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Social work practice following the COVID-19 pandemic: Reflections from Brazil, India and Scotland

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Abstract

COVID-19 impacted globally, on individual health, care systems and social reproduction. Excessive death, lockdowns and social policy change had immediate and long-term national and global implications. Attention has been given to the immediate consequences, including its disproportionate impact on parts of society such as older people, "black" and "ethnic minorities", and migrants. This raises questions for social work about wider enduring lessons including social inequality and globalisation. Reflecting across three countries, we encourage debate on future professional lessons, recognising constraints the pandemic has imposed and the dilemma of relying on historical precedents, of which we now find we have none.

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Introduction

The COVID-19 pandemic resulted in a dramatic loss of human life worldwide and presented an unprecedented challenge to communities, public health, food systems and the world of work. The economic and social disruption caused by the pandemic was devastating, tens of millions of people fell into extreme poverty, while the number of undernourished people, estimated at nearly 690 million, may increase to 132 million in following years (Alrabadi et al., 2020). Organisations such as The International Labour Organisation, Food and Agriculture Organisation, International Fund of Agricultural Development and World Health Organisation (ILO, 2020) have highlighted the differential impact of COVID-19 across diverse countries. So too, this crisis cannot be dissociated from the cumulative effects of the application of neoliberal and political policies, along with the impact of the 2007/2008 financial crisis which has still to be overcome. This complexity forms part of a structural capitalist crisis (Meszaros, 2009). Consequently, the structural causes of inequality including precarious working conditions, economic disparity, and anti-democratic political processes and institutions, are linked to concerns about social class, ethnicity, gender, education achievement, and existing social vulnerabilities in society (Paremoer et al., 2021, p. 1). In other words, we have experienced living through the pandemic within an existing financial crisis. It is our hope that the pandemic was a once in a lifetime experience and as we struggle to make sense of our experience, we recognise that we are often tempted to apply historical tools to compare contemporary realities due to a lack of historical parallels (Ferguson, 2020).

The pandemic has further highlighted the proliferation of multiple borders, and their consequent impact, within our societies including the differential experience of rural versus urban life, family, society, wealth, life in the capitalist core and periphery countries, along with the availability of national, and regional resources. The phases of pandemic, along with COVID-19 vaccine inequity, have had a lasting and profound impact on socio-economic recovery in all countries. However, in low- and lower-middle income countries in particular, urgent action is and was needed to assure equitable access for all, including through dose sharing (United Nations Development Program [UNDP], 2022). At a national level, social workers were engaged in the ethical and practice challenges (Banks et al., 2020a).

We seek to reflect the impact of the pandemic in our countries – Brasil, India, and the United Kingdom, but more specifically how this occurred in a context of economic and political crisis in all three countries. These countries represent different socio-economic and political contexts globally, the United Kingdom being at the core of global capitalism, while Brasil and India are economies of the periphery of this economic system. Social work was one of the few professions during the pandemic to speak out on these dilemmas and issues of inequality and vulnerability (Ferguson et al., 2022). We feel beholden to continue this critical reflection on the challenges experienced through the pandemic to encourage wider debate and ensure the lessons of this time are not forgotten.

We acknowledge that in our professional reflections, globally we often use similar social work concept and words, despite the context, meaning, reality, impact and experience in our national contexts being varied. Despite this, the echoes of these conversations have ongoing resonance. For example, the term, social distance, had different meanings and implications in each of our nations, including that of alienation from an already hierarchical society and enduring inequalities. This is

important as many commonly used terms such as lockdown were used, despite different contexts and their granular impacts in communities. Our paper thus draws on three stories, told to facilitate and support critical reflections on future lessons for our communities and profession, encourage professional engagement with structural social work, policy development, implementation, and evaluation, along with global professional solidarity and learning.

