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Evolving Vulnerabilities Among COVID-19 Survivors in Rural India: Lived Experiences and the Challenge of Adaptive Social Work and Policy Responses

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Abstract: The COVID-19 pandemic has both exposed and deepened structural inequalities worldwide. This hermeneutic phenomenological study explored the lived experiences of COVID-19 survivors from rural Southwest India, who were impacted by the unavailability of formal social work support and inadequate welfare infrastructure. A purposive sample of twelve individuals experiencing intersecting social, economic, and gender-based vulnerabilities was selected. Thematic analysis revealed how the pandemic shaped experiences across multiple dimensions, including health, income, caregiving roles and responsibilities, institutional interactions and support, and social relationships. The findings highlight that existing frameworks for crisis response and social protection often fail to account for lived experiences stemming from the effects of dynamic vulnerability. While anchored in a specific rural Indian context, the findings contribute to broader international debates on structural vulnerability, pandemic-induced precarity, and the imperative of adaptive social work.

Keywords: COVID-19; rural India; evolving vulnerability; lived experience; adaptive social work; resilience; social policy; structural inequality

1 Introduction

In the context of the pandemic, socio-economic and structural vulnerability with respect to the critical function of health systems has received limited attention and has been insufficiently theorized (Basu et al., 2023; Chakraborty & Maity, 2020; Khandelwal, 2020; Singh & Aditi, 2020). The existing global literature reveals that a substantial portion of pandemic-related research focuses on analyzing epidemiological metrics, such as transmission estimations, predictive modeling, and clinical care pathways (Horton, 2020; Mohanty, 2020). Such a unitary focus often overlooks the social determinants of health and the lived experiences of inequality. Concomitantly, the pandemic has slowed progress on the Sustainable Development Goals (SDGs), particularly SDG 3: Ensure healthy lives and promote wellbeing for all at all ages (WHO, 2020), further confirmed by global policy institutions (Sachs et al., 2020; United Nations Economic and Social Commission for Asia and the Pacific, 2020). Considering the interconnectedness of the SDGs (Khetrapal & Bhatia, 2020), it is evident that the pandemic's adverse impact extended beyond public health into education, income, gender equity, and social protection, amplifying exposure across multiple domains.

In Europe and the United States, COVID-19 mortality was strongly stratified by socio-economic deprivation, underscoring the syndemic nature of the crisis (McGowan & Bambra, 2022). Furthermore, the international evidence shows that women disproportionately faced problems such as employment losses and heightened childcare burdens that further reinforced prevalent structural gender inequities (Alon et al., 2020). COVID-19 exposed profound structural vulnerabilities across the Global South. In India, weak health systems, poverty, and poor sanitation heightened the risks (Acharya & Porwal, 2020), while economic inequality in Latin America limited the ability of poor households to comply with containment measures (Bargain & Aminjonov, 2021). Rural communities in Africa faced severe service disruptions and gaps in social protection (Egger et al., 2021). Broader analyses confirm elevated infection fatality rates in the global south due to limited healthcare access (Levin et al., 2022). Additionally, poverty, demographic risks, and weak infrastructure consistently worsened outcomes (Couto et al., 2024), with social and economic marginalization further intensifying inequities (Shadmi et al., 2020).

Exposure to intersecting risks during the pandemic intensified vulnerabilities (Tian, 2024), while discriminatory institutional experiences and policy shortcomings further ingrained them. Although household poverty, marginalization, and systemic neglect are known to shape precarity, their compound effects during the pandemic remain unexplored (Bambra et al., 2020; Tian, 2024). Vulnerability is often used as a classificatory term to locate "at-risk" groups such as low-income families and individuals with comorbidities (Joseph et al., 2023; Watts & Bohle, 1993). However, this risk-based framing often misses the fluidity of lived vulnerability and the emergence of new vulnerable groups (Banerjee et al., 2020), especially as the pandemic destabilized traditional social roles, intensified caregiving burdens, and disrupted informal and formal support systems.

While the core public health discourse focused on infection risk and clinical outcomes (Siller & Aydin, 2022), the phenomenological dimensions of vulnerability, such as psychosocial, economic, and institutional, primarily emerging from individual experiences and circumstances (Gopalan & Misra, 2020), remained neglected. Moreover, vulnerability is often essentialized as a quasi-natural attribute (Fawcett, 2009), reinforcing normative expectations of passivity or dependence. Such conceptual framing undermines the phenomenon of structural production of vulnerability and the capacity for agency and adaptation among those labeled vulnerable. Butler (2016) proposed a dynamic and relational understanding of vulnerability that is historically and politically situated through which power, precarity, and resistance can be examined comprehensively. Against this backdrop, this study explores the evolving vulnerabilities of COVID-19 survivors in southwest India, focusing on how vulnerability is experienced, narrated, and reshaped in response to changing institutional, familial, and economic conditions.

As an empirical hermeneutic phenomenological study, this research contributes to a growing global literature on post-pandemic recovery and adaptive social work (Kuhlmann et al., 2020; Pleyers, 2020). The study informs the need for context-sensitive, flexible, and equity-oriented responses, keeping both individual agency and structural constraints at the center, to enable a more just and resilient form of social and policy-based support systems and infrastructure. This article reports an empirical hermeneutic phenomenological study. The findings are situated within global debates on pandemic precarity and adaptive social work. The study emphasizes analytic transferability of mechanisms and does not make claims about cross-national prevalence.

2 Research Method

Design and Epistemological Approach

This study employed a qualitative research design grounded in hermeneutic phenomenology, which is particularly suited to uncovering how individuals make sense of complex, often traumatic, lived experiences (Creswell & Poth, 2016; Finlay, 2009; van Manen, 2016). Rooted in Heideggerian philosophy (1962), hermeneutic phenomenology prioritizes interpretive depth over generalizability and recognizes that meaning emerges through participants' narratives and the researcher's interpretive lens (Neubauer et al., 2019; Vindrola-Padros & Johnson, 2020). This methodology is especially relevant for social work research due to its capacity to produce knowledge by emphasizing the experiential core (Berrios, 1993; Mackey, 2005) and focusing on comprehending the complexity of human experiences (Bell, 2017; Munhall, 2007; Wilcke, 2002). Participants did not consistently or explicitly describe themselves as vulnerable. Thus, vulnerability has been employed as an analytic category to assess narrated life conditions (e.g., income loss, diagnostic delays, caregiving overload, stigma). To avoid paternalistic labeling, we relied on interpretations of first-person accounts and consistently distinguished experienced states from structurally produced conditions throughout the analysis.

