

The Influence of Needs Satisfaction and Support on the Well-Being of Physicians Deployed in Underserved Communities

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ABSTRACT ¹

This study investigated the influence of needs satisfaction and support on the well-being of physicians deployed in underserved communities. Basic Psychological Needs Theory is used as the theoretical framework, positing that fulfilling the three basic psychological needs of autonomy, competence, and relatedness can foster well-being and optimal functioning. The results revealed that meeting basic psychological needs alongside workplace conditions and individual characteristics can play distinct roles in promoting emotional, psychological, and social well-being as well as reducing the likelihood of anxiety and depression. This study suggests that promoting the well-being of human resources for health, particularly among physicians deployed in underserved communities, is crucial for achieving the Sustainable Development Goal for good health and well-being. By recognizing and addressing the diverse factors that contribute to the well-being of these physicians, healthcare organizations and policymakers can create environments that support their optimal functioning and, consequently, contribute to the overall improvement of health outcomes in underserved communities.

Keywords: Basic Psychological Needs, Well-Being, Anxiety, Depression, Physicians

1. INTRODUCTION

Well-being has gained attention in recent years as it is increasingly recognized as essential for overall health. It involves the effective functioning of individuals, which allows them to navigate everyday challenges of life, work productively and meaningfully, reach self-actualization, and make valuable contributions to their community [1].

The importance of well-being in promoting quality of life has attracted the interest of researchers to investigate various aspects of well-being, including how the work environment and occupational context can impact well-being.

In the healthcare sector, the well-being of human resources for health, such as physicians, is crucial for ensuring the effective delivery of healthcare services to the population [2]. However, studies have shown that healthcare professionals are more likely to suffer from mental health issues, such as anxiety, depression, burnout, and stress. These problems in well-being stem from the physical and emotional demands of work in a healthcare setting, which are often exacerbated by limited resources in the healthcare system [3].

Among those vulnerable to the toll of a strained healthcare system are physicians deployed in areas where there is a shortage of healthcare professionals owing to the maldistribution and migration of healthcare providers [4]. For instance, physicians under the Doctors to the Barrios Program, an intervention introduced in 1993 by the Philippine government to address the shortage of healthcare professionals in underserved communities, identified heavy workloads and inadequate preparation for the demands of their occupation in a low-resource setting as contributors to impaired well-being [4, 5]. A work-related environment that is characterized by poor social working conditions and lack of social support was also brought up to adversely affect their well-being [4].

Although previous research has shed light on the lives and experiences of physicians assigned in underserved communities, it has not thoroughly explored the positive influences on their well-being. For instance, studies on the

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impact of a work environment that satisfies and supports the need for autonomy, competence, and relatedness among physicians posted in underserved communities are scarce. Hence, this study investigated the following among physicians deployed in underserved communities:

- 1) Influence of needs satisfaction in the workplace (i.e., autonomy, competence, and relatedness) on well-being (i.e., emotional, psychological, and social well-being);
- 2) Influence of needs satisfaction in the workplace (i.e., autonomy, competence, and relatedness) on the likelihood of anxiety and depression;
- 3) Influence of needs support in the workplace (i.e., autonomy, structure, and involvement) on well-being (i.e., emotional, psychological, and social well-being);
- 4) Influence of needs support in the workplace (i.e., autonomy, structure, and involvement) on the likelihood of anxiety and depression.

The results of this study can provide insights into how the healthcare sector can look after the well-being of its human resources. Promoting the well-being of human resources for health is crucial because they play a vital role in achieving the Sustainable Development Goal for good health and well-being.

2. THEORETICAL FRAMEWORK

The Basic Psychological Needs Theory posits that fulfilling the three basic psychological needs of autonomy, competence, and relatedness can foster well-being and optimal functioning. These basic psychological needs are met when environments allow individuals to make meaningful choices, experience a sense of accomplishment, and build positive social connections [6].

Autonomy entails the ability to exercise volition and necessitates a sufficient degree of choice in one's actions. Providing options, empowering individuals to make decisions, and acknowledging their perspectives can lead to feelings of autonomy. Environments that promote autonomy motivate individuals to engage in behaviors for intrinsic and personal reasons in line with their own beliefs and values [6, 7].

Competence involves a sense of mastery that comes with achieving the desired outcomes. Setting manageable goals, offering constructive feedback, and encouraging skill development can aid individuals build their competence. Environments that provide this structure not only help individuals establish clear and attainable expectations but also foster beliefs in their ability to achieve success [6, 7].