Three stories of contexts told

Brasil

Brasil a country of enormous diversity, immense inequality, which was badly exacerbated by the COVID pandemic. Located in eastern Latin America, Brasil has an estimated population on 215,562,830 (IBGE, 2023) distributed in five different regions – North, Northeast, South, Southeast and Middle West. Brasil is one of the world's most economically unequal countries, despite being one of the wealthiest (Oxfam International, 2019); with 62.5 million people considered poor (living on less than US$5.50 per day), and a further 17.9 million people extremely poor (living on less than US$1.90 per day) representing 8.4% of the population (IBGE, 2023). It is marked by deep regional inequalities that are the result of an historical heritage which demarcates territorial use along with the political and economic setup of the country. The concentration of extreme poverty (56.8% of people) in the Northeast region (27.2% of the Brasil's population) (IBGE, 2020). Inequality is also exacerbated by ethnicity (those self-categorising as 'black' and 'pardo' comprise 55% of the population). This majority population are more socially disadvantaged compared to 'whites', with 30% of black children experiencing malnutrition and a mortality rate for those aged below 1 year old being twice as high (UNICEF, 2019). Black women earn around a third less than white men, and 44% less than white women in the job market (Miguel and Biroli, 2014, p. 45). Education levels provide a further indicator of inequality with 6.6% (11 million) of persons aged 15 years and over being illiterate, with higher rates between men than women (6.9% and 6.3% for women) and between black (8.9%) and white (3.6%) people (IBGE, 2020).

The social distancing measures imposed to contain the spread of the virus in Brasil, along with worsening of consumer and business confidence, resulted in the biggest decrease in GDP since the beginning of the collection of this data in 1901. At the start of 2020, 12.6% of Brasilian's were unemployed, with hidden unemployment estimated at 5%, of those who are no longer seeking employment, 40% of people worked in informal employment, with rapidly increasing inequality (Prates and Barbosa, 2020). Increased poverty and extreme poverty in Brasil have continued to reproduce the racial and gender inequalities that existed before the pandemic. In 2021 poverty had increased to 38%, for black women 36% for black men, compared to 19% for white women and men respectively (Nassif-Pires et al., 2021).

Existing inequality widened further with around 13.9% of the population being unemployed in 2020, against 12.7% in 2019 (IBGE, 2020), while in the same period Brasilian billionaire's wealth grew by 39% between April and July 2020 (UBS and PwC, 2020). This resulted in the further exposure of social inequality, previously been denied by elements of society (Costa et al., 2020). Importantly, the professional position of social workers in Brasil, is to consider the socio-economic and cultural determinants of social inequalities (Garcia et al. 2022), which underlines the daily struggle of the working class to survive in an extremely unequal country.

The Unified Health System (SUS) has been cited as a successful healthcare system in Latin America, for guaranteeing rights to health for all Brasilian citizens. However, underfunding has put this guarantee at risk (Souza, 2020), while during the pandemic, 72.1% of people (150 million) accessed the Public Health System (SUS) of which 3.5 million were employed.

Brasil has around 200,000 social workers registered in the 27 State Regional Councils of Social Work (CRESS) (CFESS, 2023). The profession comprises mostly women (92.9%), working in public institutions (approximately 60%), the majority employed in health, social assistance, and social security (CFESS, 2023). The profession is regulated by Federal Law 8.662/1993 along with the Ethical Code of Social Workers (Brasil, 1993), which defines professional competences and attributes. The Ethical Code maintains the professions ethical and political position, supports an ethical and emancipatory approach to address inequalities, exploitation, oppression, discrimination, and violence and acknowledges the courage and commitment of the profession to organise and provide professional practice (CFESS, 2019).

Social Work is listed as a health profession (Brasil, 1998) with 39,784 social workers employed in SUS in 2022 (Tabnet, 2023), underlining the professions importance in emergency situations such as the pandemic. Social workers comprised around 20% of the staff in Social Assistance Service with a considerable portion having precarious and/or temporary employment contracts (Ministerio da Cidadania, 2020). As a predominantly female profession, they were affected by gender inequality, with many being responsible for caring for the people they live with. Through the pandemic due to school closures, social distancing, social workers experienced an overload of stresses (in all dimensions: physical, emotional, etc.) because of the demands on them (Matos, 2020).

Social work support demand increased during the pandemic which included access to food, utilities access, income support, provision of guidance on social distance measures, services to those at high risk, that is, older people (especially those at high risk of neglect), and support to groups including those homeless, refugees, migrants, victims of domestic violence, and so on. Many of these demands required immediate assistance.

At the start of pandemic, social workers experienced a lack of personal protective equipment including masks, gloves, alcohol gel, along with challenges in having priority for vaccination against H1N1 and COVID-19 rapid testing. They faced the ongoing human tragedy of their and others fears, mourning and death. This posed difficulties in balancing the need to provide services, as well as ensure their personal rights, that is, workplace safety. Precarious working conditions often predated the pandemic (although these have continued to worsen); with staffing reductions; increased service demand partly amplified by misunderstandings of professional responsibility and competences all occurred in an environment, which included lowered social benefits (including food). Faced with this challenge, the Federal Council for Social Work has published guidance for social workers to support and ensure their professional and personal rights in the context of the health crisis and its repercussions (CFESS, 2020). The right to appropriate working conditions, enshrined in article 7 of the Ethical Code, including both fundamental principles and values, and reaffirms professional ethical and political commitments to the defence of life, freedom, and human emancipation. However, despite these regulations, between April 2020 and May 2021, 87 social workers died due COVID-19 (37.9% working in Health System and 31.1% in Social Assistance) (Garcia et al., 2021).

