THE RELATIONSHIP BETWEEN EDUCATIONAL PROGRAMS AND HEALTH MODELS IN PRESCHOOLERS

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Abstract: *One of the ambitions of any civilized society is to ensure a healthy start in life for children. To this end, kindergartens create a healthy environment for children's development and contribute to this start. Educators' knowledge of current health models, but also of the models of the parents of children in kindergarten, contributes to appropriate choices for children in terms of developing food awareness, healthy behavior, and creating appropriate health models. The study was conducted in three kindergartens and involved 24 educators and 89 parents. After applying the two questionnaires to highlight the starting points (on various health issues), a long-term intervention was developed for both categories of respondents. The results obtained highlight the importance of interventions at the kindergarten level.*

Keywords: *health models; educators; parents; intervention.*

Introduction

Health education starts early, which means that it is included in all health programmes and policies implemented from kindergarten onwards. Sorensen and colleagues (2012) argue that any health model should include prevention and remediation in correlation with the

development of people's abilities to maintain and care for their health. Thus, it should contain the following: Health education starts early, which means that it is included in all health programmes and policies implemented from kindergarten onwards. Sorensen and colleagues (2012) argue that any health model should include prevention and remediation in correlation with the development of people's ability to maintain and care for their health. Thus, it should contain the following:

- general health information and information relating to health risks
- ways to assess health (with reference to degrees of health in order to understand when it deteriorates)
- developing skills to maintain health (including ways to recover damaged health)
- involving parents in activities to raise awareness of these programs and their importance for their children.

Health and illness are socially constructed concepts, so it is necessary to understand the anthropological perspective on health. From an anthropological perspective, "healing rituals," whether traditional or modern, are not only symbolic acts, but also essential frameworks in which health and illness are constructed and reaffirmed. These ritual practices, deeply rooted in the culture of a community, provide a structured space in which individuals can go through the disruptive experience of illness, often benefiting from a strong sense of attachment and belonging. By participating in rituals, whether in the past through collective healing ceremonies or, in the present, through repetitive interactions with medical staff, patients can strengthen their social and emotional bonds, which are crucial for building psychological and physical resilience. Health and illness are socially constructed concepts, so it is necessary to understand the anthropological perspective on health. From an anthropological perspective, "healing rituals," whether traditional or modern, are not only symbolic acts, but also essential frameworks in which health and illness are constructed and reaffirmed. These ritual practices, deeply rooted in the culture of a community, provide a structured space in which individuals can go through the disruptive experience of illness, often benefiting from a strong sense of attachment and belonging. By participating in rituals, whether in the past through collective healing ceremonies or, in the present, through repetitive interactions with medical staff, patients can strengthen their social and emotional bonds, which are crucial for building psychological and physical resilience. Furthermore, informal education, transmitted through narratives and ritual symbols, shapes individual perceptions about the causes of

