

Research Article

Essential Workers Balancing Life and Work during the COVID-19 Syndemic in Spain: A Qualitative and Gender-Based Study

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Rationale. During the COVID-19 lockdown in Spain, healthcare workers have experienced productive work overload, as well as an increase in reproductive work, which has worsened their mental health. Little research has been done on nonhealthcare essential workers although they have been exposed to similar conditions. **Objective.** To explore the experiences of essential workers after the first year of the COVID-19 syndemic in Spain on work-life balance, considering different professions and reproductive work responsibilities. **Methods.** Exploratory qualitative study using a gender perspective. Eighteen semistructured interviews were conducted via telephone or videoconference between January and March 2021. Interviews included essential workers in healthcare, social work, food related, and other settings, eleven women and seven men. A thematic analysis was conducted. **Results.** The disposition of essential workers for reproductive work, task sharing, and work-life balance differed according to gender. Reproductive work was predominantly the responsibility of women; work-life balance was especially challenging for single-mother families and families with children. Being an essential worker, performing face-to-face productive work during lockdown seemed to allow a sense of “normality” and personal space. However, it appeared to lead to feelings of exhaustion due to unsustainable working conditions and pressure on reproductive work during the first year of the COVID-19 syndemic. A lack of social recognition was perceived, especially among social workers. **Conclusion.** This study raises awareness of the difficulties of combining productive work that has become essential with reproductive work in a context of extreme social isolation and little social and institutional support. It questions the role of women in reproductive work, brings visibility to professions such as social work, and highlights the need to improve their working conditions. It is urgent to implement policies to mitigate effects on mental health and its determinants in the short term and long term to reduce gender inequity.

1. Introduction

To ensure the basic functioning of society during the Spanish lockdown due to the COVID-19 syndemic, some professions considered essential (health, social work, food-related, and others) were allowed to continue working on a face-to-face

basis (royal decree-law of 29th of March) [1]. This meant that these sectors experienced productive work overload [2, 3], increased exposure to the SARS-Cov-2 virus [4], a higher demand for reproductive work [5], and increased stress [6], all contributing to a worsening of their mental health [7]. Furthermore, there has been an unequal socio-economic

impact on different professional sectors of the population [8]. This inequity can come from the difference in exposure to the virus at work (if they worked in close contact with clients or coworkers) or in the means of transportation to get to the workplace (if they did not have access to private cars) [9, 10].

Given the health and social complexity of this COVID-19 crisis and considering how social inequities have been exacerbated, the term *syndemic* will be used instead of the pandemic. *Syndemics* explain the interactions between social health determinants that contribute to understanding individual-level susceptibility and population-level disease distribution [11]. *Syndemics* broaden the focus from exclusively biomedical to transdisciplinary. Out of the various professions considered essential during the COVID-19 *syndemic*, research has focused on healthcare workers. Their mental health has been found to be worse than that of the general population, especially in women, who have experienced more stress, anxiety, depression, suicidal thoughts, insomnia, and burnout, than men [12–14]. The contributors to this worsening in mental health have been found to be those derived from working conditions, risk perception, novelty of the virus, and social change [6]. Nevertheless, some protective factors, such as the good organisation of the institutions that employ them, their relationship with staff leaders, the support of their coworkers, the security of their family, partner, and friends, have been documented [15].

Furthermore, some studies focus on coping strategies for healthcare workers such as “engaging in daily exercise, yoga and meditation; watching movies; listening to music and reading books; spending time with kids and partners or focusing on family members,” among others [16, 17]. A qualitative study found that female essential workers found it more difficult to maintain healthy habits (e.g., exercise) during this time [18]. Other studies reflect on maladaptive coping strategies such as smoking, alcohol, or online and video playing in healthcare workers and their impact on stress, anxiety, and insomnia [19, 20].

However, there is little evidence on the impact on nonhealthcare essential workers. Among these, food workers had the highest psychological impact [14]. Moreover, perceived social recognition was inversely related to psychological impact, which worsened as time passed and was higher in women. Other studies have attributed the worsening of essential workers’ mental health to being less trained than healthcare workers for this type of situation.

During the first year of the COVID-19 *syndemic*, there was an increase in the reproductive workload due to the closure of schools and day-care centres [21]. Reproductive work consists of “domestic work or other caring work that is performed without pay or the expectation of pay and not calculated as part of the gross domestic product. It involves the maintenance of social and family structures upon which productive labor depends” [22]. Traditionally, women have been made responsible for reproductive work, and during the *syndemic*, they have taken on an increased workload [23, 24]. This increase in reproductive workload in addition to the increase of demands from productive work may have made work-life balance more difficult for essential workers during the *syndemic*. Work-life balance has been defined as

“the engagement in work life and nonwork life and minimal conflict between social roles in work and nonwork” [25]. Social conditions can explain health outcomes, but attention must also be paid to the cultural reproduction of gender inequity [26]. Before the COVID-19 *syndemic*, studies already demonstrated the health impacts of family demands or reproductive work on female workers, especially manual workers. Health behaviours such as not being able to do physical activity or sleeping six hours or less a day are related to women manual workers living with children under 15 years old and having larger households. Living with people older than 65 years old can be beneficial for the health of women manual workers, as they can provide help with reproductive work [27]. There are studies that identify inequalities between gender in work-life balance during the COVID-19 *syndemic* [28]. However, either they did not study essential workers [29] or they studied them in a totally different context like the United States of America [30] or Bangladesh (which only included women) [31] or studied workers that stayed at home [32–34]. To our knowledge, work-life balance has not been studied in essential workers in Spain [35]. This is also crucial considering that essential professions tend to be feminised (to have a higher proportion of women) (e.g., healthcare, social work, cleaning...) [36]. Furthermore, in Spain, an increase in gender-based violence was observed during the *syndemic* Ministerio [37, 38].