Finally, relatedness refers to the extent to which an individual feels cared for, valued, and respected. Nurturing positive relationships, encouraging collaboration, and providing emotional support are ways of promoting

relatedness. Environments characterized by such involvement facilitate a sense of belonging, connection, and inclusion [6, 7].

Well-being includes feeling good about life and being able to function well [8]. It is portrayed as a continuum of emotional, psychological, and social well-being [9]. Individuals can move along a continuum in response to life events, changes in circumstances, or intentional efforts to improve their well-being. When individuals experience positive emotions and function effectively in their personal and social lives, they are considered flourishing and typically possess high levels of well-being. Conversely, those struggling in these areas are deemed languishing and likely to have low levels of well-being [9, 10].

Emotional well-being refers to the presence of positive feelings about one's life. This emotional aspect of well-being revolves around individuals' capacity to experience positive emotions, such as joy, gratitude, love, and contentment, as they undergo various life experiences [9]. It encompasses not only the presence of positive affect and the absence of negative affect but also the perception of life satisfaction. Promoting emotional well-being involves providing support for individuals to navigate and cope with their emotions [9, 10].

Psychological well-being relates to an individual's subjective assessment of their overall functioning in their personal life [9]. Individuals must demonstrate self-acceptance, seek personal growth, possess a sense of life purpose, foster positive interpersonal relationships, exhibit self-determination, and show environmental mastery to be considered as optimally functioning in their personal lives. Promoting psychological well-being entails creating environments that support personal growth, positive relationships, and a sense of purpose [9, 10].

Social well-being necessitates effective engagement in social life [9]. It is characterized by social integration, social acceptance, social contribution, social coherence, and social actualization [9, 10]. Individuals are considered thriving in their social lives when they feel a sense of belonging and acceptance within society, perceive themselves as making a valuable contribution, and find society meaningful with room for growth [9]. Promoting social well-being involves creating environments that foster positive social interactions, encourage community engagement, and support the development of strong social networks [9, 10].

Anxiety and depression, the most common mental health issues in the general population, can impair well-being [11, 12]. Anxiety can significantly interfere with daily functioning and adversely affect well-being, if it becomes chronic and disproportionate. It manifests as excessive worry, restlessness, and irritability [11]. Depression can also undermine well-being as its symptoms can cause difficulties in all aspects of life. It involves persistent

feelings of sadness, hopelessness, and a lack of interest or pleasure in activities [12].

Promoting a supportive environment that nurtures autonomy, competence, and relatedness can reduce the risk of anxiety and depression. Specifically, satisfying these basic psychological needs can help individuals become more resilient in the face of adversity, as they are better equipped to navigate and cope with life's challenges [6, 7].

3. METHODS

To investigate the influence of needs satisfaction and support on the well-being of physicians deployed in underserved communities, an observational, non-experimental approach was undertaken in this study. An observational, non-experimental approach is suitable for studies that neither introduce interventions nor manipulate the variables. It is useful for assessing the relationship between two or more variables collected at one point in time [13].

Setting and Participants

Less than 25% of cities and municipalities in the Philippines have reached the recommended ratio of 41 healthcare professionals per 10,000 population, as set by the World Health Organization [14]. Despite the growing number of Filipino healthcare providers over the years, those from rural, far-flung, and conflict-stricken areas in the country lack sufficient access to healthcare professionals because few physicians choose to locate themselves in these communities [15]. Factors, such as better social, economic, and professional opportunities, have contributed to their decision to concentrate in urban areas or seek employment overseas [14, 15].

The Philippine government implemented the Doctors to the Barrios Program in response to the shortage of physicians in rural, far-flung, and conflict-stricken areas due to the maldistribution and migration of healthcare professionals. The physicians under this program include those required by their scholarship in state-run medical schools for a return service and those applying voluntarily. They get deployed to provide primary healthcare in underserved communities for three years. These physicians are either assigned as rural health physicians, who attend to patients and carry out health programs, or municipal health officers, who have added administrative responsibilities. For their services, they receive compensation and additional benefits, such as scholarships for further studies in public health [4, 5, 15].

