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COVID in Context: The Lived Experience of Richmond's Low-Income Older Adults

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Abstract

Taking a phenomenological approach, this qualitative study describes the lived experiences of low-income older adults during the COVID-19 pandemic. A socio-ecological model was used to organize the five identified themes describing the lived experience: socio-economic context, Black Lives Matter and the politics of race, COVID and polarized views of COVID, interpersonal context (social connections), and individual context (feelings, beliefs, and behaviors). Study findings illustrate the intersectionality of contextual influences on the experience of low-income older adults. Study participants demonstrated remarkable resilience and coping strategies developed in response to the challenges they experienced throughout their lifetime which benefited them when faced with the pandemic, social unrest, and political events that took place in 2020. This study highlights the importance of understanding the larger context of COVID-19 which has significant implications for policy makers and public health leaders.

Keywords

COVID-19, social-ecological model, health disparities, older adults, Black Lives Matter

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Introduction

The coronavirus (COVID-19) pandemic has impacted the world tremendously. In the United States alone, the number of cases has exceeded 40 million (Centers for Disease Control and Prevention [CDC], 2021a), with approximately 22,000 of those in the city of Richmond, Virginia (Virginia Department of Health, 2021). Since the World Health Organization declared COVID-19 a pandemic, communities have implemented unprecedented measures that greatly affected many lives. Unfortunately, these experiences have not been analogous for all populations. Although certain communities have been able to make necessary adjustments, this has been more difficult for older, lower-income adults and those with existing health and social disparities. The vulnerabilities of the older adult population have been in the spotlight as eight

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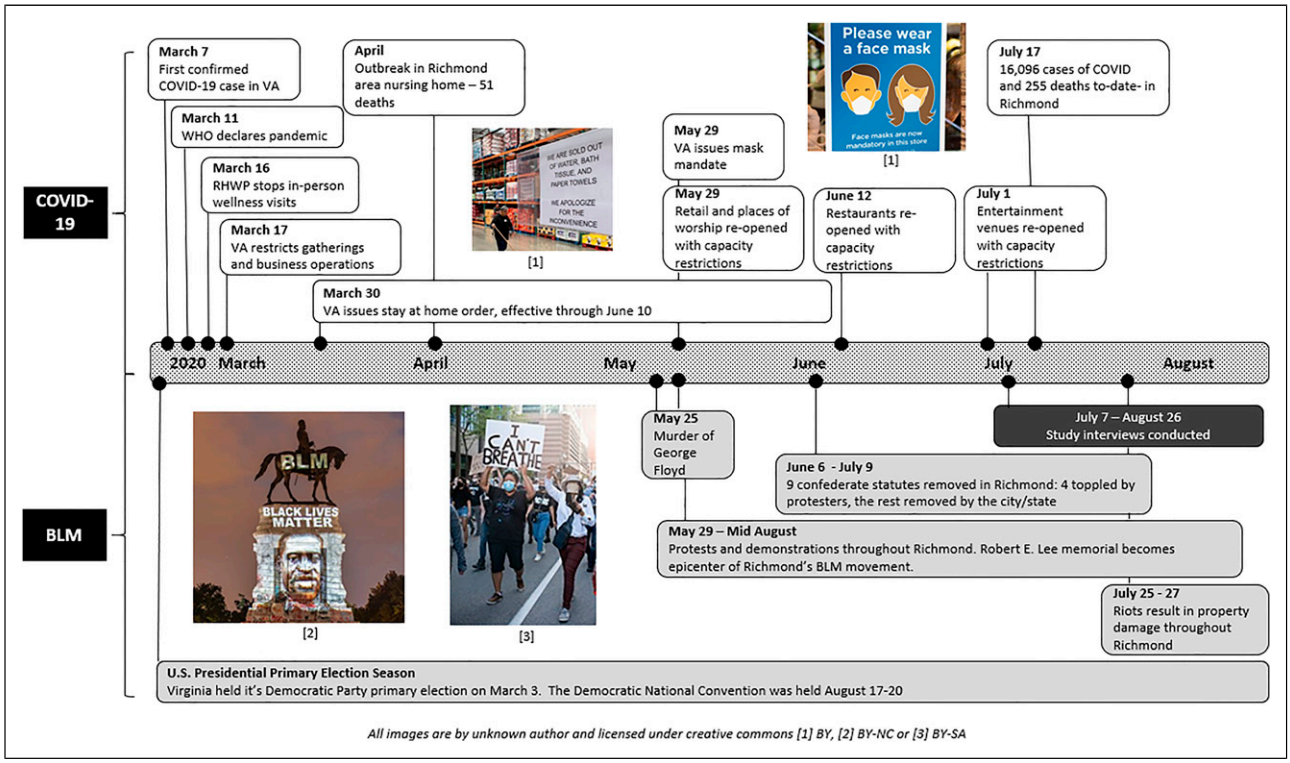

Figure 1. Contextual timeline of the study.

out of ten COVID-19 related deaths in the United States have been among adults 65 years of age and older (CDC, 2021a).

