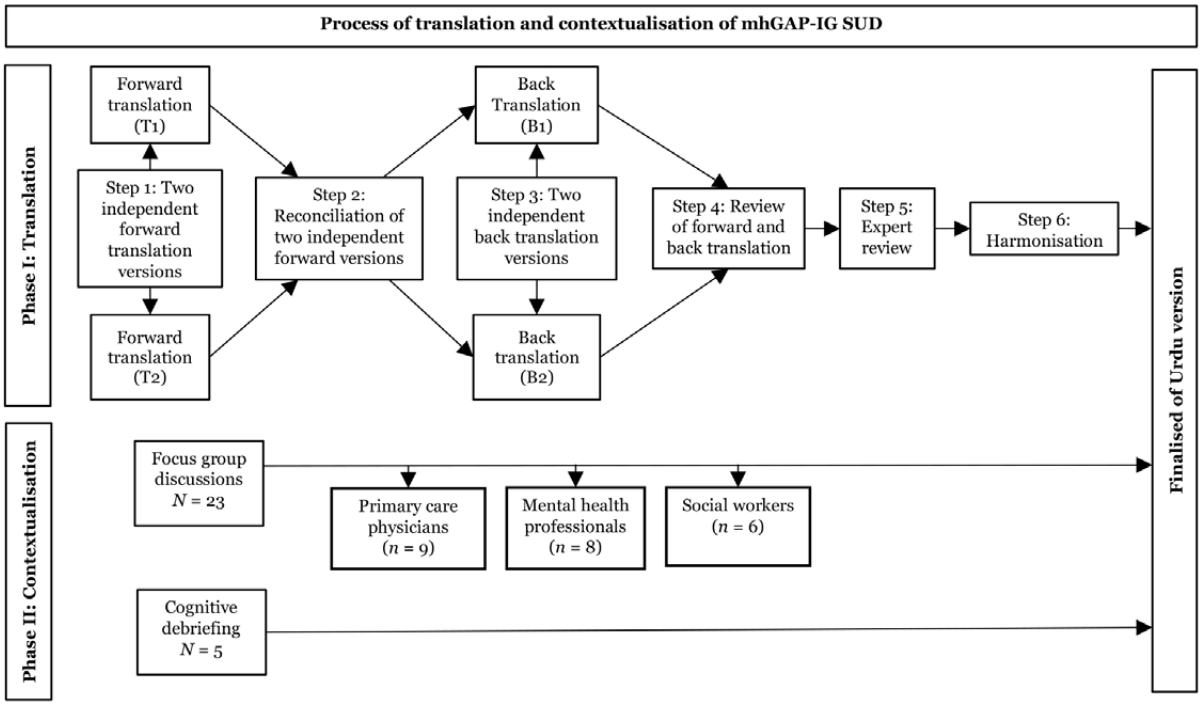


Figure 1. Process of translation and contextualisation of mhGAP-IG-SUD module.

Translation Process

Following the MAPI linguistic guidelines (22), translation was completed by a multidisciplinary team of eight members, including the principal and co-principal investigators, two psychiatrists, two psychologists, and two linguists expert in Urdu and English, respectively. The MAPI guidelines involve multiple steps: i) forward translation, ii) reconciliation, iii) backward translation, iv) review of the backward translation, v) expert review, vi) harmonisation, and vii) finalisation. Figure 1 shows the flowchart of the translation process.

In the forward translation, two Urdu translations (T1 and T2) of the SUD module were created by two independent bilingual psychologists (IY and MA), one of whom had clinical experience working with SUDs. These versions (T1 and T2) were reconciled into a single Urdu version in a consensus meeting by two independent bilingual translators and two Urdu linguists, thus ensuring semantic and linguistic equivalence. Subsequently, two independent translators, who were experts in the English language, proficient in healthcare terminologies, and blinded to the original version, produced back-translations to validate accuracy in relation to the original English version. Next, a review of the back-translations was conducted by members of the project team in a consensus meeting to ensure conceptual and linguistic equivalence. All modifications were integrated and incorporated into the prefinal Urdu version. Following this process, an expert committee comprising two psychologists, a linguist, and a bilingual psychiatrist reviewed the prefinal Urdu version of the mhGAP-IG SUD module, resolved discrepancies, and ensured clinical and linguistic accuracy. Finally, all revisions were incorporated into a single harmonised version, ensuring consistency in terminologies, module design, font, style, and layout. The final Urdu version was proofread, and any remaining typographical, grammatical, or formatting issues were corrected.

