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Essential, Yet Precarious, Mistreated, Sick and Medicalized: A Sequential Explanatory Mixed-Methods Study on Homecare Aides in Spain

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ABSTRACT

Background: Homecare aides (HCAs) are professional non-family caregivers, who support dependent individuals to live at home with dignity; yet in Spain they remain understudied and vulnerable, often facing precarious working conditions. We aimed to characterize HCAs' employment, living conditions, health, and exposure to workplace violence and harassment, considering migrant background as a key axis of inequality.

Methods: We conducted a sequential explanatory mixed-methods study. Quantitative data came from an online respondent-driven sampling survey of 324 HCAs across Spain, with stratified analyses by migrant background. Qualitative data were obtained through three focus groups and analyzed using qualitative content analysis. Findings were triangulated during interpretation.

Results: The findings suggest that precariousness extends beyond the workplace, affecting everyday life, social relationships, and health. Quantitative results showed poorer health, higher exposure to workplace violence, and greater drug use among migrant HCAs. While the qualitative data did not fully account for these differences, they offered insight into possible underlying mechanisms, such as physically demanding work and lack of resources. Qualitative findings also confirmed greater exposure to different forms of violence and sexual harassment among migrant HCAs, while revealing broader gendered patterns of violence affecting the occupation as a whole.

Conclusions: A vicious circle of poverty, poor health, and workplace violence/discrimination emerges, described by HCAs as their being "poor and enslaved." Migration background influences inequalities, but widespread structural precariousness tends to homogenize experiences, while gender dynamics further shape vulnerability. Urgent intersectional policies are needed to ensure decent work and protect HCAs' health and rights.

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1 | Introduction

The provision of care and support for people in situations of dependency is one of the main challenges for social policies in high-income countries. In Spain, as in other EU countries, a substantial share of this care continues to be provided informally within households by family members or other informal caregivers, most of whom are women, in a context of a “care crisis” marked by population ageing and rising functional dependency [1]. These demographic and social changes led to the approval of Law 39/2006 on the *Promotion of Personal Autonomy and Care for Dependent Persons* (LAPAD), which established the National System for Dependency and a catalog of benefits that includes telecare, day and night centers, residential care and, notably, the Home Care Service (Servicio de Ayuda a Domicilio, SAD).

The SAD is conceived as a service within the public social services network that enables dependent people to remain in their homes through personalized, preventive and rehabilitative interventions, including personal and psychosocial care, domestic support and assistance to families. The service is publicly owned (mainly by municipalities, within primary social care services) but may be managed either directly or indirectly through contracts with private companies or third-sector organizations. This configuration results in a model of “public ownership, predominantly outsourced provision” that shapes both service quality and the working conditions of its workforce [2]. Alongside this publicly owned circuit, and because of the inability of the public service to provide care to all people in need of support, there also exists a parallel market of fully private home-care services, directly contracted and financed by households, which further contributes to the heterogeneity of employment conditions in the sector. Consequently, “professionalized” home-care services may be provided by: (1) the public administration itself (currently the least common arrangement); (2) a private company subcontracted by the administration (the most common form); or (3) a company operating entirely in the private market.

HCAs, the cornerstone of home-care services regardless of the ownership and provision model, play a key role in safeguarding users’ autonomy and enabling them to remain at home. HCAs are home-care workers who typically work alone and provide care in multiple clients’ homes, performing all necessary tasks at each site before traveling to the next. They provide support to older adults, people with disabilities, those with chronic illnesses, and individuals with cognitive impairment in activities of daily living. Their tasks include bathing, dressing, eating, toileting, exercising, reminding users to take their medication, assisting them in moving around the home, and performing light housekeeping and basic shopping, all in accordance with a previously developed individual care plan. Unlike informal caregivers (family members or people providing care without a formal contract), all HCAs are formally accredited and employed by a company under an employment contract. However, this workforce is shaped by gender, class and ethno-racial inequalities that contribute to the invisibility and unequal distribution of care work [3–7]. That HCAs’ work is often performed in isolation within private households [5, 6] fosters vulnerable settings that may act as catalysts for workplace

violence or harassment [8]. In Spain, the HCA workforce appears to encompass at least two distinct profiles [9]: (a) Spanish-born women with extensive experience, all of whom hold a professional certificate, in some cases granted through an earlier administrative process that recognized prior work experience; and (b) migrant women, also certified, but with less experience, which, according to data compiled from official sources, may account for approximately 30% of all HCAs [10].

Over the last two decades, regulatory efforts have been made in Spain to further professionalize this occupation, setting accreditation criteria and deadlines so that all staff obtain a formal qualification, which requires specific theoretical and practical training in home-based hygiene and health care, domestic support and family nutrition, and psychosocial support and care. Nevertheless, successive extensions of these deadlines and difficulties in meeting service demand have favored the recruitment of staff without complete training, often on part-time contracts and at low wage levels [6]. Such challenges are not only rooted in the economic and political domains, but also in the prevailing cultural norms surrounding who is expected to provide care and in what manner. Traditional gender norms play a crucial role in shaping the social meanings of care, hindering both a fair redistribution of care responsibilities between sexes and the formal recognition of care work as a fully professionalized sector. All of this keeps open the tensions between the growing formalization of care and its persistent assignment as an extension of women’s domestic labor [3, 6].

This incomplete professionalization process is particularly relevant in Spain, where the growing demand for long-term care is expected to increase the need for paid care workers in the coming years [11]. In this context, migrant women have played a central role in filling care gaps, especially in domestic and home-based care, within a care regime historically characterized by limited formal provision and strong reliance on family and migrant labor [12, 13]. This makes migrant background a theoretically relevant axis of stratification when examining HCAs’ overall occupational situation.

Despite their essential contribution, particularly evident during the COVID-19 crisis, research in Spain on HCAs’ working and living conditions, health, and exposure to violence remains scarce. Existing studies are mostly qualitative and describe this occupation as invisible, feminized, and precarious [6, 9, 14–16], while quantitative evidence is practically non-existent. To the best of our knowledge, only two quantitative studies to date have focused on this group, both using convenience samples [17, 18]. One of them [17] compares 20 occupations, most of them classified as essential or frontline during the pandemic, and finds that HCAs display some of the poorest working conditions and health outcomes, including the highest prevalence of psychotropic and opioid analgesic use. These findings suggest that HCAs may represent an extreme case of labor-market disadvantage, even within broader groups already exposed to poorer working and employment conditions, such as women and manual workers.

The lack of research on this group in Spain may be partly due to the difficulty of accessing this population, as HCAs work in

private homes. In addition, many homecare services are outsourced by local governments to private providers, which often show little interest in facilitating research on working conditions. Against this background, we developed the *CuidémoNos* project, a multidisciplinary study of HCAs' employment and working conditions, workplace violence and health status. As part of this project, we previously published a paper [19] showing that HCAs' harmful working conditions were characterized by a heavy workload, a lack of technical resources and autonomy, few opportunities for professional advancement, and labor management practices that force HCAs to work in isolation. Taken together, these findings point to a form of home care employment characterized by multiple disadvantages, within a sector marked by low professional recognition and poor employment and working conditions. These disadvantages may be further shaped by migrant background, given the central role of migrant workers in home-based care and their greater exposure to labor market vulnerability and discrimination. The current paper therefore addresses the following research question: What are the key characteristics of HCAs in Spain in terms of living and employment conditions, health, and exposure to workplace violence and harassment, and how are these characteristics shaped by migrant background?