illness, expectations regarding healing, and each person's role in the recovery process, thus contributing to the cultural integration of the health experience. Our health models then shape our choices and determine our long-term health (Lamanauskas & Augenie, 2019; Al-Sane et al., 2020, Rukiyati, Siswoyo & Hendrowibowo, 2020; Besrat et al., 2024). Furthermore, informal education, transmitted through narratives and ritual symbols, shapes individual perceptions about the causes of illness, expectations regarding healing, and each person's role in the recovery process, thus contributing to the cultural integration of the health experience. Our health models then shape our choices and determine our long-term health (Lamanauskas & Augenie, 2019; Al-Sane et al., 2020, Rukiyati, Siswoyo & Hendrowibowo, 2020; Besrat et al., 2024). Therefore, health education should begin as early as possible. In this regard, the K.A.P. trio (knowledge, attitudes, and practice) is important for both parents and educators as future role models for children (Sterling, 1992; Schultz Nakamoto, 2005; Csima et al., 2018; Ying et al., 2025). The concept of E.C.E. (early childhood education) is, in fact, a European Union directive on education and highlights the importance of starting education as early as possible. Therefore, health education should begin as early as possible. In this regard, the K.A.P. trio (knowledge, attitudes, and practice) is important for both parents and educators as future role models for children (Sterling, 1992; Schultz Nakamoto, 2005; Csima et al., 2018; Ying et al., 2025). The concept of E.C.E. (early childhood education) is, in fact, a European Union directive on education and highlights the importance of starting education as early as possible. (http://european-union.europa.eu). Bronfenbrenner's social cognitive theory and environmental model (2005) assumes that the environment influences our choices, so that healthy environments lead to healthy choices. An education focused on creating healthy models will thus lead to healthier people who, in turn, will raise healthy people. Assessing our behaviours and attitudes thus provides data on what can be done to improve our health models. Bronfrenbrenner summarizes the results of research on environmental influences and proposes a way of understanding and interpreting human development based on three paradigms (Bronfrenbrenner, 2005): the child (person) is a dynamic agent who interprets and creates their own development, as well as the environment in which they grow up, so the relationship between the child and the environment is a two-way one; development is a progressive reorganisation of psychological functioning, with the cognitive, affective and social aspects being interrelated facets that enable the person to evolve in a complex world, and studies on human development are only valid if they are carried out in natural

development environments and not in laboratories. This model emphasizes and highlights how the environment contributes to our development and is all the more important when it is taken into account in all the environments in which we grow and develop. Bronfenbrenner's social cognitive theory and environmental model (2005) assumes that the environment influences our choices, so that healthy environments lead to healthy choices. An education focused on creating healthy models will thus lead to healthier people who, in turn, will raise healthy people. Assessing our behaviours and attitudes thus provides data on what can be done to improve our health models. Bronfrenbrenner summarizes the results of research on environmental influences and proposes a way of understanding and interpreting human development based on three paradigms (Bronfrenbrenner, 2005): the child (person) is a dynamic agent who interprets and creates their own development, as well as the environment in which they grow up, so the relationship between the child and the environment is a two-way one; development is a progressive reorganization of psychological functioning, with the cognitive, affective, and social aspects being interrelated facets that allow the person to evolve in a complex world; and studies on human development are valid only if they are conducted in natural development environments and not in laboratories. This model emphasizes and highlights how the environment contributes to our development and is all the more important when it is taken into account in all the environments in which we grow and develop.

The home environment blends with that of the kindergarten/school, and thus, through an appropriate partnership between the two environments, plays an essential role in the healthy growth of children, covering a wide range of aspects, from physical to emotional and social health. When educators and parents work together, they create a coherent and supportive environment that maximizes each child's potential. Some of the benefits of kindergarten-parent collaboration for healthy growth are: The home environment blends with that of the kindergarten/school, and thus, through an appropriate partnership between the two environments, plays an essential role in the healthy growth of children, covering a wide range of aspects, from physical to emotional and social health. When educators and parents work together, they create a coherent and supportive environment that maximizes each child's potential. Some of the benefits of kindergarten-parent collaboration for healthy growth are:

- Consistency in routines and expectations (children thrive in predictable environments)
- Developing healthy eating habits
- Promoting physical activity and an active lifestyle

- Early identification of health and developmental issues
- Social and emotional support
- Sharing health information and building healthy models
- Development of educational partnerships on various topics.