After securing ethics clearance to proceed with the research, this study recruited physicians from batches 38 and 39 of the Doctors to the Barrios Program as participants. These physicians were eligible as study participants because they were actively serving for at least

a year at the time of the study. This one-year requirement for deployment is based on previous literature that suggests that psychological and sociocultural acclimatization in a new environment takes about a year and that adjustment problems decrease significantly after this period [16].

Data Collection

The program coordinator disseminated the link for the online survey to eligible study participants. This study used Google Forms to conduct an online survey because of its ease of use and convenience. The online survey contained items from the Need Satisfaction at Work Scale, the Need Support at Work Scale, the Mental Health Continuum-Short Form, and the Patient Health Questionnaire-4. The first two instruments measured the independent variables in this study, whereas the last two instruments measured the dependent variables. The online survey also collected information that may have affected the relationship between independent and dependent variables.

Need Satisfaction at Work Scale. The Need Satisfaction at Work Scale is a 13-item scale designed to quantify the satisfaction of the three basic psychological needs in the workplace. Its autonomy subscale consists of four items (e.g., *I can make meaningful choices in my job*), competence subscale comprises four items (e.g., *I really feel skilled at my job*), and relatedness subscale includes five items (e.g., *I enjoy being with the people I work with*). Respondents rated their agreement with the statements on the questionnaire using a 5-point Likert scale ranging from 1 (i.e., completely disagree) to 5 (i.e., completely agree). The internal consistencies of the autonomy, competence, and relatedness subscales were 0.78, 0.81, and 0.89, respectively. The subscales also demonstrated content, factorial, and criterion-related validity [17].

Need Support at Work Scale. The Need Support at Work Scale is a 12-item scale developed to measure perceived support for autonomy, competence, and relatedness from supervisors at work. The subscale on autonomy support has four items (e.g., *Encourage me to take my own initiative at work*), competence support (i.e., structure) consists of four items (e.g., *Provides me with opportunities to further develop my competencies*), and relatedness support (i.e., involvement) comprises four items (e.g., *Shows that he/she cares about me*). Responses were quantified using a 5-point Likert scale ranging from 1 (i.e., never or hardly ever) to 5 (i.e., always). The subscales measuring support for autonomy, competence, and relatedness had internal consistencies of 0.86, 0.90, and 0.92, respectively. These subscales were found to have content, factorial, and criterion-related validity [17].

Mental Health Continuum-Short Form. The Mental Health Continuum-Short Form is a 14-item instrument derived from the Mental Health Continuum-

Long Form, which has 40 items. This commonly used instrument for measuring positive mental health includes three items on emotional well-being (e.g., *Happy*), six items on psychological well-being (e.g., *That you liked most parts of your personality*), and five items on social well-being (e.g., *That you had something important to contribute to society*). Respondents evaluated each item using a Likert scale ranging from 0 (i.e., never) to 5 (i.e., every day) to express how often they had experienced the indicators of well-being for the past month. Higher scores on the instrument and its subscales signify higher levels of well-being. The Mental Health Continuum-Short Form demonstrated excellent reliability and validity across cultures [18, 19].

Patient Health Questionnaire-4. The Patient Health Questionnaire is a four-item instrument that can screen for anxiety and depression. It contains two items to assess symptoms of anxiety (e.g., *Feeling nervous, anxious, or on edge*) and two items for depression (e.g., *Feeling down, depressed, or hopeless*). Respondents rated how often they had been bothered by the symptoms over the last two weeks using a 4-point Likert scale ranging from 0 (i.e., not at all) to 3 (i.e., nearly every day). The anxiety and depression subscales demonstrated internal consistencies of 0.83 and 0.71, respectively. These subscales also exhibited content, factorial, and criterion-related validity [20, 21].

Other Information. Additional information, such as gender, program batch, role assignment, requirement for return service, deployment to geographically isolated and disadvantaged areas (GIDAs), enrollment in graduate studies, lodging arrangements, reliability of cellphone signals and Internet connections, family in assigned areas, presence in the assigned province of other physicians under the program, and previous diagnosis of mental health conditions were requested in the online survey. These factors were identified as confounding variables in this study.

Data Analysis

Continuous variables were reported as mean and standard deviation (SD), whereas categorical variables were described using frequency and percentage distributions. Multiple linear regression at a significance level of 0.05 was carried out to investigate the influence of needs satisfaction and support in the workplace on the well-being of physicians under the Doctors to the Barrios Program. Confounding variables were included in the regression models as covariates to adjust for their effects.