Pandemic-related restrictions and social distancing measures led to challenges to necessary support for community-dwelling older adults, which increased the risk for worsening chronic conditions (Mills et al., 2020). Additionally, much research has explored the social-emotional impact of the pandemic on older adults. For instance, García-Portilla et al. (2021) found that half the women and one third of the men they surveyed reported symptoms of emotional distress attributed to the pandemic, while those *under* age 60 were more likely to report symptoms, and Siette et al. (2021) found that older adults quality of life decreased during the pandemic. On the other hand, Bundy et al. (2021) found that already isolated older adults did not experience greater loneliness during the pandemic, and other research has suggested that older adults demonstrate resilience and adaptiveness which benefited them during the pandemic (Brook and Clark, 2020; García-Portilla et al., 2021). Studies examining racial disparities of the pandemic highlight higher COVID-19 mortality rates among African Americans compared to white Americans (Dalsania et al., 2021). But to date, much of the research on the pandemic (both qualitative and quantitative) focuses exclusively on the experience of the pandemic itself, out of context from other things happening in the world—mainly the explosion of the Black Lives Matter (BLM) movement and resurfacing of decades of racial strife in the United States (U.S.). In a commentary published by the National Academy of Medicine, Wong, Washington, and Moy (Wong, et al., 2021) assert that "the traditional approach to examining disparities as static and uniform is inadequate and may potentially mask disparities" and urge researchers to consider the context of time and place. Our study does just that and demonstrates the importance of understanding COVID-19 in context.

Philosophical Approach

As an approach to research, interpretive phenomenology is grounded in the belief "that individuals' realities are invariably influenced by the world in which they live" (Lopez & Willis, 2004). Also central to phenomenology is the concept of the *lived experience* which implies not just the experiences people have, but what the experiences *mean* to the individuals (Frechette et al., 2020). Thus, taking a phenomenological approach, our study was designed to understand the lived experience of low-income older adults during the pandemic. These were the early days of the crisis, when the country, and the world, was singularly focused on containing COVID-19. What we had not planned for during the development of this study was the concurrent nation-wide racial crisis sparked by the murder of George Floyd. Yet it is within this larger societal context that our study took place (Figure 1); thus, to understand and interpret the lived experiences of the participants in our study, we started by grounding ourselves in the context of the times—the world

our participants were living in, and present-day Richmond cannot be understood without understanding its legacy of slavery and the continued impact of racism.

Context

Richmond, Virginia, is a city of nearly 230,000 people (U.S. Census Bureau, 2020) approximately 100 miles south of Washington, D.C. Forty percent of Richmond's population is Black/African American (Suarez & Nocera, 2021) and 23% live in poverty (USCB, 2020). While modern Richmond is the capital of Virginia and known as a regional hub for finance and bioscience industries, Richmond is remembered by many in the U.S. as the former capital of the Confederacy, and like other Confederate cities, has a legacy of enslavemente. The remnants of racism from the days of slavery continued to shape Richmond for over a century.

The murder of George Floyd in Minneapolis on May 25, 2020, was a flashpoint for racial politics in the U.S. and Richmond was forced to once again face its racist past. With renewed nation-wide focus on systemic racism and the empowerment of the BLM movement, thousands of protesters descended on Richmond's Monument Avenue, home to six bronze statues commemorating confederate leaders including the former president of the confederacy, Jefferson Davis, and Confederate general Robert E. Lee, to demand their removal. For over 2 months, Lee Circle became the epicenter of Richmond's BLM movement. Streets were closed for peaceful demonstration, which at times turned violent, and property damage caused by rioting protesters forced many businesses to board up (RVA Unrest, n.a.; Schwartz, 2020).