To answer this question, we adopt a sequential explanatory mixed-methods design (QUANT-QUAL), combining quantitative data (collected through strategies tailored to reach hidden populations) with qualitative insights. By integrating these perspectives, we sought to capture both structural dynamics and lived experience and to develop an interpretive framework for understanding the context of HCAs in Spain, while also highlighting the intensified challenges faced by those with a migrant background.

2 | Materials and Methods

2.1 | Study Design

We conducted a sequential explanatory mixed-methods design [20] because integrating quantitative and qualitative data enables a more comprehensive understanding of complex phenomena [21, 22]. A mixed-method, sequential explanatory approach allows us to examine the distribution of living conditions, employment conditions, health, and experiences of violence among HCAs, to assess whether these issues are more pronounced among migrant workers, and to gain an in-depth understanding of HCAs' perceptions of these dimensions. First, we collected and analyzed quantitative data from an online survey and, subsequently, we carried out focus groups to deepen our understanding of the dimensions explored in the questionnaire [21, 22].

2.2 | Data Collection

2.2.1 | Quantitative Data

We performed an observational cross-sectional study based on a sample collected using respondent-driven sampling (RDS) in its online version, WebRDS, by means of an online survey. This sampling method relies on several assumptions: (1) social ties

are reciprocal; (2) the population forms a single connected network; (3) sampling occurs with replacement; (4) participants can accurately report their personal network size; and (5) recruitment within personal networks is random. If these assumptions are met, RDS has the potential to produce asymptotically unbiased and efficient estimates for hard-to-reach populations or those without a sampling frame, potentially achieving greater representativeness [23, 24].

The study population comprised HCAs who were either working or on sick leave at the time of data collection, with a minimum of 3 months of work experience in this role. The fieldwork was preceded by a formative research phase involving a literature review, interviews, and focus groups, carried out with the support of the Plataforma Unitaria SAD, a national homecare aides' association. This phase informed the seed selection and ensured diversity in age, gender, migratory condition, size of the municipality where the service is provided, and type of employment contract. Fieldwork was conducted between April and June 2022. Data collection covered socio-demographic characteristics, living and working conditions, exposure to workplace violence and harassment, physical health, burnout [25, 26], and drug use. The final sample included 324 HCAs. Readers interested in delving into the details of the WebRDS implementation used in this study can refer to [27].

2.2.2 | Qualitative Data

Participants were purposively selected to constitute three focus groups. Inclusion criteria included being employed in Spain under an HCA contract, either as the participant's sole job or complemented with other jobs and having at least 3 months of experience. Focus groups were formed based on purposive sampling, aiming for maximum variability in terms of age, sex, company (public or private), employment contract (permanent or temporary), working day (full or part-time) and geographical area of work. The research question had a twofold purpose: to describe employment and living conditions, health status, and exposure to violence and harassment among HCAs, but also to explore whether these experiences differed among migrant HCAs. Consistent with this, the groups were: (a) Stakeholders (current HCAs), with a background in political and social activism, to provide a contextual perspective and a comprehensive view of the sector; (b) Female migrant HCAs, as they constitute a particularly vulnerable group; (c) Men, to explore possible differences in employment conditions and exposure to violence, because they work in a highly female-dominated sector traditionally associated with women. The inclusion of this focus group intended to provide contextual insight into gendered patterns within the sector. No financial compensation was offered. The stakeholder group was a mixed group of eight HCAs; the men's group consisted of four participants; and the migrant HCAs group included five women (Table 1). We recruited HCAs from across Spain with the support of the Unitary Platform of Home Care Assistants (Plataforma Unitaria SAD in Spanish): a group formed mainly through social media that unites SAD professionals in Spain to highlight their work, dignify the profession, and demand labor rights. Due to the WebRDS method, it was not possible to ensure that participants in the qualitative phase also took part in the quantitative

TABLE 1 | Participant characteristics by focus group.

	Total (n = 17)	Stakeholders (n = 8)	Male group (n = 4)	Immigrant group (n = 5)
Age, n (%)				
36–50	8 (47.1)	1 (12.5)	4 (100)	3 (60)
51–60	6 (35.3)	4 (50)	0 (0)	2 (40)
> 60	3 (17.6)	3 (37.5)	0 (0)	0 (0)
Sex, n (%)				
Women	13 (76.5)	8 (100)	0 (0)	5 (100)
Men	4 (23.5)	0 (0)	4 (100)	0 (0)
Immigrant status, n (%)				
Spanish	12 (70.6)	8 (100)	4 (100)	0 (0)
Foreigner	5 (29.4)	0 (0)	0 (0)	5 (100)
Geographic work area, n (%)				
Rural (< 10,000)	1 (5.9)	0 (0)	1 (25)	0 (0)
Intermediate (10,000–500,000)	13 (76.5)	7 (87.5)	3 (75)	3 (60)
Urban (> 500,000)	3 (17.6)	1 (12.5)	0 (0)	2 (40)
Years of professional experience in HCS, n (%)				
< 10 years	3 (17.6)	0 (0)	2 (50)	1 (20)
10–20 years	10 (58.8)	5 (62.5)	1 (25)	4 (80)
21–30 years	4 (23.5)	3 (37.5)	1 (25)	0 (0)
Company type, n (%)				
Public	4 (23.5)	3 (37.5)	1 (25)	0 (0)
Private	13 (76.5)	5 (62.5)	3 (75)	5 (100)

Abbreviation: HCS, home care service.

survey; therefore, the linkage between both samples was conceptual rather than at the respondent level. The qualitative sample was purposively selected based on the WebRDS formative work [27] and on quantitative findings showing differential distributions by migrant background.

Between June and July 2022, online focus groups were conducted online via Microsoft Teams. We chose to conduct the groups online given the geographical dispersion of the HCAs who agreed to participate. The qualitative phase was designed to deepen the understanding of the quantitative results (precarious employment conditions, multiple health problems, high levels of medicalization, and high exposure to violence and harassment) and to explore whether the experience of migrant HCAs were even worse. All sessions were audio recorded and transcribed verbatim. Code saturation was achieved after a single round of focus groups [28]. Each session lasted an average of 140 min. Data saturation was achieved by repeated responses in focus groups [29].

