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"You Can't Help a Child if You Don't Know Something Yourself": A Qualitative Study of Barriers to Education in an Underserved West Baltimore Community

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There have been numerous efforts to simultaneously increase awareness and reduce the impact of health disparities and educational inequities. Initiatives have included designing, testing and training on selective interventions, as well as promoting progressive policymaking at local, state, and national levels. Input from the community is essential in building a cradle-to-career continuum of learning and other associated supports. A series of five different focus groups were held with various stakeholders in an underserved community—mothers in a prenatal program (n = 5); youth and young adults (n = 9); community residents (n = 13); principals (n = 5); and teachers and school staff (n = 14). These focus groups were intended to inform research on how children are learning, and how community supports impact student learning. Key themes that emerged included barriers to educational achievement and health promotion, which includes mental health and self-esteem, parental support, early childhood education, and access to healthy food options.

Keywords: *family studies, Promise Neighborhoods, community-based participatory research, focus groups*

Volumes have been written describing research, theory and opinion as to the causes and correlates of disparities in health and educational outcomes in the United States. Still, there is little agreement on the etiology or resolutions of the inequality in opportunity and outcomes faced by many of our most vulnerable citizens, especially those citizens in under-resourced communities of color. There is, however, increasing agreement that health outcomes and educational achievement are influenced by factors outside of their respective sectors, such as social, family, and neighborhood conditions including poverty, structural racism, and environmental hazards (Chen, Martin, & Matthews, 2007; Evans, 2004; Murnane, 2007). The interdependence of health and educational attainment starts early and continues throughout someone's lifespan. For example, children with health challenges, such as asthma or diabetes tend to attend school less frequently and perform more poorly on measures of academic attainment (Haas & Fosse, 2008; Kearney, 2008). Children with lower levels of educational attainment tend to have less economic success and worse health across their lifespans (Case, Fertig & Paxson, 2005; Heckman, 2008; Lynch, Kaplan & Shema, 1997). Consequently, any effort to understand the drivers of health outcomes, educational attainment or poverty should begin with examining the relationship between the three. Using an ecological framework, this article describes the interaction of factors that focus groups participants note create barriers to health promotion and educational attainment in an underserved and under resourced community in West Baltimore.

Literature Review

Using data from 12 nationally representative studies, Reardon (2013) found that the gap in standardized test scores of high- and low-income families has grown by about 40% over the

previous three decades. The college enrollment and completion rates have displayed a similar trend, with increased rates of graduation for wealthy students but no improvements among poor families (Reardon, Baker, & Klasik, 2012). It seems, however that the income-achievement gap is present at the onset of schooling and persists, but does not increase, through the child's educational life-course. This would suggest that, above and beyond differences in school quality, environmental and social factors are contributing to the gaps in educational achievement and attainment observed between high- and low-income students. These findings are supported by other researchers who have identified academic achievement gaps by race and income that are present by the time a child enters kindergarten (Brooks-Gunn et al., 2003; Magnuson et al., 2004; Yeung & Pfeiffer, 2009). Although there have been many efforts to measure and address school readiness through remediation or improved access to early childhood education, affecting meaningful change may necessitate the purposeful alignment of health and educational programming in areas that are traditionally outside their sphere of influence. For example, there are many early interventions such as prenatal care to reduce low-birth weight (Avchen, Scott & Mason, 2001), responsive parenting programs (Barth & Liggett-Creel, 2014; Weisleder & Fernald, 2013), reduction in the incidence and impact of poverty and housing instability (Burgard, Seefeldt & Zelner, 2012; Fantuzzo et al., 2013) that have historically operated in silos, but have known impacts on child academic and health outcomes.

A report by the National Research Council (NRC) and the Institute of Medicine (IOM) described the interplay of behavioral, environmental, systemic and social factors in the relatively poor health outcomes of U.S. citizens compared to the health outcomes for people in other developed nations (NRC and IOM, 2013). The authors also described disparities in health outcomes by gender, ethnicity and geography; with variations in mortality of up to 25 years by census tract (Kulkarni et al., 2011; NRC and IOM, 2013). Researchers have adopted the ecological model to explain the observed variation in health outcomes at the individual, family, and neighborhood levels (NRC and IOM, 2000). The ecological model is useful in that it describes individual variation in outcomes, while accounting for factors such as income and ethnicity that contribute to unequal access and outcomes. The interaction of factors at the individual, family, and neighborhood levels places the observed disparities in health and education outcomes in context and illustrates their similarity in origin and their reciprocal nature. In order to imagine the weight that disparities may play in driving poor outcomes it may be useful to take a more detailed consideration of the conditions that constitute the ecology under discussion.