India

Located in South Asia, India is the world's third-largest economy, measured by purchasing power parity (PPP) terms (Sahoo et al., 2023), has the second highest population in the world (1.366 billion) (World Bank, 2021) and a population density of 462 per sq. km. Prior to colonial rule by the United Kingdom, India was one of the wealthiest countries in the world (McQuade, 2017). India is a country of multiple nations, with 22 officially recognised languages and nearly 1600 spoken languages, multiple ethnic identities, with numerous religious practices, cultures, and social

practices. The UN-Habitat (2022) report estimates that Indian urban population was 483,099,000 in 2020 and it will increase to 542,743,000 by 2025. This growth in urbanisation will result in the urban population increasing from an estimated 31.8% in 2011 to 38.6% by 2036 (National Commission on Population, 2019). Almost 30% of the rural population live in poverty (Bhadra, 2021). In terms of levels of poverty, India ranks 102 out of the Global Hunger Index of 117 countries, 50% of the poor are chronically poor, with poverty being gendered and also inherited between generations (Mahapatra, 2002). An estimated 76% of the rural poor are unable to afford nutritious food (Raghunathan et al., 2021). Agoramoorthy and Hsu (2020) highlight the importance of the caste system, especially as poverty is clustered in the marginalised castes, who have poor access to resources and precarious lives. Critics such as Roy (2021) argue the reasons for the enduring legacy of poverty are a result of both political and administrative apathy, poor governance, centralised power structure and abuses of power. While poverty features in all elections, with further poverty relief programmes launched, little changes in precarious lives at grass roots level (Bhadra, 2021), while any disaster provides double jeopardy for the poor (Have, 2018).

Changing economic structures and urbanisation within India have resulted in large migratory movements of people (Breman, 2005), the majority being precarious without any employment guarantees or social security and consequently move between villages to harvest crops on a seasonal basis, with workers in non-seasonal times being employed in manufacturing and construction sectors. Gupta and Lebel (2020) estimates that in 2020 there were around 600 million internal migrants in India. The lockdown caused widespread panic and many migrants in the cities attempted to return to their rural hometowns in their home states (Irudaya Rajan et al., 2020). The size of this internal migration, along with a 4-hour notice period, cut off income for many, resulting in little or no resources to live, suggesting that the Indian government had not considered the implications on the lockdown (Irudaya Rajan et al., 2020). In rural areas the sudden return of migrants increased the stresses on rural infrastructure and job availability (Bhadra, 2021). The service sector has also increased with greater informal employment due to the declines in manufacturing industry (Chowdhury, 2021), that is, the so-called gig economy (Vyas, 2021). Acharya and Christopher (2022) highlighted how the well-being of individuals was impacted due to social category (caste). The numbers of migrant 'blue-tent' or 'silver-sheeted' within cities or their periphery increased and resulted in new forms of segregation or enclosure. Irudaya Rajan et al. (2020) highlighted that the lockdown also resulted in the closure of schools and colleges, with a rise in domestic violence, increases in childhood marriages and higher rates of mental health crisis.

Bhadra (2021) argued that India's harsh and unplanned lockdown caused its own humanitarian crisis rather than effective slowing the spread of COVID-19, particularly for marginalised, precarious, indigenous and caste groups. As a result, the death estimate is estimated to be 10 times higher than the official record of 4 million until July 2021 (Biswas, 2021). Furthermore, almost 66% of the Indian health workforce were concentrated in urban areas, resulting in rural areas being either unable to access suitable services or needing to travel to urban centres or both (Karan et al., 2021). Thiagarajan (2021) highlights neoliberal reform resulted in increased market-based solutions, but with worsening outcomes and increased costs, while non-market solutions based on solidarity, trust and rights gained ground. Despite little evidence of effectivity, during the pandemic or before, the government has increased its role of purchaser of services from private care providers using insurance and contracts (Thiagarajan, 2021). The rapid rise of an ageing population, alongside low levels of fertility and low mortality (Sahoo et al., 2023). These have increased longer terms concerns about economic output longer-term, public health as well as pension and health system sustainability (Lee et al., 2011). Growth in private care has worsened accessibility to services for those without means (Sahoo et al., 2023). This has created high levels of 'out of pocket' expenses (Rajalakshmi et al, 2023) which affected the poor the worst during the pandemic.