4. RESULTS

A total of 79 (24%) of the 324 physicians belonging to batches 38 and 39 of the Doctors to the Barrios Program participated in the online survey. They were deployed in their assigned areas for a mean of 26.20 months (SD =

7.71). Most of the respondents, whose role was rural health physicians, were supervised by municipal health officers. In contrast, liaisons from the Department of Health or the local government were the immediate supervisors of respondents acting as municipal health officers. The characteristics of the study population are summarized in Table 1.

Table 1. Distribution of the Surveyed Physicians under the Doctors to the Barrios Program by Characteristics

Gender	n (%)
Female	52 (66%)
Male	26 (33%)
Prefer Not to State	1 (1%)
Batch	
Batch 38	69 (87%)
Batch 39	10 (13%)
Role Assignment	
Rural Health Physician	54 (68%)
Municipal Health Officer	25 (32%)
Return Service	
Required	55 (70%)
Not Required	24 (30%)
GIDAs	
Assigned	55 (70%)
Not Assigned	24 (30%)
Graduate Studies in Public Health	
Enrolled	76 (96%)
Not Enrolled	3 (4%)
Lodging Arrangements	
Within the Rural Health Unit	14 (18%)
Separate from the Rural Health Unit	49 (62%)
Residing with the Family	16 (20%)
Communication and Information Technology	
Rating of 5 (reliable)	13 (17%)
Rating of 4	15 (19%)
Rating of 3	37 (47%)
Rating of 2	12 (15%)
Rating of 1 (unreliable)	2 (3%)
Family in Assigned Areas	
With	12 (15%)
Without	67 (85%)
Other Program Physicians in the Province	
With	45 (57%)
Without	34 (43%)
Diagnosis of Mental Health Condition	
With	6 (8%)
Without	73 (92%)

The sampled physicians agreed that their need for autonomy, competence, and relatedness was satisfied in their workplace. They also expressed that they often received support from their immediate supervisors for their need for autonomy, structure, and involvement. The ratings of needs satisfaction and support in their assigned areas are listed in Table 2.

Table 2. Ratings of the Survey Respondents on Needs Satisfaction and Support at Work

	Mean \pm SD	Interpretation
Needs Satisfaction		
Autonomy	3.79 \pm 0.59	Agree
Competence	3.82 \pm 0.51	Agree
Relatedness	3.59 \pm 0.65	Agree
Needs Support		
Autonomy Support	3.71 \pm 0.71	Often
Structure	3.54 \pm 0.75	Often
Involvement	3.55 \pm 0.87	Often

Based on their responses to the Mental Health Continuum-Short Form, 44 (56%) of the surveyed physicians under the Doctors to the Barrios Program were considered flourishing, six (8%) were languishing, and 29 (37%) were neither flourishing nor languishing. The results of their responses on the Patient Health Questionnaire-4 revealed that 15 (19%) of them were likely to have anxiety with depression, whereas 11 (14%) were likely to have anxiety and 3 (4%) have depression.

Multiple linear regression demonstrated that satisfying the need for competence ($\beta = 0.30$, $p = 0.03$) and relatedness ($\beta = 0.33$, $p = 0.01$) of the sampled physicians had a positive influence on their emotional well-being. On the other hand, the strength of cellphone signals and Internet connections in their assigned areas had a negative influence on their emotional well-being ($\beta = -0.29$, $p = 0.01$). This regression model showed that 46% of perceived emotional well-being could be explained by needs satisfaction and other covariates ($R^2 = 0.46$, $p < 0.001$).

Providing autonomy support ($\beta = 0.15$, $p = 0.62$), structure ($\beta = 0.17$, $p = 0.57$), and involvement ($\beta = 0.29$, $p = 0.06$) did not significantly affect the emotional well-being of the surveyed physicians. However, the strength of cellphone signals and Internet connections adversely affected their emotional well-being ($\beta = -0.31$, $p = 0.01$). In this regression model, 36% of the variation in perceived emotional well-being could be explained by the combination of needs support and the covariates assessed in the study ($R^2 = 0.36$, $p = 0.01$).

Meeting the need for competence ($\beta = 0.41$, $p = 0.001$) substantially contributed to the psychological well-being of the surveyed physicians. This regression model, consisting of needs satisfaction and other covariates, accounted for 55% of the variance in perceived psychological well-being ($R^2 = 0.55$, $p < 0.001$).

