



Youth and decent work in the health and social care sector

An evidence synthesis

Youth Hub, Global Health Workforce Network, World Health Organization

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Abbreviations

GHWN	Global Health Workforce Network
ILO	International Labour Organization
LMIC	low- and middle-income countries
NEET	neither employed nor in education or training
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
UNDP	United Nations Populations Fund
WHO	World Health Organization

Executive Summary

Youth and decent work in the health and social care sector: An evidence synthesis

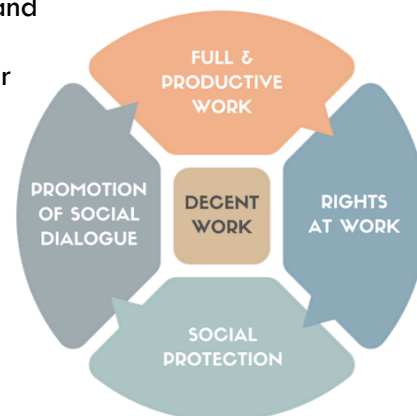
Purpose

This paper explores the available evidence base, context and reality of decent work for youth in the health and social care sector. Furthermore, it provides the foundation for advancing the substantive advocacy, education, research, policy and action agenda for decent work and youth in the sector, through the WHO-led Global Health Workforce Network (GHWN) and its thematic Youth Hub.

Background

Youth in the world today: The world has more young people than ever before. By 2020, it is projected that there will be over 3.5 billion people under the age of 30 [1]. Presently, there are 1.8 billion people between the ages of 10 and 24, and 89% of this age demographic lives in low- and middle-income countries [2]. With such a large population of young people around the world, an unprecedented window of opportunity for economic growth emerges – a demographic dividend [2]. A feature of this demographic dividend is that the working-age population is larger than the non-working age population; however, to capitalize on this dividend the right policies must be developed and implemented at the right time alongside significant, well-planned investment in young people [2]. Yet, there remain far-reaching challenges to employment for young people which has led United Nations organizations to highlight decent work for youth as a priority across programmes [3].

Youth and decent work: Work is central to the well-being of people and families over the life course. Youth often face unique and significant challenges to securing decent work. This includes difficult school-to-labour market transition periods, and high rates of employment in the informal economy which bars youth from the social protections of formal employment [4]. Unemployment and working poverty rates disproportionately affect young people globally and these trends have remained stable over the last decade. Some 71.1 million (13.1%) young people around the world are unemployed, and 158.5 million young workers live in extreme or moderate poverty (i.e. existing on less than US\$ 3.10 per day) [4]. The International Labour Organization (ILO) estimates that of the 21.8% of youth who are neither employed nor in education or training (NEET) globally, the vast majority are young women (76.9%) [4]. While the disproportionate distribution of NEET young women differs in magnitude geographically, this trend is present in every region of the world due to traditional gender roles and expectations of childbearing, marriage, and unpaid care labour that falls on women and girls [5]. Gender inequity continues to be a cross-cutting and complex determinant that impacts the economic and educational opportunities of young people around the world [5].



Youth working in the health and social care sectors. Over the last decades, the health and social sector has become the biggest employer of young people, and employment rates have risen faster for young people in this sector than any other age strata [1, 2]. This is reflected in nearly every country around the world regardless of the socio-economic context. The health and social care sector is expected to create 40 million new health worker jobs by 2030, each supported by an additional two supportive jobs with a total job creation potential for over 120 million [6]. These new jobs are mostly being filled by youth, women, and in particular by young women [4, 5, 7]

Gender and work. Gender inequity continues to be a cross-cutting and complex determinant that impacts the economic and educational opportunities of young people around the world [5]. Gender norms, biases, discrimination and violence remain instrumental in hindering the full occupational participation for women and those whose gender identity is outside of the binaries [5, 7, 8]. Notably, UNFPA's Gender Inequality Index demonstrates gender inequalities, which closely follows the proportion of young people within populations [2]. Any attempts to create interventions, implement employment strategies, and develop policy for young workers must use gender-transformative approaches that tackle the root causes of systemic gender-based biases and inequities that affect employment conditions, remuneration, career progression and leadership opportunities [4].

Youth engagement in the health and social care work agenda. In 2017, the inaugural Youth Forum was held at the 4th Global Forum on Human Resources for Health in Dublin, Ireland [9]. Students and early career professionals from the health sector and beyond gathered to voice their collective vision for the future of the health workforce. As an immediate response to the Youth Call for Action in 2017, the Global Health Workforce Network (GHWN) Youth Hub was created by the World Health Organization (WHO). From the group's conception to now, an inter-professional community of practice has convened, which focused on issues of work in the health and social care sector. The Youth Hub's strategic aims include driving youth-inclusive policy-making nationally, regionally and globally.

Key findings

1. Young and newly qualified health and social care workers face **alarmingly high rates of verbal, psychological, physical and sexual violence in the workplace** across the globe. Age and gender are often associated with increased exposure to violence.
2. **Gender stereotyping, bias, discrimination and violence** in the health and social care workforce are experienced by youth within both the training and work environments.
3. Students, new graduates, and young workers often **lack the social capital or power to respond, report or address experiences of discrimination based on gender, race, ethnicity, religion, and ability** within their work environments. These factors need to be at the center of the decent work research agenda to identify evidence-based strategies to mitigate them.
4. **Higher rates of burnout** are seen in younger workers, students and new graduates compared to in older and more experienced demographics of workers.
5. **Issues of work-life integration**, inadequate mentorship, occupational segregation and patriarchal work environments influence students and early career professionals' occupational decisions.
6. Students and new graduates across professions **often carry large debts from their training** which often **factors into career choices**.
7. **Mixed remuneration models** with a **core salary** component are preferred by early career practitioners as they allow for **better work-life integration**.
8. **Gender-transformative¹ policies and research** must be applied in the context of social security and adequate earnings due to the intersection with traditional gender roles and gender wage gaps.