Kindergarten also plays an essential role in preparing children for school and is an important predictor of their academic success, health, and personal achievement into adulthood. Although knowledge of numbers and vocabulary acquired in kindergarten are strong indicators of children's readiness to learn when they enter school, theories and research suggest that self-directed learning skills are also essential for coping with the challenges of primary school. They also play a role in classroom engagement skills, leading to person-environment fit strategies that reflect children's task orientation and diligence. Studies suggest that classroom engagement skills are robust predictors of later success in primary school. Research also indicates that the development of executive functions underlies individual differences in classroom engagement. Thus, the development of early interventions that strengthen school readiness can help avoid the risks of subsequent academic and social deficits in childhood and adolescence. Kindergarten also plays an essential role in preparing children for school and is an important predictor of their academic success, health, and personal achievement into adulthood. Although knowledge of numbers and vocabulary acquired in kindergarten are strong indicators of children's readiness to learn when they enter school, theories and research suggest that self-directed learning skills are also essential for coping with the challenges of primary school. They also play a role in classroom engagement skills, leading to person-environment fit strategies that reflect children's task orientation and diligence. Studies suggest that classroom engagement skills are robust predictors of subsequent success in primary school. Research also indicates that the development of executive functions underlies individual differences in classroom engagement. Thus, the development of early interventions that strengthen school readiness can help to avert the risks of subsequent academic and social deficits in childhood and adolescence. (Fitzpatrick, 2012; Hover, 2015).

Recently, learning environments (kindergartens, schools, universities) have been transformed to be as child- and youth-friendly as possible. Such an environment is a democratic environment based on children's rights, where all participants are accepted, teaching and learning processes are organized according to the interests and needs of children, health, safety, and protection measures are taken for them, and means are used to ensure that spaces are as sustainable and environmentally friendly as possible. This has led to an increase in the

quality not only of the teaching-learning process but also of the environment in which it takes place. Recently, learning environments (kindergartens, schools, universities) have been transformed to be as child- and youth-friendly as possible. Such an environment is a democratic environment based on children's rights, where all participants are accepted, teaching and learning processes are organized according to children's interests and needs, health, safety, and protection measures are taken for them, and means are used to ensure that spaces are as sustainable and environmentally friendly as possible. This has led to an increase in the quality not only of the teaching and learning process but also of the environment in which it takes place. (Cabanoglu & Sevim, 2019)

This study refers to early childhood and children's experience in kindergarten, in order to identify issues related to health education—how programs are structured around this concept, how all children, and even their parents, are included in activities, and how meals and related activities are monitored.

The investigation was conducted on two levels:

- By screening activities in kindergartens to highlight an existing health education plan, these results then become starting indicators for developing an intervention in this area.
- Engaging parents as educational partners through parenting activities focused on health education.

The expected outcomes of the research are to improve health education programs at the institutional level, identify the existence of K.A.S. in both educators and parents, and build opportunities for collaboration in educational partnerships between them.

Objectives:

- Surprising initial indicators in the process of developing/improving educational plans focused on health issues.
- Highlighting areas for improvement and indicators to track in order to bring about change (based on monitoring children's existing activities and eating habits in kindergartens).
- Engaging parents in a closer relationship with the kindergarten.

Sample description

In this study, the sample consisted of teachers from three kindergartens in the western part of the country and parents from these kindergartens, to the extent that they wished to participate voluntarily in the study. There were 24 teachers, aged between 25 and 54 (average age of the sample m=41.37). The number of parents who participated in the study

was 84, of which 3 were fathers and the rest were mothers. Their ages ranged from 25 to 36 (average age m=29.03). In this study, the sample consisted of teachers from three kindergartens in the western part of the country and parents from these kindergartens, to the extent that they wished to participate voluntarily in the study. There were 24 teachers, aged between 25 and 54 (average age of the sample m=41.37). The number of parents who participated in the study was 84, of which 3 were fathers and the rest were mothers. Their ages ranged from 25 to 36 (average age m=29.03).

Instruments used:

The instruments used in the study are a questionnaire focused on activities related to health education and a questionnaire assessing K.A.P. for educators and parents, adapted from existing models.

The questionnaire focused on health activities covered the following areas: knowledge about food and eating, eating routines in kindergarten, lessons and activities related to growing food (fruit, vegetables), sports, food preparation. The response options for this questionnaire are: once per semester, several times per semester, once per week, several times per week (2-3 times/week). The questionnaire focused on health activities covered the following areas: knowledge about food and eating, eating routines in kindergarten, lessons and activities related to growing food (fruit, vegetables), sports, food preparation. The response options for this questionnaire are: once per semester, several times per semester, once per week, several times per week (2-3 times/week).