The *syndemic* theory is compatible with a critical theory approach. Critical theory disrupts and challenges the status quo and offers a way of reinterpreting the world by examining how power relations affect society [39]. It allows us to question the mandates that have exclusively focused on avoiding transmission of COVID-19, forgetting that we live in an unequal society. This theory is the foundation of gender perspective, also known as feminist research (herein gender perspective) which allows a closer look at the inequities that arise in this context. A gender perspective considers the social division by gender and contemplates its hierarchy, power relations, and oppressions that account for existing social inequities and their impact on health [40]. This raises the importance of incorporating a gender perspective that addresses expectations, social roles, and stereotypes of men and women (from a cis-binary perspective).

There is a need to grasp how the experience of leaving home to do productive work in stressful conditions, across all essential worker professions, intersects with the increase of reproductive work demands and how work-life balance was dealt with during this period from a gender perspective. Attending narratives of essential workers through qualitative research helps us to better comprehend their experience. Therefore, the aim of the study is to explore the experiences of essential workers during the first year of the COVID-19 *syndemic* in Spain on work-life balance, considering different professions and reproductive work responsibilities. To meet this objective, the following research questions were formulated: How has work-life balance been articulated according to the different profiles of essential workers, gender, and care workload? Which factors have psychosocial impacts according to reproductive responsibility?

2. Methods

2.1. Design. We used a qualitative methodology with an exploratory design [41] taking a critical theory and gender perspective. The application of the qualitative methodology in health research allows the identification of gender inequalities, recognises complexity (intersectionality), focuses on vulnerable and disadvantaged groups, and is oriented towards social change [42, 43]. This perspective in qualitative research validates people's voices and experiences to elucidate axes of oppression. The results intend to challenge decisions made by authorities and power structures in order to promote social transformation. This interpretation of the world examines other sources of inequity (e.g., type of profession) and how they relate to gender (cis-binary) by identifying those intervening factors (expectations, social roles, and stereotypes of men and women) in a holistic approach [41].

This qualitative study comes from a mixed methods project conducted at the Foundation University Institute for Primary Health Care Research Jordi Gol i Gurina (IDIAPJGol) on the social impact and mental health in Spain and other countries of Latin America during the COVID-19 syndemic. This mixed methods project performed a cross-sectional study through an online survey directed to the general population living in Spain during the first lockdown (April-May 2020) [44]. Data from the survey were analysed quantitatively, and participants were invited to participate in qualitative interviews on more specific topics. One of the topics that emerged as relevant from the cross-sectional study was work-life balance in essential workers.

2.2. Sample, Recruitment, and Participants. The study sample was selected from the cross-sectional survey [44]. Overall, 191 people reported being essential workers and expressed interest in participating in a qualitative interview. We carried out a purposive and reasoned sampling which meant that we called potential participants until we reached data saturation. We aimed for five people from different professions (organised into four groups: health workers, food, social work, and "others" of all other professions) looking for diversity in terms of sex-gender (with greater representation of women due to the greater response from women to the initial survey), level of education (as a proxy for socioeconomic status), and whether they lived with a person under 18 or a dependent person. Out of 43 people contacted by telephone and/or email, twenty people finally agreed to an interview. Two participants had to be excluded after the interview because, although they had reported working in areas considered essential, they did not leave their homes to do productive work and did not perform essential work activities during the lockdown. However, their interviews could be included in other qualitative studies that come from the same survey and have a more general focus on the experience of lockdown. In total, eighteen interviews were included, of which eleven were with women and seven with men, with an age range from 29 to 57 years for women and from 27 to 65 years for men (see Table 1). Data saturation

was reached after 18 interviews, and therefore, there was no need to contact more participants from the survey. We reached data saturation when we identified that the experiences of the participants did not contribute anything new.

2.3. Data Collection. We conducted eighteen semistructured interviews following an interview guide (see Table 2) to explore their experiences of lockdown, reproductive work, productive work, experiences of COVID-19, and measures and management of the syndemic. The interview guide was piloted by three researchers. The fieldwork occurred between January and March 2021.

Due to the recommendations for physical distance, the interviews had to be conducted via phone call or through video conference platforms, based on the participant's choice. Out of the eighteen interviews, eight were conducted by video call through video conference platforms that had security measures in place. Consent for audio or video recording was requested at the beginning of the interview. The interviews lasted 30–50 minutes on average.

2.4. Analysis. A thematic analysis was carried out: first, we familiarised ourselves with the data, we transcribed the content of the interviews and anonymised the data, and we generated initial codes, searched for categories (and sub-categories), and then defined and named categories [45]. The transcribed text was coded using Atlas.ti version 8.4.3. The codes were generated from the text, inductively. After this process, there was an interpretation of these codes by categorising them. Thus, the analysis level was first manifest and later latent and more interpretative considering our critical perspective. The categories were discussed to respond to the objective of the study. There was a triangulation and reflexivity process (the research team's reflections were recorded in a field diary), deepened with a literature review, and was sensitive to social inequities in health. This triangulation was analytical [41] and was carried out by four different researchers. One researcher coded all the interviews and other three coded several interviews and then met to pool them and discuss discrepancies. Discordances were resolved through a reflective process in order to reach a consensus. After this process, the researcher who had coded all the interviews presented the results to the other six researchers to triangulate and pool possible interpretations of the data as well as categories.