Key Recommendations

1. **Increase investments in youth-responsive decent jobs and work conditions** at national, regional and local levels.
2. **Commit to developing and implementing national strategies for youth employment** in line with the Sustainable Development Goal (SDG) target 8.b.
3. **Apply a health systems approach for ensuring safe work environments** in terms of strategies and organizational interventions specifically targeted at youth and young professionals.
4. **Adopt gender-transformative and intersectional approaches to employment strategies and policies** for ensuring youth-responsive interventions, to ensure equity, impact and reach.
5. **Address and eliminate the root causes of inequity and barriers for youth** in terms of gendered pay gaps, leadership, representation and harassment.
6. **Establish mentoring and transition programmes** for trainees, students and graduates to demonstrate cost efficiencies in attracting, absorbing and retaining new entrants from the labour market
7. **Expand the research and evidence base on youth-inclusive issues** on the following key areas: a positive work environment for youth and early career professionals; the intersections of salaries, social protection and youth workers in the health and social sector; and gender-transformative approaches.- particularly within and across low and middle income countries (LMIC)
8. **Establish mechanisms for meaningful youth engagement on the decent work agenda** in all policy, planning and programming decisions at local, regional, national and global levels

¹Gender-transformative approaches include those that seek to promote equality by (a) fostering critical examination of inequalities and gender roles, norms, and dynamics; (b) recognizing and strengthening positive norms that support equality and an enabling environment; (c) promoting the relative position of women, girls, and marginalized groups; and (d) transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities

Youth in the world today

Today, the world has more young people than ever before. By 2020, it is projected that there will be over 3.5 billion people under the age of 30[1]. Presently, there are 1.8 billion people between the ages of 10 and 24, and 89% of this age demographic lives in low- and middle-income countries (LMIC) [2]. With such a large population of young people around the world, an unprecedented window of opportunity for economic growth emerges – a demographic dividend through youth[2].

One feature of the demographic dividend is that the working-age population is larger than the non-working age population; however, to capitalize on this dividend, policies must be developed and implemented at the right time alongside significant, well-planned investment in young people [2]. Yet, there remain far-reaching challenges to employment for young people which has led United Nations organizations to highlight decent work for youth as a priority across programmes [3].

YOUTH, DECENT WORK, & SDGs

- **TARGET 4.4:** By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship.
- **TARGET 8.6:** By 2020, substantially reduce the proportion of youth not in employment, education or training.
- **TARGET 8.b:** By 2020, develop and operationalize a national strategy for youth employment and implement the Global Jobs Pact of the International Labour Organization.

Figure 1. United Nations Sustainable Development Goals – decent work for youth.

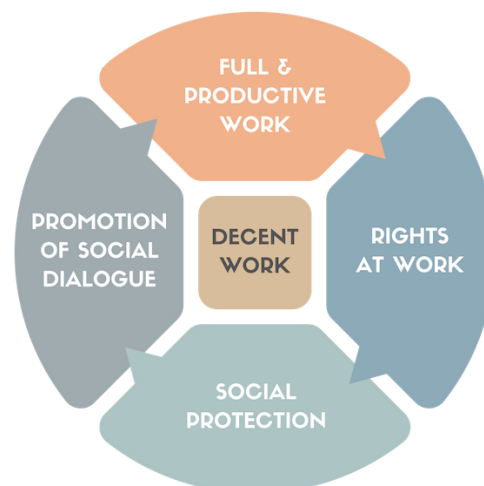


Figure 1. ILO components of decent work.

Youth and decent work

According to the International Labour Organization (ILO), decent work is “productive and delivers a fair income; provides security in the workplace and social protection for workers and their families; offers prospects for personal development and encourages social integration; gives people the freedom to express their concerns, to organize and to participate in decisions that affect their lives; and guarantees equal opportunities and equal treatment for all” (p. vi) [10]. Work is central to the well-being of people and families over the life course.

Youth often face unique and significant challenges in securing decent work. This includes difficult school-to-labour market transition periods, and high rates of employment in the informal economy which bars youth from the social protections of the formal economy[4].

Unemployment and working poverty rates disproportionately affect young people globally and these trends have remained stable over the last decade. Some 71.1 million (13.1%) young people around the world are unemployed, and 158.5 million young workers live in extreme or moderate poverty (i.e. existing on less than US\$ 3.10 per day) [4].

Working poverty is present across all regions where there is a greater prevalence of young people employed in informal jobs; 76.7% of young workers are employed by the informal economy compared with 57.9% of workers in older demographics [4].

ILO estimates that of the 21.8% of youth who are neither employed nor in education or training (NEET) globally, the vast majority are young women (76.9%) [4]. While the disproportionate distribution of NEET young women differs in magnitude geographically, this trend is present in every region of the world due to traditional gender roles and expectations of childbearing, marriage and unpaid care labour that falls on women and girls [5].

Gender and work

Gender inequity continues to be a cross-cutting and complex determinant that impacts the economic and educational opportunities of young people around the world [5].

Gender norms, biases, discrimination and violence remain instrumental in hindering full occupational participation for women and those whose gender identity is outside the binary [4, 5, 8, 9]. Notably, UNFPA's Gender Inequality Index demonstrates gender inequalities closely follow the proportion of young people within populations [2].

Any attempts to create interventions, implement employment strategies, and develop policies for young workers must use gender-transformative approaches. Those should tackle the root causes of systemic gender-based biases and inequities that affect employment conditions, remuneration, career progression and leadership opportunities [4, 5].

Youth working in the health and social care sector

Over recent decades, the health and social sector has become the largest employer of young people, and employment rates have risen faster for young people in this sector than any other age strata [3, 4]. For example, between 2005 and 2015, the proportion of youth in the health workforce has increased by 30.5% in Canada, 38% in the United Kingdom and Mexico, 90% in Colombia, doubling in the Philippines and the United Republic of Tanzania, while nearly tripling in Bangladesh [4]. This phenomenon is reflected in nearly every country around the world regardless of socioeconomic context.