The K.A.P. (Knowledge, Attitudes, and Practices) is a model that does not have a single assessment scale, but rather a methodological approach or conceptual framework used to assess and understand what people know (knowledge), what they believe and how they feel (attitudes), and what they do (practices) in relation to a particular topic. Studies show that there is a relationship between what mothers know, do, and believe during pregnancy in relation to health and the development of the fetus and later the newborn child (development from a health perspective) (Dennis et al, 2021). Existing models comprise three distinct sections: health knowledge, health attitudes, and health practices. All scale models are organized in this way, and some of them are organized around a specific issue such as oral health, food consumption, diet, etc. (Cleland & Mauldin, 1983; Hiew et al, 2015; Anand et al, 2015; Haron et al., 2020; Peng et al., 2020; Melariri et al., 2024). The questionnaire used in the study includes two items related to knowledge, five items related to attitudes, and five items related to practices. The answers to the first category (knowledge) refer

to areas in which parents consider themselves knowledgeable, and for the other two categories (attitudes, practices), the answers to each item range from 1 to 5, where 1 means total disagreement and 5 means total agreement. The K.A.P. (Knowledge, Attitudes, and Practices) model is a model that does not have a single assessment scale, but rather a methodological approach or conceptual framework used to assess and understand what people know (knowledge), what they believe and how they feel (attitudes), and what they do (practices) in relation to a particular topic. Studies show that there is a relationship between what mothers know, do, and believe during pregnancy, in terms of health and the development of the fetus and later the newborn child (development from a health perspective) (Dennis et al, 2021). Existing models comprise three distinct sections: health-related knowledge, health-related attitudes, and health-related practices. All scale models are organized in this way, and some of them are organized around a specific issue such as oral health, food consumption, diet, etc. (Cleland & Mauldin, 1983; Hiew et al, 2015; Anand et al, 2015; Haron et al., 2020; Peng et al, 2020; Melariri et al., 2024). The questionnaire used in the study comprises two items related to knowledge, five items related to attitudes, and five items related to practices. The answers to the first category (knowledge) target areas in which parents consider themselves knowledgeable, and for the other two

Results and discussions

For the first objective, a questionnaire was administered to teachers regarding the frequency of health education activities in kindergarten. The results obtained are:

- dimension knowledge about food and eating - 45.83% of the total have activities several times per semester, 25% once a week, and 29.16% several times per week,
- food routines in kindergarten - 100% of routines are followed in kindergarten - meal times, calorie intake calculations, etc.
- lessons and activities related to growing food (fruit, vegetables) – 33.33% have activities of this kind once per semester and 66.66% have activities of this kind several times per semester.
- sports - 100% of the kindergartens in the study have sports activities twice a week (all three kindergartens have a sports teacher who comes and teaches these classes),
- food preparation/cooking – 54.16% engage in such activities once per semester, while the remaining 45.84% engage in such activity's multiple times per semester.

These initial indicators led to the formulation of a 12-week intervention (once a week) in institutions on the following topics:

- the importance of health education that is started early on in life.
- What culinary traditions and eating habits, deeply rooted in culture, influence individual and public health (the impact of globalization on traditional diets and the increase in lifestyle-related diseases. Some examples of topics covered: the impact of fast food on traditional diets, the role of food in ceremonies and cultural celebrations, and their implications for health) how culinary traditions and eating habits, deeply rooted in culture, influence individual and public health (the impact of globalization on traditional diets and the increase in lifestyle-related diseases. Some examples of topics covered: the impact of fast food on traditional diets, the role of food in ceremonies and cultural celebrations, and their implications for health)
- how different cultures define health and illness, focusing on Romanian culture, how these perspectives influence the search for medical care, adherence to treatment, and even recovery in the event of illness.
- the anthropological approach to health – what health models exist, how they are distributed across our country, how the internet and social media have created new "digital cultures" of health, the role of health influencers, patient forums as sources of "knowledge" parallel to official medicine, etc.
- developing food awareness, encouraging physical activity, and promoting personal hygiene through a thematic and interactive program
- ways of organizing storytelling circles – focused on health (physical, emotional, etc.)
- addressing family involvement in various kindergarten programs related to health.