Statistics from the Centers for Disease Control and Prevention (2013) illustrated the racial health disparities that exist in the United States. In 2009, African Americans had higher rates of mortality from heart disease (24%), stroke (18%), and homicide (470%) than Whites. African Americans have twice the rate of HIV infections as Whites and double the rate of infant death. In 2013, African Americans were almost twice as likely to be uninsured as Whites, while Hispanics were three times more likely to lack insurance. Similarly rates of obesity were higher for African Americans (47.8%) and Hispanics (42.5%) than Whites (32.6%). The teen birth rate among African Americans and Latinos was twice that experienced by Whites. African Americans (17%) and Latinos (12%) were more likely to be unemployed, not complete high school and live below the federal poverty level compared to their White counterparts (8%). In 2011, about 17% of Whites between the ages of 18 and 24 had not completed high school, compared to 24% of African Americans and 30% of Hispanics. The poorest Americans were 25% less likely to graduate high school than the wealthiest Americans (Centers for Disease Control and Prevention, 2013).

In addition to the ecological framework, the concept of cumulative risk may be useful in understanding the contextual barriers to education and healthcare in low-income communities (Masten et al., 1993). Each of the conditions described (e.g., income↔ health↔ education↔ income) may influence or share some reciprocal risk with the next. In this scenario, the risk accumulates for individuals over the lifespan at the individual, family, and community level, so that the barriers and outcomes are almost interchangeable. For example, ethnic minority children are at increased risk of poverty. Children in poverty and ethnic minority youth are at increased risk

of poor educational and health outcomes. Attending a school with a high concentration of children in poverty and ethnic minority children puts you at increased risk of poor educational outcomes. Children who do poorly in school are at increased risk of poverty as they transition into adulthood. In neighborhoods that have almost no racial or economic diversity, the risk factors for poor health and educational outcomes are endemic and serve to concentrate the likelihood for additional poor outcomes over time (Bankston & Caldas, 1996; Rumberger & Palardy, 2005).

Moving beyond the simple cataloging of barriers to educational achievement and health equality will require innovation, experimentation and, perhaps most importantly, listening to not just what is needed, but what works. In many cases, access to resources that are designed to improve outcomes and reduce disparities is not enough. For example, eating breakfast has been shown to improve cognition and reduce absenteeism; however, in one study of students enrolled in a free and reduced meal program, African American students were more likely to skip breakfast than their White school mates (Basch, 2011). Similarly African Americans who have health insurance through Medicaid use their benefits at rates well below Whites (Gavin, Adams, & Herz, 1998; Herz, Chawla, & Gavin, 1998). Other examples include the disparities of African American women in the uptake and completion of human papillomavirus (HPV) vaccination as well as in their use of reproductive healthcare services (Golden, 2014; Okafor, Hu, & Cook, 2014). These disparities in uptake despite the availability of services suggest a need to improve programming, both in design and communication to meet the needs of the community they are serving.

The Promise Heights Initiative

Children facing educational, health, and safety challenges can be found in neighborhoods across the country, in cities, suburbs, rural, and tribal areas. The challenges facing these children are tough and no quick fix exists. Multi-faceted approaches are needed so that all children have access to resources that can make their families healthy and successful. Inspired by the Harlem Children's Zone Promise Neighborhoods are place-based efforts to provide children with integrated, coordinated, high quality academic, social, and health programs and supports from the cradle to college to career (Harlem Children's Zone, 2010). Strong schools are core to every Promise Neighborhood, as is family and community engagement. The Promise Heights Initiative in West Baltimore was awarded one of ten Promise Neighborhoods planning grants by the U.S. Department of Education in 2012 (United States Department of Education, 2015).