2.3 | Data Analysis

2.3.1 | Quantitative Analysis

Weighted percentages were estimated using the RDS-II estimator with bootstrap-based 95% confidence intervals (95% CI). We evaluated convergence of all estimates across recruitment waves through convergence plots (Figures S1 and S2 in the

supporting information). Analyses were conducted using the RDS package [30] in R software version 4.4.1. Stratified analyses by country of birth were performed to explore potential inequalities related to migrant background. The variable “Country of birth” was dichotomized into “Spain and Western countries” and “Other countries,” the latter including individuals born in Latin America and the Caribbean, Eastern Europe, and Africa (Table S1 in the supporting information). Where available, reference values from population-based surveys were included in the result tables to contextualize the findings through comparison with indicators from other relevant population groups.

2.3.2 | Qualitative Analysis

Content analysis was used as the analytical approach. Two researchers (R1 and R2) independently read and reread the field notes and transcripts. Subsequently, R1 conducted the initial coding of the focus group transcript in discussion with R2 until consensus was reached. Based on the agreed coding criteria, R1 then proceeded to code the remaining transcripts. In cases of uncertainty, coding decisions were again discussed and resolved by consensus. The data were then cleaned and organized hierarchically into themes [31]. The criteria for organizing the material into themes were their suitability for explaining, expanding or contrasting the numerical results, and their repeated presence [32, 33] (Table 2). However, we also sought variability and conceptual significance: we included themes or categories

TABLE 2 | Overview of the coding process.

Theme	Categories
Employment and living conditions: qualitative data	• Poor working with “no life at all”
Health and drug use: qualitative data.	• “Poor and enslaved”: they are going to kill us with work • Employment Conditions Shaping Health and Well-being • Accumulated Effects of Work on Pain and Medication Use
Discrimination, violence and harassment: qualitative data	• Gender differences in the expression of health complaints • Differences in cases of violence and harassment based on migration status • Gender-based violence and discrimination

that showed diversity of experiences or that highlighted substantive features of the phenomenon. To ensure rigor, the final results were discussed with the other researchers who had not been involved in data collection or initial analysis. A working draft was shared with them for feedback [34]. Data management and qualitative analysis were conducted using ATLAS.ti software.

2.3.3 | Data Integration

In this study, data integration was carried out at both the methods and interpretation stages. At the methods level, integration was achieved through merging [20], combining the quantitative and qualitative datasets to provide an overall picture of the HCAs’ context in Spain and how it is shaped by migrant background. The quantitative and qualitative findings were then presented in a single report but in separate sections: first, the quantitative results on employment conditions, exposure to violence and physical health, and on how migrant background shapes or exacerbates this context [20, 35]. During the interpretation phase, both types of results were triangulated by R1, R2, R3 and R4, and jointly discussed in order to obtain an overall, integrated understanding. To do this, the quantitative and qualitative findings were brought together in a joint display (Table 3) to visualize relationships between quantitative and qualitative data. Joint displays facilitate triangulation by allowing the systematic visualization of convergence and divergence between quantitative and qualitative results [36]. In this study, the joint display was used to link the distributional patterns observed in employment and living conditions, health status, and experiences of violence and harassment with HCAs’ qualitative accounts, thereby enhancing the explanatory value of the qualitative findings.

3 | Results

3.1 | Sociodemographic, Employment and Living Conditions: Quantitative Data

Table 4 summarizes the estimated sociodemographic, employment and living conditions profile of HCAs based on RDS weights. The vast majority are women (95.2%) and over 40 years old (78.5%). Population references place this profile within a highly feminized and relatively older occupational group compared with the overall salaried population. It is estimated that one third were born outside Spain, a proportion closer to that

observed among salaried manual women than in the overall salaried population.

The table also shows a profile marked by economic vulnerability and precarious employment conditions. A sizeable proportion of HCAs reported material deprivation: 11.5% lack access to a basic protein-based meal every 2 days, and 24% have relied on informal or institutional support for basic needs in the past year. Most are employed by outsourced private companies (78.3%), with only 2.5% directly employed by the administration. Wages often fail to cover household needs (80.3% vs. 32.8% in the overall salaried population). Although most HCAs had permanent contracts (76.4%), as also observed in the population references, full-time employment was much less common: only 35.2% worked full-time, compared with 85.0% of the overall salaried population and 65.7% of salaried manual women.

By migrant background, the results suggested a more disadvantaged profile among migrant HCAs across several dimensions. Compared to HCAs born in Spain and Western countries, migrant HCAs appeared to be slightly younger and tended to report having children in their care more often, while they seemed less likely to care for elderly or sick relatives. They also tended to report lower salaries, greater material deprivation, and more frequent combination of HCA work with other jobs. Part-time contracts also appeared to be more common among migrant HCAs.

3.2 | Health and Drug Use: Quantitative Data

Table 5 shows that HCAs report a prevalence of poor self-rated health (43.1%) that is approximately twice as high as that observed in the overall salaried population and among female manual salaried workers. Chronic or long-term illness or health problems affected 44.3% of participants, a prevalence slightly below national estimates. Chronic musculoskeletal disorders affect 37.6% of HCAs, primarily involving pain in the shoulders, neck, and/or upper limbs (25.9%). Metabolic conditions were reported in 14.9%, with high cholesterol being the most common (8.3%). Around two thirds of HCAs are classified as experiencing moderate or severe burnout, while possible burnout alone accounted for 12.3%.

Use of tranquilizers, sedatives or sleeping pills in the past 30 days is reported by 42.8% of HCAs, clearly above the figures observed in the Spanish general population (9.7%) and among

TABLE 3 | Integrated joint display of employment, living conditions, health, and exposure to violence and harassment in HCAs.

Quantitative variable	Key quantitative finding	Related qualitative categories	Integrated interpretation
Sociodemographic, employment and living conditions			
Material deprivation/ Salary insufficient	High material deprivation (24%); 80.3% report salary does not cover needs	Poor working with “no life at all;” “Poor and enslaved”	Quantitative and qualitative findings converge in showing that economic precariousness is pervasive and extends beyond income, shaping everyday life through deprivation. Qualitative findings suggest that it is difficult to detect differences among migrant workers and non-migrant workers in their subjective accounts.
	Migrant HCAs: Material deprivation: 33.4%; 85.4 report insufficient salary	—	
Working time/ Precarious employment	64.8% part-time; majority subcontracted (Precarious employment)	Poor working with “no life at all;” “Poor and enslaved”	Precarious contracts and fragmented time intensify instability, shaping daily life beyond work. Qualitative findings suggest that poor employment conditions are so widespread that they tend to standardize the experiences of HCAs.
	Migrant HCAs: part-time: 75.4%	—	
Health and drug use			
Self-rated health & burnout	43.1% poor health; high burnout	Employment conditions shaping health and well-being	Qualitative findings show that health outcomes are driven by pervasive poor employment conditions affecting all HCAs rather than individual characteristics.
	Migrant HCAs Poor self-rated health: 48.1%; Burnout moderate-severe: 66.2%	—	
Musculoskeletal disorders & drug use	High prevalence of pain and analgesic use	Accumulated effects of work on pain and medication use	Pain and medication use emerge as cumulative effects of prolonged exposure to physically demanding work environments.
	Migrant HCAs: Musculoskeletal disorders: 52.8%; Opioids painkillers: 39.3%	—	
—	—	Gendered expression of distress (physical vs. psychological)	Qualitative data extend the analysis by revealing gendered patterns in the experience and expression of health problems (physical vs. psychological), adding dimensions not captured quantitatively.
Violence and harassment			
Workplace violence	High prevalence of verbal violence (50.4%)	Differences in verbal violence by migrant status	Qualitative findings contextualize violence as shaped by structural vulnerability (migrant status)
	Migrant HCAs Verbal violence: 58.6%		
	—	Gender-based violence and discrimination (not examined quantitatively)	Qualitative findings explain verbal violence through gender norms.
Sexual harassment	16.2% reported harassment	Differences in violence by migrant status	Sexual violence and harassment emerged as a major problem, with specific vulnerabilities among migrant HCAs.
	Migrant HCAs 25.8%		

TABLE 4 | Profile of HCAs by sociodemographic, employment and living conditions.