Vulnerability research commonly relies on secondary data for estimation purposes, ignoring the qualitative factors that have a negative impact (Spiers, 2000). To ensure evidence-informed and effective welfare policies and social work interventions, it was necessary to understand the compounded vulnerabilities caused by the pandemic, which ranged from livelihood to health (Black & Enos, 1981; Polkinghorne, 1988). This interpretive method challenges the "taken-for-granted" views and orients them toward new understanding or reviews previously ignored views (Finlay, 2009; Laverty, 2003, p. 22; Neubauer et al., 2019), and centers on the subjective, relational, and structural dynamics shaping everyday life under crisis (Bell, 2017).

Research Setting and Participants

The study was conducted in Maharashtra, a southwestern Indian state significantly affected by COVID-19 and characterized by unevenly distributed public health infrastructure and sporadic formal social work provision. Participants were selected using purposive sampling, which aimed to identify individuals with intersecting economic, social, and health-related vulnerabilities (Coyne, 1997) and to incorporate emerging diversity within the intersectional identities and contexts of their experiences.

Participants were recruited through a combination of publicly available health data and referrals via professional and community networks. To reduce selection bias, all referrals were approached systematically. The final sample consisted of 12 participants, aged between 23 and 68 years, who had contracted and recovered from COVID-19.

Participants were excluded if they had significant cognitive impairments, were advised against discussing COVID-19 due to trauma, were pregnant or medically high-risk at the time of recruitment, or expressed an inability to participate for logistical or psychological reasons. Exclusion criteria were guided by both ethical frameworks and a sound methodological approach to minimize harm in post-trauma inquiry (Indian Council of Medical Research [ICMR], 2020; National Association of Social Workers [NASW], 2021; World Health Organization [WHO], 2020).

Data Collection and Sampling

Data were collected during the post-pandemic recovery period, amid ongoing uncertainty and fear. Prior to recruitment, consultations were held with local physicians and community-based informal social workers to validate the appropriateness and sensitivity of the research design. These consultations and the comprehensive literature review formed the core structure of this phenomenological study (Mackey, 2005; van Manen, 2016). Each participant provided formal, informed consent for both participation and the audio recording of the interviews, in line with the ethical principles outlined by Orb et al. (2001) (Table 1). To recruit a diverse group of participants, a purposive sampling method was employed (Coyne, 1997; Palinkas et al., 2015).

Table 1: List of Study Participants

Sr No.	Name (Pseudonym)	Age	Occupation	Gender	Education
1.	Pratima	55	Doctor	F	BAMS
2.	Ranjana	60	Livestock Keeper	F	Not Any
3.	Sita	62	Farmer	F	Not Shared
4.	Radha	42	Homemaker	F	High School
5.	Seema	27	Student	F	B.Sc. Physics
6.	Rahim	40	Teacher	M	B.Sc.
7.	Ram	68	Labor	M	Not Shared
8.	Shankar	44	Pharmacist	M	M.Sc. Chemistry
9.	Sumitra	40	Counselor/Social worker	F	MSW
10	Karna	55	Labor	M	Not Any
11	Gaurav	23	Photographer	M	B. Sc Chemistry
12	Sumedh	55	Businessperson/Naturopath	M	B. Tech

A semi-structured, open-ended interview format was adopted, allowing participants to guide the conversation. The main guiding question was, “How has your lived experience with COVID-19 been?” The core focus of interviews was to capture the phenomenon of the lived experience of COVID-19 and navigating through their vulnerabilities (Roulston, 2010). Open-ended questions were used to elicit individual perspectives and capture meanings of lived experiences, descriptions of events, emotions, opinions, and suggestions related to their

COVID-19 encounters (Creswell & Poth, 2016). To protect participants from intrusive questioning, the key questions were intentionally kept broad (Baker et al., 1992).

Interviews were conducted either in person at the participant's preferred location or by telephone, depending on the participant's preference and safety considerations (Kvale, 2007; Roulston, 2010). This hybrid approach was necessitated by public health constraints and recognized as potentially influencing narrative depth. Ensuring the trustworthiness of the study, the reflexive memos documented these differences for analytic transparency. Telephone interviews lack context and spontaneity, so we used explicit probes and ensured brief follow-ups. Core themes stayed largely consistent, but in-person interviews gave a richer context. We used pseudonyms and masked identifying details.

The durations of the interviews ranged from 7.29 to 74.12 minutes, with an average of 27.88 minutes. Interviews were conducted in Marathi, the participants' native language, and then transcribed and translated into English to preserve the original semantics and the cultural and linguistic essence. To ensure the ethical conduct of the qualitative study, standards regarding social justice, privacy, and confidentiality were adhered to (Hammersley & Traianou, 2012; Shaw, 2003).

Data Analysis

Each transcript was assigned a unique number and a pseudonym for the respective participant to ensure the confidentiality of their identities (Orb et al., 2001). Individual audio recordings were reviewed multiple times to ensure analytical depth and rigor in the analysis (Roulston, 2010). For data analysis, a coding table was developed based on the methodological framework proposed by Smith, Flowers, and Larkin (2009). The coding approach proposed by Larkin, Watts, and Clifton (2006) was used for qualitative data analysis. Each transcript was analyzed, first by applying cumulative coding to identify the patterns of meaning within the narrative; in the second stage, integrative coding was used to identify patterns of meaning across all transcripts (Larkin et al., 2006). Along with research notes (Nowell et al., 2017) and the codes, the synthesis led to the main themes and sub-themes (Braun & Clarke, 2006). These themes represent both individual trajectories and shared social patterns, grounded in the context of structural marginalization (Table 2).