The health and social care sector is expected to create 40 million new health worker jobs by 2030, each supported by an additional two supportive jobs with a total job creation potential for over 120 million [6]. Further, there is evidence to suggest that for every health care professional job that is created, two other jobs are created in other sectors. These new jobs are mostly being filled by youth and women, namely by young women [4, 5, 7]. Women make up nearly 70% of the health workforce globally, of whom half perform labour that is

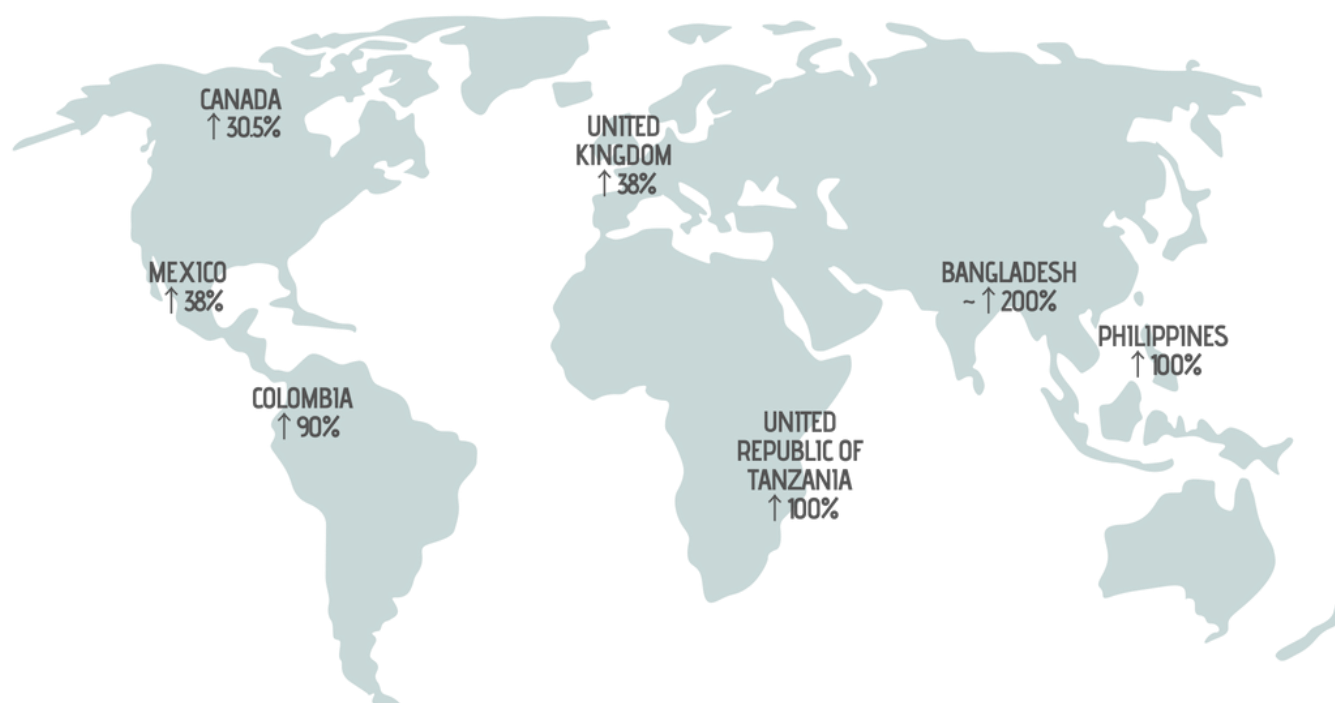


Figure 2. Proportion increase of youth employed in the health sector 2005–2015 (4).

unremunerated and unrecognized. This gap amounts to US\$ 1.4 trillion or 2.35% of the global gross domestic product [5, 6, 10, 11]

Gender inequity is widespread in all facets of the health and social care workforce, including occupational segregation, the safety of work environments, remuneration, decision-making and representation [5]. In order to ensure the sustainability of health systems globally, the impact of gender and age must be addressed in conjunction, given a women-majority and young health workforce.

Despite the expected growth of employment in the health and social care sectors, a shortfall of 18 million health workers is estimated by 2030 mostly in low and middle-income countries (LMIC) [3]. The High-Level Commission on Health Employment and Economic Growth called for an expansion and transformation of the global health workforce in order to reach the health-related SDGs by 2030 [3, 7, 11, 12].

Investment in the health workforce, and subsequent job creation, provides a substantial opportunity to avert the rising rate of youth unemployment. Consider the Africa region, where 70% of the population is under 30 years old. At present, the region has the highest youth unemployment rate and the lowest health worker density in the world [13].

Universal Health Coverage (UHC) will not be achieved by 2030 without the right investment in decent work for youth in the health and social sector. However, the right investments must be coupled with **youth-responsive gender-transformative policy-making** and to ensure a supported, fit for purpose and healthy workforce for today and tomorrow.

Youth engagement with the health and social care work agenda

In 2017, the inaugural Youth Forum was held at the Fourth Global Forum on Human Resources for Health, in Dublin, Ireland [9]. Students and early career professionals from the health sector and beyond gathered to voice their collective vision for the future of the health workforce.

The Call for Action emphasized the notion that youth in the health workforce are an essential stakeholder and play a vital role in the human resources for health agenda [9]. Furthermore, the call reiterated the commitment of youth to the human resources for health agenda to support the path to UHC and health for all [9].

As an immediate response to the Call for Action in 2017, the Global Health Workforce Network (GHWN) Youth Hub was created by WHO.

1. Engaging youth in relevant policy dialogues with their priorities being promoted across sectors nationally, regionally and globally.
2. Mainstreaming human resources for health as a focal area of work within institutional mandates of youth organizations.
3. Ensuring students and early career professionals are aware of their labour rights and have the capacity to advocate and negotiate for them on national, regional and global levels.
4. Supporting youth collaboration inter-professionally across sectors to address education and youth employment issues in the health and social sector.
5. Strengthening data and evidence on education and youth employment in health and social care and its connection to SDGs.

The Youth Hub is an inter-professional community of practice focused on issues of work in the health and social care sector. Its strategic aims include driving youth-inclusive policy-making nationally, regionally and globally.

Purpose of the review

The purpose of this report is to explore youth and decent work in the health and social care sector with specific attention to interventions, solutions and ways of addressing current challenges. The findings of this paper will be used to advance youth-responsive workforce action and support the substantive work of the Youth Hub across its five aims through advocacy, education, research stimulation and policy.