Contextualisation: FGDs and Cognitive Debriefing Interviews

The contextualisation of the final Urdu version was accomplished in two steps. First, FGDs with stakeholders, including health professionals, were conducted to gather their input in terms of the relevance, acceptability, and practical utility of the mhGAP-IG SUD-Urdu module. Second, cognitive debriefing interviews aligned with MAPI's pilot-testing parameters were carried out to ensure clarity and accurate comprehension of the Urdu version.

Sampling Method and Eligibility Criteria

For the FGDs, a convenient sampling strategy was used to recruit participants from three major cities of Pakistan, namely Islamabad, Karachi, and Lahore. The inclusion criteria for the participants were as follows: i) minimum experience of 1 to 2 years working with SUDs; and ii) willingness to provide informed consent. We excluded nonpracticing/retired professionals and those without direct patient contact.

We conducted three FGDs (N = 23) with i) psychiatrists and psychologists (Islamabad, n = 8); ii) social workers (Karachi, n = 6); and iii) PCPs (Lahore, n = 9). The demographic characteristics of the FGD participants are presented in Table 1. The sample size for this study was not determined based on statistical

Table 1. Demographic characteristics of participants of FGDs (N = 23).

Characteristics	Average	Range
Age (years)	28.3	21 to 47
Years of work experience	4.6	1 to 9
Gender (n, %)		
Female	12	52.2
Male	11	47.8
Group (n, %)		
Group 1: Primary care physicians (Lahore)	9	40
Group 2: Mental health workers (Islamabad)	8	34
Group 3: Social workers (Karachi)	6	26

power calculation but on the principle of thematic data saturation—a standard framework in qualitative research (23). This decision aligns with the qualitative methodological recommendations demonstrating that 80% to 90% of core themes with high levels of codes are often discovered (24). By the third FGD, no new insights emerged, indicating that data saturation had been achieved.

For the cognitive debriefing interviews, purposive sampling was used to recruit PCPs who had knowledge of SUDs. Individual interviews were performed with the recruited PCPs (N = 5). This small sample size for interviews is methodologically optimal, with a study suggesting four to six participants as standard for identifying critical flaws in comprehension (24). This framework confirmed that adequate thematic saturation had been achieved. The demographic characteristics of the participants are provided in Table 2.

Data Collection

A semi-structured interview guide was developed and reviewed by the project team. The interview guide explored the usability of the Urdu module in primary healthcare settings in terms of clinical relevance and ease of use/difficulty with the current structure, navigation, layout, and linguistic accuracy (e.g., tone, clarity, and content comprehensibility). Open-ended questions and probes were used to encourage detailed discussion and to explore diverse views and opinions from the interviewees. Meanwhile, the FGDs were conducted in the Urdu language by trained research assistants under the supervision of the senior researchers (IY and MA). Each FGD lasted 60 min to 90 min, was audio-recorded with the participants' consent, and was transcribed verbatim.

For the cognitive debriefing interviews, the participants were provided with the mhGAP-IG SUD-Urdu guide and asked to read randomly chosen sections. This was followed by a series of questions asking them to describe what they understood after reading those sections. The questions and probes focused on the appropriateness, comprehension, and linguistic accuracy of the contextualised guide.

Qualitative Data Analyses

Recordings of the FGDs and interviews were transcribed verbatim by the project team. All transcripts were translated into English. Then, the data were analysed using a six-step thematic analysis within an inductive framework (25). This process involved repeated transcript reading for familiarisation and semantic coding. Two researchers, the principal investigator and a research assistant, independently coded and developed the initial themes. The interviews were reread line by line, and different colours were used to organise data segments to identify themes. Next, the themes were reviewed, refined, named, and categorised. Similarities and differences in the data were assembled and organised in sequence. Furthermore, discrepancies were resolved to achieve consensus. This study adhered to the guidelines imposed by the Consolidated Criteria for Reporting Qualitative Research (COREQ) (26).

Table 2. Demographic characteristics of participants for cognitive debriefing (N = 5).

Participant ID	Age	Gender	Designation	Familiarity with mhGAP-IG SUD module
R1	26	M	Medical officer	Yes
R2	22	M	Staff nurse	No
R3	24	M	Staff nurse	No
R4	24	F	Psychologist	Yes
R5	22	F	Psychologist	No

mhGAP-IG = Mental Health Gap Action Programme Intervention Guide; SUD = substance use disorder; M = male; F = female.