Table 2: Themes and Sub-Themes

Theme	Sub-theme
Theme 1: Embodied Vulnerability and Existential Insecurity	1.1 Disconcerting Encounters with Pandemic-Disrupted Daily Life
	1.2 Emotional Costs of COVID-Positivity
	1.3 Resilient Bodies Navigating Embodied Vulnerability
	1.4 Stigma Fragmenting Sense of Self
Theme 2: Evolved Vulnerabilities	2.1 Facing Multifaceted Lockdown Trauma

Disintegrating Economic Survival	2.2 Enduring Vulnerabilities of Post-Recovery Livelihoods
Theme 3: Gendered Embodiment of Invisible Pandemic Vulnerability	
Theme 4: Fragile Families with Pandemic's Relational Vulnerability	
Theme 5: Deteriorating Institutional Failures and Abandonment	5.1 Diagnostic Uncertainties and Being Helpless
	5.2 Deep Existential Vulnerability of Hospitalization
	5.3 Navigating Pandemic-Induced Despair of Healing
Theme 6: Trust-Mistrust of Embodied Institutional Vulnerability	6.1 Fractured Dependability to Self-Managed Care
	6.2: Seeking Alternative Paths for Healing
Theme 7: Evolving Post-COVID Health and Wellness Vulnerabilities	

Ethical Considerations

All research procedures adhered to the ethical frameworks of the World Health Organization (2020), the Indian Council of Medical Research (2020), and the National Association of Social Workers (2021). Ethical review was informed by principles of non-maleficence, autonomy, and justice. All guidelines from local public health authorities on human subjects research during the pandemic were complied with. The National Association of Social Workers Code of Ethics (2021), which emphasizes respect for the dignity, privacy, and autonomy of all individuals, serves as the standard disciplinary ethical standards in social work. Consent was obtained through a two-tier process: first, for voluntary participation, and second, for audio recording. All study-related questions that participants had were addressed before the interview. As a standard ethical practice aimed at preventing harm, the study excluded highly vulnerable individuals or groups, such as those with cognitive impairments or individuals who had recently experienced trauma (ICMR, 2020). Reflexive notes throughout the research process documented ethical responsiveness and researcher accountability (Hammersley & Traianou, 2012; Shaw, 2003). Participants were de-identified during the data analysis and further dissemination (Orb et al., 2001).

Findings and Results

The analysis began with primary coding to capture the rich, individual experiences of COVID-19 survivors and was followed by secondary coding to group similar patterns. Through the iterative integration of both levels of coding, seven main themes and eleven sub-themes emerged, representing both the lived experience during the pandemic and the structural dimensions of evolving fragility.

Theme 1: Embodied Vulnerability and Existential Insecurity

This theme reflects how participants experienced psychological fragility and physical insecurity under conditions of uncertainty that emerged not only from the disease but also from disrupted routines, misinformation, and inadequate institutional support.

Sub-theme 1: Disconcerting Encounters with Pandemic-Disrupted Daily Life

Participants reported that heightened exposure risks intensified anxiety, especially when health awareness was low and healthcare access was limited. Rahim recalled, "At that time, the situation was hard. No one knew what COVID was. COVID is fatal—that was the situation in the beginning. Everyone thought so. This was the image created in the news and elsewhere." Pratima, a local physician, experienced compounding vulnerabilities due to inadequate guidelines and processes, insufficient resources, lack of adequate protection, and uncontrollable exposure risks due to patients withholding exposure histories, she added: "Before going close (to the patient), one must inquire (about their infection status). Many do not give history."

These narratives show how information gaps, frontline occupational hazards, and institutional failures intersect to generate existential insecurity (Castañeda et al., 2015; Quesada et al., 2011).

Sub-theme 2: Emotional Costs of COVID-Positivity

Participants described grief, isolation, hospitalization, and financial burden intertwined to escalate emotional burdens. Sumitra, who lost both parents while contracting COVID-19 herself, reflected: "In the first 2-3 weeks, there was shock due to the death of my mother and father… Then this infection is to me… I was admitted. I was there in that hospital for 7-8 days." Such cumulative trauma illustrates how vulnerability extends beyond physical illness into psychological and social domains (Banerjee, 2020). Others described stigma and intensified emotional distress triggered by neighbors, as Gaurav noted: "The one on the first floor (neighbors) made a lot of outcries: 'This patient should not be here! It will be good to have a private room!" Similarly, Karna, a daily-wage farm worker, experienced alienation: "This is not my village, and I have no right to seek assistance."

These accounts demonstrate that emotional burdens were not merely individual but socially mediated through community norms and stigma (Galea et al., 2020; Phelan et al., 2008).

Sub-theme 3: Resilient Bodies Navigating Embodied Vulnerability

Despite suffering from physical symptoms and psychological distress, some participants demonstrated resilience and developed coping strategies that enabled them to endure illness. Sumitra found temporary relief through rest, while Ram spoke of intense mental distress, but noted: "For four days, it was very intense… I could not eat anything … I was scared whether I would live or die!" Such testimonies highlight resilience as a dynamic capacity for adaptation (Windle, 2011), but one constrained by limited psychosocial resources and persistent uncertainty (Polizzi et al., 2020). In these cases, resilience did not erase vulnerability; rather, it coexisted with and was shaped by structural deficits in healthcare and support.

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Sub-theme 4: Stigma Fragmenting Sense of Self

Stigma shaped how participants understood themselves and their relationships. Shankar recalled, "Help? There is no help. No one helps others. Near also (smiles), they do not come! (They used to say) Stay away! You must stay away! Means, this is ignorance." Seema was denied access to her father's cremation: "The village council head said they would not allow the cremation...(they said) 'We will not allow it!'"

Gender roles further intersected with stigma, with women disproportionately bearing both caregiving and exclusion (Smith et al., 2021). Theme 1 shows embodied-relational precarity in the form of fear and stigma co-produced distress, especially where institutional signals were inconsistent.

Theme 2: Evolved Vulnerabilities Disintegrating Economic Survival

Economic precarity was both intensified by the pandemic and prolonged by the lasting health and social consequences of COVID-19. Participants' accounts show how pre-existing economic vulnerabilities intersected with lockdown measures to generate new crises and hinder recovery, which highlighted the structural fragility of livelihoods in informal and small-scale work.