Support for relatedness through involvement ($\beta = 0.40$, $p = 0.01$) positively influenced the psychological well-being of the sampled physicians. However, only 37% of the variability in perceived psychological well-being was explained by the regression model ($R^2 = 0.37$, $p = 0.004$).

Additionally, satisfying the need for competence ($\beta = 0.35$, $p = 0.01$) and relatedness ($\beta = 0.34$, $p = 0.01$) of the sampled physicians had a positive effect on their social well-being. The variables included in the regression model accounted for 50% of the variation in the perceived social well-being ($R^2 = 0.50$, $p < 0.001$).

Involvement ($\beta = 0.47$, $p = 0.002$) also helped foster the social well-being of the surveyed physicians. Regression analysis revealed that approximately 43% of the variance in perceived social well-being could be accounted for by factors, such as needs support and covariates ($R^2 = 0.43$, $p < 0.001$).

The effect of fulfilling the need for autonomy ($\beta = -0.02$, $p = 0.92$), competence ($\beta = -0.17$, $p = 0.29$), and relatedness ($\beta = -0.04$, $p = 0.77$) in decreasing the likelihood of anxiety among the sampled physicians was found to be insignificant. Interestingly, lodging arrangements (i.e., living with their family) contributed to heightened levels of anxiety ($\beta = 0.31$, $p = 0.02$). However, these results were inconclusive ($R^2 = 0.28$, $p = 0.06$).

Furthermore, the relationships between autonomy support ($\beta = -0.15$, $p = 0.65$), structure ($\beta = -0.08$, $p = 0.78$), and involvement ($\beta = -0.05$, $p = 0.75$), and the likelihood of anxiety were not significant. In contrast, surveyed physicians from batch 38 exhibited higher levels of anxiety than those from batch 39 ($\beta = 0.32$, $p = 0.04$). Lodging arrangements also influenced the likelihood of anxiety ($\beta = 0.87$, $p = 0.01$). However, needs support and covariates in the regression analysis accounted for only 30% of the variability in anxiety levels ($R^2 = 0.30$, $p = 0.04$).

Satisfying the sampled physicians' need for competence ($\beta = -0.33$, $p = 0.03$) at work was associated with a reduced likelihood of depression. On the other hand, those with a previous diagnosis of mental health conditions ($\beta = 0.37$, $p = 0.003$) were more prone to experiencing depression. The regression model explained 37% of the variance in the severity of depression ($R^2 = 0.37$, $p = 0.004$).

Finally, the influence of autonomy support ($\beta = -0.52$, $p = 0.07$), structure ($\beta = 0.02$, $p = 0.95$), and involvement ($\beta = -0.03$, $p = 0.82$) on the occurrence of depression among the surveyed physicians was negligible. However, previous diagnosis of mental health conditions ($\beta = 0.35$, $p = 0.002$) was related to the likelihood of depression. The regression model, which included needs support and covariates, explained 50% of the variability in the severity of depression ($R^2 = 0.50$, $p < 0.001$).

5. DISCUSSION

As seen in this study, meeting the need for competence among physicians deployed in underserved communities can bring about emotional, psychological, and social well-being in addition to reducing their likelihood of

depression. Literature has shown that being skillful and effective in the healthcare profession can elicit positive emotions, such as satisfaction and fulfillment at work. This sense of accomplishment at work, in turn, can promote self-efficacy and give healthcare providers a sense of purpose. When healthcare professionals are also recognized and appreciated for their competence, they feel a sense of belonging and social connection in the workplace. Additionally, they are less likely to experience deficits in well-being, such as depression, because professional development helps healthcare providers to be better equipped in handling challenges and coping with stressors inherent in the profession [22, 23, 24, 25, 26].

This study revealed that relatedness in the workplace of physicians deployed in underserved communities can foster their emotional and social well-being, while involvement from their immediate supervisors can facilitate psychological and social well-being. Previous studies have shown that physicians feel less exhausted physically, emotionally, and cognitively when their need for relatedness is satisfied. For example, positive relationships in the workplace can reduce the burden of work-related stress and feelings of isolation. Receiving social support from colleagues and supervisors amidst the various challenges of working in an unfamiliar environment can also contribute to productivity and well-being. This social support includes engaging in meaningful interactions, feeling understood, and being appreciated [25, 27, 28, 29, 30]. Furthermore, physicians gain a sense of purpose and enjoy social well-being when they fulfill the public purpose of their profession, such as promoting the health of the community. By actively participating in efforts that address health disparities, they become agents of positive change in society [31].