Results

Key Findings from the Translation Process

The forward and back-translation processes resulted in semantic and conceptual equivalence between the English and Urdu versions of the mhGAP-IG SUD module. All changes and revisions made were documented throughout the process, and discrepancies related to semantic language and clinical terminologies were resolved through consensus. Therefore, the translation process involved not only linguistic adaptation but also iterative refinement to ensure that the intended clinical concepts originally presented in English were preserved in the Urdu version.

The expert review committee refined the translated content at both the technical and conceptual levels in terms of clinical and conceptual accuracy, as well as contextual relevance. Although the clinical algorithms and pathways remained the same, significant refinements were made to enhance clarity and ensure utility for primary care settings in Pakistan. For example, to enhance specificity, "severe intoxication" was changed to "a state of severe intoxication" and "severe alcohol intoxication" was revised to "a state of severe intoxication resulting from alcohol use." Some of the words were further simplified to enhance comprehension (e.g., "the patient's condition stabilises" was revised to "the patient's condition improves").

Additionally, in cases wherein translation altered or diluted their intended meanings, some clinical terms (e.g., "psychoeducation," "depression," and "motivational interviewing") were retained in English and presented in Roman Urdu, where appropriate, to maintain clinical accuracy. Furthermore, the definitions of these clinical terms were added in parentheses. For example, "flashback" was defined as "the sudden recall of a past event." Similarly, definitions of various other clinical terms were added, such as "withdrawal," "tolerance," "psychoactive," and so on. These modifications reflected a preference for conceptually equivalent and readily understandable wordings rather than direct literal translations.

Findings from the Contextualisation Process (FGDs)

The thematic analyses of the FGDs generated three overarching themes: i) usability of and integration into primary care practice; ii) linguistic, semantic, and contextual appropriateness; and iii) clarity, standardisation, and readability of the module. Across the three themes, the participants generally considered the Urdu module comprehensive, relevant, and potentially useful in routine clinical practice. However, they also identified specific areas where translation required further simplification or clarification to reduce ambiguity during clinical decision-making.

Theme 1: Usability of the mhGAP-IG SUD-Urdu Module and Its Integration into Primary Care Practice

This theme describes the participants' perceptions regarding the module's usability in terms of structure and clarity, as well as the integration of the Urdu version module into primary healthcare settings in Pakistan. The participants agreed on the usability, structured format, and practicality of the module as a resource for non-specialist PHCPs working in the field of addiction treatment. Furthermore, the structured and stepwise flow of protocols for assessment and management was perceived as a strength in facilitating the use of the translated module in routine practice. They also reported that the structured guide would be very useful, considering the high numbers of patients and limited consultation time in primary care settings. They added that the structured format would minimise ambiguity, improve recall, and allow systematic assessment. As one participant shared, "The structure guides me through the assessment process." Thus, usability was linked not only to the language of the translation but also to the way the translated content could be incorporated into routine clinical workflows.

Furthermore, the participants highlighted that the module seemed applicable to the local context, as it reflects clinical scenarios commonly encountered in local practice, making it contextually relevant for routine use in Pakistan. They also perceived sections on assessment and management (SUB-1 and SUB-2) as particularly valuable, with one participant saying, "It provides improved clinical confidence in SUD care delivery in the absence of specialised training."

Theme 2: Linguistic, Semantic, and Contextual Appropriateness

All the participants showed consensus on how the module featured conceptual translation into the Urdu language (and not literal translation) and how it explained clinical concepts well. They stated that the literal translation of clinical terminologies led to decreased clarity and increased misunderstandings. In contrast, conceptual translation enhanced clarity and usage. The participants emphasised that the Urdu translation should communicate the intended clinical concept directly rather than reproduce the literal structure of a sentence.

They also suggested refinements, such as further simplifying some sentences, particularly those stating conditions related to substance use. For instance, the sentence "If the patient does not regain consciousness after using the substance, it can be due to the effects of medication" can be better interpreted as "If the patient is unconscious after the substance use and is not regaining consciousness, think of a drug overdose." In addition, the phrase "leaving substance addiction" was changed to "withdrawal symptoms that occur after leaving substance use." Similarly, the participants suggested replacing "controlling one's behaviour" with "a behaviour that the person is unable to control," "loss of awareness" with "the state of severe intoxication," and "agitated" with "restless." These examples demonstrated that the participants identified difficulties at the levels of individual terminologies and sentence-level meanings. The suggested changes aimed to make clinical instructions more direct and to reduce the possibility of misinterpretation, particularly in urgent situations requiring immediate assessment or intervention.