Sub-theme 1: Facing Multifaceted Lockdown Trauma

Lockdowns halted all income-generating activities, which were particularly detrimental for economically vulnerable groups. Rahim ran into a major financial crisis after using loans and savings to launch a venture that collapsed. He added, "I just opened the coaching classes, and immediately there was a lockdown. It created this economic crisis... Everything was stopped… Means closed." Similar shutdowns halted informal services (e.g., events, street trade), eliminating income for months.

Such testimonies illustrate how workers in small enterprises and informal sectors, lacking social protection, faced severe financial hardship (International Labour Organization, 2020; Nicola et al., 2020). Comparable patterns were reported globally as street vendors in Latin America and domestic workers in Africa faced immediate income loss due to movement restrictions and absent state safety nets (Ogando et al., 2022). These patterns highlight how lockdowns exposed structural vulnerability, where work precarity was compounded by exclusion from institutional relief.

Sub-theme 2: Enduring Vulnerabilities of Post-recovery Livelihoods

For many, economic recovery lagged far behind physical recovery. Persistent fatigue, stigma, and fear of reinfection limited survivors' ability to return to work. Sumitra recalled, "After the death of my parents, my health was so down that I did not have the stamina to sit, stand, and speak. Because of that, my work was stopped entirely." Her experience aligns with evidence on post-COVID fatigue as a barrier to re-engagement in economic activity (Greenhalgh et al., 2020). Post-viral fatigue and stigma slowed labor reentry, embedding income fragility.

Taken together, these narratives reveal how economic vulnerability during the pandemic was not merely a temporary loss of income but a dynamic, structural condition, produced through the interaction of illness, stigma, and inadequate social protection.

Theme 3: Gendered Embodiment of Invisible Pandemic Vulnerability

During the pandemic, gender-specific vulnerabilities became extremely evident. Pratima, a private physician, carried out her clinic duties alone while looking after her COVID-19-diagnosed spouse. She explained, "My test was negative, so I was relaxed. He was isolated… And after three days, I had chills in the night… when tested, it came out positive." Her account illustrates how women often compromised their own health while prioritizing care for family members (Power, 2020).

Ranjana, a livestock keeper, surfaced the intersection of gender, rural labor, and access to healthcare: “When doctors used to come to check on me sometimes, I used to be in the grazing fields. They used to come there to check on me.” Her narrative shows how women in informal rural sectors were doubly burdened, managing subsistence work while navigating disrupted healthcare access (Wenham et al., 2020).

These narratives resonate with global evidence that shows how the pandemic intensified unpaid care burdens and disproportionately affected women’s employment and health worldwide (Alon et al., 2020; Wenham et al., 2020).

Theme 4: Fragile Families with Pandemic’s Relational Vulnerability

Vulnerability was relational and spread across households. The burden of care, fear of infecting others, juggling paid/unpaid labor, and managing household duties under isolation converged to destabilize family functioning. Karn described the strain of leaving his son alone during quarantine: “... tension means my son was alone here. Two cattle. How would one person manage it? At least there should be food arrangements for him. But he prepared rice and survived for 15 days." Similarly, Sumitra balanced paid work, caregiving, and domestic chores, noting. At that time everything was from home, son, son's school, husband's office, calls, my work for the agency, and all online sessions.” She eventually engaged her son in household tasks to manage competing demands. Other participants, such as Shankar, found their children distressed by the situation. At the same time, households like those of Ranjana, Sumitra, and Rahim faced additional challenges when multiple family members were infected simultaneously.

These accounts illustrate how emotional and psychological distress were compounded by logistical challenges of caregiving under isolation (Prime et al., 2020). Relational vulnerability was particularly acute for women, who disproportionately absorbed increased domestic burdens (Craig & Churchill, 2020), and for families without extended kin networks to provide relief. Similar findings have been documented globally, where pandemic conditions intensified parenting stress, disrupted family cohesion, and heightened risks of child neglect or mental health decline (Chung et al., 2020; Cluver et al., 2020). These narratives show that vulnerability within families was not merely an accumulation of individual burdens but a relational condition shaped by gendered expectations, unequal access to institutional support, and the structural invisibility of caregiving labor.

Theme 5: Deteriorating Institutional Failures and Abandonment

Participants often felt failed by public systems such as healthcare, bureaucracy, and social policy, especially when diagnosis, care, or support was delayed or insufficient.

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Sub-theme 1: Diagnostic Uncertainties and Being Helpless

While healthcare systems were overwhelmed by the COVID-19 pandemic, particularly in areas with limited resources (Lal et al., 2021), delays in testing or improper sampling and diagnosis processes increased distress. Seema recalled her experience at a rural health center: "They are so tired that when you must take a throat swab, they just keep it on the surface and take (the sample) ... which means if the test was (detected earlier as) positive, we could have taken quick treatment." Radha reported missed tests despite visiting testing facilities.

Such lapses generated psychological stress and reinforced exclusion for those in unorganized labor and rural communities (Duggal et al., 2022; Sen-Crowe et al., 2020). These experiences exemplify broader structural deficiencies in healthcare delivery during the pandemic (Lal et al., 2021).

Sub-theme 2: Deep Existential Vulnerability of Hospitalization

For those requiring hospitalization, the lack of beds and chaotic processes produced both physical risk and existential distress. Sumitra recalled: "Doctors used to leave in their vehicles, and people used to run after them… Because there was no vacancy. People were waiting outside. Patients are outside the hospital." Shankar described how insurance and billing disputes further compounded suffering: "When I talked with the insurance company again, the insurance company told me that this is the particular rule and does not pay anything else. However, hospital management was saying that we cannot accept this particular component."

Such experiences highlight how systemic flaws, from inadequate capacity to bureaucratic inefficiencies, intensified feelings of abandonment and mistrust in institutions (Ahmed et al., 2020; Czeisler et al., 2020). Globally, similar scenes unfolded, from ICU shortages in the United States to oxygen crises in Latin America and Africa, underscoring the shared nature of institutional fragility in crisis (Biccard et al., 2021; Bravata et al., 2021; Ferrante & Fearnside, 2024; French et al., 2021; Mahase, 2022; Schwalb et al., 2022).