2.5. Ethical Considerations. This study complies with the ethical criteria of the Declaration of Helsinki and Good Research Practice. The data have been handled according to the General Data Protection Regulation 2016/679 of the European Parliament. The project (20/063-PCV) has received the approval of the Clinical Research Ethics Committee of the IDIAPJGol. Participants gave their oral consent at the beginning of the interview. They expressed their consent to be recorded as well. The recordings were stored in a safe folder that will be deleted at the end of the study. Transcriptions have been anonymised. To ensure the quality

TABLE 1: Socio-demographic characteristics of respondents who were engaged in essential work during the first wave of the COVID-19 syndemic in Spain.

id	Sex	Age	Cohabitation	Children/dependent people	Country of birth	Education level	Field	Type of essential work
1	Woman	57	Not alone	2 (22 and 24 years old)	Spain	University or higher	Social work	Soup kitchen organiser
2	Woman	52	Not alone	No	Spain	University or higher	Others	Ministry of justice civil servant
3	Woman	33	Not alone	No	Spain	University or higher	Social work	Resources for asylum seekers
4	Woman	29	Alone	No	Spain	University or higher	Healthcare	Paediatrician
5	Woman	31	Alone	No	Uruguay	University or higher	Social work	Homeless shelter
6	Woman	55	Alone	No	Spain	High school	Healthcare	Nursing assistant
7	Woman	53	Not alone	2 (19 and 23 years old)	Spain	Vocational training	Food industry	Meatshop seller in the market
8	Men	55	Not alone	2 (23 and 31 years old)	Spain	Vocational training	Others	Sanitary container manufacturer
9	Men	55	Alone	No	Spain	Vocational training	Others	Security guard
10	Men	65	Not alone	1 (adult stepdaughter)	Spain	University or higher	Healthcare	Primary care physician
11	Men	27	Not alone	No	Spain	University or higher	Healthcare	Researcher (virologist)
12	Men	44	Not alone	2 (1 and 3 years old)	Argentina	University or higher	Healthcare	Emergency doctor
13	Men	51	Not alone	3 (13, 17, and 18 years old) 1 dependent brother	Spain	Vocational training	Others	Postwoman
14	Men	45	Not alone	3 (5, 9, and 11 years old)	Spain	University or higher	Others	Harbour master
15	Woman	35	Not alone	1 (1 year old)	Spain	University or higher	Healthcare	Clinical psychologist
16	Men	43	Not alone	2 (2 and 4 years old)	Spain	University or higher	Social work	Homeless shelter
17	Woman	39	Not alone	2 (1 and 5 years old)	Spain	University or higher	Healthcare	Primary care researcher
18	Woman	35	Not alone	2 (13 and 19 years old)	Spain	High school	Food industry	Bakery worker

TABLE 2: Thematic overview of the semistructured interview script.

Lockdown	(i) What was the impact on emotional health during the lockdown according to gender and reproductive work responsibilities? (ii) How did the participants perceive cohabitation at home during lockdown according to gender and reproductive work responsibilities? What kind of difficulties did they face?
Care	(i) How did their role in essential work impact care relationships (dependent people, minors, elderly people. . .) and the distribution of reproductive work in the household?
Paid work	(i) What kind of challenges did they experience in the work environment during the first year of the syndemic? (ii) How did the working conditions and relationships with coworkers change during the first year of the syndemic?
COVID-19 experiences	(i) Were they afraid of contagion of COVID-19? What was the risk they perceived related to COVID-19? (ii) Had they, a relative or a person close to them been positive for COVID-19 or had to be quarantined for being a close contact? What were these experiences like? (iii) Did they experience stigma or discrimination for being an essential worker? What were these situations like? (iv) What was the experience of non-Spanish born participants of having family in their country of origin during the first year of the syndemic?
Measures and management of the syndemic	(i) What do they think about the measures implemented by the government and health authorities in response to the COVID-19 syndemic?

of the manuscript, we have followed the Standards for Reporting Qualitative Research [46]. They have been added as supplementary information (available here).

2.6. Researcher Characteristics and Reflexivity. This research team is sensitive to social inequities in health which led us to take a gender perspective. Having a gender perspective means that the research team needs to acknowledge the power relations that involve them as well as the participants from the study and how these are the source of inequities. This implies that the research team must carry out a process of personal reflection to recognise their own privileges and oppressions as they might affect the interpretation and the discussion of the results of the study. It is also important that the team keep a field diary (to enhance reflexivity in this regard). They need to carry out intentional and reasoned sampling to guarantee the diversity (especially of gender) of discourses. The interview script needs to have a gender perspective and tries to avoid reinforcing stereotypes. Analysing transparently and authentically the research teams’ own identities and personal experiences in gender relationships were discussed in order to comprehend and interpret the results according to the participants’ narratives. The team is aware that gender relationships intersect with other inequities axes and has discussed them and tried to identify them. It is important as well to embrace the flexibility to be able to adapt to the narratives of the participants and to interpret them from a gender perspective. This research team is an interdisciplinary team (from social and medical sciences background) with diversity in terms of gender, age, reproductive work experience, and some have gone through a process of migration. The characteristics of the research team may also affect the results of the study. This research team may have paid particular attention to results that may reveal inequalities.

3. Results

The results were grouped into five emergent categories: psychosocial impact according to different living and health conditions, challenges of work-life balance, productive work as a way out, social recognition was not equitable, and discursive position on the syndemic’s management. A summary of the categories and subcategories is presented in Table 3.

3.1. Psychosocial Impact According to Different Living and Health Conditions. Overall, the lockdown was a troubling time for the participants, especially for those in charge of young children or dependent people. However, some men who were not in professions working directly with the public like the harbour master or the security guard, commented that because of their productive work and previous experiences, they were comfortable being alone, and that lockdown was, therefore, not entirely negative. Women expressed more feelings of loneliness during this period.

At the beginning of the lockdown, many of the informants reconsidered who to live with. They considered their relationships with cohabitants, the physical space of their home, and fear of contagion. Most expressed that having adequate housing represented a great privilege: the importance of having natural light, spacious houses or flats, a terrace, gardens, or living in a village and how it allowed them to cope better. On the other hand, those living in the countryside perceived the accessibility to health services to be difficult.

ID6 Woman: “When the confinement began, I went to my ex-husband’s house (. . .), because it seemed to me that being with someone was better than living alone. But well, I didn’t continue because of course, with your ex, logically, you don’t get on well. Then I went back home, and I was alone again.”

TABLE 3: Categories and subcategories of analysis.