The Promise Heights Initiative is a holistic endeavor to empower children, students, teachers, families, and other stakeholders of West Baltimore's Upton and Druid Heights communities to achieve their potential. The neighborhood was once Baltimore's premier African American community replete with jazz clubs, dance halls, theaters, and other cultural hubs of the community and home to educated, professional property owners, including doctors, lawyers, and retailers. Urban renewal of the 1960s and 1970s destroyed much of Upton's historic architecture, replacing it with public housing. Today, the area is known nationally for inspiring the television show "The Wire," which depicted the illegal drug trade in West Baltimore (Simon, 2002-2008). The Promise Heights Initiative currently serves residents through a collaborative between a university, community-based non-profit organizations, faith-based organizations, and schools. Its goal is to improve educational outcomes for youth, and to ensure that families are healthy and successful.

Based on 2010 U.S. Census data, the Baltimore Neighborhood Indicators Alliance estimates that the Upton/Druid Heights communities are currently home to approximately 10,342 residents, 28% of whom are children (Baltimore Neighborhood Indicators Alliance, 2015). There is little racial and economic diversity in the community as 92% of the population is African American and 65.6% of households have an income less than $25,000 per year. Nearly three out of five children (59%) live in poverty, as compared to 34.1% in Baltimore City overall. As in the case of many poverty stricken communities, the educational attainment for Upton/Druid Heights residents is low, with 33.2% of the residents 25 years of age and older having obtained less than a high school diploma or equivalency. Only one out of every three residents between the ages of 16 and 64 are

employed (36.5%). This compares to approximately three out of five individuals in Baltimore City as a whole (60.1%). The Upton/Druid Heights community also has fewer neighborhood businesses per 1000 residents than Baltimore City as a whole: 19 per 1000 as compared to 25.4 per 1000 in 2013 (Baltimore Neighborhood Indicators Alliance, 2015). From 2005-2009, there were higher incidence rates of domestic violence (55 vs. 40.6 per 1000 residents), non-fatal shootings (108.7 vs. 46.5 per 10,000 residents) and homicide (37.9 vs. 20.9 per 10,000 residents) compared to Baltimore City (Baltimore City Health Department, 2011).

The extant literature and statistics demonstrate that the Upton/Druid Heights community is at risk for both poor health outcomes and educational disparities. In order to identify the barriers to educational achievement and improved health outcomes, the current qualitative study was employed. Using a community-based approach at every level, it was designed for the community to provide input as to what issues need to be addressed at the individual, family, and neighborhood levels across the lifespan in order to overcome the barriers to educational achievement.

METHODS

Description and Selection of Participants

Participants were recruited between May 2013 and October 2013 with flyers placed in schools and organizations throughout the Upton/Druid Heights communities. These venues were targeted purposefully to capture individuals from diverse settings who may not have been previously exposed to programs offered by the Promise Heights Initiative. Participants were required to be 18 years of age or older and live or work in the community.

Procedures

Qualitative techniques were used to examine the experiences of residents and educators in the Baltimore neighborhoods of Upton and Druid Heights. As the aim of this research was to capture not only what issues the community felt future interventions should address, but also why these issues are important, focus group methodology was chosen as it enabled the research team to understand the context behind the decision-making process of the participants. Key informant interviews were conducted when scheduling conflicts arose and were used as a validity check against the group discussions with individuals of similar backgrounds. These qualitative methods were also ideal as they provide participants the opportunity to have their voice heard regardless of literacy level. The University of Maryland Institutional Review Board approved the research protocol.

Data collection

The focus group discussions/key informant interviews were conducted in conference rooms and offices in several locations in the Upton/Druid Heights communities from June 2013 to October 2013. As shown in Table 1, these locations included neighborhood schools, community and faith-based organizations. Each focus group discussion/key informant interview lasted 45-60 minutes and was audio recorded and transcribed by the authors.

Using a community-based participatory research approach (CBPR; Israel et al., 2003), a multidisciplinary committee, in partnership with the Promise Heights Initiative's Community Partners Advisory Board (CPAB), developed a semi-structured interview guide, which organized the questions around topic areas relevant to the community (Table 2). Focus groups were facilitated by one of three senior level researchers with the support of graduate research assistants as note-takers. The facilitators had conducted prior research in the West Baltimore community and had developed a familiarity with the neighborhood. They ensured that the conversations stayed on topic, captured additional topics for continued discussion outside of the focus group, and ensured that all participants had the opportunity to participate in the conversation. The note-takers captured non-verbal cues and managed the audio recording.