The impact of the pandemic on children included school closures increased the pressure on care givers, the non-provision of nutritional supplements to those below 6 years old which exacerbated social and health issues for children. Accusations of child sexual abuse and child labour increased during lockdown period (Ramaswamy and Seshadri, 2020). Furthermore, 3.3 million Indian children were malnourished (Nguyen et al., 2021).

Social work education in India is over 70 years old and its skills are often used to support developing social cohesion, as well as empowering individuals, groups and communities (Hare, 2004). Social workers are often focussed on co-ordinating volunteers to undertake counselling, meet family needs, providing for those in need and undertaking referrals. Challenges for social workers included restricted mobility due to the lockdown, lack of financial support or information, lack of supplies for relief efforts (Prasad et al., 2022, p. 11). So too, almost 20% of social workers sample reported the death of a close relative (Prasad et al., 2022). Consequently, the pandemic impacted on everyone but in different and nuanced ways (Prasad et al., 2022, p. 54).

Scotland

The United Kingdom comprises four nations which together make up the United Kingdom, a member of the G7 wealthiest countries a former member of the European Union (EU) (BBC, 2018) and a former colonial power. Scotland is situated in the north of the United Kingdom and while its landmass is around a third of the United Kingdom, its population is around 5.4 million people, or 8.2% of the UK population (BBC, 2018). Most of the population reside in one of the seven major cities which are geographically situated in the North, East, and South of the country.

Within the United Kingdom, Scotland has devolved government functions for areas such as health and social care and education, while other policies and legislation (see, for instance, defence, most taxation, and social benefits) are still largely decided by the government in Westminster (London). The United Kingdom and devolved governments coordinated their response to the COVID-19 pandemic through several intergovernmental for a with each of the devolved administrations through the Scottish government being able to make different decisions about how to react to various issues, but these largely reflected in UK-wide actions.

The impact of COVID-19 was felt nationally and while we initially were interested in focussing on Scotland alone, but it was clear that the UK literature provided a broader perspective of social work challenges which also impacted in Scotland. Significantly, older people suffered higher death rates and were often discharged from hospital into care homes without negative COVID-19 tests which spread infection in care homes, as did rotating patients in hospitals (Christie, 2020; Dancer et al., 2021). Care homes themselves lacked proper testing, and adequate personal protective equipment for staff, resulting in the rapid spread of the virus in a contained population (nrscotland.gov.uk, 2020).

Johnson (2022) highlights that during the COVID pandemic inequalities widened. The pandemic also highlighted existing inequalities among different minority ethnic groups in England and Wales, with those groups also experiencing higher excess mortality compared to the white British population (Platt and Warwick, 2020). In COVID-19 admissions to ICU units, a higher proportion came from more deprived areas and similarly, mortality was significantly higher for those living with greater socio-economic deprivation (Lone et al., 2021).

Social workers throughout the pandemic provided services while lacking adequate supplies of protective equipment; having limited support and supervision (due to working online and a lack of knowledge and experience of managing disasters), along with solutions to reach those living in isolation and in rural communities (Dominelli, 2021). Owens et al. (2023) highlights that prior to the pandemic there were already staff shortages (110,000 across health and social care), high levels

of stress, burnout, poor morale and excessive workloads. Based on a scoping review of 967 papers, they identified that the pandemic worsened existing restricted funding, staff sickness rates, recruitment problems and effected both morale and well-being (Owens et al., 2023). Social workers also experienced moral challenges in the allocation of resources (Banks et al., 2020b). Personal Protective Equipment (PPE) for social workers was initially unavailable and later limited (Sen et al., 2022). This was set against the backdrop of widening social inequality, expectations of state provision for an ageing population, the widening use of new technology when access to basic Internet connections could be sporadic across many areas of the country, as along with the prohibitive cost of purchasing equipment for those on low or no income.