Basic Psychological Needs Theory suggests that satisfying an individual's need for autonomy can lead to well-being because they perceive their actions as self-congruent and volitional. Self-governance is crucial for initiating and regulating one's behavior through which other needs can be better realized [6, 7, 32]. However, this study was unable to demonstrate such a relationship between autonomy and well-being among physicians assigned to underserved communities. Previous studies have also shown the unique contribution of autonomy to the well-being of physicians as non-significant [25, 30]. High ratings in the autonomy subscale by the surveyed physicians and the effect of culture can explain for this result [25, 32].

Among the confounding variables included in the regression analyses, workplace conditions (i.e., strength of cellphone signals, reliability of Internet connections, and lodging arrangements) and individual characteristics (i.e., program batch and previous diagnosis of mental health conditions) could adversely affect the well-being of physicians deployed in underserved communities or increase their likelihood of anxiety and depression.

Growing dependency on cellphones and the Internet could be attributed to feelings of loneliness and an increased need for social assurance [33]. Physicians whose lodging arrangements include their families exhibited higher anxiety levels, possibly because adapting to a new cultural environment can be challenging and may contribute to feelings of anxiety, especially if their families face difficulties in adjusting. They must also consider the well-being of their families while fulfilling their professional roles and responsibilities. Additionally, physicians deployed for a longer period in underserved communities experienced higher levels of anxiety, probably because of the pressure to attend to patients, who became close to them [34]. A previous diagnosis of mental health conditions also predisposed them to depression, as recurrence can occur when coping with challenges in a highly stressful environment becomes problematic [35].

6. LIMITATIONS AND FURTHER RESEARCH

This study had several limitations that could affect the generalizability of the results.

First, the study adopted an observational, non-experimental approach, limiting the ability to establish causation. While examining the relationships between variables, it cannot confirm that the observed associations are causal. Future research using longitudinal studies can provide more robust evidence. Conducting in-depth interviews or focus group discussions can also provide valuable insights into the nuances of needs satisfaction, support, and well-being.

Second, this study relied on self-report measures for variables, such as needs satisfaction, support, and well-being. Self-reported data may be influenced by social desirability bias, and participants might provide the responses they perceive as socially acceptable. The inclusion of objective measures or data triangulation could enhance the validity of the findings.

Third, the study focused on physicians from batches 38 and 39 of the Doctors to the Barrios Program in the Philippines. The generalizability of these findings to other healthcare contexts or populations may be limited. Future research should involve diverse samples to enhance the external validity of the results.

Fourth, the online survey used in the study may introduce a response bias, as participants who choose to respond may differ systematically from non-responders. Understanding the characteristics of non-responders can provide insights into the potential biases in the study's findings.

Finally, the online survey only garnered a 24% response rate. Future research could explore other strategies for recruiting more participants. Using a larger sample size can improve the generalizability of the results and

strengthen the ability of the study to identify significant associations.

7. CONCLUSION

This study provides insights into the likely influence of needs satisfaction and support, workplace conditions, and individual characteristics on the well-being of physicians deployed in underserved communities. The results highlight the critical role of meeting the needs for competence and relatedness in promoting the well-being of these physicians. The study also revealed the adverse influence of workplace challenges, such as unreliable cellphone signals and Internet connections, on emotional well-being. Living arrangements, program batches, and previous mental health conditions emerged as influential factors affecting anxiety and depression levels among physicians in these challenging environments.

The insights provided by this research contribute to the ongoing discourse on the well-being of healthcare professionals, especially those serving in underserved areas. The identified factors can inform targeted interventions and support mechanisms aimed at enhancing the work environment and mitigating the risks of anxiety and depression.

As global efforts continue to address health disparities and achieve Sustainable Development Goals related to good health and well-being, prioritizing the well-being of healthcare providers in underserved communities has emerged as a crucial aspect. Future research incorporating longitudinal designs and diverse healthcare settings can further enrich our understanding and guide the development of effective strategies for sustaining the well-being of healthcare professionals working in challenging contexts.

8. DECLARATION OF COMPETING INTERESTS

The authors declare that they have no conflicts of interest.

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