Sub-theme 3: Navigating Pandemic-Induced Despair of Healing

Persistent health issues (e.g., throat pain, leg weakness), fears of reinfection, and mismanagement of medication (e.g., distribution of remdesivir without explicit consent) all produced ongoing vulnerability. Some turned to home remedies when formal care failed. Sumitra described the distress of medication mismanagement: "I was also given remdesivir. The remdesivir procured for me, which I got after a lot of calling and inquiring, they distributed among other patients (without consent)."

Others recounted persistent weakness, pain, or fears of reinfection, leading some to turn to home remedies when formal care failed. Such accounts illustrate how institutional mismanagement prolonged suffering and produced enduring vulnerability, pushing survivors to improvise care outside of formal systems. Theme five specified India-particular mechanisms such as diagnostic delays in rural facilities, scarcity of beds, and insurance/payment frictions that convert acute illness into prolonged hardship, linking embodied experiences to bureaucratic and infrastructural failures.

Theme 6: Trust-Mistrust of Embodied Institutional Vulnerability

Participants frequently described feelings of abandonment by public systems such as healthcare, bureaucracy, and social policy, particularly when diagnosis, treatment, or institutional support was delayed or insufficient. These inadequacies left them oscillating between dependence on institutions and reliance on embodied or alternative forms of care.

Sub-theme 1: Fractured Dependability to Self-Managed Care

Participants expressed deep ambivalence toward biomedical guidance, shaped by inadequate health education, misinformation, and inconsistent institutional responses. Shankar recalled resisting medical advice: “Blood thinning… I did not want to have blood-thinning treatment because I knew my body and what kind of infection I had. It was just a cough.”

This self-determined choice reflected his reliance on embodied knowledge in the absence of trusted guidance. Similar accounts highlighted how participants assumed responsibility for self-care in a climate of fear, without institutional guidance or assurance. As Chou et al. (2021) note, mistrust often emerges not from ignorance but from institutional failures of communication, transparency, and compassion.

Sub-theme 2: Seeking Alternative Paths for Healing

In the context of mistrust and systemic failure, many participants turned to alternative healing practices, including Ayurveda, homeopathy, dietary regimens, and mindfulness-based coping strategies. Gaurav explained: "Everyone suggested I take this and that. But I never consumed anything from outside. I mostly consumed homeopathic remedies. But someone gave me two-three Ayurvedic (herbal) remedies. I took that much!"

Similarly, Sumitra, a trained counselor, combined her professional knowledge with guided self-imagery, self-suggestions, and meditation (Brooks et al., 2020). Shankar adhered to a strict, nutritious diet, meditation, and mild exercise, while Gaurav found the exercise regimen suggested by his homeopathic physician helpful in overcoming fear and loneliness. Others described using vernacular remedies as pragmatic tools.

When dominant healthcare systems were unavailable or overwhelmed, rural communities relied on alternative care (Charan et al., 2021; Maikhuri et al., 2024). Homeopathic and Ayurvedic medicines saw increased use during the pandemic, especially where modern healthcare was inaccessible or lacked public trust (Tillu et al., 2020). Globally, reliance on non-biomedical healing also increased in regions with limited institutional credibility or capacity, a dynamic well-documented in health systems literature (Maikhuri et al., 2024). These narratives underscore that mistrust in biomedical institutions was not simply a rejection of science but a relational phenomenon shaped by structural vulnerability, institutional opacity, and the search for meaning and control under uncertainty. Vulnerability here was not merely the absence of biomedical support but the lived experience of negotiating uncertainty in contexts of systemic failure.

Theme 7: Evolving Post-COVID Health and Wellness Vulnerabilities

This theme captures the lingering physical, psychological, and behavioral challenges participants faced following clinical recovery from COVID-19. Their narratives reveal that

vulnerability after infection was chronic, embodied, and socially mediated, highlighting the long tail of the pandemic's impact. Sumitra described persistent physical strain: "My weight increased by seven to eight kilograms during COVID. Now my struggle is only the weight I gained. I am after the weight loss slowly. Now, I also breathe out when walking. I suffer from gasping while walking."

Such accounts resonate with global evidence that post-COVID conditions, commonly referred to as Long COVID, include respiratory, neurological, and psychological symptoms that endure months after infection (Nalbandian et al., 2021; World Health Organization, 2022).

Psychological vulnerabilities were also prominent. Radha reported ongoing stress and insomnia after losing her husband: "I cannot say, I mean, frequently I feel! This tension is only that our person expired so suddenly." Radha was left without treatment for her trauma and struggled with anxiety and insomnia. These experiences underscore hybrid forms of post-crisis embodied vulnerability shaped by health vigilance, trauma, mistrust, cognitive-emotional fatigue, shifting health beliefs, and the fragility of informal health safety nets.

While some participants engaged in coping strategies such as dietary changes, meditation, or reliance on traditional remedies, most lacked access to formal rehabilitation or mental health services. Such patterns mirror the global scenario in which post-COVID care remains fragmented, underfunded, and often inaccessible, particularly in low- and middle-income contexts (Brooks et al., 2020; Czeisler et al., 2020). Even in high-income countries, Long COVID patients reported insufficient institutional recognition and support (Davis et al., 2021).

Collectively, these findings emphasize that post-recovery does not automatically translate to resilience. Instead, survivors often faced a muted but persistent form of vulnerability that risked becoming entrenched health inequity in the absence of sustained, systemic support. Post-COVID care must therefore be understood as part of the broader global challenge of addressing evolving, multidimensional vulnerability.