Furthermore, the participants highlighted that the adapted terms are aligned with commonly observed presentations of symptoms. However, they suggested improving clarity in high-risk assessment instructions, such as modifying referral guidance within suicide risk assessment pathways to avoid ambiguity, as other mhGAP modules were not included in the Urdu translation.

Theme 3: Clarity, Standardisation, and Readability of the Module

The participants reported that the translations were clear, readable, and easy to comprehend. They emphasised that the translated module maintained a formal and didactic tone and ensured high fidelity to the original clinical terms. They also agreed with the decision to retain standardised key terms, such as "motivational interviewing" and "psychoactive substances," as well as clinical terms in their original forms to maintain consistency with global clinical practice, as was also suggested by the expert group.

However, minor changes were suggested to improve clarity in the content in terms of sentence length. As one participant stated, some sentences were a bit long and required reading them twice to understand. For example, the instruction "If the patient has difficulty breathing due to substance overdose and is also becoming less conscious, you must take immediate treatment measures" was considered complex, and a suggestion to break it down into two sentences was provided. This feedback indicated that although the overall translation was easy to comprehend, sentence length in some sections could affect the rapid comprehension of clinically important instructions. These observations resulted in minor linguistic modifications to enhance clarity and readability.

Another important suggestion was to avoid moralistic terminologies. As one participant shared, "If we use harsh or judgemental words, patients may feel frustrated or disengaged, and their trust and compliance with treatment may decrease. We need to use terms that reflect care, not judgement." Based on this insight, certain revisions were made. For example, the sentence "People addicted to substances often face social problems" was revised to "Individuals who use psychoactive substances may require social support and treatment."

Findings from Cognitive Debriefing Interviews

Feedback from the cognitive debriefing interviews ensured individual-level comprehension validation. Here, the participants

were asked to read randomly chosen sections of the module independently and provide immediate feedback on whether or not they were easy to understand. No issues were identified requiring modification of clinical pathways; instead, refinements were limited to language clarity and phrasing.

Discussion

To the best of our knowledge, the present study is the first systematic attempt to translate and contextualise the WHO's mhGAP-IG SUD module into the Urdu language for implementation in the Pakistani primary healthcare setting. The findings indicated that the study aim was achieved through a multistep, systematic, iterative, and participatory process (21), which resulted in an Urdu version with improved semantic clarity, conceptual equivalence, contextual relevance, and readability while retaining the core clinical algorithms and pathways of the original module. The results of the forward and back-translations, validated by a team of expert reviewers, indicated that the adapted version of the module accomplished conceptual equivalence while improving clarity, readability, and cultural relevance. Minor semantic changes were completed to ensure comprehensibility before the prefinal version was produced.

Subsequently, the FGDs with potential stakeholders and cognitive debriefing interviews revealed that revisions were primarily required in relation to technical terms and cultural expressions. These results indicated that the translated content and subsections of the module were clear and understandable while preserving the components of the original intervention guide. This methodological triangulation approach ensured the credibility and depth of the findings for semantic and conceptual equivalence. In this way, the results are consistent with previous research, which emphasised the use of an iterative approach for contextualisation to ensure fidelity in preserving the core functions of the intervention while optimising its clarity, implementation, and effectiveness for local contexts (27). Overall, the findings demonstrated strong semantic, conceptual, and cultural equivalence, as well as appropriateness and improved accessibility for non-specialists working in primary and community-based care settings.

A key insight from this study is the need to prioritise conceptual equivalence over literal translation when translating clinical guidelines (22). The participants repeatedly emphasised that word-for-word translation for medical terms/concepts often resulted in ambiguities or semantic distortions that could disrupt the flow of expression in sentences. For example, English terms were retained along with Urdu for comprehensibility. Consequently, culturally neutral terms were chosen to align with contextual communicative norms and to decrease potential discomfort among healthcare providers. These findings are consistent with previous mhGAP-IG translation research conducted in other LMICs, which reported the need for contextual refinements where linguistic challenges emerged in translating culturally subtle constructs (28).