Within this report, the health and social care sector encompasses “all occupations that contribute towards improved health and well-being in the health and health-related social care sectors, and thus refers to the health and social workforce engaged in health care in all its deliverables” (p. 3) [14].

There is no singular definition of youth, even across United Nations organizations. The intention of this paper is not to purport a “best” or single definition. Rather the intention is to review literature that includes youth or young people, named by the researchers, as a population within their research.

Figure 3. GHWN Youth Hub aims.

Furthermore, we recognize that not all students and early career workers are “youth”, yet we posit that a large portion of this population globally is under the age of 35 years. Similarly, not all youth workers are students or early career workers. Our intention is not to define or separate these populations because often there are intersecting barriers that affect young people, those who are students, and individuals in their early career in the health and social care labour markets.

Methods

We utilized the National Collaborating Centre for Methods and Tools framework for rapid reviews [15]. Rapid reviews support the identification and evaluation of available evidence to support policy-making and programme planning similar to systematic reviews [15]. This approach allows for a review and synthesis of literature in a timely manner. As a first step for the Youth Hub, this method allows for an exploration of literature at the intersections of multiple concepts exploring key messages and strategies.

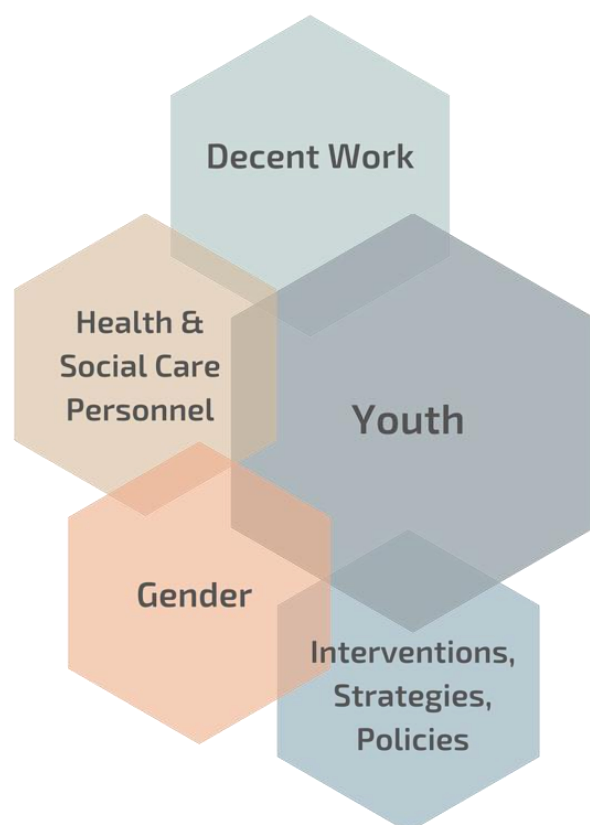


Figure 4. Search concepts.

Search strategy

The search strategy for this scoping review was developed from the ILO’s Decent Work Agenda (2008) that outlines four interconnected pillars that are priorities of decent work [10]. This includes job creation, rights at work, social protection and social dialogue. In addition, gender equality is included as a cross-cutting theme across the four elements.

These four core elements are expanded upon further into ten substantive categories of the Decent Work Agenda including:

1. employment opportunities;
2. adequate earnings and productive work;
3. decent working time;
4. combining work, family and personal life;
5. work that should be abolished;
6. stability and security of work;
7. equal opportunity and treatment in employment;
8. safe work environments;
9. social security; and
10. social dialogue, workers’ and employers’ representation [10].

With the support of a reference librarian, the four components of decent work (see Figure 6) were explored in the literature and used to develop a search strategy using major and minor headings in addition to abstract and title combinations. The databases used included CINAHL and Ovid MEDLINE, focusing in on the health, social and allied care literature.

Each of the four components of decent work was also searched separately with a specific focus on gender. It is important to note that the components in Figure 6 are often interrelated. Furthermore, the papers retrieved and summarized in this report are often interconnected.

Considering the plethora of literature published on decent work in the health and social care sector, limiters were applied including: literature between 2008 and 2019; and only in English. The authors recognize that these restrictions on years and language may have excluded pertinent literature. The Youth Hub hopes to include other languages in future reports with the expansion of membership. No restrictions were applied to the type of publication or research methods used in the results. After applying the search limiters, 746 results were reviewed by title and abstract.



Figure 6. Components of decent work searched.

Study selection

Firstly, all results were reviewed by title and abstract and were labelled as “include”, “exclude” or “uncertain”. For all literature labelled as include and uncertain, full text formats were retrieved and reviewed according to the criteria below.

In addition to focusing on a component of decent work, literature included in this report must meet at least one of the following criteria:

1. Focus on youth, students or new graduates as those delivering health and social care services.
2. Include age disaggregated analyses and/or results.

After the 746 results were reviewed by title and abstract, 140 were reviewed in full text, and 102 were met the criteria and were included in this report.



Limitations

As mentioned previously, an extensive body of literature exists on decent work within the health and social care sector, and much could not be included in this rapid review. In alignment with the intended purpose of this report, a wide exploration of themes was key to inform the substantive work of the Youth Hub across its pillars (advocacy, education, research stimulation and policy). However, in turn this review

reflects only a portion of an extensive body of literature. It is the hope of the authors to support focused reviews on specific elements in this literature to further examine the key findings in more depth and detail.

Defining youth: There is no common definition or conceptualization of “youth” or young workers in the

health and social care sector. This reveals a challenge in the divergent ways authors in the retrieved literature define concepts like “youth” or “new graduates”.

Additionally, this also challenged our ability to locate and include literature that included young people within their sample population when this group was not specified in the title or abstract.

Place and profession: No limiters were placed on disciplines, occupations, or professional groups. However, nursing and medicine represent the majority of the literature retrieved. A very limited number of results were found that focused on or included youth social care workers. Youth community health workers were widely underrepresented in the literature considering their vast population and impact across the globe. This has been identified as a possible site of collaboration with another WHO GHWN group – the Community Health Worker Hub.

Most of the literature found related to high-income or high-resource countries and contexts. There was a notable lack of results that examined rural and remote youth workers in the health and social care sector.