Table 1

Description of Focus Group Discussion/Key Informant Interview Participants

Group (Number of Participants)		Date (2013)
Teachers/School Staff	14	Jun 18
Community Resident	1	Jun 24
Community Residents	12	Jun 25
Principals	4	Sep 26
Young Adults	9	Sep 27
Principal	1	Oct 3
Mothers in a Prenatal Program	5	Oct 10
Total	46	

Table 2

Questions used in Focus Group Discussions/Key Informant Interviews

Topic Area	Primary Questions
Introduction	1. State your first name, tell us how long have you lived in the neighborhood and how would you describe it?
Barriers/Facilitators to Learning	2. What enables or prevents learning among Promise Heights students at school? 3. What enables or prevents learning among Promise Heights students at home/outside of school?
Job Readiness	4. How do you feel that the teenagers and young adults here are being prepared for a job/career?
Targeted Goal Areas	5. We are now going to ask about four "goal" or "results" areas that Promise Neighborhood will be targeting. We are interested in knowing if: A. You feel this goal is appropriate for your community B. You feel we are measuring it appropriately (1) Ensuring Students are Healthy (2) Families and community members support learning in Promise neighborhood schools (3) Students have access to 21st-century learning tools (4) High school graduates obtain a postsecondary degree, certification, or credential
Wrap-up	6. What additional goals/results do you want to see achieved in the community? 7. Is there anything else that comes to mind that we didn't already talk about?

Data Analysis

The study used both a CBPR and grounded theory approach to qualitative data analysis. Immediately after completion of each focus group, the note-takers transcribed the recordings. Concurrent to the transcription, the facilitators met to discuss overall themes emerging from the discussions. The first three authors then reviewed the transcripts and open coded them to identify additional themes. These themes were shared with the CPAB at two time points—midway through and at the completion of data collection. The CPAB assisted in identifying the relationships between the open codes (axial coding) and generating additional codes to be used for the qualitative data analysis. Once the codes were finalized, the first author reread all transcripts and selectively coded any data that related to the core variables identified by axial coding.

RESULTS

A series of focus group discussions/key informant interviews were held with various stakeholders in an underserved community—mothers in a prenatal program ($n = 5$); youth and young adults ($n = 9$); community residents ($n = 13$); principals ($n = 5$); and, teachers and school staff ($n = 14$). The original purpose of the focus groups was to inform research on how children are learning and of community supports for student learning. Key themes that emerged discussed barriers to educational achievement and health promotion including

- mental health and self-esteem,
- parental support,
- early childhood education, and
- access to healthy food options.

Mental Health and Self-Esteem

The theme of mental health and self-esteem emerged repeatedly in all of the focus groups. The West Baltimore community, which was the focus of this research, has been characterized by high levels of community violence for decades. The repeated trauma of this violence was evidenced by the majority of the respondents. During one of the principal focus groups one participant described how mental health and self-esteem can impact education:

> . . . every single day you're dealing with students in severe crisis and every single day, the administrative team is not able to focus on the instructional side but looking at how can I get this child out of crisis? Complete meltdowns. And again, once you hear their stories and the trauma that they had this summer, it's almost like, I told someone that the kids in this building, this is the roughest group of kids that I've ever worked with and I've worked with kids all over, and that they resemble to me adults who are coming home from Iraq or who came from Vietnam where they have suffered severe trauma and they're caught in this cycle of post-traumatic stress syndrome. The stress, the littlest thing, something that you and I have built up the coping skills to be able to address, the slightest thing can send them into total meltdown and its often violent meltdown. It's often throwing things, kicking over things, screaming, cursing and you're talking kids off of ledges every single day. All day. Every single day.

Another principal stated,

> Every student in this building—and I can tell you that there is not one that doesn't have a story where they need some form of wraparound service. The drug treatment is necessary. The gang intervention and awareness is extremely necessary . . . There are a slew of wraparound services that I would like to see come in as partnerships so that the school can truly become a community school."

In both principal focus groups, the principals felt the need for "mental health interventions for children and youth to support instructional learning.

This sentiment was echoed by teachers and school staff:

> Behavior is what you learn at home and social emotional health and coping skills are things you learn at home. In a very stressful environment, our children might not be learning appropriate coping skills or appropriate behavior and what's acceptable in the community might not be acceptable here.