Similarly, studies in Nigeria and Tunisia highlighted the importance of accurately translating terminologies and service delivery guidelines in ensuring the feasibility and cultural relevance of mhGAP-IG (29, 30). In the present study, refinements were made by replacing literal phrases with vernacular equivalents to ensure the clarity, relevance, and acceptability of the Urdu module, thus achieving accurate information delivery in clinical settings. This highlights the significance of participant-informed revisions in enhancing the face validity of the module. Moreover, the structured and stepwise approach highlighted in the module facilitates clinical decision-making, reduces clinicians' ambiguity, and supports systemic service delivery, especially in settings with high patient volumes and limited consultation times. This significant finding highlights the importance of module acceptability in primary healthcare settings.

Overall, our findings are consistent with previous studies conducted in other LMICs, which reported the significance of accurate linguistic and contextual modifications for the effective integration of mental health services into primary healthcare settings (30, 31). The integration and implementation of the mhGAP-IG module have been carried out in over 80 countries, and its translations have been used in approximately 20 languages (4). This integration of mental health services into national-level primary healthcare systems has been increasingly recognised as a feasible and scalable approach in LMICs to reduce treatment gaps for SUDs (17).

Notably, effective implementation requires that clinical guidelines be accessible and culturally relevant for frontline healthcare providers. However, in Pakistan, there is a lack of existing contextualised evidence-based guidelines to support non-specialists in healthcare settings (6). Pakistan has an organised three-tiered public healthcare system comprising the following: i) primary care for basic healthcare, staffed by trained physicians and nurses; ii) secondary care for referrals and inpatients; and iii) tertiary care for specialised services (15). Therefore, to achieve successful implementation, primary healthcare was considered the first level of contact for the integration of the mhGAP-IG SUD-Urdu module in this study. Based on the study's findings, the translation and contextualisation of the SUD module can be considered a scalable and cost-effective intervention that can be integrated into the current Pakistani healthcare system.

The study has several strengths, such as the use of rigorous translation procedures (22), followed by contextualisation using FGDs and cognitive debriefing interviews, which allowed data triangulation (25). These enhanced the credibility of the contextualisation process by allowing linguistic, clinical, contextual, and individual-level comprehension issues to be examined separately. Moreover, the inclusion of specialised and non-specialised healthcare workers, such as nurses, medical doctors, physicians, psychiatrists, psychologists, and social workers, in the contextualisation process improved the overall practical relevance and implementation readiness of the mhGAP-IG SUD-Urdu module. Furthermore, the study documented each translation step, along with consensus-based decisions, transparency, and replicability.

Despite these strengths, several limitations should be considered. First, the participants in the FGDs and debriefing interviews were recruited from urban healthcare settings, which may limit generalisability to rural or remote areas. Additionally, although the study followed an iterative translation and contextualisation process, it did not evaluate the effectiveness and clinical utility of the module. Thus, future research may use different methodologies, including randomised controlled trials, to evaluate the effectiveness and scalability of the contextualised module within primary healthcare and community-based settings.

Implications for Practice

The findings of this study have significant implications for clinical practice and service delivery in Pakistan's primary healthcare system. In particular, the contextualised evidence-based intervention guide supports non-specialist PHCPs with structured and standardised care delivery for SUDs, thereby decreasing the caseload of the country's tertiary healthcare system. Moreover, integrating the module into the system offers a scalable and cost-effective strategy for reducing the treatment gap of SUDs.

Conclusion

This study presented a systematic translation and contextualisation of the WHO's mhGAP-IG SUD module into its Urdu version. The first contextualised version, available on the WHO website, serves as a culturally and linguistically appropriate intervention. Thus, the study bridges a critical treatment gap by making the WHO's mhGAP guidelines more accessible to non-specialised PHCPs and frontline workers, thus offering support for quick assessment, management, and follow-up for SUDs. Finally, the study demonstrates that successful contextualisation requires a culturally grounded, system-aware, and participatory approach. We recommend the inclusion of this guide in pre-service training and its integration into Pakistan's primary healthcare system for better long-term outcomes.

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Ethics of Study

This study was approved by Pakistan's National Bioethics Committee for Research (reference number: NBCR-1020/23/970). Written and verbal informed consent was obtained from all participants prior to participation. Participants provided signed consent forms to confirm their voluntary participation. Confidentiality and anonymity of participant information were maintained throughout the study in accordance with ethical research standards.

Conflict of Interest

The authors declare that they have no conflicts of interest, financial or otherwise, that could have influenced the work reported in this manuscript.

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Authors' Contributions

Conception and design: IY, MA
Analysis and interpretation of the data: IY, MS
Drafting of the article: IY, MA
Critical revision of the article for important intellectual content: IY, SH, MA
Final approval of the article: IY, MA, MS, SH, ABK, NC
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