Like other U.S. cities, Richmond was profoundly impacted by the pandemic and policies in place to curb its spread. The crisis began in March of 2020 when the Commonwealth of Virginia restricted the size of gatherings, limited business operations to essential services only (e.g., grocery stores), and eventually issued a stay at home order (Wise, 2021). As the virus spread, news of an outbreak in a local nursing home leading to 51 deaths in April putting Richmond on the map as the severity of the outbreak was second only to the original Seattle outbreak (Martz, 2021). By the end of May, Virginia's governor issued a mandate requiring masks be worn indoors; this pronouncement was made simultaneous to the re-opening of retail business and places of worship with capacity restrictions (Wise, 2021). By early July, 4 months after the initial COVID-19 response, Richmond had over 17,000 reported cases of COVID-19 and 266 deaths (WRIC Newsroom, 2020). During this shut-down, programs supporting lower income and at risk-communities, including the Richmond Health and Wellness Program, were forced to rapidly adjust their service delivery models (Winship et al., 2020), and some, including Feed More's meal delivery programs had to temporarily cease operations (Feed More, 2020).

As part of a mixed methods study to identify and assess COVID-19 impact and needs, the goal of this qualitative component is to better understand the lived experiences of low-income older adults and how they managed the everyday challenges during the COVID-19 crisis.

Methods

Because of the need for rapid data collection and analysis to identify and quickly respond to any identified needs, a mixed-method convergent design (qualitative and quantitative data were collected in a parallel process) was used for this study. This paper reports on the qualitative interviews and associated survey data collected from the interviewees with the survey results reported in a separate publication.

Procedures

The surveys and interviews were conducted by two trained research assistants. All procedures were approved by VCU's Institutional Review Board (HM20019366) and all participants provided verbal consent. Due to the COVID-19 precautions in place at the time of data collection, the surveys were administered via telephone and the interviews were conducted remotely and audio recorded using a secure Google Meet platform.

Recruitment

A convenience sample of survey participants was recruited during telephonic wellness visits with the Richmond Health and Wellness Program (a wellness education and care coordination program operating out of five low-income senior apartment buildings and a community center) (Parsons et al., 2019). Interview participants were subsequently recruited from among the survey participants with aim of interviewing 15% of those surveyed. Gift card incentives were provided to all participants.

Survey Instruments

A demographic survey was administered to collect data on age, gender, race, ethnicity, education level, and living situation. The Epidemic—Pandemic Impacts Inventory Geriatric Adaptation (EPII-G) (Grasso et al., 2020; Manning et al., 2020) was used to learn about the impact of the coronavirus disease pandemic on various domains of health, and positive coping behaviors (permission to use the EPII-G was granted by Dr. Grasso).

Interview Guide

A semi-structured interview guide was developed by the research team. Questions began broadly to allow flexibility for participants to share their experiences and subsequently

Table 1. Description of Interview Participants (N=15).

	n	%
Income		
Less than $10,000	9	60
Between $10,000–$14,999	4	27
Between 15,000–$29,999	2	13
Race		
White	2	13
Multi-racial	2	13
African American	11	73
Education		
Eighth grade or below	1	7
Some high school	3	20
High school graduate	5	33
Some college	5	33
College graduate	1	7
Living status		
Lives alone	11	73
Lives with spouse, roommate, or relatives	3	21
Homeless	1	7
Sex		
Male	7	47
Female	8	53
Age		
Mean	64.6	
Range	55–76	
Utilized food assistance programs (Meals on Wheels, Supplemental Nutrition Assistance Program, commodity box, or food banks)	8	53
Since the corona disease pandemic have you felt or experienced any of the following?		
Depression	7	47
Fears	7	47
Nervousness	5	33
Sadness	9	60
Worry	8	53
Loneliness	7	47

narrowed to facilitate discussion around specific topics (including how they are staying socially connected, positive experiences since the pandemic, and sources of strength).

Analysis

Descriptive statistics were used to summarize demographic characteristics of the fifteen interview participants and selected EPII-G measures are reported by frequency of responses.

The interview recordings were professionally transcribed, de-identified, and the transcripts were analyzed in Atlas.ti v9 (https://atlasti.com/). Using an inductive approach, a team of six transdisciplinary aging researchers (Sargent et al., 2020) began by independently reading two transcripts and highlighting words/phrases that summarized or represented what was being said ("in-vivo coding") (Saldana, 2011). The initial codebook was then developed through team discussion and categorization of the in-vivo codes. Each transcript was subsequently coded by two researchers; codes were compared and consensus formed on any discrepancies. Through an iterative discussion process, the research team collaboratively organized and ordered the codes into themes (Castleberry & Nolen, 2018).