Conceptualizing Relational, Structural, and Experiential Vulnerability

The coronavirus pandemic forced a renewed interrogation of complex meanings and manifestations of vulnerability. In public health as well as policy narratives worldwide, vulnerability often functions as an agreeable descriptive label for signifying at-risk groups (Munari et al., 2023). However, as a conceptual device, this usage risks reifying complex, dynamic relations into static categories and thereby obscuring the mechanisms that generate risk. In this paper, we adopt a relational and structural model of vulnerability that treats vulnerability as produced through relations among bodies, institutions, labor markets, and social norms, and continually reproduced (and potentially contested) by social arrangements rather than as an intrinsic attribute of particular people. In line with Butler's relational view, this study understands vulnerability as co-produced through social relations, institutions, and power dynamics. We explore this by examining how participants' lived experiences connect with institutional rules, labor markets, and gendered care systems, moving past individualistic or deterministic explanations. This reorientation matters for social work practice because it alters what is measured, who interventions are designed for, and how accountability for harm is allocated (Butler, 2016; Munari et al., 2023; Quesada et al., 2011; Singer, 2017).

Relational and Embodied Vulnerability

Vulnerability is experienced in and through exposure to several factors, such as infection, the failure of care systems, stigma, and economic precarity (Kapilashrami & John, 2023). Judith Butler's political-theoretical reframing shows that vulnerability is not simply a dispositional deficit but a set of relational exposures that constrain and at times enable forms of agency and collective resistance (Butler, 2016). From a phenomenological and social work perspective, prioritizing first-person narratives reveals how pain, fear, physical limitations, and social exclusion interdependently create lived vulnerability through the interplay of symptoms, social meanings, and institutional responses. Recent qualitative Indian work on migrant and informal workers, for example, documents how debt, food insecurity, transport shutdowns, and social suspicion directed at returnees became embodied as anxiety, illness, and social isolation during lockdowns (Choolayil & Putran, 2021; Kundu & Debnath, 2024; Mookerjee & Roy, 2023; Nath et al., 2023; Raju et al., 2021; Singh, 2021; Yadav & Priya, 2020). Adding to the complexity, gendered norms and relational dependencies made women more vulnerable to the indirect effects of COVID-19 disruptions (Afridi, 2023). These accounts push us to treat bodies as interpretive sites where structural failures are materially registered.

Structural Vulnerability as Process

Structural vulnerability locates the production of risk in political economy, labor regimes, healthcare access, and bureaucratic rules rather than in individual pathology (Ahu et al., 2020; Kohut et al., 2024). Medical-anthropological perspectives show how institutional insults (legal exclusion, precarious employment, inadequate social protection) are embodied in patterns of illness and constrained choice (Litavec & Basom,2023; Quesada et al., 2011; Reineke et al., 2023; Thapa et al., 2021). In India, large-scale empirical studies found that the predominantly informal labor market, weak social security, and uneven reach of relief measures were primary drivers of the pandemic's differentiated harms in the form of massive earnings losses, food insecurity, and incomplete coverage by state relief (Kesar et al., 2021; Nath et al., 2023). These structural dynamics help explain why caregivers, daily-wage laborers, and rural households experienced deeper and more persistent harms than many formal-sector workers (Dang et al., 2025; Mittal et al., 2023). Reading vulnerability structurally therefore redirects intervention away from individual-centered interventionist objectivity toward reforming policy, social protection, and labor regulation (Katz et al., 2019; Munari et al., 2023).

Attributed Versus Lived Vulnerability

Another analytical move distinguishes vulnerability as an attribute assigned by institutions (for targeting, triage, or funding) from vulnerability as narrated and experienced by people on the ground. Programmatic categories such as "elderly," "comorbidities," or "migrant workers" serve administrative purposes but can misalign with how people describe their own precarities, such as loss of livelihood, caregiving exhaustion, stigma, or distrust (Mookerjee & Roy, 2023; Singh, 2021). Social work practitioners should prioritize addressing vulnerable life circumstances as they are experienced by individuals, rather than focusing on predetermined demographic groups (Virokannas et al., 2018). Phenomenological and interpretative methods (e.g., hermeneutic phenomenology, interpretative phenomenological analysis [IPA]) allow us to capture how individuals narrate precarity, thus revealing

mismatches between institutional labels and lived needs (Polkinghorne, 1988; van Manen, 2016).

Vulnerability as Dynamic and Processual

The pandemic underlined that vulnerability is not a one-off status but a process that evolves across epidemiological, economic, and social time. Acute infection could precipitate long-term impairment (post-COVID morbidity), economic displacement, or altered household roles; similarly, short-term relief without structural reform produced recovery trajectories that were incomplete or regressive (Nath et al., 2023). Static lists of "at-risk" groups miss those whose risk emerges only after clinical recovery or through cumulative institutional failures. Syndemic frameworks highlight how social determinants and comorbidities interact with COVID-19, demonstrating that disease clusters and social disadvantage exacerbate each other (Bambra et al., 2020; Singer, 2017). Practically, this means social protection systems and social work case management must be capable of longitudinal, context-sensitive monitoring and adaptive response.

Implications of Dynamic Vulnerability on Social Work

Social work necessitates multi-level interventions that acknowledge the relational and structural determinants of vulnerability. Micro-level casework should be integrated with mezzo and macro strategies, including advocating for social protection and comprehensive health coverage, fostering robust community support networks, and utilizing trauma-informed frameworks to address the structural, political, and personal dimensions of social harm (Bowen & Murshid, 2016; Brooks et al., 2020). Indian social work scholarship and practitioner reports show how professionals improvised community-based responses (food distribution, mental-health helplines, legal aid) while simultaneously calling for structural reforms such as universal access to health care, portability of entitlements for migrants, and formal recognition of labor protections in the informal sector (Bhadra, 2021).

Conceptual clarity on evolving vulnerability has direct methodological consequences. Research should move beyond cross-sectional vulnerability checklists to mixed-methods designs combining longitudinal quantitative indicators (earnings, food security, service access) with qualitative narratives that reveal how people interpret and negotiate risk. Sampling frames should deliberately include those who fall into vulnerability after crises (caregivers, those with long COVID, return migrants). Researchers and practitioners should ethically avoid paternalistic labeling, ensure consent processes, reporting, and program design respect dignity and self-definition, while acknowledging power imbalances in defining vulnerability (Polkinghorne, 1988; van Manen, 2016).