At the end of the intervention program, the following changes were agreed upon with the teachers and kindergarten management: healthier food choices in children's daily diet, improved personal hygiene behaviours among children (more monitoring activities in this regard and more prevention activities proposed for the next semester and school year), new socio-emotional development activities, activities to develop teachers' skills (focused on attracting activities to kindergartens that facilitate this – identifying courses for them to participate in), choosing new ways of working to achieve greater parental involvement (more activities with parents, more frequent information, choices of directions to follow from kindergarten to home

– for example, kindergarten activities on a chosen theme to be duplicated by activities at home on the same theme).At the end of the intervention program, the following changes were agreed upon with the teachers and kindergarten management: healthier food choices in children's daily diet, improved personal hygiene behaviours among children (more monitoring activities in this regard and more prevention activities proposed for the next semester and school year), new socio-emotional development activities, teacher skills development activities (focused on attracting activities in kindergartens that facilitate this—identifying courses for them to participate in), choosing new ways of working to achieve greater parental involvement (more activities with parents, more frequent information sharing, choosing directions to follow from kindergarten to home—for example, kindergarten activities on a chosen theme to be duplicated by activities at home on the same theme).The frequency and content of health-related lessons at kindergarten level were monitored at the end of the semester, the following year after the end of the two semesters, and it was found that after each semester new lessons (with new content) were added or lessons focused on health topics were held more often. The same questionnaire as the one initially applied was used for the re-evaluation, and the main changes were made in the area of knowledge about food and eating—after the first evaluation, there was an increase from 45.38% to 61.3%, then an increase to 64.3% in the second evaluation and to 71.3% in the last evaluation (as the frequency of lessons several times per semester). In terms of food preparation with children, the increase was not as spectacular (from 54.16% to 53.2%, then to 54.3% and 55.1%). The fact that more lessons focused on food and nutrition were introduced highlights how educators chose to respond to the intervention, and this highlights the importance of institutional intervention programs on this topic. The frequency and content of health-related lessons at kindergarten level were monitored after the end of the semester, the following year after the end of the two semesters, and it was found that after each semester new lessons (with new content) were added or lessons focused on health topics were held more often. The same questionnaire as the one initially applied was used for the re-evaluation, and the main changes were made in terms of knowledge about food and eating—after the first evaluation, there was an increase from 45.38% to 61.3%, then in the second evaluation an increase to 64.3%, and in the last evaluation to 71.3% (as the frequency of lessons several times per semester). In terms of food preparation with children, the increase was not as spectacular (from 54.16% to 53.2%, then to 54.3% and 55.1%). The fact that more lessons focused on food and nutrition were introduced

highlights how educators chose to respond to the intervention, and this highlights the importance of institutional intervention programs on this topic.

Thus, by implementing a program focused on health education and monitoring the progress made at the kindergarten level in terms of the changes achieved as a result of the program, the kindergarten is transformed from a simple place of care and learning into a proactive environment for promoting the health and overall well-being of children, laying the foundations for a healthy life.