Categories	Subcategories
Psychosocial impact according to different living and health conditions	(i) Housing impact (ii) Emotional impact (iii) Social impact
Challenges of work-life balance	(i) Coping with confinement (ii) Relationship with partners and cohabitants (iii) Distribution of reproductive work responsibilities (iv) Self-care
Productive work as a way out	(i) Going outside-working conditions and work-life balance (ii) Work relationships (iii) Risk perception and experiences COVID-19
Social recognition was not equitable	(i) Social recognition and visibility at work (ii) Discrimination
Discursive position on the syndemic's management	(i) Role of institutions (government and media) in work-life balance (ii) Social and future concerns

Participants commented on the inadequacy of their home to be able to do the activities they could not do outside during this time. For example, those who alternated teleworking with face-to-face productive work expressed how unprepared their house was to do their productive work: having to buy furniture and setting a temporary workspace in the living room and taking it out every day to do other activities. Some also commented on their insufficient space to be able to do physical exercise at home. Furthermore, those with children felt that having space for playing both inside and outside was important.

ID3 Woman: "There were times when I was teleworking. It was more complicated because we had to buy a table and a chair. (. . .) Then we already had our little office set up. Very precarious because we set it up in the living room and had to pick it up every day."

Regarding feelings of loneliness or isolation, the ten-day room isolation, due to close contact with a case or being COVID-19-positive, was perceived as a great emotional challenge. In particular, women described feelings of sadness and great demotivation.

ID13 Woman: "That really brought me down. (. . .) I admit that when I was locked in a room, being alone and in a very small space, it affected me, and I found it overwhelming".

Some participants, who lived in a different city or country from their family or loved ones, expressed fear of their loved ones getting infected or not being taken care of. Feelings of guilt emerged for not being there when needed (to take care of dependent people, especially in end-of-life situations).

ID4 Woman: "I don't know, you also feel bad for not being there to help. Like. . . Yeah, that feeling of not being able to be there with your loved ones, when. . . when they're unwell, right?"

In the case of migrant people, who had family in their country of origin, there was another layer of worry that came from the difference in policies or protective measures and their perception of the risk of contagion in that country.

In terms of social connectivity, participants expressed that the support they received from partners, friends, and productive work colleagues was key to cope with emotional challenges. Nevertheless, this was not perceived as enough. They expressed the need for further human contact and to feel intellectually stimulated by their friendships. Furthermore, people with children who depended on grandparents said that they stopped seeing friends not to put their elder family members at risk for COVID-19, thus increasing their feeling of loneliness and isolation. In this regard, some young women expressed concern about the lockdown (the length of the restrictions and the frustration and exhaustion they caused). In this regard, some young women expressed concern about the lockdown (the length of the restrictions and the frustration and exhaustion they caused).

ID18 Woman: "I don't know if they're going to give us a prize or something for having sacrificed so much and having left our lives aside, everyone. (. . .) Are we going to live forever? We're all going to die! But I don't want to be protected from death without living. In other words, what's the point of dying 15 years later, but not living? Well, no, I don't want that, and I don't know who does."

Regarding access to psychological treatment, healthcare workers were offered a psychological care service that was set up in their workplace, which was highly appreciated.

The rest of the professions were not offered such services. Some women who were not healthcare workers expressed that the psychological treatment (either public or private, not provided by their workplace) they received during lockdown did not meet their expectations. This was either because they only received pharmacological treatment or because they did not feel comfortable with online consultations, as they did not feel much intimacy.

Those participants with previous health conditions (for example, a participant with HIV) experienced interruptions in care: visits, diagnostic tests, and procedures were canceled during the lockdown and were recovered after the measures were lifted. Some initiatives were valued positively, such as the hospital pharmacy sending hospital treatment to the patient's homes.

3.2. Challenges of Work-Life Balance. Based on participants' narratives, the reproductive workload fell mostly upon women, whether they were essential workers or not. Men generally said that tiredness made it difficult for them to contribute to reproductive work, and some were not involved at all. In the case of women, they assumed that they

would take on most of the domestic activities once they got home and did not complain about this difference. Despite this, some essential workers whose partners (men) were retired or unemployed said that their partners did most of the reproductive work. Both men and women acknowledged that they had no prior agreements or conversations on how to manage reproductive work.

ID16 Man: "I mean, because when I got home, I was so exhausted that I was useless to her."

Interviewer: "Who does more things at home?"

ID18, Woman: "Well, even if I was the one who went out to work, I was still the one doing everything at home. That's just the way it is."

Participants described some differences in the type of reproductive work they did depending on their gender. Women generally carried out tasks such as cleaning, feeding their children, or helping them with homework, while men carried out other tasks such as cooking, bathing, or playing with their children, as well as those that involved going out of the house, for instance, grocery shopping or taking out rubbish (the latter were not done by them prior to lockdown). Some women noted that they were afraid to go out because of their fear of getting infected and were replaced by men in doing these tasks.

ID16 Man: "Well, I play more with the children and X (partner) is in charge of feeding them because I don't have the patience to feed them, but I take care of the cooking and the beds and the clothes. Or... No, the clothes are taken care of by X (partner). But I'm in charge of shopping and rubbish and so on... But everything just kind of flows doesn't it?"

Generally, in couples that were in charge of dependent people or children, it was usually the woman (essential worker or partner of an essential worker) who changed her schedule (reduced her working hours or made them more flexible) to reconcile productive work and reproductive work. Due to the lockdown, some participants were left without support from their families (because it was not allowed or to prevent parents from becoming infected), which increased the burden of reproductive work. In some cases, a person was paid to do the work related to child-rearing. The hired people substituted mostly for men's reproductive work, while when women returned from productive work, they took over reproductive work.

ID14 Man: "My wife did not work for a long time. She stopped working after we had our first daughter to take care of her. Well, logically, the domestic chores fell more on her than on me."

Families that were economically well-off (e.g., the doctor) started to adopt new habits, like ordering take-out, in order to reduce reproductive work during this time.