Results

Fifteen interviews were completed (15% of survey participants). The interviews ranged in length from 21 to 55 minutes. The interview sample is described in Table 1. Interviewee responses to the EPII-G survey are highlighted in Table 2. The identified themes describing the lived experiences of low-income older adults are easily understood within a socio-ecological model. Socio-ecological frameworks recognize multiple levels of influence on individuals' beliefs and behaviors as well as the complex interplay between the levels whereby the outermost circle represents the

Table 2. Selected Results of Interview Participants' Responses to Epidemic – Pandemic Impacts Inventory (EPII) (N=15).

Epidemic—Pandemic Impacts Inventory Geriatric Adaptation (EPII-G)	
Social activities	% Yes Responses
Separated from family or close friends	60%
Unable to visit loved one in a care facility (e.g., nursing home and group home)	60%
Family celebrations canceled or restricted	80%
Planned travel or vacations canceled	60%
Religious or spiritual activities canceled or restricted	60%
Economic	
Unable to get enough food or healthy food	20%
Difficulty getting places due to less access to public transportation or concerns about safety	27%
Physical distancing and quarantine	
Isolated or quarantined due to possible exposure to this disease	60%
Positive change	
More quality time with family or friends in person or from a distance (e.g., on the phone, Email, social media, video conferencing, and online gaming)	60%
More time in nature or being outdoors	73%
More time doing enjoyable activities (e.g., reading books and puzzles)	67%
More appreciative of things usually taken for granted	100%
Paid more attention to personal health	93%
Paid more attention to preventing physical injuries	87%
Epidemic—Pandemic Impacts Inventory (EPII) Racial/Ethnic Discrimination Addendum	
Felt unsafe to take safety measures such as wearing a mask or bandana because of race/ethnicity	13%

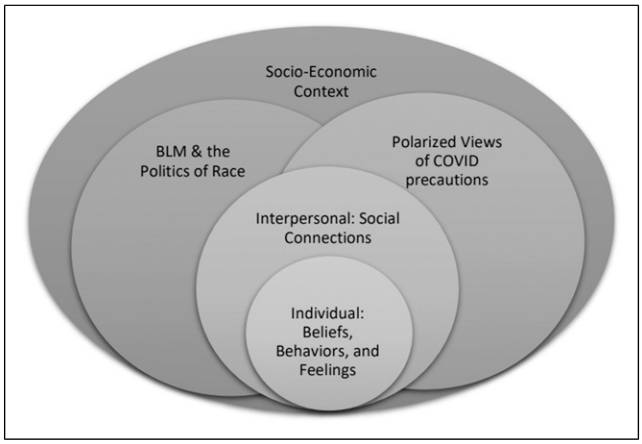

Figure 2. Qualitative themes shaping the lived experience of older adults.

overarching societal context which impacts all lower levels down to the level of the individual (CDC, 2021b) (Figure 2).

Theme 1: Socio-Economic Context

Participants shared their experiences with financial challenges and available resources since the pandemic began. Of the participants interviewed, 60% had an income of less than $10,000 annually, well below the federal poverty level. Participant 6 explained, "Everybody is out here scrambling, trying to get some finances because that's what I would like to do... So, that's one of the major problems for a lot of people, especially black people." Prior to the pandemic, 53% of participants stated that they received food assistance (e.g., meals on wheels), but only 20% indicated in the EPII-G survey that they currently were unable to get enough food. Many participants noticed an increase in support from community-based organizations, religious organizations, and the city department of health during the pandemic, as evidenced by Participant 5: "[Church] is donating food and they are passing the food out, and plus, the Richmond Public School also passes out free lunches to the elder people around here as well." Seventy-three percent of participants resided in an apartment complex; a critical role of the housing management was mentioned in terms of increasing access to available resources.

Access to food notwithstanding, most participants discussed the impact of limited resources in relation to financial adversity. For example, one participant explained,

> I normally would go in and buy the inexpensive brands of bleach, you know like, I guess you'll call it generic or essential brands of bleach. You know, dish lotion, soap powder, the Lysol, you know, that stuff. And once the pandemic came, these things went up to a ridiculous price…So, a lot of times I ended with nothing because I couldn't afford that top shelf stuff (P10).