Bridging the Local and the Global

Evidence emerged in India on migrants, informal workers, rural households, and healthcare workers, reveals mechanisms that are not unique to India but are repeated in low-resource settings globally such as highly informal labor markets, fragmented social protection, and institutional mistrust produce cascades of harm (Bambra et al., 2020; Kesar et al., 2021; Mookerjee & Roy, 2023). Translating local phenomenological findings into a relational/structural model thus enables analytic transferability without crude generalization. The mechanisms (diagnostic failures, labor precarity, care burdens, bureaucratic exclusion)

can be specified and tested across contexts, which is more likely to allow social workers to design context-sensitive but mechanism-informed interventions.

The survivors' stories in this study show how the pandemic changed what vulnerability looks like in everyday life. Building on the conceptual framing above, the narratives remind us that vulnerability is not a fixed label but a process that is produced through interactions among bodies, families, institutions, and policy choices. The pandemic expanded existing disadvantages while generating new forms of marginalization (Ahmed et al., 2020; Lal et al., 2021). We expand the Indian context as an analytic case with mechanistic transferability derived from phenomenological understanding of factors such as diagnostic uncertainty, labor informality, gendered care burdens, and bureaucratic exclusion to the global context across Africa, Latin America, and parts of Europe and North America.

Our findings make three linked points. First, vulnerability is embodied and relational, evidenced by how people experienced physical illness, fear, stigma, and caregiving burdens together, not as separate problems. These layers were mutually reinforcing. For example, post-COVID fatigue made work impossible, further increasing economic strain and social exclusion. Second, vulnerability is structurally produced as derived from the delays in testing, overcrowded hospitals, insurance and billing failures, and weak social protection, which turned individual illness into prolonged hardship. Third, vulnerability is situational and dynamic as it evolved after clinical recovery into long-term health, economic, and psychosocial struggles. The interaction of these layers with marked individual and structural factors formed a processual vulnerability that evolved across health, income, and care responsibilities.

These points have practical implications. The turn to alternative remedies (homeopathy, Ayurvedic herbs, local practices) was not merely cultural but was often a response to institutional failure and lack of trusted care (Charan et al., 2021; Tillu et al., 2020). Rather than dismissing culturally accepted practices, social work and public health professionals should research, regulate, and integrate them into community care when appropriate, ensuring protection from unsafe or exploitative approaches (Alon et al., 2020; Chou et al., 2021).

Economic and gendered vulnerabilities require urgent attention. Informal and daily-wage workers in this study faced long recoveries because health effects, stigma, and lack of credit prevented reentry into work. Cash transfers, emergency credit, and job reintegration programs targeted at those whose status changed during the pandemic can reduce persistent hardship (Ogando et al., 2022; Kesar et al., 2021). Women's additional unpaid care burdens and care-related health costs point to the need for gender-responsive recovery measures (Afridi, 2023; Dominelli, 2021).

The pandemic exposed the absence of formal social work responses in many local settings. Where social workers were present, they buffered distress and linked people to services. Embedding social work in clinics, quarantine centers, and outreach programs would help translate policy commitments into on-the-ground support (Banks et al., 2020; Mishna et al., 2022). Alongside this, mental health and rehabilitation services must be sustained beyond the acute crisis to address long-term embodied vulnerabilities (Brooks et al., 2020).

Comparable evidence has emerged globally. In Latin America, pandemic responses were hindered by the widespread informality of labor markets, limiting the reach of income assistance programs (Busso et al., 2021). As a result, issues with adequacy, delays, and

insufficient targeting were noted, and many vulnerable groups were left out (Henry, 2020; Garrido et al., 2023), which further intensified the vulnerability during the pandemic (Halpern & Ranzani, 2022). In sub-Saharan Africa, community resilience strategies were adapted in locally specific ways (Conduah & Ofoe, 2025), and informal protection systems shifted significantly in response to crisis pressures (Devereux, 2021; Oware et al., 2025). Herron et al. (2025), in a Canadian study of older rural adults, found that formal welfare supports combined with strong community resources were central to resilience. Broader analyses also stress that building resilience in rural contexts requires structurally grounded and inclusive forms of social protection (Rusere et al., 2025).

This study supports a shift from static categories of "at-risk" groups toward ongoing, context-sensitive monitoring and rights-based, adaptive interventions that recognize vulnerability as lived and changing. Doing so will require better coordination among health systems, welfare programs, and social work practitioners so that policy responses follow lived realities rather than assume them.

3 Discussion

The survivors' stories in this study show how the pandemic changed what vulnerability looks like in everyday life. Building on the conceptual framing above, the narratives signify that vulnerability is not a fixed label but a process produced through interactions among bodies, families, institutions, and policy choices. The pandemic extended existing disadvantages while generating new forms of marginalization (Ahmed et al., 2020; Lal et al., 2021).

Our findings make three linked points. First, vulnerability is embodied and relational: people experienced physical illness, fear, stigma, and caregiving burdens together, not as separate problems. These layers were mutually reinforcing; for example, post-COVID fatigue made work impossible, which increased economic strain and social exclusion. Second, vulnerability is structurally produced: delays in testing, overcrowded hospitals, insurance and billing failures, and weak social protection turned individual illness into prolonged hardship. Third, vulnerability is situational and dynamic as it evolved after clinical recovery into long-term health, economic, and psychosocial struggles.

These points have practical implications. The turn to alternative remedies (homeopathy, Ayurvedic herbs, local practices) was not merely cultural; it was often a response to institutional failure and lack of trusted care (Charan et al., 2021; Tillu et al., 2020). Social work and public health actors should not automatically dismiss such practices; instead, they should engage with them in the form of research, regulate, and, where appropriate, integrate culturally accepted strategies into community care while protecting people from unsafe or exploitative approaches (Alon et al., 2020; Chou et al., 2021).

Economic and gendered vulnerabilities require urgent attention. Informal and daily-wage workers in this study faced long recoveries because health effects, stigma, and lack of credit prevented reentry into work. Cash transfers, emergency credit, and job reintegration programs targeted at those whose status changed during the pandemic can reduce persistent hardship (Ogando et al., 2022; Kesar et al., 2021). Women's additional unpaid care burdens and care-related health costs point to the need for gender-responsive recovery measures (Dominelli, 2021).