ID12 Man: "I had never ordered take-away food. And we started the routine of well... I'm Argentinian. And in Argentina we come from quite a culture of delivery and here, as it wasn't that much, we didn't use it. And now, of course you realise that in this pandemic everyone was ordering and well it's easier. And if financially, let's say, you can afford it, of course, it solves your life quite a bit."

Regarding family organisation, greater importance was given to essential jobs than to nonessential ones, and within the essential ones, those involving greater responsibility were prioritised, which in our study were mostly carried out by men (harbour master; emergency doctor and head of the department; social worker and head of homeless shelter resources).

The closure of schools meant that the children of essential workers spent more time than usual on screens, and not all of them adapted to the academic demands. Some participants with small children commented on the exhaustion from creating activities and games to distract them. Once the lockdown was over, some children were no longer motivated to leave the house, either because they still could not see their friends or because they no longer felt like socialising. Participants with adolescent children agreed that this period was even more difficult for them because of the complexity of re-establishing friendships while respecting the measures. The school was seen as an ally in recovering social relationships and personal space for adults in the family.

The theme of self-care emerged as a need to disconnect from a context perceived as adverse. Examples of this self-care reported by participants are exercise, recreational activities, and healthier cooking. A woman with teenage children gained personal space by not having to accompany them to extracurricular activities. In contrast, those with young children experienced increased insomnia, sedentary lifestyles, and difficulty in combining self-care with reproductive work. However, they also reported an increase in alcohol intake, marijuana use, or over-eating as coping strategies to reduce anxiety.

Men in particular appreciated spending more time with their family and being able to play with their children. In the de-escalation period, both men and women appreciated going back outside for sports or walks, as it allowed them to be in contact with nature and to be outdoors.

ID12 Man: "Before I did not think about spending so much time at home, and now I see that I need it. (...) It's good to do activities with the family and so, because (...) maybe at the weekend I get infected, and I must do quarantine at home."

3.3. Productive Work as a Way Out. In general, there was a feeling of privilege among the essential workers for being able to continue their face-to-face productive work. In contrast, some commented on their family being on a strict lockdown and feeling as though their life was interrupted.

They argued that going out to do productive work during the months of lockdown allowed them to socialise, avoid feeling cooped up at home, and maintain some normality in their lives.

ID8 Man: "I was very lucky to have those eight, ten hours that I spent at work. Well, they cleared my head; they made me focus on something else (...). And that was very therapeutic."

It was noted that jobs had to adapt to this new situation. Some changed their organisation during this time by alternating days of the week to reduce the transmissivity of the virus. This was the case for those in the healthcare sector but also for social workers and other professions such as the postwoman. Attending fewer days was very welcome because they were able to devote more time to reproductive work and self-care. Some sectors had to expand their services to adapt to the increasing demand of the population. Some jobs required workers to change positions during this time, which created tension: being new to a job and needing to learn much, having new coworkers who they did not trust and not being valued at the new post. Some participants expressed fear of future financial repercussions or of becoming unemployed. This was the case for people with manual jobs, such as the saleswoman at the butcher's shop in the market. These changes and struggles affected their work-life balance, as they arrived home more stressed and tired.

ID3 Woman: "What happens is that, well, what you really do is put out fires. And then, well, they did not realise that you were really going to contribute."

Managers who showed flexibility to enable greater work-life balance were highly valued, especially among women. Receiving support from both bosses and colleagues was perceived as a fundamental emotional support network in this situation. On the other hand, participants also commented on difficulties with communication with their superiors, which was sometimes complex, excessive, or had to be done virtually. This made it difficult to manage productive work and to separate private and working life spaces. It was noted that there were some confrontations with colleagues over disagreements on COVID-19 measures implemented at work.

Healthcare and social workers, as well as the Ministry of Justice civil servant (who worked especially on domestic violence cases), noted how difficult it had been to manage the effect of this syndemic on their clients. They commented that they had witnessed more attempts at self-harm and suicide, reports of domestic violence, people living in poverty or homelessness, and seeking political asylum.

Due to this awareness of the struggles of the population, there was a social rhetoric of heroism related to essential workers that made many of the participants feel that they could not fail because vulnerable people depended on them. For example, the 65-year-old primary care doctor said he would not retire as long as he felt he was still needed.

ID1 Woman: "In this sense, being an essential worker really helps you to outdo yourself. (...) We must move forward because we can't leave anyone behind."

This idea has, in some cases, given them the strength to continue, although in other cases it has led to burnout (especially in women). Social and healthcare workers commented that at the beginning of the syndemic, they were more motivated and energetic and willing to contribute (even as volunteers outside working hours) in a time of crisis. Over time, exhaustion and pessimism about the future began to get through to some participants. They commented that the high workload and stress caused some of their colleagues to quit their jobs.

ID15 Woman: "(about the lockdown) I remember it as some days of acceleration in general... But of course, because I suppose nobody knew how long it was going to last, right? (...) That, if we had known, maybe we would have been a bit more careful, (...) a pace that we could tolerate a bit more."

In most workplaces, access to personal protective equipment (PPE) at the start of the syndemic was very difficult. In some, it was even paid for by the workers themselves, which was not appreciated. Some professions (healthcare and armed forces but not the private security guard) were provided with COVID-19 test (PCR and/or antigens), and others (social workers) were not, and this difference in protocols was lived with injustice and frustration.

Regarding the use of this equipment, nonhealthcare workers, like the postwoman, commented that it was not easy to get used to the mask and other measures (e.g., gloves, suits...), while healthcare workers complained about the difficulty of working in full PPE. On the other hand, women doing public-facing jobs, like the nursing assistant going to old people's homes, complained that users resisted the use of masks, thus putting them at risk. In the de-escalation period, when nonessential coworkers returned to face-to-face productive work, some participants commented feeling more at risk for contagion. In general, the participants highlighted the lack of information and clear protocols at the workplace.