	Overall <i>n</i> = 324 RDS percentage (95% CI)	Reference values		Spain and western countries <i>n</i> = 259 RDS percentage (95% CI)	Other countries <i>n</i> = 62 RDS percentage (95% CI)
		#1	#2		
Sex					
Male	4.8 (2.1–7.6)	52.3 (a)		5.8 (1.7–9.8)	2.9 (0.9–4.7)
Female	95.2 (92.4–97.9)	47.7 (a)		94.2 (90.2–98.3)	97.1 (95.2–99.0)
Age					
< 40 years old	21.5 (7–36)	39.1 (a)	38.9 (b)	20.6 (4.9–36.4)	24.0 (0.0–45.0)
40–54 years old	55.2 (45.9–64.5)	43.2 (a)	41.7 (b)	52.3 (43.7–60.8)	60.5 (21.2–82.0)
> 54 years old	23.3 (10.3–36.3)	17.7 (a)	19.4 (b)	27.1 (13.0–41.2)	15.5 (1.8–62.7)
Country of birth					
Spain	67.1 (57.6–76.5)	79.5 (a)	68.2 (b)	—	—
EU-15	1.6 (0–4.3)			—	—
USA	0.2 (0–0.7)			—	—
Other	31.2 (22–40.4)	20.5 (a,c)	31.8 (b,c)	—	—
Dependents (in the personal sphere)					
None	51.9 (36.9–66.9)			52.9 (36.6–69.2)	48.2 (14.8–81.7)
Children under 6 years old	23.2 (12.4–34)			17.2 (5.3–29.1)	37.0 (6.3–67.8)
Elderly persons not fully autonomous	17.6 (6.5–28.7)			21.3 (9.9–32.7)	9.7 (0.0–41.2)
Persons with disabilities	7.3 (1.9–14.3)			10.0 (2.2–18.8)	1.8 (0.0–17.0)
Persons with chronic illnesses	4 (2.5–17.3)			3.2 (2.2–19.3)	5.9 (0.0–28.4)
Material deprivation					
Indicator 1: No (d)	11.5 (1.2–21.9)	5.4 (e)		12.3 (5.0–33.9)	10.1 (6.9–73.1)
Indicator 2: Yes (f)	24.0 (9–39)	11.0 (g)		20.2 (4.6–35.8)	33.4 (0.0–68.0)
Service municipality size					
< 10,000 inhabitants	26.7 (10.9–42.5)			28.0 (10.8–45.2)	23.4 (0.0–46.1)
10,000–100,000 inhabitants	34 (21.6–46.5)			32.1 (17.5–46.7)	39.7 (19.8–79.6)
> 100,000 inhabitants	39.2 (24.9–53.6)			39.9 (24.4–55.5)	36.8 (10.5–60.5)
Employer					
Private company	19.2 (9.2–35.1)			16.7 (7.1–31.1)	24.4 (10.0–63.4)
Subcontracted private company	78.3 (59.4–86.7)			80.1 (59.3–87.7)	74.5 (35.6–89.6)
Public administration	2.5 (1.6–13.2)			3.1 (1.6–18.1)	1.1 (0.0–8.0)
Salary covers basic household needs					
Always/Many times	19.7 (12.4–27)	67.2 (h)	48.5 (i)	21.9 (10.8–33.0)	14.6 (1.9–57.3)
Sometimes/Only once/ Never	80.3 (73–87.7)	32.8 (h)	51.5 (i)	78.1 (67.0–89.2)	85.4 (42.7–98.1)
Moonlighting					
Additional non-HCA job	9.5 (3.4–18.4)	2.7 (a)	2.9 (b)	7.9 (0.6–17.8)	13.9 (6.9–55.5)
Works exclusively as a HCA	90.5 (81.6–96.6)	97.3 (a)	97.1 (b)	92.1 (82.2–99.4)	86.1 (44.5–93.1)
Seniority as a HCA					
< 3 years	25.3 (17.6–33.1)			24.4 (15.6–33.1)	28.5 (3.2–53.9)
3–10 years	34.8 (23.4–46.3)			36.8 (22.8–50.8)	32.0 (10.8–53.1)

(Continues)

TABLE 4 | (Continued)

	Overall <i>n</i> = 324 RDS percentage (95% CI)	Reference values		Spain and western countries <i>n</i> = 259 RDS percentage (95% CI)	Other countries <i>n</i> = 62 RDS percentage (95% CI)
		#1	#2		
> 10 years	39.8 (29.2–50.5)			38.8 (25.7–52.0)	39.5 (16.2–62.8)
Employment contract					
Permanent	76.4 (69.4–83.4)	77.1 (a)	70.8 (b)	75.4 (65.8–85.0)	77.7 (58.0–97.3)
Temporary	23.6 (16.6–30.6)	22.9 (a)	29.2 (b)	24.6 (15.0–34.2)	22.3 (2.7–42.0)
Working time					
Full-time	35.2 (20.5–49.9)	85.0 (a)	65.7 (b)	40.1 (23.4–56.8)	24.6 (6.9–73.6)
Part-time	64.8 (50.2–79.6)	15.0 (a)	34.3 (b)	59.9 (43.2–76.6)	75.4 (26.4–93.1)

Note: (a) Own elaboration based on Spanish Labor Force Survey, second quarter of 2022. Salaried workers. (b) Own elaboration based on Spanish Labor Force Survey, second quarter of 2022. Salaried manual women. (c) It does not distinguish between Western and non-Western countries. (d) Can your household afford a meal with meat, chicken, or fish (or a vegetarian equivalent) at least every two days? (e) Own elaboration based on Living Conditions Survey, 2022. (f) In the last 12 months, has your household had to turn to relatives, friends, or any non-profit or religious organization to provide food, clothing, or other basic goods (or money to acquire them)? (g) Own elaboration based on Living Conditions Survey, 2020. (h) Own elaboration based on Panel OTS, first quarter of 2023. Salaried workers (25–64 years old). (i) Own elaboration based on Panel OTS, first quarter of 2023. Salaried manual women (25–64 years old). EU-15, the 15 member states of the European Union before the 2004 enlargement: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and the United Kingdom; USA: United States of America.