On the other hand, some participants identified ways that the pandemic was actually reducing financial challenges to accessing resources. For instance, the city's public

transportation system temporarily stopped charging to ride the bus. Since many participants rely on public transportation, they found this beneficial, although as a participant explains, having to take public transportation requires risk:

> I travel on the train or the bus…, I don't drive. My car has been repo'd years ago. But I haven't gotten another car. So, I'm stuck here in this house. Or if I go out, I take my precaution, my mask, gloves... And it's not free to go. Even though it's a blessing that I don't have to pay. But to go somewhere, you have to be covered up and thinking about bringing home what you might have caught on the bus (P11).

Theme 2: Black Lives Matter and the Politics of Race

While the interview guide focused specifically on COVID-19, without prompting, participants frequently discussed the impact of the political strife and protests happening around them in response to the murder of George Floyd. For many participants, the rallies and protests were happening outside their doors: "...the violence that went on over and over again on Broad Street; some of it one block from here; some of it 100 feet down the street" (P3).

Some participants noted that the resource limitations they were experiencing were not a result of financial constraints or the pandemic, but were attributed to the racial violence occurring in Richmond: "I know that shopping is getting a little bit more difficult because so many things are closed up, and many are not reopening….7–Eleven was closed for a while because they trashed that in the violence around here" (P3).

The majority of the participants identified as black/African American or multi-racial, and fear resonated in many of the interviews, for example: "I mean it is scary for a black man to go out here, especially a handicapped one. The way the kids are acting now, they are talking about police killing the blacks, but no, it is blacks on blacks that is killing the blacks. Like we are genocide-ing our own selves, and I just cannot deal with that" (P9). Fear of violence was also described:

> I'm just worried about other people, how they handle it because the way they react because not only in this building but all around the city because people have been cooped up and then they get out, and they show their frustrations by shooting people, violence, and all this crap going on now (P4).

Theme 3: Polarized Views of COVID Precautions

Participants spoke of COVID-19-related policy changes impacting their day-to-day living, some of which they found beneficial, such as free fares for bus rides, and some of which led to conflict, such as mask mandates. All of those interviewed were aware of standard COVID-19 precautions such as wearing masks and social distancing. Sixty percent of those interviewed indicated on the EPII-G that they had isolated or quarantined themselves due to possible exposure to the virus. Many participants expressed frustration and even offense with those who flouted the precautions: for example, "every store that I go into, you got signs out there saying 'masks required.' But yet you got people walking around the store with no masks, and management is not enforcing" (P10) and, "if you are asymptomatic, or if you don't care whether you die or not, that's your privilege. But don't put your beliefs onto somebody else who is trying to stay alive" (P9). Many participants spoke of a sense of personal responsibility to curb the spread of COVID-19, for instance,

> I have personally said, "Please put your mask on. Our drivers are getting sick. And we won't continue to have free rides. We need to put our masks on. Everybody needs to do their part." And the guy said, "Well, mine broke." So, we offered them a mask. We give him a mask…. But if you outright do not want to wear one or you refuse to put one on, you jeopardize everybody else on the bus (P11).

This frustration was experienced not just with strangers out in the community, but also within the walls of their homes, particularly those who lived in apartment buildings. A few participants observed an increase in frustration and anger among residents in their buildings due to both inconveniences resulting from COVID-19 precautions, such as having to wait longer for the elevator due to restriction in the number of passengers at one time, as well as from differing perspectives on the need to take precautions:

> Now, there is some tension developing with the masks and all that...we are only supposed to have a couple people on the elevator at a time, and of course, 250 people in here and two small elevators, that is not going to work. The rule makes sense, but the self-discipline of people in this building is not going to allow that to happen. We have flare-ups, and people get angry, and they go a little bit further in what they say to one another than probably they would normally. And so, that is starting up and has started being noticeable…(P3).

The polarizing views of the pandemic have also led to television being both a source for pandemic information and a source of stress for some participants. Participant 8 spoke of the political-tinged debates constantly on tv, "I hear things on the tv, and you get people talking about, well, you can't tell me what to do with my body. You can't tell – but, you need to respect other people" and participant 4 reported, "I stopped watching TV so much because it was making me so upset" and on the other hand, participant 13 indicated the opposite: "I was watching the news before the COVID-19, and I just watch it even more now."

Theme 4: Interpersonal Context—Social Connections

Participants frequently discussed remaining at home more and limiting in-person social interactions because of the pandemic.