In terms of risk perception, many essential workers, especially women, feared getting infected and infecting their family members and therefore complied with stricter measures than the restrictions in place at the time. Others felt that because they were essential workers, they were more aware of the risk and had greater knowledge of how to avoid infection than other people. Some participants, particularly women, were concerned about how they would cover their position at work or how they would care for their young children if they got infected.

ID17 Woman: "It overwhelmed me, although where I work, the truth is that there aren't many of us, we don't have many people in the same place. But I don't know, I had the

feeling that just by going out in the street I would catch it (COVID-19). (...) Well, what felt overwhelming was; I have a son (...) who was one year and three months old at the time, right? So, I was very worried that if I got infected, I would have to isolate myself from him. (...) Because he was very small, and I did not want to stop breastfeeding him.”

In order to protect some older essential workers, as the 65-year-old primary care doctor explained, younger workers took on tasks where they were more exposed to the virus: younger doctors attended the respiratory cases where COVID-19 was suspected, and he attended patients with no COVID-19 symptoms and did televisits from home.

3.4. Social Recognition Was Not Equitable. All participants were essential workers, but not all of them felt socially recognised. There were some participants who did not feel they deserved social recognition because they did not consider their productive work to be important enough or as important as healthcare workers and claimed “they were just doing their job.” However, healthcare and social workers (except for medicine and nursing) did express a lack of recognition for their productive work during this period. Researchers even felt pressure and criticism for not working quickly enough and finding solutions to the syndemic. In the case of the civil servant, she complained that this profession is frowned upon because there is a belief that “they work too little and get paid too much” and claimed that this is not her case.

ID1 Woman: “We applauded the healthcare workers, and I applauded the most. Because it’s true that they are the ones who have taken the most personal risk to help the rest, right? (...). And I think that, well, if we have endured the little we have endured, it is also largely because of this social work that is often not seen.”

Doctors explained they have received recognition mostly through social networks and perceive it as too distant. Other participants felt some kind of recognition from colleagues, clients, or patients. Many commented that the recognition should come in the form of improved working conditions. These working conditions have an important role in their ability to balance their work-life.

ID16 Man: “That, all the essential ones who have kept the country going during the time of lockdown are the lowest paid jobs. Both in the social sector and in the commerce sector, supermarkets, bus drivers, etc. (...) We have had three suicide attempts by people who have been treated and one who committed suicide, and we have had to live through it. And we are not health workers, and we have had to manage it, and we have been alone to do that. (...) So that’s what makes me not want to come to my job, because I have lost the motivation that my job used to give me.”

Some people did not feel appreciated by their company, especially those who were less able to make decisions in relation to their productive work, such as the security guard who also had a disability.

ID9 Man: “Let’s see, (...) for the subcontracting company or people where I am, we are numbers. We are numbers. Because when I do my work, I don’t expect to be thanked, but at least some kind of gesture. But no. (...) The bosses say, “that’s what we pay you for.””

These workers (e.g., social workers and the security guard) also explained that, unlike healthcare workers, they had not chosen a risky profession. Moreover, in some cases, they took on health-related responsibilities (outbreak control among clients) for which they did not feel prepared.

There were several men who experienced fear of discrimination for being essential workers. Some participants (healthcare and social workers, as well as the security guard and the sanitary container manufacturer) reported that they had friends who did not want to meet them for this reason or that neighbours avoided them.

ID9, Man: “Eh, the only thing I’ve seen is that people (...) are almost staying away from me, because of fear of contagion. Yes, yes, even people in my building, people who have known me since I was a child. Erm... Going up in the lift, even though I wear a mask, they’d rather walk up the stairs than go with me.”

3.5. Discursive Position on the Syndemic’s Management. Essential workers’ narratives on managing the syndemic showed empathy with the difficulties faced by the government. They found it difficult to choose between saving the economy and saving lives and understood that the management of the syndemic was very complex. Nevertheless, there was a lot of mistrust and discontent with the authorities, as their policies had an important impact on their life and on their productive and reproductive work. They complained about the inconsistencies between central and regional governments and other countries, about disputes between political parties, and about specific measures that they felt restricted their freedom.

When asked about where the responsibility of the management of the syndemic fell upon (whether in the society or in the authorities), middle-aged participants were more inclined to frame it as an individual responsibility and blamed certain groups of people, especially young people, for acting irresponsibly. Nevertheless, most agreed that responsibility is shared between society and the authorities. Some social workers reflected on the inclusion of the population in decision-making and on increasing citizens’ empowerment and involvement in measures.

ID5 Woman: “Well, I think that (. . .) it is essential for the individual to be part of the decisions so that they experience them as their own. If it is imposed on them, it tends to generate a lot of rejection.”

Some participants expressed their preference for stricter measures (similar to the first lockdown), and that compliance should have been better ensured. In contrast, social and healthcare workers felt that too many fines have been imposed.

Other essential workers also complained about the over-information provided by the media and social media. They felt that the media was biased towards the narratives of political parties and was not informative. They noted that to protect their mental health, they needed to disconnect from the media. Most participants had great concern for the social impact of the syndemic on vulnerable people.

ID 14, Man: “I think it’s an explosive mix. Honestly, I don’t know how it’s going to end. Unemployment in addition to the general weariness from this bug and from the (political) contradictions.”

Regarding work-life balance, the participants commented on the difficulties of being an essential worker and not having a social support system (their family) or institutions available (schools and nurseries). Moreover, a single mother commented that the management of the syndemic did not consider the situation of single-parent families, which made it difficult to carry out tasks outside the home such as shopping.

ID18 Woman: “And the other mother, well, she’s on her own with her child too. Sometimes she left the child at home because she was told that she couldn’t go (shopping) with the child.”

A social worker was very worried about future lockdowns and government decisions, as he believed that the only solution he saw for dealing with the challenges of work-life balance during future lockdowns would be for him or his partner to give up productive work.