Educational/training literature: When searching for literature that includes the student and youth demographics, naturally, an abundance of results will focus on educational and training priorities and their implications. In an attempt to focus on work, literature on experiences in the context of education were excluded. However, this separation in the results was often nuanced. We acknowledge that there is significant overlap and entanglement between the concepts of work and education for students and youth particularly in the health sector.

Intersectionality: In exploring gender as a cross-cutting component of decent work, understanding how socially constructed factors such as race, class, ethnicity, gender identity, sexuality and ability intersect with youth workers in the health and social care sector is vitally important. However, the literature retrieved was significantly limited in the inclusion and exploration of intersecting social factors aside from gender. Not all youth face the same work experiences, just as older demographics do not all experience work in the same ways. Race, class, ethnicity, gender identity, sexuality, and other socially constructed factors must be explored thoroughly in the context of youth and decent work in the health

and social care sector in order to gain a comprehensive understanding of what and how interventions and policies can improve decent work for youth.

Findings

The following pages outline the findings in the literature on the four components of decent work in the health and social care sector. The specific component is defined in detail, key findings are shared, and recommendations for action made. More detail then follows on the key messages, recommended interventions, strategies and programmes outlined in the literature retrieved.

Equal opportunity and treatment in employment



Equal opportunity and treatment in employment is a cross-cutting element of decent work that refers to issues of social justice, including discrimination by gender, race, ethnicity, or against indigenous peoples, individuals with disabilities, and rural or migrant workers [16].

The ILO measures equal opportunity and treatment in employment by indicators including occupational segregation by sex, the gender wage gap, employment of persons with disabilities, and equal remuneration of men and women [16].

Key findings

- Experiences of gender stereotyping, bias, discrimination and violence in the health and social care workforce begin in training programmes and are experienced with a staggering prevalence by young and newly qualified workers.
- Issues of work-life integration, inadequate mentorship, occupational segregation, and patriarchal work environments influence students and early career professionals' occupational decisions.
- Students, new graduates and young workers often lack the social capital or power to respond, report and/or address experiences of inequity within their work environments.

- Gender, age (and other factors including race, ethnicity, religion, and ability) need to be at the center of research on decent work for ensuing strategies.

Recommendations for action

- Active and intentional mentoring opportunities that facilitate alignment between mentors and mentees on gender, specialization, ethnicity, race and other factors.
- Flexible hours and scheduling for training, residency and fellowship programmes should be explored to decrease occupational segregation.
- Family-friendly policies in training and work environments must be developed and implemented to support the well-being of individuals, families and the working lives of

those who have, or wish to have, children or have caregiving responsibilities.

- Reporting mechanisms, support for victims and zero tolerance policies

Findings

Opportunities for and treatment of workers within the health and social care sector are not equal. As discussed widely in global health today, gender is a major factor for decent work that is cross-cutting in each and every indicator. In global health, the intersections of age and gender in decent work are being discussed and studied to a lesser degree than the discourse occurring on the intersections of health and leadership. Some major themes in the literature focus on pregnancy and parenting, gendered violence and occupational segregation.

Much of the literature retrieved focuses on interventions for medical students, residents, and early career professionals via strategies for occupational segregation and underrepresentation of racialized populations in specialized fields. This includes both organizational and programme development in specialties like vascular, orthopaedic, neuro-, and cardiothoracic surgery fields as well as psychology [17-20].

Key strategies include early exposure to the field and programmes that include ongoing mentorship. In the United States of America, an orthopaedic summer programme was developed for medical students between their first and second years of training. The outcome of this programme were higher odds of both women and underrepresented groups applying to orthopaedic residency programmes after completing the 8-week programme [19].

For residents who are training in fields with significant occupational segregation or are underrepresented in their specific programme, social media has been identified as a potential tool to seek out mentorship and for networking. It offers the opportunity for residents to seek out same gender, sex, race, ethnicity mentorship for specialties that are often unavailable in large numbers at single institutions [20]. This underscores the importance of technology, not only for substantive training, as commonly thought, but also for expanding individuals' networks and building a community of support to navigate the experience of underrepresentation in a field.

to gender discrimination and violence should be implemented in the training and working environment.

Organizational programmes include subcommittees and taskforces on national and regional bodies developing formal mentorship networks, a speaker series and bureau, training grants, and the development of inclusive policies. For example, of particular significance is the creation of policies supporting safe working environments for pregnant surgical fellows and exposure to radiology [18].

Furthermore, it is imperative that policies for both pregnancy and parental leave (adoption included) during any stage of training in any profession be developed and implemented to support the well-being of individuals and families [21-25]. These policies should be tailored to the contextual needs of a programme and their populations and created through processes of engagement with youth workers in their programmes.

Pregnancy and parental leave need to be treated as empowered decisions that are supported by work and training environments for youth in the health and social care sector [24]. In Lebanon, a recent study found that pregnancy remains influential in the perceived and actual admission of interns to training programmes [26].

These policies need to be rights-based and supported by training and work environments in order to facilitate the well-being of individuals. The literature signals that family-centered policies need to consider not only leave, but flexible scheduling, part-time training opportunities, baby-friendly feeding environments, and on-site or at-home child care [27]. However, there is no one-size fits all. In the United Kingdom, part-time work was identified by early career pharmacists who are Black, Asian and minority ethnic women as a barrier to career progression [28].

Thus, the development of policies must address the ensuing implications after implementation for creating further inequity and discrimination for groups who already face multiple and intersecting barriers. The experiences of those in the health and

social care sector who are pregnant or newly parenting point to substantial barriers to well-being and work during this phase, particularly compounded by traditional gender roles for women [29-33].

Family-friendly policies are a significant component of equal opportunity and treatment for youth workers because of pregnancy and new parenting typically paralleling training or early career stages. Similarly, with many countries with ageing populations, family caregiving is also a key consideration for policy development and implementation as caregiving roles also often fall upon young women within traditional gendered roles [5].

Another key issue facing youth in the health and social care sector safe is work environments that include a high incidence of gendered discrimination and violence. Residents in Saudi Arabia found that female trainees face a significantly higher prevalence of sexual harassment than men [34]. A study based in the United States of America looking at sexual harassment among residents and medical students highlighted multiple barriers that stop victims from reporting; these include shame, poor treatment by the authorities, and fear of not being believed [35, 36][37].