Another staff member stated, "It's social-emotional and I know there's a push on the academic piece but you have to develop a child's sense of self-esteem and their spirit before they can be ready and primed for all of the other pieces."

Community residents had similar views of how the social-emotional needs of the children and youth were not being met in the community. One resident remarked,

> It does have to do with mental health issues. That certainly needs to be addressed. But our people don't like to talk about it. It's swept under a rug. It's kept in a dark closet." In response to this, another resident stated, "Well, it's clear to me that a lot of people around here have pretty low self-esteem.

One more community resident pointed out the impact of these mental health issues on the school environment,

> Some of our kids, they have problems, emotional problems, mental problems and that school, does not, don't have the proper staff to work with these kids and their special needs. And that child will be left behind. We don't want to leave none of our kids behind, no matter what the special needs are because I think that a country as powerful as ours and the government that we have, they should be willing and able to help the parents, help the schools, help the educators, whoever it might be to meet the needs of these special kids.

Parental Support

Participants from all stakeholder groups described the need for parental support in two areas: (a) to cope with parents' own social-emotional issues; and, (b) to be able to support their child's learning. For both areas, participants felt it was important to meet the parents where they are and work from there.

Parental support—Social-emotional issues. Before one could work with parents about how they can help their children academically, participants saw the need to address parents' own social-emotional issues. One principal recounted the following situation:

> Dad was shot, killed. He was shot riddled with bullets. Fifteen times this man was shot, ok? These kids know death and doom. Mom took them to the trial. So instead of coming to school to share with us, oh, this is what has happened. She brings the kids to drop them off. They were totally off. They're running, and by the time I figure, by the time I get to the bottom of it, I'm like lady, have you had any grief counseling? . . . We have no kind of grief counseling. No kind of counseling in place, and then you send these kids, these kids are trying their best to deal with this, but mom is sick herself. So mom needs some help, some intervention as well. But that's what we deal with, and then we're supposed, we're trying to educate them.

Other principals in both focus groups shared similar stories about families coping with grief after a homicide with no counseling or support.

Teachers and school staff described instances where it was apparent that parents were using substances that made it hard for them to parent. One participant shared,

> I think *we need* additional services for parents who are struggling with alcoholism or drug abuse. In terms of conferences I've had with parents I've found that there were times where I couldn't even communicate the services that are available to help a child because a parent was experiencing trouble in that area . . .

Parental support—Child's learning. One principal stated,

> My parents want what all parents want and that's that they want their kids to have more than what they have. But they're not quite sure what that looks like. And so they'll send the kids to school but they don't necessarily know how to support kids in homework.

A second principal had a similar remark,

> I think they do what they, for the most part, most of the families do what they can do. Even being in the early, early elementary years, some of the math is struggling, the parents they don't know how to do it when it goes home. It's a struggle.

Teachers and school staff pointed out that they "help parents understand that we're there for them just as much as we're there for the children." Some of the strategies employed include workshops to show families how to support learning at home for children in elementary, middle, and high school, and parenting classes for families with younger children. However, it was pointed out that these programs have varying success. Reasons for this included the belief that some parents "don't want to reach out and accept help because I don't want people to realize that I have those troubles myself."

Parents themselves saw that they had limitations in their capabilities to help their children, yet some were not aware of some of the workshops and programs mentioned by school staff. One parent stated,

> My daughter she done brought a bunch of homework that I didn't know nothing about at all. I think these schools round here in the neighborhood, I think they should have more open houses for the parents to come down, so the parents could sit down and learn stuff they self. Because you can't help a child if you don't know something yourself.

On the flip side of this, there were community residents who did see that there were opportunities for parents to participate in school activities. Some parents even spoke about their level of participation:

> I attend meetings. I participate in classroom activities with the kids. I go on field trips with the kids. When he's out of school, I stay at home, I read with him. I study his flash cards with him. I do things I know that's going to enhance his learning because I think, for me personally, I have to be involved.

Early Childhood Education

Moving from parental support to early childhood education, youth and young adults of the community saw the need for additional parental support for children's education starting in early childhood. One young man stated,

> I think that in a child's education a lot of people should know that children learn so young. That children pick up on things at a very young age and if we could find some type of, or make some type of, program which could teach the parents 'Hey maybe you should read to your child at six months' or 'Hey maybe you should, when your child's home teach him his ABCs' because kids little kids pick up things like that [snaps fingers for emphasis].