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Herron et al. (2025), in a Canadian study of older rural adults, found that formal welfare supports combined with strong community resources were central to resilience. Broader analyses also stress that building resilience in rural contexts requires structurally grounded and inclusive forms of social protection (Rusere et al., 2025). This study supports a shift from static categories of "at-risk" groups toward ongoing, context-sensitive monitoring and rights-based, adaptive interventions that recognize vulnerability as lived and changing. Doing so will require better coordination among health systems, welfare programs, and social work practitioners so that policy responses follow lived realities rather than assume them.

Policy and Practice Implications

The findings underscore that policy and practice responses to COVID-19 must recognize vulnerability as relational, dynamic, and structurally produced rather than as a fixed attribute. Embedding social work within both health systems and community structures is essential, ensuring that psychosocial support, case-finding, and referral mechanisms are not treated as peripheral but integrated into primary and secondary health delivery (Banks et al., 2020; Mishna et al., 2022). Mental health and rehabilitation must be considered integral to recovery planning, with community-based services, structured follow-up for post-COVID conditions, and accessible rehabilitation clinics addressing long-term embodied and psychosocial vulnerabilities (Brooks et al., 2020; Nalbandian et al., 2021; World Health Organization, 2020).

At the level of social protection, pandemic recovery requires adaptive mechanisms that respond to shifting needs. Evidence from India and other regions demonstrates that emergency cash transfers, wage protections, and rapid credit lines targeted to workers and households disrupted by illness, stigma, or employment loss can mitigate the risk of temporary shocks evolving into long-term exclusion (Gentilini, 2022; International Labour Organization, 2020; Ogando et al., 2022). The gendered nature of pandemic experiences, particularly the disproportionate burden of unpaid care work borne by women, highlights the necessity of gender-responsive recovery planning, including childcare provision, income assistance for informal workers, and policies designed to redistribute care responsibilities (Afridi, 2023; Dominelli, 2021; Wenham et al., 2020).

The study also points to the need for constructive engagement with culturally embedded health practices. Reliance on Ayurvedic remedies, homeopathy, and local healing strategies was not merely a matter of tradition but a pragmatic response to institutional mistrust and health system gaps. While such practices must be subject to scrutiny and regulation, respectful incorporation of safe and widely accepted remedies could enhance both trust and reach in community health strategies (Chou et al., 2021; Tillu et al., 2020). At the same time, strengthening diagnostics, communication systems, and trust-building measures within healthcare institutions is vital for countering misinformation, reducing delays, and alleviating stigma (Lal et al., 2021; World Health Organization, 2020).

Policy frameworks must move beyond static categorizations of "the vulnerable" and adopt tools that can monitor vulnerability as an evolving process. Robust but straightforward monitoring mechanisms located within primary care and social work practice, connected to rapid-response funding streams, would allow assistance to follow the changing contours of lived precarity rather than remain bound to rigid administrative classifications (Bowen & Murshid, 2016; Gentilini, 2022). Taken together, these implications reinforce that recovery from COVID-19, in India and globally, must be equity-driven, context-sensitive, and capable of adapting to the shifting realities of those most affected.

4 Limitations of the Study

This research was conducted in a region with distinct social and public health characteristics, specifically in the southwestern part of India. The findings, therefore, reflect a particular social and temporal context and may not be generalizable to other parts of India or global settings. As a phenomenological inquiry, the study's intent was not representativeness but depth, foregrounding the lived experiences of participants during a specific historical moment of the pandemic. Such narratives are necessarily situated and may evolve as memories shift and post-pandemic conditions change.

Recruitment posed considerable challenges. In the absence of a centralized or standardized database of COVID-19 survivors, participation relied on informal networks and referrals. Several individuals, particularly those who had lost family members, declined participation. In contrast, others limited the length or depth of their narratives because of emotional strain or the competing demands of work and caregiving. In some instances, family members mediated the consent process, which further influenced access. These dynamics reduced the sample size and constrained diversity.

The study also included narratives about the use of alternative healing methods, such as homeopathy and herbal remedies. These accounts were presented as part of participants' lived experiences, not as evidence of clinical efficacy. Questions of medical effectiveness, safety, or broader outcomes lie outside the scope of this study and require future interdisciplinary research.

While the study offers important insights into how vulnerabilities were experienced and narrated in the acute and immediate aftermath of COVID-19, its cross-sectional design limits the ability to track how such vulnerabilities evolve over time. A longitudinal approach would be necessary to capture the ongoing processes of recovery, adaptation, and structural change. These limitations, common to pandemic-related qualitative research in both India and international contexts, should be borne in mind when interpreting the findings and applying them to policy and practice.

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5 Conclusion

The lived experiences of COVID-19 survivors presented in this study reveal how the pandemic exposed and intensified multiple layers of vulnerability. A phenomenological lens demonstrates how these processes are embodied, relational, and historically situated, underscoring the critical role of public health, social work, and welfare policy in addressing them. The findings affirm that unless long-standing structural vulnerabilities are systematically addressed through rights-based, equity-driven reforms, crises will continue to generate new forms of marginalization. Narrow clinical or socio-economic definitions of vulnerability are insufficient; responses must account for lived experiences, especially in under-resourced or institutionally neglected settings. The pandemic highlighted the urgent need for inclusive, adaptive, and context-sensitive interventions. Social work must be integrated more fully with health and policy systems, providing psychosocial support, facilitating access to services, and ensuring continuity of care not only during crises but throughout recovery and beyond. Policies that recognize the interconnected nature of health, economic security, caregiving, gender relations, and community trust are better positioned to strengthen resilience.

By situating these findings within broader debates on structural and relational vulnerability, the study contributes to global efforts to reconceptualize vulnerability as a dynamic process rather than a fixed status. In low-resource and fragile settings globally, resilient recovery hinges on aligning public health, social work, and welfare policy to rebuild trust, reduce exclusion, and foster equitable futures. Unless structural drivers of precarity are addressed, pandemic-like crises will continue to generate new exclusions. Integrating social work with health and welfare systems, through trust-building, longitudinal monitoring, and gender-responsive protection, is central to adaptive, equity-driven recovery.

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