Abbreviations: HCAs, Home-care aides (HCAs); RDS, Respondent-Driven Sampling (RDS).

women in general (12.1%). Use of anti-inflammatory drugs or non-opioid analgesics is reported by 76.7% of participants, while opioid analgesic use reached 25.8%, also clearly exceeding population reference values.

By migrant background, burnout and the use of tranquilizers, sedatives, or sleeping pills appeared to be broadly similar among migrant HCAs and those born in Spain or other Western countries. However, migrant HCAs tended to report a poorer physical health profile across several indicators. The use of painkillers also appeared to be more frequent among migrant HCAs than among those born in Spain or other Western countries (39.3% vs. 19.5%).

3.3 | Workplace Violence and Harassment: Quantitative Data

Table 5 also presents the prevalence of workplace violence and harassment reported by HCAs. Verbal violence is experienced by one in two HCAs (50.4%), while physical violence is reported by one in 10 (10.1%). In the previous year, 16.2% of HCAs reported having experienced of one or more episodes of sexual harassment at work. By migrant background, verbal violence and sexual harassment tended to be more frequent among migrant HCAs.

3.4 | Employment and Living Conditions: Qualitative Data

This section is grounded on the quantitative finding that HCAs experience precarious employment and living conditions. The qualitative findings revealed to what extent this precariousness permeates and shapes their daily lives.

3.4.1 | Poor Working With “No Life at All”

Their working days are so exhausting that they eliminate any possibility of a personal life. Their precarious employment

conditions go beyond the workplace, affecting their daily lives and impacting their family and social relationships. As a result, HCAs identify themselves as working poor—people with no life of their own.

We're working poor; we can't even afford the 'luxury' of going to the cinema, it's as simple as that. (...) Lots of colleagues have an undeclared job, because with a part-time contract of 25 h, which is six hundred-and-something euros, if they're single mothers with young kids to support, they really can't make ends meet and have to look for extra work in the afternoons, as long as they don't have a split shift. And if they do have a split shift, they work at weekends, so there's no work–life balance—in fact, there's no life at all

(P2_GF_Stakeholders)

They experience a constant sense of exhaustion and a lack of control, which affects their overall well-being. For many, their wage is the only income entering the household, either because they are separated and live alone with their children, or because their husbands remain in their countries of origin. Poverty is such that many of them have to turn to organizations such as Cáritas Española or the Red Cross to ask for food.

It's the way this sector is organized (...) it's just wicked what they've done to us. It's so well set up that all the elements come together: we're women, many of us separated, with family responsibilities, in precarious jobs, with a double or triple work burden, so poor we have to go to charity food banks. I've got colleagues who go to the Red Cross and to Cáritas to ask for food, just to be able to eat, and it's always the same.

(P1_GF_Stakeholders)

TABLE 5 | Health status, drug use and violence and harassment experiences among HCAs.

	Overall <i>n</i> = 324 RDS percentage (95% CI)	Reference values		Spain and western countries <i>n</i> = 259 RDS percenta (95% CI)	Other countries <i>n</i> = 62 RDS percentage (95% CI)
		#1	#2		
Health status					
Self-rated health (fair, poor or very poor)	43.1 (28–58.2)	19.1 (a)	24.2 (b)	40.2 (23.2–57.2)	48.1 (13.2–82.9)
Chronic or long-term illness or health problem	44.3 (29.6–51.1)	48.5 (a)	53.7 (b)	40.7 (23.7–53.6)	55.4 (13.5–97.3)
Chronic musculoskeletal disorder (≥ 1 of the following)	37.6 (23.8–51.4)			32.1 (15.2–48.9)	52.8 (11.0–94.6)
Muscular pain in shoulders, neck and upper limbs	25.9 (12.4–39.4)			22.9 (7.9–38.0)	34.4 (3.4–79.1)
Back pain	24.2 (11.1–37.3)			26.0 (10.5–41.6)	20.8 (2.1–68.3)
Lower limb pain	23.1 (10.5–35.7)			19.9 (5.8–33.9)	32.0 (0.9–66.0)
Tendinitis	10.8 (4.8–23.6)			6.8 (4.7–24.7)	21.2 (1.5–63.1)
Epicondylitis	4.9 (2.1–15.9)			4.9 (1.1–20.8)	5.0 (1.3–39.8)
Chronic metabolic condition (≥ 1 of the following)	14.9 (8.3–30.6)			13.1 (6.9–37.2)	19.9 (1.3–54.4)
High cholesterol	8.3 (2.7–16.5)			6.7 (1.2–23.4)	12.6 (1.0–40.8)
Hypertension	4.8 (2.1–19.5)			6.3 (1.8–25.3)	1.4 (0.9–28.0)
Obesity	3.6 (0.4–10.8)			2.6 (0.2–13.9)	6.0 (0.0–39.3)
Diabetes	2.0 (0–12.0)			1.7 (0.0–9.8)	3.0 (0.0–24.0)
Burnout (moderate or severe) (c)	63.8 (52.7–74.9)			63.3 (50.1–76.6)	66.2 (39.0–93.4)
Burnout (severe) (d)	12.5 (8.3–31.9)			12.6 (7.6–36.8)	12.8 (0.0–39.1)
Drug consumption (past 30 days)					
Tranquilizers, sedatives or sleeping pills	42.8 (27–58.6)	9.7 (e)	12.1 (f)	41.2 (23.3–59.0)	45.2 (6.2–84.3)
Anti-inflammatories or non-opioid analgesics	76.7 (65.5–88)			74.6 (61.5–87.6)	82.9 (0.5–51.6)
Painkillers (opioids)	25.8 (11.9–39.6)	4.0 (e)	4.8 (f)	19.5 (3.8–35.3)	39.3 (9.4–69.2)
Violence and harassment (past 12 months)					
Experienced verbal violence at work (at least once)	50.4 (34.9–66)			47.1 (29.8–64.4)	58.6 (24.0–93.1)
Experienced physical violence at work (at least once)	10.1 (4–23.8)			10.2 (4.3–23.2)	10.4 (0.5–42.5)
Experienced sexual harassment (at least once)	16.2 (5.4–26.9)			12.0 (3.7–24.6)	25.8 (0.0–48.9)

Note: (a) Own elaboration based on Spanish Health Survey, 2023. Salaried workers weighted by sex, age and occupational class according to Spanish Labor Force Survey. (b) Own elaboration based on Spanish Health Survey, 2023. Manual salaried women weighted by age according to Spanish Labor Force Survey. (c) Work-related Copenhagen Burnout Inventory score ≥ 50. (d) Work-related Copenhagen Burnout Inventory score ≥ 75. (e) Survey on alcohol and other drugs in Spain, 2022. Men and women (15–64 years old). (f) Survey on alcohol and other drugs in Spain, 2022. Women (15–64 years old).
Abbreviations: HCAs, Home-care aides; RDS, Respondent-Driven Sampling.