For the second objective, the results of the first two items in the questionnaire indicate what parents think about their knowledge (which of the listed categories they consider themselves to know best). Thus, 89% of parents consider that they know best the category "regular medical check-ups," followed closely by the category "healthy eating habits" with a score of 71%. For the other categories (food, sports and exercise, others), the results were not conclusive enough because parents chose to place the concepts they knew in the first two places and did not place anything in the following places, or only a few responded to categories 3, 4, and 5.For the second objective, the results of the first two items in the questionnaire indicate what parents think about their knowledge (which of the listed categories they consider themselves to be most knowledgeable about). Thus, 89% of parents consider themselves to be most knowledgeable about the category "regular medical check-ups," followed closely by the category "healthy eating habits" with a score of 71%. For the other categories (food, sports and exercise, others), the results were not conclusive because parents chose to place the concepts, they were familiar with in the top two places and did not place anything in the following places, or only a few responded to categories 3, 4, and 5. For example, in the "other" category, where responses were open-ended, most respondents did not fill in anything. Identifying the categories that parents are sufficiently familiar with led to the selection of intervention topics that are less familiar to them in order to supplement the information they have, so that their choices for their children are increasingly health-oriented. The responses to the attitude items reveal the following: 84% of parents consider that investing in health is very important for their child; on the second item, 79% of parents consider themselves responsible for their child's health; on the third item, 83% of parents consider it too difficult to manage both nutrition and sports with their busy schedule; on item 4—trust in doctors for healthy choices—66% of parents totally agreed (20% agreed and 14% were neutral); and on the last item, 93% of parents totally agreed that mental health is just as important as physical health. For example, in the "other" category,

where responses were open-ended, most did not fill in anything. Identifying the categories that parents are sufficiently familiar with led to the selection of intervention topics that are less familiar to them in order to supplement the information they have, so that their choices for their children are increasingly health-oriented. Regarding the responses to the attitude items, they reveal the following: 84% of parents consider that investing in health is very important for their child; in the second item, 79% of parents consider themselves responsible for their child's health; in the third item, 83% of parents consider that it is too difficult to manage both nutrition and sports with their busy schedule; in item 4—trust in doctors for healthy choices—66% of parents totally agreed with this (20% agreed with this and 14% were neutral), and in the last item, 93% of parents totally agreed that mental health is as important as physical health. In terms of practices, the responses highlighted the following: 93% of children consume fresh fruit and vegetables several times a day; 67% of children exercise regularly (this category includes not only sports but also daily 30-minute walks outside with the child); 47% of children have acquired hygiene habits; 64% of children have regular medical check-ups even if they are not sick; 44% of children sleep 8-9 hours every night. All of the parents' responses in all three categories led to the development of an intervention program at the kindergarten level. The intervention was carried out over a period of 12 weeks, once a week, and targeted. In terms of practices, the responses highlighted the following: 93% of children consume fresh fruit and vegetables several times a day; 67% of children exercise regularly (this category includes not only sports but also daily 30-minute walks outside with the child); 47% of children have acquired hygiene habits; 64% of children have regular medical check-ups even if they are not ill; 44% of children sleep 8-9 hours every night. All the parents' responses in all three categories led to the development of an intervention program at kindergarten level. The intervention was carried out over a period of 12 weeks, once a week, and targeted

- What culinary traditions and eating habits, deeply rooted in culture, influence individual and public health
- ways of perceiving illness and health throughout history
- describe specific healing rituals in a particular community and analyse how symbolism, community participation, and belief in healing powers influence the perception of illness and patient recovery (e.g., the healthy food pyramid and its evolution over time)
- analysis of healthcare systems (hospitals, clinics, public health policies) from the perspective that they themselves

are social products, reflecting values, power, and ideologies (how we choose a doctor, a clinic, etc., what our benchmarks are and how they are culturally influenced, what advertisements influence us the most and why, etc.)

- differences between parental health models across generations
- what are the reliable sources of information from which we obtain information about health, food, and nutrition?
- scientifically validated child health programs
- ways to adapt children's nutrition and sports programs to their parents' work schedules.