ID16 Man: “Well, look, I think that one of us should leave the job. (. . .) I mean, we would have to learn to live without a salary. So that at least one person would have the energy and strength to be confined. Because if we’re both with both things, we don’t. . . the children end up suffering. Then we would have to see which of us would have to give up work to focus on lockdown.”

Participants did not suggest measures that the government could take to support them in order to balance better work-life during a syndemic but have explained the impacts the policies have on this area of their lives.

4. Discussion

In our study, the narratives on work-life balance were different depending on gender and profession. According to women, work-life balance was difficult, especially when having young children. Some men also endorsed this opinion but expressed that it was even more difficult for their partners (women). This period was especially difficult for single-mother families and for those with young children. However, for both men and women, being essential workers and leaving home amid lockdown allowed them to maintain some sense of normality and have personal space, which was seen as positive. There were differences in the experiences according to job responsibility and whether they were in a care sector (health or social care) or not. Essential workers demanded that recognition should imply improving working conditions and salaries, and in the social sector, there was also a demand for greater social recognition. It is a sector that responds to the needs of the most vulnerable people and that is neglected by society and the government. In terms of government response to the syndemic, some felt that the measures should have been stricter, and others felt that these did not allow for the social life they required to live a fulfilling life, as well as to provide care.

Among our findings, the main difference between women and men essential workers with reproductive work responsibilities was that, from the men’s perspective, their tiredness after productive work did not allow them to do reproductive work, while women continued to take on work outside and inside the home. During the lockdown, essential work was a protective factor for depression in men, while in women it was a greater risk for anxiety. On the other hand, men who lived with children under 18 or with dependent people were found to have higher levels of anxiety than women [44]. The main reason for this could be the naturalisation of women’s role in the household as the main carer [47] and the lack of communication and agreements regarding sharing reproductive work tasks [48]. Women appeared to feel more responsible for reproductive work, while men focused on their own experiences of self-care [49]. Moreover, the types of tasks performed by women and men were different, with men performing tasks that could be considered more rewarding, such as playing with children. This is consistent with other studies that also reported that men acquired, during the lockdown, the habit of grocery shopping and taking out the rubbish. Doing these types of activities allowed them to leave home, which was considered as a privilege at the time. Furthermore, this study found that the lockdown increased the volume of reproductive work by 25%, and although men increased their workload, it did not compensate for the existing inequity [24]. Moreover, the closure of schools and other public institutions during the lockdown implied a reorganisation of reproductive work and several challenges, especially for women [50, 51]. Policies failed to consider the challenges of single mothers by putting in place physical distancing measures that hindered

reproductive work networks [21, 52]. They were disproportionately affected by the consequences of the syndemic (higher unemployment rates and poverty) [53], they expressed how this kind of life was not worth living, and they perceived the measures as worse than getting COVID-19.

According to our findings, engaging in essential work was seen as positive in contraposition to staying at home in lockdown. This was not perceived equally by those with young children or dependent people, as the syndemic increased the pressure of reproductive work. An important aspect illustrated by this is the family composition: being a single parent, both parents being essential workers, one of the parent's teleworking and doing reproductive work [54]. Many parents that participated in our study were concerned about their children's wellbeing—having an essential worker parent may have been stressful—as well as scared to spread the virus in their family. We think it is important to consider essential workers as part of a family system, not as isolated individual, and to understand how they may have been forced to prioritise productive work over reproductive work during this time and the impact this can have. This situation also calls into question the relationship between reproductive work and social determinants.

Job recognition is closely linked to the visibility of productive work [55, 56]. An example of this is the health professions, especially medicine and nursing, which in Spain were applauded every day during lockdown and recognised socially. Participants from other sectors felt recognised by their users, clients, or patients because in this interaction, they gained visibility. However, they felt that they were not recognised by the rest of society. Furthermore, there is a perception that professions related to the social field, which are predominantly feminised, were undervalued. During the syndemic, society has focused on the incidence and morbimortality of the SARS-COV-2 virus and less on the social impact of the most vulnerable groups, such as homeless people, asylum seekers, and migrants in an irregular administrative situation. This translates into less visibility and recognition of social issues; thus, it is essential to give greater importance and translate into higher budgets for social care and improved working conditions for social workers [57, 58]. While healthcare professions have been prioritised to receive the vaccine against COVID-19, no coverage has been given to other professions, such as, for example, supermarket shop assistants, even though they were more exposed to the virus than the rest of the population [59]. This favours social inequities within the essential workers' sector itself. This is very relevant taking into consideration that these professions took on responsibilities for which they were not trained. On the other hand, experiences of discrimination for working outside the home emerged, especially among those with less skilled jobs in terms of training, e.g., security guards. Previous studies have found that essential health workers are more likely to experience stigma and harassment, especially when it intersects with racism, violence, and police involvement [60]. In our study, it seems that it was more related to educational or socio-economic status, as participants who suffered stigma and discrimination occupied

positions of less power in their work (e.g., security guard, nursing assistant).

We found a diversity of opinions about the management of the crisis: most participants agreed that it was an unforeseeable and complex situation. However, they also noted inconsistencies between policies and applicability in practice and were unhappy about the effect all measures had on them and their families, especially women. A study argues for the role of the authorities in managing the crisis since they had little foresight or control over the disproportionate effect this syndemic has on women, but how they have the responsibility for mitigating the effects [52]. Moreover, a study from the USA documents the lack of representation of essential workers, especially those in woman-dominated professions, in decision-making bodies [36]. There is also a general under-representation of women in COVID-19 management committees in Spain [61], where medical scientists, especially men, have been invited as experts and decision-makers. Including more women, especially those from essential work professions, in decision-making bodies could push forward policies that protect the work-life balance.

According to our study, participants expressed a worsening of emotional health (that has deteriorated over time), general weariness, and a pessimistic view of the future, which might last for a long time [35, 62]. Experiences from other emergencies speak of the risk of a slow winding and persistent disaster [63]. This implies that the social impact and mental health of essential workers are extremely relevant aspects of current crisis management and the future of society. The syndemic provides us with the opportunity to explore the inequities that arise and to adapt our policies to mitigate the effects on vulnerable populations, taking into consideration that the pandemic is still unfolding, and its impact needs to be monitored further. In Table 4, we include results of our study as well as those of other studies, to make some proposals to prevent the negative impact of the syndemic on essential workers.