Choo et al. describe the movements of #TimesUp and #MeToo within health care, identifying that sexual

harassment, gender pay gaps and violence against trainees are imperative issues to intervene on [38]. Person-centred policies for sexual harassment and violence need to be grounded in safe, trusting, well-resourced mechanisms for reporting and support. At Addis Ababa University in Ethiopia, a short-term intensive intervention was developed across students, educators and faculty to create a “bottom-up, top down” strategy for future action on gender equity [39]. Aside from this example, there is a dearth of literature on interventions and programmes targeting gender and youth in the health and social care workforce.

More research on existing and new strategies need to consider both gender and age as often associated factors with higher experiences of gendered discrimination and violence. We contend, however, that similar to wider society, gender bias, discrimination and violence are not experienced equally for groups with multiple intersections of marginalization, such as LGBTQ+ populations, people of colour, people with disabilities and new immigrants. Strategies at the intersections of youth and gender in the health and social care workforce must be developed and evaluated through an intersectional lens to ensure equitable and meaningful interventions are being implemented.

Safe work environments



are seen in younger workers, students and new graduates as compared to older and more experienced workers.

Safe work environments include any factors that are essential to the safety of workers and their protection from occupational hazards and risks [16]. The ILO measures safe work environments by indicators such as rates of occupational (fatal and non-fatal) injuries, time lost, and employment injury benefits [16].

Safe work environments within the health and social care sectors also include workplaces free from violence, harassment and bullying, that are supportive and healthy, maintaining safe workloads and limiting unwarranted occupational stress.

Key findings

- Higher rates of burnout are seen in younger workers, students and new graduates as compared to older and more experienced workers.
- Youth workers globally face alarmingly high rates of violence including verbal, psychological, physical and sexual violence. Age and gender are often associated with increased exposure to violence.

- Investments in safe work environments for youth workers yield significant cost savings, enable quality care, and the well-being of workers.
- Current issues for safe work environments in the health and social care sector cannot be treated merely as issues of youth; safe work environments for youth workers are issues of the health system.

Recommendations for action

- Implementation of policies and practices to ensure a safe and supported training and work environment.
- Strategies for building safe work environments must take a systems approach. They should target all levels of participants in care systems: from institutional administration to new workers, the public, and the infrastructure.
- Psychosocial, employment and professional mentorship must be made available to support transitions from training to employment and early career development.
- Successful interventions in the literature include curriculum development, programmes on resilience and mindfulness, transition and mentorship programmes, simulations and cognitive rehearsals.

Findings

A major implication of safe work environments is a healthy workforce. Globally, health and social care workers are facing serious challenges to their physical and mental wellness. A plethora of literature exists on the well-being of the health and social care workforce.

Stress and Burnout

Consistently, across the literature retrieved, higher levels of stress and burnout symptoms were reported in young workers, students and new graduates compared with other groups.

Burnout can be understood through three components specifically relating to the self and others within a work-stress context: emotional exhaustion, depersonalization and a reduction in the level of personal accomplishment [40].

Burnout has significant impacts on health outcomes including chronic fatigue, hypertension, sleep disturbances and headaches; similar health outcomes are seen in response to other personal stressors. In addition to the personal effects, burnout impacts organizations through absenteeism, turnover intention and low commitment to the organization [41].

Burnout affects youth workers, students and new graduates regardless of country, setting, profession, cadre or discipline. In South Africa, 31% of paramedic students suffer from burnout [42]. In Australia, radiography students report daunting levels of burnout or risk of burnout with 89% of students at the end of their first year exhibiting at least one symptom of burnout; increasing to 97% at the end of their third year [43]. Additionally, over 90% of first-year students report high levels of reduced personal accomplishment [43]. Health and social care workers entering the workforce are already exhibiting alarmingly high rates of burnout before entering an often difficult, transition to practice. Thus, there is a need to ensure interventions are occurring during training programmes for students.

In one study looking at plastic surgeons, burnout was found to affect residents considerably more than practising surgeons with low personal accomplishment scores at 42.22% for residents compared with only 7.5% of those in practice [44]. In China, burnout symptoms in physicians ranged from 66.5–87.8% with higher prevalence for younger physicians, and those who have fewer years of experience [45].

Similarly, age is a significant predictor of burnout in social work [46]. In the United Kingdom, 81% of early career social workers were found to be prone to burnout due to a hostile working environment where they had been either threatened or assaulted in the preceding year [47]. Similar findings were found among Canadian new graduate nurses, where 66% reported severe burnout related largely to poor work conditions [41, 48]

Often students are met with two different sources of immense stress; one stemming from the academic environment, and secondly from the clinical work environment [43, 49]. The transition from student to worker is associated with uncertainty, fear and feelings of incompetence [50, 51].

Other factors that compound anxiety included long working hours, adapting scientific knowledge to practice, limited contact with family and friends, poor support and lack of leisure time [50, 52, 53]. Unmanageable workload is another significant cause for burnout among this group [54].

Violence

Violence against health workers is an increasing problem that the health sector faces around the world. Workplace violence covers a spectrum of behaviours, from abuse, bullying, threats and discrimination to assaults [36]. The costs and implications of violence against health workers affects health systems, organizations, economies, and individuals. With a global health and social care worker shortage, recruiting, retaining, and supporting young people to continue working in this sector is vitally important. Safe work environments free from violence are a prerequisite for recruitment and retention of young health workers.

Studies from across the world show a high prevalence of workplace violence within the health and social care sector [54–65]. Age, gender and years of experience are highlighted across the literature as factors associated with higher levels of violence.

Nearly 84% of residents across three training hospitals in Saudi Arabia reported at least one type of harassment or discrimination [34]. A study from the United Kingdom reported that nursing students were assaulted significantly more than any other grade of

nurse in the psychiatric setting [49].

The perpetrators of violence vary by context. In Sri Lanka, over 90% of new dentistry students report emotional, physical or sexual violence perpetrated by senior student colleagues [66]. In Italy, nursing students reported violence being perpetrated by staff, teachers, supervisors and interdisciplinary colleagues [67]. Patients and the wider community are also identified in the literature as perpetrators of violence.