Early childhood education was seen by many participants as the long-term solution to the needs of children in the community. One community resident who was also on staff at one of the schools made the following remarks in the school staff focus group,

> Well I did want to commend Head Start, I've been around Head Start for since I've been in the city 23 years and all the children, I say 95% that come through the Head Start program, to me and to other *nursery* schools, not only are they healthy mentally but physically there's a difference in how they handle

> Pre-K. They're totally different. I know those children have had Head Start so I hope Head Start will be here even after I pass.

Principals saw the benefits of learning during early childhood. One "recognized that the issue is starting even earlier than first, second grade. Its starting in Head Start, Pre-K, K . . . we've got to intervene earlier if we're going to be successful." Another stated, "Teaching is a lot of work. Teaching in an arena where there's not a lot of home support, or not a lot of prior schooling before Pre-K or kindergarten, it takes a lot of work to get children where they need to be."

Access to Healthy Food Options

It is interesting that the second theme to be stated repeatedly in all focus groups has a major impact on physical health—access to healthy food options. This key theme was especially salient for participants and generated a lot of discussion. Participants spoke of children and families not being exposed to healthy food options, not having access to stores that sell healthy food, and not knowing how to prepare fresh food.

The principals spoke about what they have done to be a source of healthy food for the children and youth in the community. One spoke of how they don't just provide breakfast and lunch but dinner as well. In addition that school has partnered with the Maryland Food Bank to send food home with children over the weekends. The principal stated, "Being able to do that helps a lot because when you're hungry it's very hard to do anything." However even though the schools provide healthy food options, the principals didn't feel that the children were always eating healthy food as evidenced by the following statements:

> They don't eat them. They don't eat healthy meals and they don't have exposure to healthy meals. Part of our struggle has been that our kids come to school having not been fed and whatever the option is in the cafeteria, they may not seize that, they would more so choose to go over to the corner store and buy 15 bags of chips and soda. So they come in and they're already on sugar overload and then at lunchtime, they may try to sneak out again for the same kind of snacks. Some of the kids do take advantage of the cafeteria meals but it is the portion size. I don't know how any student . . . *can be full off those small portions*[1]

In the second principal focus group, one continued these thoughts by stating, "that's challenging when you know they don't have a whole lot but they have that [chips and sodas]." Teachers and school staff as well as community residents all reiterated statements that the children always had chips and sodas to snack on.

One participant in the teacher and school staff focus group mentioned that she felt the issue had to do with what is available in the community. During the discussion, the following exchange occurred:

> I had an orange and yellow pepper and the kids asked me what that was and I said 'oh it's a pepper.' And they're like 'What?' "Well, have you ever seen a green one?' 'Oh yeah, yeah.' So just the level of . . . "*Exposure*" . . . exposure to available food in this community to get them fresh produce, get them fruits and vegetables. We do have a program here that allows them to have those experiences but they are hesitant to try something new. It's different so they don't want to try it and they are comfortable eating the food that they want . . .

In one of the parents groups, it was also mentioned that not all parents expose their children to healthy food. One stated, "Just 'cause you don't eat them don't mean you shouldn't have your child try them because you never know what they may like."

Outside of what is offered at school, many spoke of the limited access to healthy food options. Many residents from all stakeholder groups described the limited options in the one grocery store remaining in the community and transportation issues being a factor in getting to grocery stores and farmers' markets in other areas of the city. In four of the groups, the exact same statement was

[1] Italics represent comments interjected by other participants during the focus group conversations.

made, "Transportation is a key factor." One group of parents spoke at length about the closing of a local grocery store and the worry that the one left was going to close as well. The heated discussion went like this:

> And the [grocery chain name] I live by and their shelves look like them spaces right there [gestures to empty library bookshelf]. So they must be ready to shut down next because that one right there, where's the food? Where you supposed to go to market? So that leaves people with no choice, the ones who don't have transportation but to go to the corner store and buy canned goods this or that canned goods, or go to the steakhouse and buy processed nuggets and the processed stuff versus being able to go to the actual grocery store and buy fresh foods.