On the EPII-G, 60% of the participants reported that they were separated from family, were unable to visit loved ones, and had restrictions to their religious activities and 80% reported cancellation of family events due to COVID-19. During the interviews, many participants lamented not being able to visit with family, "Because of the COVID-19 you have to spend more time with yourself. You cannot go out and spend time with your family like you normally would" (P13). And while some discussed regular telephone or virtual contact with friends and family, they noted it was not the same as visiting with them in person: "I can Facetime, but all of that is nothing compared to being or seeing family in the flesh. I have grandbabies" (P8). On the other hand, some participants found ways of adapting their routines in order to continue socializing in-person, but in a safer manner: "what we do now is we sit outside, and we spend more time gossiping, and talking about other people, and just making fun of everybody, and the good old stuff" (P3).

Besides family, many interviewees discussed their churches as a major source for social connection. Participants explained the many strategies their churches used to maintain connection with the congregates: from services streamed to YouTube to telephone-based Bible studies, to drive-in services:

> But I can connect with them, and then we have what we call class leaders, and they reach out and call your members just to see how they are doing. And usually, after church service, I will call my cousin or somebody, and we will just talk about the service. So, we connect that way by phone, totally by phone. So, that is twice a week (P7).

Despite the reduction of physically being with friends and family, 60% of the participants indicated on the EPII-G that they actually spent *more* quality time with friends or family since the pandemic. For instance, participant 1 used the pandemic as an opportunity to reconnect with out of state relatives: "…I have reached out to a few cousins—one lives in New York and one lives in New Jersey—that I have re-connected with after several years of separation."

Theme 5: Individual Context: feelings, beliefs, and behaviors

Feelings. The survey results showed that over 50% of the participants reported experiencing sadness or worry, and 47% experienced loneliness since the onset of the pandemic. During the interviews, some participants were open about the ways that the pandemic impacted them emotionally. Often it was discussed in terms of fear or loss. For instance, many participants expressed concern for the wellbeing of their loved ones: "I want my family safe… I really want them safe; I do not want to lose any of them" (P2). Anxiety about protecting one's own health and the emotional toll of limiting social contact was articulated by a few participants, for instance, "I guess I just feel depressed because there's really nowhere to go that you feel safe going" (P4).

On the other hand, many spoke of losses they experienced, yet minimized the emotional impact, for instance, when asked about challenges:

> I do not have any, other than connecting with friends visually...These are people I was very, very close with. But I am not depressed or felt left out because I know they are dealing with their families and their issues, and the time we used to spend together is just a different platform now, so I understand that (P7).

Behaviors. The need for practicing social distancing led to increased technology utilization for those with access (e.g., virtual visits by church members or telehealth visits) and created a positive attitude toward technology that allowed them to maintain connections, "so, modern technology [Netflix, Google, On-line ordering] has made this pandemic a lot easier to deal with, and we all are to be thankful and grateful, and do like we are asked to do" (P8). Participants also reporting engaging in sedentary activities, though for some this was not new behavior. For example, participant 2 reported, "Nothing has changed. I don't go anywhere. I just watch TV and go to sleep."

Over half the participants reported on the EPII-G spending more time in nature (73%) or more time doing enjoyable activities (67%). Some people commented on their increased involvement in leisure activities or finding new hobbies to spend their time alone, as evidenced by this comment: "I involve myself in activities. For one, I do a lot of reading, writing, watching old movies, crossword puzzles, things like that. Oh, and plants and stuff like that. So, that is how I spend my time most of the time" (P1), or participant 14's walking routine: "Oh, I go walking. I go walking at the track. I wear my mask, and I go out to the track and set my iPhone, and I get my steps in."

Changes in activity engagement extended beyond social activities and also impacted health behaviors. Nearly all participants reported on the EPII-G that they were paying more attention to their personal health (93%) and to preventing physical injuries (87%) since the start of the pandemic. All participants expressed a preference for seeing their doctors in-person and several, like participant 3, indicated concern that they were not receiving the same care when doctor appointments were conducted by telephone: "I have not had blood pressure checked or any of that stuff in six months, because the last interview I had with my PCP was by phone, and that is about worthless."

Beliefs. Many participants' comments suggested an internal locus of control, as evidenced by identification of successful coping mechanisms which allowed participants to remain hopeful about the future. Faith and religion were frequently cited as a source of strength as was maintaining a positive attitude in general:

> I know God has got something else in me to do. So that is how come I got to stay strong... You will be so much happier if you do not see the negative in everything, and just have fun. I mean, life is fun. There are a lot of things. There are sad things; there are all kinds of things, but not as a lifestyle" (P12).