Underreporting of violence is described as common. Findings from the literature suggest that health workers believe reporting the event is useless, time-wasting and could lead to repercussions in the future [35, 68]. It is likely that most cases of violence are not formally reported, and the current prevalence represents only a small percentage of the overall picture. Policies of zero tolerance for violence in health and social care work perpetuated by patients, colleagues or those in positions of power must be coupled with safe, supportive and adequately resourced reporting mechanisms.

A study in Ethiopian public health facilities revealed that over half of participants stated there were no reporting procedures in place for violence [63]. While gaps in reporting procedures and infrastructure are detrimental to any individual facing violence, nurses aged 22–25 indicate four times higher odds of violence compared with those aged 36–52 [63].

Safe work environments are imperative within the rights of an individual, but also to recruit and retain new practitioners. In Canada, it is reported that 18–30% of new graduates will leave their current position or the profession in the first year, and this increases to between 37–57% in the second year [69]. This comes at a cost to the health and social care sector of approximately Can\$ 25 000 [69, 70]. There are major costs to the individual, the workforce and the health system if unsafe work environments are left unaddressed.

Differing interventions promoting safe work environments are outlined in the literature, focused both at the individual and organizational level.

Interventions

Successful interventions to address burnout, workplace violence and wellbeing are outlined below:

Panagioti et al. found that interventions to reduce burnout in physicians were limited in success when they were individually driven, but that better

outcomes were achieved from organizational interventions [71].

Interventions focused on individual psychological support or behaviour change include workshop programming on mindfulness and resiliency in practice and education [72–77]. A 10-week resiliency and mindfulness programme for medical interns in Australia led to reductions in stress and burnout [77].

A systematic review and meta-analysis on interventions to reduce burnout in physicians suggest only small benefits from individual-based interventions, suggesting that burnout is a systems-based issue that cannot be meaningfully targeted through individual interventions alone. Interestingly, these individual interventions were found to be less effective for younger physicians [71].

Institutional leadership, management and decision-making bodies in community or care facilities need to be considered participants in strategies to create safe and healthy work environments for youth workers in the health and social care sector. This includes significant roles by educators, administration and preceptors [48, 54, 75, 78–81]

Strategies for interrupting and addressing violence including bullying in the workplace include educational approaches in curriculum, simulation and cognitive rehearsal [75, 81–83]. Interventions in educational environments could yield strong outcomes for students because they are unaffiliated with clinical institutions at this stage [74]. An integrative review by Sidhu & Park names eight important concepts to inform how educational curricula can play a role in addressing bullying; these include: empowerment, self-efficacy, self-awareness, awareness about bullying, support, communication, collaboration and socialization [75]. Additionally, while not found in our review of the literature around youth workers, legal avenues must be available for those facing violence using a supportive, survivor-centered approach.

Mentored transition programmes including residencies and support programmes increased the intentions of newly graduated practitioners' intention to stay in their work environments and professions [20, 84–89]. A systematic review of mentoring programmes for new nurses identified positive outcomes for the mentor, mentees and organizations [88]

Those included improved wellness of practitioners, reduction of stress, and sustained impacts on anxiety, general health and self-compassion [84].

Mentored transition programmes are not only imperative for the positive outcomes on individuals and organizations but signal a substantial cost benefit making such programmes a smart return on investment [89]. A 3-year pilot project for nurse mentoring, included an estimated (minimum) cost saving over the period of the project of nearly US\$ 1.5 million [90]. Combinations of workshops, mentored programmes and clinical supervision support have shown positive results for most participants [91].

It should be noted that policies have been implemented in some countries to intervene on bullying, for health care worker protection. However, these policies have not been

evaluated widely or in the context of youth, student and new graduate workers.

With a young health and social care workforce globally and a higher prevalence of burnout and violence being faced by young, trainee and new graduate workers, interventions and strategies that support safe work environments will have impact today, and for years to come.

Social security and adequate earnings



than other sectors (8).

Social security refers to the supports, protections and benefits for workers when facing events and circumstances including illness, disability, parental leave, injury, unemployment, old age, health care, poverty and dependents [16]. The ILO measures social security by indicators such as old-age pensions, public social security expenditures, health care costs and out-of-pocket spending, sick leave and unemployment benefits [16].

Adequate earnings can be understood as a minimum living wage to all workers in exchange for productive work or income for those in need of social protection [16]. The ILO measures adequate earnings through indicators that include work poverty rates, low pay rates, hourly earnings and minimum wages [16]. Of particular importance is that the health sector, on average, has a larger gender pay gap

Key findings

- Students and new graduates across professions often carry large debts from their training and this is often factored into career decisions such as specializations and job selection.
- Mixed remuneration models with a core salary component are preferred by early career practitioners as they allow for better work-life integration.
- Gender-transformative policies and research must be applied in the context of social security and adequate earnings given the intersection with traditional gender roles and gender wage gaps.

Recommendations for action

- Further research is needed on the intersections of salaries, social protection and youth workers in the health and social sector, particularly in LMICs.
- Record, recognise, redistribute, remunerate, and reward women's unpaid work in health and social care.
- Exploration of diversified remuneration schemes.
- Social security protections promoting work-life integration for workers are urgently needed.
- Ensuring that entry-to-practice wages across professions do not deter individuals from entering particular specialisations or professions.

Findings

The area of social security and adequate earnings is of emerging interest in the study of the health workforce. However, this area for youth health workers in particular is an under-researched area and must evolve as a body of literature in order to reflect policy and practice requirements [92]. Little was found in the literature on the identification of strategies and interventions that specifically explore or examine the impacts on the youth demographic.

Adequate earnings

The retrieved literature supports the notion that young health care professionals prefer consistent payment based on salaried work; young doctors prefer contracts where they are paid by fixed income rather than dependent on the amount or type of activities performed (such as fee-for-service) [93-95]

Typically, early career health professionals seek financial stability and diversified remuneration options to suit their lifestyle.