3.4.2 | “Poor and Enslaved”: They Are Going to Kill Us With Work

Participants clearly stated that they have “no life at all” and even went further, warning that “they are going to kill us with work.” Stakeholders, migrant women and men alike described themselves as “slaves” or argued that their working conditions are close to what could be considered a form of modern slavery.

It's illegal, you're supposed to have some rest time. It can't be like this; we're not slaves, we're workers.
(P1_GF_MigrantWomen)

You're a complete slave, really... anyway. You kind of fool yourself (...), because I do like it, I've always worked in caring for people.
(P2_GF_MaleHCAs)

Not with public money, and not by making people precarious and effectively enslaving another person.
(P6_GF_Stakeholders)

The intense and continuous nature of the employment and working conditions contributes to a sense of exploitation, resulting in a feeling of “slavery” and exhaustion caused by the work. They describe their employing conditions as deplorable, yet emphasize that this is the only job they have and that they fear losing the only source of income available to them.

They're going to work us to death. We're going to end up as users of the service at the same time as we're working in it. Because none of us is going to make it to 67 (...) I see it day after day: my colleagues who are over 60 are on sick leave. In their early fifties they're already off sick, they retire while on sick leave.
(P8_GF_Stakeholders)

I don't have a full-time contract, which means I'm going to end up as a poor pensioner, even more precarious than I am now while working (...) I don't want that future.
(P7_GF_Stakeholders)

But there are a lot of people who are afraid, you know? They're really scared because it's the only thing they've got.
(P2_GF_MigrantWomen)

Precarious employment and working conditions led to a persistent sense of poverty and powerlessness, making workers feel “poor” and deprived of their fundamental rights.

3.5 | Health and Drug Use: Qualitative Data

Quantitative results indicated worse self-reported health and drug use among migrant HCAs but did not examine gender differences because the small number of male participants did not allow for systematic gender comparisons or causal

inference. The qualitative data provided insight into the general mechanisms underlying perceived health and drug use, but did not identify any possible explanations of the poorer outcomes among migrant HCAs. However, it does examine gender differences.

3.5.1 | Employment Conditions Shaping Health and Well-Being

All HCAs (men, women, regardless of their place of origin) enjoy caring and they like older people, but many reported feeling burned out or overwhelmed because of their employment and working conditions. Health status and drug use are shaped primarily by employment and working conditions. Participants clearly attribute their poor health and unhealthy habits to harmful labor conditions.

Sometimes it's people from outside, the coordinators, other people, and sometimes even the users themselves or their relatives who wear us down, you know? And by the time you get home, you're already completely burned out.
(P1_GF_MigrantWomen)

So in the end, you're just in this constant stress, like “I'm not going to make it, hurry, hurry, hurry,” right? That constant rush... You have to eat your sandwich running from one house to the next.
(P2_GF_Stakeholders)

Why do we have depression, why do we have anxiety, why do we struggle with low self-esteem? Because we are the working poor.
(P8_GF_Stakeholders)

3.5.2 | Accumulated Effects of Work on Pain and Medication Use

Pain and medication use emerge as cumulative effects of prolonged exposure to precariousness, long working careers, lack of mechanical aids, demanding working and bad employment conditions. HCAs with longer work experience report persistent, widespread pain in their arms and a general deterioration in health, often starting the day with ibuprofen. Several workers stated that their health was good during the first 10 years on the job, but progressively worsened due to the physical strain involved, particularly when lifting or transferring clients without mechanical aids and performing these tasks alone. In contrast, HCAs with fewer years of experience or who are assigned to services that do not involve mobilizing or bathing dependent individuals generally do not report musculoskeletal pain. However, they do mention issues related to poor eating habits.

The first thing in the morning is ibuprofen, to endure the pain in my shoulders.
(P2_GF_MigrantWomen)

I'm 54 years old (...) I've been on sick leave many times. It started with my knee. Then it was my back, and later it

ended up being my arm, and so on. Until about 9 years into the job, I was doing great, I felt wonderful. At that time, there were no hoists yet, no assistive equipment. So, it was our bodies doing all the work, and I ended up broken.

(P5_GF_MigrantWomen)

I have degenerative osteoarthritis in my cervical spine, I suffer from fibromyalgia, and since November (...) I've been under investigation by a neurologist who suspected I might have multiple sclerosis or ALS (...) After all the tests, I was diagnosed with neuropathy in my legs and arms, due to my job.

(P7_GF_Stakeholders)

After years of service, pain becomes a constant presence in their lives, something they are forced to manage either on their own or by seeking care at specialized pain clinics. In fact, some report such poor health or such widespread chronic pain that they consider applying for disability benefits. However, this is often not a viable option, as the resulting pension would be insufficient to cover their basic needs and those of the dependents in their care.

Because you're in pain (...) You go [to the pain clinic] just to relieve it, and when I go there, I think, damn, I'm getting sick... and it's not even like you can say, "Well, I'll end up messed up at 50, 60, 40, 30 or even 20 years old (...) I'll get a disability pension of €600 or €700 and maybe I can study or find another job to combine with." No, on top of everything they give you €380, €400, at most €500—it's impossible. You can't afford it. And for someone close to 55, they only get 75% of the regulatory base.

(P8_GF_Stakeholders)

3.5.3 | Gendered Expression of Distress (Physical vs. Psychological)

Physically, nearly all participants reported experiencing musculoskeletal problems, with many HCAs continuing to suffer from tendinitis, widespread pain, or cervicalgia. In focus groups, HCAs frequently highlighted issues such as low self-esteem, anxiety, and stress. The differences HCAs, both men and women, were mainly related to how the illness manifested and was expressed, rather than to how often they fell ill. Both male and female HCAs report experiencing musculoskeletal issues and widespread pain. However, male HCAs tend to emphasize physical discomfort over psychological or emotional distress, while female HCAs more frequently report mental health concerns such as anxiety, stress, and other non-physical symptoms in addition to physical ailments.

My arms hurt—my coworkers will know what I mean. But they must be hurting every day (...) it's something I've gotten used to, this daily pain.

(P1_GF_MaleHCAs)

And another characteristic of homecare aides in Madrid—and I think across all of Spain—is low self-esteem.

(P8_GF_Stakeholders)

When men are part of the workforce, task assignment often differs by gender, leading to distinct health risks. Men are typically assigned to care for dependent individuals and occasionally perform basic home maintenance, whereas women are predominantly tasked with domestic chores such as housekeeping and meal preparation.

It was in a service I shared with a female colleague, caring for a person with morbid obesity (...) She did the washing and the man—me—handled the transfers. The women wouldn't do it, only us (...) But it's true they gave us more of the heavy lifting than the women. I mean, they assigned us to do the mobilization tasks just because we were men.

(P3_GF_MaleHCAs)

3.6 | Discrimination, Workplace Violence and Harassment: Qualitative Data

The quantitative findings identified that HCAs' experiences of violence at work were highly diverse, and migrant background was associated with greater exposure to violence and harassment. However it did not examine gender differences because the small number of male participants. The qualitative findings reinforced the patterns of violence identified but also revealed the existence of gender-based verbal violence discrimination. On top of this, the lack of institutional support in cases of aggression or harassment heightens the vulnerability of all HCAs, specially for migrants workers.

