# Supplementary Material 1

# Detailed Interview Methodology and Procedures

## 1. Interview Procedures

Interviews were conducted following a semi-structured protocol to ensure consistency while allowing for the exploration of participant-specific insights (Moser & Korstjens, 2018).

- **Setting:** Sessions were held in private clinical offices for in-person participants or via encrypted online platform (Google Meeting) for those in remote areas to ensure confidentiality (Curry & Nunez-Smith, 2015).
- **Duration:** Interviews lasted between 30 and 45 minutes, a timeframe sufficient for reaching thematic depth in healthcare professional interviews (Farre & Rapley, 2017).
- **Documentation:** Data were captured through detailed contemporaneous notes recorded on paper with the explicit consent of the participants, ensuring a robust trail for thematic synthesis (Moser & Korstjens, 2018).

## 2. Ethical Safeguards and Consent Protocols

The study adhered to international ethical standards and received formal approval (Notification No. EAB/27790/24).

- **Consent:** Informed consent was obtained from all 32 participants prior to data collection. This process involved disclosing the study's purpose, risks, and benefits as per the Declaration of Helsinki guidelines (Farre & Rapley, 2017; Haar et al., 2024).
- **Confidentiality:** To protect participants within the current healthcare climate in Myanmar, all data were pseudonymized. This strategy mitigates risks associated with professional disclosure in sensitive environments (Haar et al., 2024).
- **Data Security:** Field notes and digital summaries were stored on encrypted, password-protected devices, with physical notes kept in locked cabinets accessible only to the primary researcher (Farre & Rapley, 2017).

## 3. Qualitative Coding Process

The raw interview data were analyzed using a systematic three-stage thematic analysis based on the framework established by Moser & Korstjens (2018) and Curry & Nunez-Smith (2015).

| Coding Stage | Procedure | Objective |
|---|---|---|
| **Stage 1: Open Coding** | Initial line-by-line review of interview notes to identify raw concepts (Moser & Korstjens, 2018). | To break down data into discrete incidents or ideas (e.g., "lack of time," "patient stigma"). |

| | | |
|---|---|---|
| **Stage 2: Axial Coding** | Grouping initial codes into broader categories based on relationships and shared characteristics (Curry & Nunez-Smith, 2015; Xiao et al., 2021). | To organize codes into sub-themes such as "Resource Constraints" or "Cultural Barriers". |
| **Stage 3: Selective Coding** | Integrating and refining categories to form the final overarching themes (Moser & Korstjens, 2018; Wittink et al., 2022). | To establish core findings, such as the transition from biomedical to holistic care. |

### 4. Thematic Framework Table

The following codes were utilized to categorize the challenges and drivers of model implementation, grounded in the biopsychosocial theories of Bolton (2023) and Farre & Rapley (2017):

| Primary Theme | Associated Codes | Description |
|---|---|---|
| **Holistic Application** | *INT-CARE*, *PSY-SOC* | Mentions of integrating psychological and social well-being into somatic treatment (Bolton, 2023; Engel, 1978; Borrell-Carrio et al., 2004). |
| **Systemic Barriers** | *RES-LIM*, *TIME-P* | References to inadequate staffing, lack of equipment, or high patient volumes (Kadu & Stolee, 2015; Saw et al., 2019; Swanson et al., 2015). |
| **Socio-Cultural Context** | *CULT-RES*, *STIGMA* | Patient or family resistance to non-biomedical approaches due to fear of stigma (Mead & Bower, 2000; Hatala, 2012). |
| **Institutional Needs** | *TRN-GAP*, *SUP-REQ* | Expressions of the need for formal continuing education and interdisciplinary support (Katantha et al., 2025; Mosca et al., 2020; Frost et al., 2021). |

### 5. Interview Questions

**Part 1: Quantitative Survey (Likert-Scale 1-5)**

*Scale: 1 = Never/Strongly Disagree, 5 = Always/Strongly Agree*

1. How frequently do you consider a patient’s social support system (family/community) when deciding on a treatment plan?
2. How often do you evaluate the psychological state (stress, trauma, mood) of a patient during a standard consultation?
3. How frequently does your clinical setting provide enough time to discuss non-medical issues with patients?
4. How often do you collaborate with other healthcare roles (nurses, social workers, technicians) to provide holistic care?

5. To what extent do you feel your formal education prepared you to address psychological distress in patients?
6. How often do patient financial constraints prevent you from fully implementing the biopsychosocial (BPS) model?
7. How frequently do you use psychological screening tools or specific social-history questions?
8. How often do you feel that the traditional biomedical approach is insufficient for the patients you treat?
9. Rate the frequency of using patient-centered communication (active listening, shared decision-making) in your daily practice.
10. How often do you perceive that your peers/colleagues support the use of a biopsychosocial approach?

**Part 2: Qualitative Interview Questions (Thematic)**

*Designed for "Nuanced Exploration"*

11. In your own words, how do you define the transition from "treating a disease" to "treating a person"?
12. Can you describe a specific case where understanding a patient's social background changed your medical diagnosis or treatment?
13. What is the single biggest barrier to BPS adoption in your specific rural or urban setting?
14. How do you manage the "time-poverty" of a busy clinic while still trying to provide holistic care?
15. How has the current socio-political crisis in Myanmar changed the "social" needs of your patients?
16. Do you believe your patients expect a traditional "paternalistic" doctor (just giving pills) or do they value the BPS approach?
17. How do you address mental health stigma when trying to discuss psychological factors with a patient?
18. What specific training have you sought out on your own to improve your BPS skills?
19. Describe the difference in BPS adoption between your age group (25-35) and senior medical staff.
20. How does the lack of private consultation space in rural clinics affect patient disclosure?
21. What is the most common reason you "revert" to a strictly biomedical approach?
22. How do you assess "spiritual" or "cultural" beliefs as part of your social assessment in Myanmar?

23. In what ways could the national healthcare policy better support young professionals using this model?
24. How do you measure "success" when using the BPS model if the patient's physical illness is terminal or chronic?

**Part 3: Barriers & Contextual Setting (Mixed-Methods)**

*Focusing on the "Resource-Limited" aspect*

25. **Setting:** Do you work primarily in a Rural, Urban, or Peri-urban environment?
26. **Experience:** How many years of clinical experience do you have in resource-limited settings?
27. **Barrier Ranking:** Rank these four barriers from most to least obstructive: Time, Funding, Training, Cultural Resistance.
28. **Incentive:** Would you be more likely to use the BPS model if it were a formal requirement in national clinical guidelines?
29. **Patient Impact:** On a scale of 1-10, how much does the BPS model improve patient treatment adherence in your experience?
30. **Future Outlook:** On a scale of 1-10, how optimistic are you that the BPS model will become the standard of care in Myanmar in the next decade?