At the height of the pandemic, workers in the NHS were (literally) applauded in streets at night for the work they were undertaking, although it was evident that those who also provided social care were often left out of the media portrayal of those on the 'front line' (Golightley and Holloway, 2020; O'Leary and Tsui, 2020a). The government in England following the pandemic refused to address health sector unions demands for higher wages, leading to large numbers of the health sector undertaking protracted industrial action. Social workers also saw their wages curtailed resulting in their union (UNISON) pledging to ballot for potential industrial action (Samuel, 2023). Social workers during the acute pandemic period had to manage the anxiety and uncertainly of service users, while often placing their own needs, worries and concerns as secondary, all against a backdrop of media portrayal and historic attitudes which tended to view the profession as being inferior to other roles within health and well-being. It is unclear what enduring mental health issues workers will need to deal with, what ongoing support will be available and the worsening impact of socio-economic conditions including precarity, fuel and food poverty such as isolation loneliness, and class inequalities.

Challenges: Echoes across three countries

While difficult to separate the collective from the individual, we recognise that the COVID-19 pandemic highlighted many socio-economic processes are not always directly observable, along with the importance of the key lessons from the pandemic that require ongoing consideration. As such we need to reflect on the lessons from our different realities, which has included the enormous levels of precarity and social inequality, the lack of PPE globally, the ongoing inequality of whom had access to vaccines, and the impact on social work and those who social work delivers support too.

The relationship between the global health crisis and the subsequent economic crises has impacted on the living and working conditions of mostly the working class around the world, this had included the rise of precarious employment such as the gig economy (Huws et al., 2019). It was inevitable that the consequences of these social demands would need to be addressed by social workers. The lessons from the pandemic required society and the profession to reexamine challenging questions such as equity, equality and how resources should be distributed, particularly as the later involves questions about both access and allocation (Gupta and Lebel, 2020). Debates to enable fair access require consideration of social inclusiveness to public services, as well as the causes, and how some can dominate access to resources using both the market and non-market contexts of services (Gupta et al., 2021). Social inclusiveness and universal access would enable people to access, public services including that of water, education, food, free healthcare, all of which would reduce precarity and vulnerability to disease and the impacts of disaster (Mikulewicz, 2018).

The challenge therefore for the profession, is that it requires ongoing considered and ethical practice which defends the interests of the working class. The fight for justice, equality, universal

public policies, rights-based employment and service access in all contexts to be the daily agenda of social workers (see for instance Duarte, 2017). This requires professional theorisation and strategies to support the collective organisation of social workers, in solidarity with working class social movements to support the interventions proposed by social workers (Ferguson, 2017).

Macro engagement is required as the socio-economic policies are a result of neoliberalism, including 'gig economy', economic liberalisation, reduced social protection, and increased structural inequality (Schrecker and Bambra, 2015). Increased levels of precarity in all our societies was seemingly less noticeable before the pandemic. The global economic shock along with the experience of the pandemic demonstrated the inbuilt and growing insecurity in our societies. There is an urgent need for increased support to deal with these structural concerns and precarity, along with universal rights and support particularly groups such as children, homeless, older people, refugees, and those with suffer from discrimination. Greater awareness of social reproduction in households and labour, may also provide opportunities to reshape political, social production responses and contribution to life and work (Stevano et al., 2021). The pandemic has reaffirmed the world is interlinked, that many problems and solutions require global collaboration and solidarity, along with a recognition of our interdependency and reliance on each other. Consequently, our theoretical and practice understanding of governance, accountability and social structures require constant engagement by professionals and citizens alike (Kenkel, 2020).

The social work context in each country differed due to their socio-economic, political and cultural contexts but we have also identified similar professional echoes in all three countries which provides us with opportunities for wider learning. The three countries comprise three capitalist economies although at different stages, all with right wing governments, which created demands and challenges for social workers during and post-pandemic. The capitalist system also sought to gain from the crisis, see for instance the massive fraud related to the provision of PPE in the United Kingdom as well as the recognition that the system also increased social inequality with austerity solutions being promoted for economic crises and policy responses. Thus, social inequality should be viewed and addressed as a government commitment in agreement with society. The United Nations General Assembly (UN, 2006) has agreed 'the right of people to live in freedom and dignity' and recognised 'that all individuals, in particular vulnerable people, are entitled to freedom from fear and freedom from want'. Consequently, the profession should work with communities to identify and support resistance to policy changes which propose, and which have attacked civil liberties, human rights. Privatisation of systems health pre-the pandemic has demonstrated the need for universal state led mass health and care systems.