Following the intervention, the results were as follows: educators gained a broader perspective on what parents do, believe, and practice with their children, so the elements chosen for health-centred programs were specifically tailored to the current needs of children (and, to some extent, their parents). This was the main gain for the institutions where the intervention program was implemented, and it led to a proactive approach to health for all three institutions. A second gain was that in all three institutions, joint parent-child programs on health were implemented (cooking workshops, presentations on healthy food choices with guest specialists, partnerships for informed decisions, etc.), which was also reflected in increased parent engagement in the kindergarten community. A third benefit is the development of programs at the kindergarten level, in collaboration with educators, parents, or specialists, focused on developing food awareness, encouraging physical activity, and promoting personal hygiene through a thematic and interactive program (some examples of this are: the "Little Healthy Explorers" program, "My Magic Garden," plant growing workshop, healthy cooking workshops, healthy emotions club, movement games, etc.).Following the intervention, the results were as follows: educators gained a broader perspective on what parents do, believe, and practice with their children, so the elements chosen for health-cantered programs were specifically tailored to the current needs of children (and, to some extent, their parents). This was the main benefit for the institutions where the intervention program was implemented, and it led to a proactive approach to health for all three institutions. A second benefit was that all three institutions implemented joint parent-child programs on the topic of health (cooking workshops, presentations on healthy food choices with guest specialists, partnerships for informed decisions, etc.), which was also reflected in increased parent engagement in the kindergarten community. A third benefit was the development of kindergarten-level programs, in collaboration with educators, parents, and specialists,

focused on developing food awareness, encouraging physical activity, and promoting personal hygiene through a thematic and interactive program (some examples of this are: the "Little Healthy Explorers" program, "My Magic Garden," plant growing workshop, healthy cooking workshops, healthy emotions club, movement games, etc.).
The results highlighted the role that kindergarten can play in promoting healthy educational models and in communicating effectively with parents to create valuable partnerships in raising and educating children.

Conclusions

The intervention programs initiated and implemented at the kindergarten level were based on the starting indicators monitored for both groups of respondents—educators and parents. They focused on improving the content and frequency of lessons on health-related topics, as well as on increasing parents' adherence to the healthy models promoted in kindergarten and the programs implemented by educators. The intervention programs initiated and implemented at the kindergarten level were based on the starting indicators monitored for both groups of respondents—educators and parents. They focused on improving the content and frequency of lessons centred on health, as well as on increasing parents' adherence to the healthy models promoted in kindergarten and the programs implemented by educators.
The results tracked over three semesters after the interventions highlight their usefulness and role in all three kindergartens where they were implemented. Such programs implemented at the kindergarten level increase the level of communication between educators and parents, based on shared values and beliefs (in this case related to health, but the topics can be extended to other subjects), lead to the identification of parental values on topics of interest to the kindergarten (education, health, etc.) and their use in appropriate programs for children, a proactive and personalized approach to children's health, building partnerships for informed decisions (in this case regarding children's health, but can be extended to other topics of interest to them), creating a supportive environment for children and strengthening the role of the kindergarten as a credible informational, educational, and formative environment for children. The results monitored over three semesters after the interventions highlight their usefulness and role in all three kindergartens where they were implemented. Such programs implemented at the kindergarten level increase the level of communication between educators and parents and are based on common values and beliefs (in this case related to health, but the topics can be extended to other subjects), lead to the

identification of parental values on topics of interest to the kindergarten (education, health, etc.) and their use in programs appropriate for children, a proactive and personalized approach to children's health, building partnerships for informed decisions (regarding children's health in this case, but can be extended to other topics of interest to them), creating a supportive environment for children, and strengthening the role of the kindergarten as a credible informational, educational, and formative environment for children.

Limitations of the study

The main limitation of the study is the relatively small number of subjects. A second limitation is that this questionnaire refers to health in general, not to a specific aspect of it. For an in-depth study, the items should, in the future, be precisely adapted to the target population (age, education level, culture) and to the specific health topic (e.g., children's hygiene, children's nutrition, etc.). The third limitation of the study is that it did not address the issue of children's leisure time spent on devices.

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