Higher salaries were identified as a key factor for deciding to migrate by college and specialist nursing graduates in Serbia [96]. Salaries must also be considered in relation to country contexts and incentives to migrate [97]. Low salaries were also identified by student nurses as a key challenge to practising in India [98]. Migration of young health workers is a major consideration for health and social sectors within countries both at both ends of the movement, however, scant literature is available on the topic specifically for the youth demographic.

In Singapore, students perceived the salary of nurses to be too low compared with other health care professionals; this study highlighted the need to make new graduate salaries in nursing comparable to other health care professions to ensure sufficient recruitment to the nursing workforce [99].

Student loans and Debts

Not only are salaries for new graduates identified in the literature as an issue, but student loans and debts affect many students and new graduates across professions.

In 2016 the Association of American Medical Colleges reported that 76% of medical graduates had an average debt of US\$ 190 000 [100]. Notably, in the United Kingdom, it is estimated that physicians are unlikely to be able to fully repay their

student loans over the course of their working lives, with female physicians being disproportionately less likely [101]. There has been a trend towards a significant and increasing gender pay gap between newly trained physicians in New York State which signals that the repayment of student loans may be a topic for further research examining gendered influences on remuneration and social security [102].

The nursing literature has discussed the challenges of nursing student debt [103]. Not only is debt a concern for the workforce, but it was identified as an impediment to returning to school for further education [103].

Student physical therapists in the United States loan debt stands at US\$ 96 000 [104]. Dental school graduates have among the highest amounts of debt, which causes additional stress to students [105, 106]. Remuneration and salaries are key considerations for education and career trajectories when leaving training with debts having an effect on individuals' well-being during training and after graduation [105, 107]

Interventions

Of the few strategies retrieved through this review, most were rural incentive programmes, training grants and pay-for-performance schemes.

Pay-for-performance schemes offer an alternative approach to fee-for-service models [108-110]. In Canada and Mozambique incentive programmes for nurses and various care health professionals have been used as a potential intervention for staffing in rural areas [111, 112]. For new general practitioner graduates in Australia, rural incentives increased the entries to rural practice settings [113].

One prominent example of a policy intervention with unintended consequences is the implementation of new contractual agreements for junior doctors in the United Kingdom, introduced by the National Health Service [114]. The new contractual agreement increased the working hours and, further, included working over the weekends in addition to putting in place a new payment scheme [115]. A survey that targeted the junior doctor (intern) workforce in the second year showed that as a result of the new contractual agreement more

than 20% of respondents changed their intended specialties, mostly shifting from community-based practice to hospital-based; 30% of those who intended to pursue the general practitioner track reported changing to different specialty tracks [116]. Within the context of models of care moving towards community-based, primary health care, these trends have concerning implications. It is important to note that female majority occupations and professions tend to have less societal value within the health and social care sector that impacts wages and remuneration. Similarly, as more women enter male-dominated occupations or specializations wages tend to fall.

Additionally, this policy signals the need for true and authentic meaningful youth engagement in policy-making in the health and social care sector.

Remuneration and diversified options must be rethought in order to strengthen workforce retention and quality from the beginning of training and early career roles to suit individual needs [94]. This incentivizes young professionals and matriculating students to be open to all aspects of health work [94, 95]

Future research needs to be focused on LMICs to provide the needed evidence to support youth to enter and remain in the health and social care workforce, accounting for and addressing the unique challenges and opportunities in those countries. Much of the current available literature on young health professionals both in or about to enter the formal system are studies conducted in western, high-income countries.

Even though education and training are key policy directions, major attention must be focused on decent working conditions for that young, women-majority workforce in order to support workers, patients and communities.

Meaningful Youth Engagement

Effective and strategic youth-inclusive policies will have sustainable effects. Not only will youth-inclusive policies support the challenges facing global health today, but they will also yield impacts far into the future for youth and for the health of populations.

This opportunity requires meaningful youth engagement in policy-making through the provision of dedicated, representative, self-organized, accountable and rights-based approaches [117]. It is

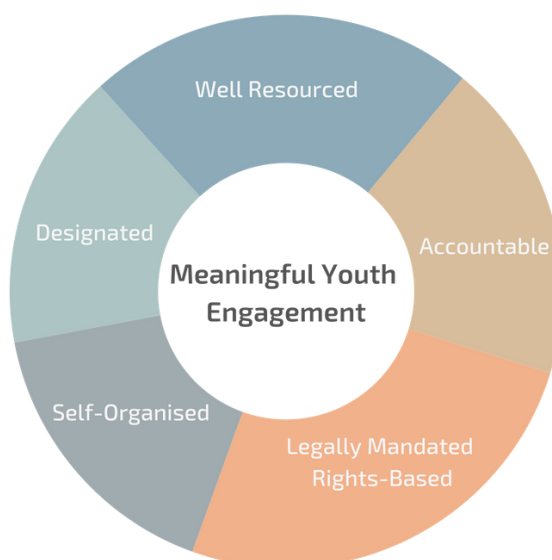


Figure 5. United Nations Major Group for Children and Youth – Principles of meaningful youth engagement (120).

through these meaningful engagement processes that youth can rightfully participate and shape policies affecting their present and future. Health workforce planning and policy-making must put youth as a priority in all their programmes of work.

Conclusion

Achieving UHC and the SDGs will require massive expansion of the global health workforce, particularly in LMICs which have the greatest health needs and shortages of health care workers [3, 7]. The future workforce required to deliver UHC and the SDGs will be young, and women-predominant.

Although, the identified literature provides an overview of the context and strategies for youth and decent work in the health and social care sector, there remain significant gaps. The literature is focused on high-income countries and largely on health disciplines such as nursing and medicine as opposed to social work, community health workers, and other social care occupations.

Research agendas need to emerge across LMIC where shortage of health workers, higher disease burden, higher youth unemployment rates, and the largest population of youth reside for evidence-informed policy. As largely absent from our search, focus needs to be placed on rural, remote, conflict, and post-conflict contexts of work, in particular for young women.

The vast majority of the literature retrieved described, analysed and explored the challenges present for youth and decent work in the context of the health and social care sector; there was less focus

on solutions, interventions and best practices—in particular, organizational or system-level interventions or programmes.

In conclusion, there is no health without the health workforce, no health workforce without youth, and no youth without decent work.

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