There is a widened need to understand and consider the inroads, impact and consequences of neoliberalism and austerity on our societies (Singh and Cowden, 2015). This is not only on citizens and services but also the profession itself. The context of social work practice required wider theorisation and debate on how the profession should seek to address this impact in differing contexts (see for instance (Garcia et al., 2021; Ornellas et al., 2018; Spolander et al., 2014, 2016)). Intervention and action are necessary at three levels: (1) adequate provision of social assistance (social, socio-educational), (2) management and (3) planning and political-organisational (planned action aimed at mobilisation and political-organisational assistance). In relation to social work, it is necessary to map and understand working conditions of social workers in our three countries, and globally. The work of social work requires us to also consider the impact of managerialism, professional discretion and the factors which encourage or deter recruitment and retention such as adequate remuneration, safe working conditions, access to specialist equipment and permanency of employment. This would only be achieved through solidarity and collaborative work across the profession, along with interprofessional and intersectoral engagement in our respective countries and internationally to improve conditions.

Theoretical and practice training for qualifying students during the pandemic was severely impacted in many countries, resulting in rapid changes to be made to both teaching and practice education. This requires an open, honest appraisal and reflection on the impact on our professional training, not only where practitioners might have missed essential skill and knowledge development but also how we empower students to consider structural problems in society and engagement with communities as their core work.

Throughout the pandemic and even now afterwards, social work has experienced higher levels of demand for services, which has impacted on workloads, required intensive working from home using online and technology. A significant lesson is to revisit our collective approaches and support and openly explore professional, national and global challenges in our future. This should include demanding ongoing mental health support for society and the profession as it deals with the consequences of the high death rate and resulting societal impact. Thus, we need to retain our commitment to humanity and have support for an uncertain future but also use the opportunity to organise politically, remembering that the caring professions were considered heroes by policy makers until issues of renumeration and working conditions were raised.

The social work role is much greater than its administrative demands, requiring relationship-based work. While during the pandemic less face-to-face contact with service users was undertaken, bureaucratic burdens increased due to demands for greater risk-assessed visits, the need for protective equipment, which required much greater understanding of the skills of the profession due to the new demands and suggested new interventions. Pandemic social work widely used technologies in intervention, but we should not forget the importance of in person face-to-face intervention, often critical to the development of trusting relationships, support understanding of the wider context of the person you are supporting due to all the criticisms of telework for social work (Lloyd and Payne, 2009).

Ethical challenges for practitioners extended beyond the needs of providing services without adequate PPE to include questions related to maintaining trust, privacy, dignity, and service user autonomy through the delivery of services via remote relationships. So too, questions arose about whose and how rights need to be balanced with the needs of different communities, demanding challenging decisions about if or whether to break or bend policies in the interests of service users. This was in part mirrored by the complexity of working with communities and health staff, many of whom were similarly seeking to balance their own professional and organisational requirements. This underlines the challenges for social work needing to be assertive, inter-disciplinary and engaging with wider health and welfare system and policies, such that the profession ensures that it supports the design, implementation and evaluation of care and health services which address the needs of residents in each of our countries.

Conclusion: Social work profession in a post-pandemic world

The legacy of the pandemic highlights globally the need for social work to support those most isolated or experiencing social crises and recognise the interconnectedness of humanity. Globally, social work needs to consider lessons but also the impact of policies such as neoliberal and marketized economies are increasing precarity, impacting on human rights and social reproduction in our society. The pandemic helped shine a light on this increased precarity, vulnerability and discrimination. The professions response needs to redouble its efforts to address the challenges of social reproduction, to help shape political and democratic responses to ensure good lives for all in the world. If social work does not adequately analyse the present challenges, the profession will not have a clear professional understanding of what is necessary for a humane and socially just society in a post-pandemic world. This also requires us to reflect on our assumption of the context, how

and the role of social work profession in the social division of labour. Nissen (2020, p. 310) affirms: 'social work should be part of this body of emerging knowledge and practice and can be'.

We also need to consider the implications for our professional workforce, which is largely female, state employed profession (although India is dominated by private NGOs, corporate social responsibility) (Jacob, 2016) and its relationships to power, perceptions of gender and ethnicity. The profession being impacted by changing traditional care contexts requiring our consideration (Deku et al., 2021). However, we should increasingly be focussed on micro/macro intervention debates, to evaluate our professional role and purpose, how we engage increased use of technology (including artificial intelligence), along with the loss of confidence in skills and expertise because of the pandemic and neoliberal reforms. At a national level, the profession should remain committed and continue to demand the extension and preservation of human rights and structural change. We should therefore be vigilant to ensure that the lessons of COVID-19 are learnt, and that be mindful the ongoing existing inequalities will not just disappear (O'Leary and Tsui, 2020b).

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