3.6.1 | Differences in Cases of Workplace Violence and Harassment Based on Migration Background

Women HCAs frequently faced different types of violence, including sexual harassment. However, among women migrant HCAs, violence as a topic came up spontaneously in focus group, suggesting that it was a relevant and deeply rooted issue in their day-to-day working lives.

...from that point on, just because I'm Black, someone even called me "a stupid Black woman"...

(P4_GF_MigrantWomen)

Verbal abuse often targeted the color of their skin or country of origin, and in some cases, they were outright denied entry into the homes. Instances of sexual harassment included being offered money in exchange for sex or being inappropriately touched.

Just being immigrants already brings problems. Then, being women also brings problems. Because when we go to provide a service to a man, an elderly man, maybe with dementia, here comes the sexual harassment issue.

Like, "I'll give you €10, €20," or things like that. It's always the same story.

(P3_GF_MigrantWomen)

It was a case of sexual harassment. He [the user] just wanted to have sex, that's it (...) I've even been locked inside a house before (...) That's what us foreign women deal with, I mean, where I live that's what we deal with.

(P3_GF_MigrantWomen)

When workers report incidents to their coordinators, they are often ignored unless the situation escalates to physical violence or sexual harassment. In cases of sexual harassment, the solutions vary: sometimes the worker is replaced by another female colleague; other times, the task is reassigned to a pair of HCAs or to male homecare aides, if available.

Like, when I complain to the company, they just change the worker. And I go, no, that's not the issue. The issue is talking to social services, to the family, so they see what's actually happening.

(P3_GF_MigrantWomen)

Here in Murcia (...) there were many cases of sexual harassment. I don't know if the order came from the City Council or the company, it was a few years ago (...) now they don't assign men to us; male users are now given to male colleagues.

(P2_GF_MigrantWomen)

3.6.2 | Gender-Based Workplace Violence or Harassment

Male HCAs report experiencing discrimination based on their gender, particularly when some clients refuse to allow them into their homes simply because they are men. They were turned away many times because "they didn't want to be assisted by a man."

It hurts me psychologically when you won't open the door after 12 years, or when I have to justify that just for being a man, they either want you or they don't for the job—or that you're supposed to understand it, because of the way people used to be raised...

(P1_GF_MaleHCAs)

The violence suffered by male HCAs was primarily verbal in nature, such as the use of disrespectful language, questioning of their role, and derogatory comments. These experiences, rather than physical or sexual violence, are linked to gender norms that challenge the presence of men in the caregiving profession. Many of these workers feel marginalized and report that this mistreatment negatively impacts their mental health and overall well-being.

I was washing the dishes and a man, a user, came up to me and said: "look at that fucking faggot, doing the dishes—get out of my house"

(P2_GF_MaleHCAs)

That they would understand that a man can also do any job just like any woman, right? I mean, I actually wasn't accepted anywhere. It was like, "this guy is not coming in here." They'd put you in a really humiliating position, because you'd show up at the house with the female worker... And well, they just didn't want you.

(P1_GF_MaleHCAs)

4 | Discussion

This is the first mixed-methods study to describe the employment and living conditions, health status, and exposure to workplace violence and harassment among HCAs in Spain. The findings reveal a highly vulnerable group, characterized by precarious working conditions, poor health, high levels of medicalization, and frequent exposure to violence and harassment at work, despite their essential role in an ageing society. If, in addition, they have a migrant background, the situation is even worse.

The quantitative results suggested differences by migrant background, whereas the qualitative analysis did not point to substantial differences in employment, living, and health conditions or medication use between migrant HCAs and native-born HCAs. Qualitative findings suggest that poor employment conditions are so widespread that they tend to standardize the experiences of HCAs, making it difficult to detect differences among migrant workers and non-migrant workers in their subjective accounts. In fact, all HCAs in the focus groups reported similar experiences of precarious employment and high medicalization, suggesting that structural aspects of work shape daily life regardless of origin.

As in other contexts [37–39], HCAs in Spain are mainly women over 40, with a high proportion of migrants and low wages. From an intersectional perspective of the social determinants of health, HCAs constitute a vulnerable workforce that requires special attention from public health policies. Their adverse context is exacerbated by job precariousness, as highlighted by the results of our study. A substantial proportion of HCAs are limited to part-time contracts with salaries that often fail to cover basic household needs. Moreover, although many of them report that they would like to supplement their wages with an additional job, the irregular schedules and the high physical and psychological demands of their HCA work usually make this impossible in practice. Altogether, this situation locks them into a cycle of poverty and material deprivation, further intensifying their precariousness and vulnerability. HCAs themselves report a worsening of their already precarious conditions because of the outsourcing of dependency care services by public administrations. At present, most HCAs are employed by private companies operating under a public–private model, with limited oversight regarding occupational health and safety. This lack of regulation worsens their working conditions, an issue also identified in the Spanish residential care sector [40]. In the case of home-based care, the situation may be even more severe, given that their workplace is the private household, where occupational risks are rarely, if ever, assessed.

Sexual violence and harassment emerged as a major problem, with a pattern suggesting greater vulnerability among migrant HCAs. Several factors have been identified as determinants of this violence. A recent systematic review points out that violence is more likely when caregivers attend to users with mental health problems, addictions, or limited mobility [41]. Other contributing factors include reduced domestic spaces or the absence of clearly defined individual care plans, both of which increase the risk of abuse [42]. Situations of violence and harassment at work reflect a structural issue within the sector that affects both women and men, although their specific manifestations differ by gender. Qualitative findings revealed gendered patterns in experiences of violence, underscoring gender as a key structuring factor. Women appear to be more exposed to various forms of violence, particularly sexual violence. In contrast, for male HCAs, performing tasks typically associated with female roles can challenge their masculinity in the eyes of some users and family members, exposing them to dismissive attitudes, verbal abuse, or diminished social recognition [43]. Migrant HCAs spontaneously explain violence situations while this didn't happen in stakeholder group. Evidence suggests that HCAs tend to view violence as "part of the job" when it is associated with dementia or medication: aggressive behaviors tend to be seen as symptoms of the disease rather than as abuse [42]. Violence is internalized and accepted as part of the professional role. HCAs cope emotionally with these incidents and tend to assume that they must "endure, manage, and prevent" violence rather than acknowledging and reporting it; thus, in the long term, this idea places the responsibility on the worker herself rather than on the organization [42]. Violence is systematically swept.

Given this occupational environment, characterized by harmful working and employment conditions and frequently situated within highly vulnerable contexts that can lead to workplace violence or harassment, HCAs exhibit severely deteriorated physical and mental health, in line with findings from other authors [38, 44–46]. Many HCAs mention musculoskeletal and mental health problems, which is consistent with previous literature in Spain [9, 14]. Consequently, and confirming previous results based on non-probabilistic samples [17], the use of tranquilizers, sedatives or sleeping pills and painkillers is excessive, more than four times higher than in the general population, resulting in a highly medicated workforce. Despite experiencing pain, many HCAs continue working. Qualitative findings pointed to gender patterns in the manifestation of health problems. Female workers, who make up the majority of the workforce, tend to report psychological symptoms (such as stress or burn-out) more frequently, while male workers focus more on physical symptoms associated with physical exertion and functionality [42]. These differences are interpreted in relation to gender norms that influence how illness is perceived and communicated [42].