Finally, it is important to better comprehend the phenomenon of productive and reproductive work during the syndemic and how it intersects with different situations of power and oppression, types of productive work, sector and responsibility, social recognition and institutional appreciation of their productive work, family structures and composition, one's responsibility in the family's reproductive work, as well as other intersectional divisions such as gender, sexual orientation, age, social class, and ethnicity. Future research in this area should take an intersectional perspective to accommodate all these experiences, especially in a syndemic context [67, 68]. Furthermore, both social science experts and their knowledge have been set aside, generating an asymmetry in the knowledge and measures, that have been rather biologic than social. This is extremely relevant in terms of who has been invited to the decision-making process and seen as an expert or essential, and who has been set aside. Therefore, there is a need for dialogic thinking and working [69].

TABLE 4: Proposals to mitigate the negative impact on the emotional health of essential workers during critical periods.

Title	Summary	Source
Flexibility in schedule and work arrangements	Reduce or intercalate shifts between workers so that they have days off	Findings of our study
	Individualise schedule taking into consideration the worker's input	Findings of our study
	Implement organizational training that teaches employers how to provide more job flexibility (in terms of allowing employees to make their own hours and of providing the option of working from home)	[30]
	would substantially benefit employees who have caregiving responsibilities by reducing stress and psychological distress	
Protection	Availability of flexible work arrangements was associated with higher job satisfaction and less work-family conflict	[64]
	The government should provide basic materials and supplies, security, work subsidies, and tests for essential workers and their families	[65] Findings of our study
Working culture	At work: separate private and working life spaces	Findings of our study
Sick and parental leave	Require employers to provide both sick leave and parental leave for at least as long as schools and daycares are inoperational	[52]
Salary and aid	Improve salarial conditions of essential workers	Findings of our study
	Aid single parents	Findings of our study
	Provide subsidized emergency childcare	[52]
Mental health	Provide financial stimuli directly to families	[52]
	Clinical psychological intervention for all essential workers and psychiatric intervention if needed	[15, 65] Findings of our study
	Self-counseling and participation in society	[65]
	Prevention and mitigation are far more important than cure	[66]
Family dynamic	Support for staff in isolation/quarantine	[15]
	Couples should have more conversations to negotiate how they share the reproductive work	Findings of our study
Recognition and visibility	Recognise the additional effort the essential worker has had to make	Findings of our study
Policy	Recognise social work	Findings of our study
	Include essential workers in the decision-making of policies	Findings of our study

5. Limitations

For this study, we had a sample with a higher proportion of women and university graduates. We did not reach out to more people from other socio-economic sectors. On the other hand, it was not possible to carry out the interviews in person due to the epidemiological situation at the time. However, it was possible to establish sufficient rapport during the interviews thanks to the video calls and thus to obtain results and fruitful conclusions. In addition, virtuality allowed us to have the opportunity to interview people from different parts of Spain.

6. Conclusions

This study explores the experiences of essential workers on work-life balance during the first year of the COVID-19 syndemic in Spain. It draws attention to the difficulties of combining productive work that has become essential with reproductive work in a context of extreme social isolation and little external help. It ponders the role women have in reproductive work as being even more intense during the syndemic and how men, unlike women, had the opportunity to choose their involvement in reproductive work as well as the specific tasks with which they felt more comfortable. It brings visibility to those professions that have not been recognised during the syndemic such as social work and

highlights the need to improve the working conditions of all these professions, especially in terms of income. During the syndemic, the vision has been too narrow in only including the sanitary or healthcare points of view, and our study tries to open the scope to other professions and other impacts from a gender perspective. Measures taken to reduce the impact of COVID-19 have been applied homogeneously in a heterogeneous population which has disproportionately affected women, essential workers with children, and other vulnerable groups. We have seen how policies that mitigate the effects on mental health and its determinants in the short and long term are urgently needed to reduce gender inequality.

7. Future Research

We have identified different areas where future research would be interesting: identifying differences in work-life balance in essential workers according to social class and migration background; identifying differences in work-life balance in essential workers according to support networks; identifying differences in work-life balance in essential workers according to different household sizes and ages of their children and dependent people; experiences of essential workers who are single parents during lockdown or a review or policies to mitigate effects of the syndemic in essential workers' work-life balance.

Data Availability

Data cannot be shared publicly because of ethical restrictions. The Ethics Committee does not allow us to share the data publicly as our data contain sensitive personal information and cannot be fully anonymised. Data are available from the Research Ethics Committee of the IDIAPJGol (contact via cei@idiapjgol.info) for researchers who meet the criteria for access to confidential data.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

The authors have specified the authors' contributions using the CRediT (Contributor Roles Taxonomy) author statement [70]. Catuxa Máiz-Mazueta designed conceptualisation, investigation, formal analysis, and data curation, wrote the original draft, wrote the article, and reviewed and edited the article. Laura Medina-Perucha developed a formal analysis, wrote the article, and reviewed and edited the article. Anna Berenguera wrote the article, reviewed and edited the article, and did a funding acquisition. Tomàs López-Jiménez wrote the article, and reviewed and edited the article. Israel Rodríguez-Giralt wrote the article, and reviewed and edited the article. Pablo Cerezo Sepúlveda did investigation and formal analysis, wrote the article, and reviewed and edited the article. Constanza Jacques-Aviñó contributed conceptualisation, investigation, formal analysis, and data curation, wrote the article, reviewed, and edited the article, and did supervision.

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Supplementary Materials

We are submitting Standards for Reporting Qualitative Research (SRQR) checklist [46] as suggested by Health and Social Care in the Community with indications to where to find each piece of information. (*Supplementary Materials*)

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