Many participants reported taking control of the pandemic situation in ways they are able to, such as going to the grocery store in the morning when there are fewer people and wearing a mask.

While many people maintained a positive attitude, they simultaneously exhibited a sometimes-nihilistic attitude, "Things are, you have to accept things that you can't do anything about. I can't do nothing about COVID, the president can't..." (P10). This external locus of control described participants' acceptance of notions perceived beyond their power of influence, "Well, I do have bills that be popping up. But if I don't have it, guess what? I don't have it. And they can't get it. So, it's just that simple. Don't need me sweating" (P2).

Discussion

Much of the research to-date has focused exclusively on COVID-19: people's attitudes and beliefs, people's experiences, and the negative (and sometimes positive) effects the pandemic has had on people's lives. Our study adds to the literature by illustrating the complexity of people's COVID-19 experiences and the importance of context in interpreting the experience: how the pandemic's socio-economic context which included politics of race and BLM as well as COVID-19 and the polarizing views of the pandemic impacted interpersonal experiences and individual outcomes. Researchers and public health professionals have focused on pandemic-related impacts such as access to food and medical care and social isolation; however, these are challenges our study participants, as low-income older adults, had already been experiencing. Similar to a recent study by Bundy, et al. (2021) that found already isolated older adults did not experience increased feelings of loneliness during the pandemic, we found that the challenges our participants faced, while exacerbated by the pandemic, were not new, and thus were discussed in the interviews with a level of nonchalance and indifference. However, our study highlights the complexities of the social and political environment, beyond just that of the pandemic, that impacted personal and environmental resources. The ripple effects of the pandemic, protests, and political activity impacted the availability of resources, opportunities for social engagement, and added to an already volatile climate. In fact, for many of our participants it was the fear of violence from the political rallies at the time that limited access to resources such as groceries rather than the pandemic itself.

Similar to the study by Sigurvinsdottir, et al. (2020), we found perceived level of personal control was a critical component of emotional state and participation in social activities and behaviors. Our analysis illustrated that high levels of internal locus of control enabled participants to feel a sense of strength, resulting in the successful use of coping mechanisms. Participants expressing high levels of internal locus of control described leaning on spiritual beliefs, positive outlook, and a focus on personal choice and autonomy. Contrarily, those that expressed low external locus of control described stress and discomfort resulting from a lack of power to influence and control their environment. Creating a safe environment and minimizing the virus risks were dependent upon others complying with safety and security protocol. Low compliance by others created a feeling of loss of personal power, a frustration also identified in a study by Brooke and Clark (2020).

Limitations

There are several limitations to this study that must be noted. First, this study explores the lived experiences of one particular community, in one particular geographic area. The experiences we report do not represent the experiences of all people, but rather show the importance and need for understanding context and how it influences individuals' experiences. Due to the COVID-19 precautions in place, the interviews were conducted over the telephone. Thus, excluded from our study was the portion of the community which does not have the financial resources to afford telephone service. Lastly, our interview sample was purposefully selected by research staff. To obtain the richest data for analysis, talkative individuals and those who shared their experiences without prompting during the administration of the EPII-G survey were recruited for formal interviews; thus, selection bias must be considered when interpreting results.

Conclusion

The use of a mixed-methods approach contributes to the comprehensive illumination of the multi-level effects of the pandemic on the everyday lives of low-income older adults, providing credibility to the findings. We have demonstrated the importance of understanding the larger context of COVID-19 which has significant implications for policy makers and public health leaders. To provide truly person-centered care, the health care workforce must understand not just the clinical needs of their clients, but the political, economic, and social context in which they live. Furthermore, one size fits all policies will not sufficiently address the unique needs of specific and individual communities. In Richmond, as in many other communities, the demonstrations in reaction to the murder of George Floyd intersected with the pandemic in unique ways, resulting in intersectional challenges and experiences that influenced outcomes. Study

participants demonstrated remarkable resilience and coping strategies in response to the challenges they experienced throughout their lifetime which benefited them when faced with the pandemic, social unrest, and political events that took place in 2020. Policies to mitigate the effects of events such as a pandemic should acknowledge and address the contextual factors that reinforce or hinder the development of coping strategies.

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