Limited access to purchase healthy food and the availability of processed food as well as fast food options was also discussed as a problem in the community. One younger community resident pointed out that the "only thing around here is fried foods. Fried chicken. A fried chicken spot on every corner." This group went on to discuss that many do not know how to shop and prepare healthy food. They commented:

> When people do go to the market, a lot of women who get Food Stamps or benefits to get free food or whatever. It's up to them what they choose to eat and when they going into this market it's pretty clear what they get. It's not always, they don't get the greens or the vegetables or the fruit. They go in and they get the cereal and the snacks and sometimes they don't even get real food, like chicken. . . . *"They do get vegetables and stuff. They get the canned veggies instead of the fresh veggies. They last a lot longer."* . . . .Yeah but they take a lot of the process, they take a lot of the good stuff out of them, me personally. It seems like if stuff lasts longer it got bad stuff in it. It's as simple as that. Chicken don't last that long. You cut its head off and you cook it. You don't have it sitting around waiting a week for you to cook it.

Both community resident focus groups agreed. One resident stated,

> Processed foods, it's a lot of stuff in it we not really supposed to be eating. We were brought up on fruits and vegetables out of the garden. Nowadays, everything is out of the can and that is so unhealthy. They bring meat that is precooked and you gotta heat it up. That's not a good thing. Everything should be, on a daily basis, fresh products, I think. That's just my opinion. I know it'll be costly but it's something you gotta deal with.

Others spoke of mostly having access to microwaveable processed foods stating, "Everything is microwaveable. All foods that's microwaveable is not always healthy. So it's not always cooked properly." When home-cooked meals were discussed, the consensus was that they take too long to prepare when parents are busy.

The bottom line in all of this was summed up well by one of the principal participants who discussed the impact of hunger on education and health by stating, "the hunger, of course, does impact the mental health as well because if you're hungry you can't focus. And it also impacts learning . . . but the reality, here in the school house, is that they're hungry."

DISCUSSION

Community members and educators identified four significant barriers to education that exist in West Baltimore. Three of the barriers identified are not directly related to education and illustrate the need for wraparound programs to address factors outside of the school environment that are limiting the ability of children to learn in the classroom setting. It is important to consider these findings in relation to the ecological theory discussed earlier in this article. It is clear that the observed disparities in health and education in the literature have an impact on the participants' experiences within these neighborhoods. Participants noted factors at the individual, family, and neighborhood levels that lead to the barriers limiting education and health outcomes for residents in this under-resourced, urban, African American community. These factors should be considered in developing interventions that address barriers to educational achievement and health promotion in similar communities.

Comparing these results to the findings from focus groups conducted as part of other Promise Neighborhood needs assessments demonstrates the consistent issues facing the under-resourced communities these programs service: early childhood education was a focus in both the Cypress Hills Promise Neighborhood (Brooklyn, NY) and DC Promise Neighborhood Initiative (Washington, DC). In addition, the importance of parent involvement and availability of healthy food were identified in the DC Promise Neighborhood as issues, while the Cypress Hills Promise Neighborhood also identified the need for "social-emotional well-being" (Cypress Hills Promise Neighborhood, 2015; DC Promise Neighborhood Initiative, 2011).

Limitations

All focus groups are limited by the potential for selection bias; where individuals who attend and participate may be different from individuals who do not participate. The study team attempted to solve this by systematically engaging a broad range of individuals and recruiting from several different locations. However, there is the potential that these findings are not generalizable to the entire Upton/Druid Heights neighborhood. The choice of moderator also could bias the group discussion. Steps were taken to avoid this by using experienced focus group moderators who, while faculty at the University of Maryland familiar with the Upton/Druid Heights area, were not involved in the day-to-day activities and programs of the Promise Heights Initiative.

Conclusion

The Upton/Druid Heights community of West Baltimore is subject to a host of behavioral, environmental, systemic and social factors that have led to both poor health outcomes and educational disparities. In order to identify the barriers to educational achievement and improved health outcomes, this qualitative study was designed for the community to provide its input on what issues need to be addressed at the individual, family, and neighborhood levels across the lifespan in order to overcome the barriers to educational achievement. Four key themes emerged from focus group discussions in the community of various stakeholders—(a) mental health and self-esteem, (b) parental support, (c) early childhood education, and (d) access to healthy food options. The valuable insight provided by the community as to what needs to be addressed in order for children to achieve success from cradle to career can be used by not only the target community but also by similar communities across the United States in order to improve educational outcomes for the most vulnerable communities.

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