The lack of occupational risk assessments, combined with harsh economic conditions, often prevents them from even considering applying for disability benefits, either because mutual insurance companies systematically fail to recognize the occupational origin of their health problems, or because the benefits they would receive are insufficient. As a result, many resort to medication, often self-administered, to manage their pain and

remain on the job, a phenomenon known as sickness presenteeism. This behavior has been linked to long-term physical ailments and mental exhaustion, with significant consequences for both the workers and the healthcare and social protection systems [47].

Overall, the results of this mixed-methods study suggest that migrant background appears to play an important role in shaping inequalities, while also being closely interconnected with the structural conditions and gender dynamics that shape HCAs' experiences. Generally speaking, the increased vulnerability of HCAs lies at the intersection of gender, race, and social status [5]. Unlike low-income native-born individuals, migrant caregivers (who are also from disadvantaged social classes) are often perceived as guests in the host country and are denied full citizenship status. These structural disadvantages reinforce their subordinate position within families and institutions, creating asymmetrical power relations between caregivers and care recipients. In turn, they perpetuate vulnerability and social exclusion, particularly among migrant workers [48]. Thus, racism is structured through various logics of action, among which are the logic of inequality, which functions to justify the economic exploitation of certain groups; the logic of difference, which perpetuates mechanisms of segregation; and the logic of gender-based discrimination, which directs structural inequality particularly toward women, with a heightened impact on those who are migrants or racialized [49]. It should be stressed that the migrant HCAs included in this study are in a regular administrative status and have established roots in Spain. Beyond this group, however, in the care sector, there are care workers in even more precarious circumstances, marked by informal employment and the absence of a regular residence permit, with some even living in the home of the person they care for. These situations likely intensify workers' harmful exposures and may amplify migrant-related inequalities to their most extreme form.

Finally, this study is not exempt from certain limitations. One limitation of this study is the potential for selection bias in the qualitative sample, since stakeholders constituted the largest group of participants. Given their leadership or representative roles, their narratives may have placed greater emphasis on labor-related, organizational, and strategic issues than on everyday care experiences. Although this may have limited the diversity of perspectives captured, it also provided a structured and informed viewpoint that helped contextualize the accounts of migrant men and women. In this sense, stakeholders' contributions complemented individual experiences and supported a more comprehensive understanding of employment conditions in home care services. Additionally, the small qualitative sample may not fully capture the diversity of experiences. Another limitation is the small sample size of migrant participants, which calls for caution when interpreting comparisons between native-born and migrant HCAs. These comparisons should therefore be understood less as an assessment of each individual difference and more as an indication of whether the observed differences follow a consistent pattern. We also do not present quantitative data disaggregated by sex, due to the low number of male survey participants, which does not ensure the reliability of the quantitative results for this group. However, by presenting the qualitative findings from a focus group with men, we identified gender differences in the types of discomfort most commonly reported by men and women (physical vs.

psychological or emotional distress). The study also has strengths. The mixed-methods design allowed for triangulation of quantitative and qualitative data, enhancing the validity and interpretability of the results. The use of joint displays facilitated a structured comparison and greater integration of the results. The qualitative findings helped identify both convergence and complementarity between the methods. By incorporating migration background (a key driver of inequality) the study highlights differential exposures.

5 | Conclusions

Labor precariousness, physical and emotional strain, and the various forms of workplace violence and discrimination to which HCAs are exposed together point to a markedly adverse context. Within this context, having a migrant background may operate as an additional layer of vulnerability, contributing to the persistence of a cycle of poverty from which it may be difficult for these workers to escape. The qualitative findings suggest that the widespread precariousness of care work tends to homogenize experiences across migrant and native HCAs, while also revealing gendered patterns and specific vulnerabilities to violence not captured in the quantitative analysis.

While the implementation of policies and programmes aimed at guaranteeing social rights related to long-term dependency care has led to significant growth in the professionalized care sector, it remains highly deregulated. The protection of social and labor rights is significantly weaker compared to other sectors and is characterized by discriminatory working and pay conditions. These issues have been further exacerbated by the negative impact of the privatization of home care services, which has led to a deterioration in working conditions for care workers and a widening of health inequalities.

It is essential to recognize that HCAs play a key social role in promoting the well-being of a growing number of dependent individuals. Therefore, comprehensive public policies with a feminist, intersectional and economic approach are needed, considering the internal segmentation observed among HCAs, particularly regarding migrant background, which has emerged as a key axis of inequality within this workforce. Ensuring decent working and employment conditions for requires addressing low pay, job fragmentation, and barriers to the provision or acquisition of assistive devices that could help preserve workers' health.

Policymakers must address the structural precariousness affecting this group to break the cycle of poverty and material deprivation they experience, thus contributing to a more sustainable and equitable home care system. Addressing the situation of HCAs is not only a matter of justice for the workers themselves, but also a necessary step toward ensuring the dignity, quality of life, and quality of care for the dependent population they serve.

Author Contributions

Albert Navarro-Giné, María Feijoo-Cid, Sergio Salas-Nicás and María Isabel Fernández-Cano. conceived the study idea and its design. Albert Navarro-Giné, María Feijoo-Cid, Sergio Salas-Nicás, Valeria Stuardo Ávila and María Isabel Fernández-Cano. participated in the formative

research phase. Albert Navarro-Giné, Pedro Ferrer-Rosende and Laura Esteve-Matalí collected the quantitative data. Pedro Ferrer-Rosende analyzed the quantitative data. María Feijoo-Cid and María Isabel Fernández-Cano. were responsible for the collection and analysis of the qualitative data. Albert Navarro-Giné drafted the initial manuscript. Pedro Ferrer-Rosende, María Feijoo-Cid, Sergio Salas-Nicás, Laura Esteve-Matalí, Valeria Stuardo Ávila and María Isabel Fernández-Cano. reviewed and edited the article and contributed to the interpretation and discussion of the results. All authors contributed to subsequent revisions, read and approved the final version of the manuscript, and provided critical input from their respective areas of expertise, enriching the overall work.

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Ethics Statement

The study received ethical approval from the Ethics Committee of the Autonomous University of Barcelona (CEEAH-5920). All participants were adequately informed and provided consent prior to their participation.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions. Quantitative datasets analyzed during the current study are available from the corresponding author on reasonable request. Qualitative data are not available due to privacy or ethical restrictions.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Figure S1: Convergence plots for variables related to sociodemographic characteristics, employment, and living conditions.

Figure S2: Convergence plots for variables related to health status, drug use and violence and harassment experiences.

Table S1: Country of birth of foreign-born HCAs.