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Tanulmány

Exploring the practices and habits of mothers in raising and caring for young children, with particular regard to health education and health literacy

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Abstract:

Nowadays, health has become an important value, which can be interpreted both on an individual and social level. From the point of view of laying the foundation for a healthy life path, the early years of life are of particular importance, because the health-supportive habits learned during the period before school age have a long-term effect. In the early years of life, the child spends a significant amount of time in both formal and informal educational arenas, so it is important that they support the child in establishing a healthy lifestyle with their uniform educational effect. In order to be able to implement differentiated education as a teacher, in which the formation of the child's health literacy plays a prominent role, it is essential to get acquainted with the child's family's education and care practices and habits. In the spring of 2023, we conducted a pilot study with the participation of 10 mothers, in the framework of which we used semi-structured interviews to find out what kind of child raise and care practices and habits characterize the everyday life of families bringing up young children, what the mothers' health literacy is like, how healthy lifestyle education is carried out in the family and what role and tasks parents and grandparents have in these life situations.

Keywords:

early childhood, habit formation, health education in the family, mothers' health literacy

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Introduction

The health indicators of a society are largely determined by the personal well-being of the individuals who make up the society. According to this, a community can be considered healthy if its members are themselves healthy. In our work, we interpret health - according to the WHO (1948) definition - as a complex state that includes the physical, mental and social well-being of the individual. Optimum individual development is the basis of healthy growth to adulthood and the formation of productive, sustainable and prosperous communities. In addition to the foundation of health, the importance of the early childhood life period is highlighted due to the following factors:

- the first years of life are characterised by a dynamic development of the nervous system (Johnson, 2005; Egyed, 2011),
- early attachment patterns have a strong impact on emotional-social development (Bowlby, 1969; Ainsworth & Bell, 1974),
- the early years of life are also indisputably important in terms of habit formation (Keltner, 1990),
- a strong habit system decreases the number of family conflicts (Kliewer & Kung, 1998),
- investment into early childhood education pays off in human capital, which has an influence to the performance of economy as well (Heckman et al., 1997; Heckman & Masterov, 2007; Heckman & Schultz, 2007; Camilli et al., 2010).
- efficient early childhood prevention and intervention will pay off many times over in the long run (Schweinhart, 2016; Danis, 2020;).

Early childhood education and care can be linked to both formal and informal arenas, of which the family raising the child has a primary role, but the institutions providing the child's care during the day also have a significant impact. Institutional education can be effective if the teacher gets to know the everyday life of families raising children. The identification of the educational influences prevailing in the family is the basis for the coordination of education taking place in different arenas and for individual, differentiated institutional education. In terms of everyday education and care activities, the mapping of the family influence system in our country has not been the focus of research until now (Danis, 2021). This lack is mitigated by the large-scale, questionnaire research of Nyitrai & Darvai (2013), where they asked parents of nursery school children about their own habits at home, their education and care practices, and the forms of forming healthy habits at home.

Our study presents the results of a pilot study carried out in the spring of 2023, the purpose of which was to get a comprehensive and detailed picture of the everyday life of families raising young children, and at the same time offer aspects and contribute to the foundation of a questionnaire data collection. We were able to use the results of the data collected during the

pilot to develop a measurement tool for a quantitative, cross-sectional study involving nearly 600 (N=598) parents of preschool-aged children, which will take place in January 2024, and which sought to explore the correlations between parental health literacy and their children's health-supporting habits. From the results of the large-scale research, it is clear that parents' health literacy and educational level correlate with children's health-related habits (Csima et al., 2024).

The significance of parents' health literacy and habit formation

From the 1980s, the study of health literacy and its impact on well-being came to the fore. Health literacy is the set of abilities of an individual that help them to make intelligent decisions about his health (Pleasant & Kuruvilla, 2008; Sørensen et al., 2015). Health literacy was organized into a twelve-dimensional integrated conceptual model by Sørensen et al. (2012). (Table 1). There are two guiding principles in the model: one focuses on the process of obtaining health-related information (access, understanding, evaluation and application of information), the other covers different areas of health (health care, disease prevention, health promotion) (Finánczet al., 2021).

Table 1.

Dimensions of health literacy. Source: Sørensen et al. (2012)

Health literacy	Access to relevant information on health	Understanding relevant information on health	Evaluation of relevant information on health	Application/ use of relevant information on health
Health care	Ability to access information on health care	Ability to understand information on health care and its relevance	Ability to interpret and evaluate information on health care	Ability to make intelligent decisions in health care issues
Prevention	Ability to access information on risk factors	Ability to understand information on risk factors and its significance	Ability to interpret and evaluate information on risk factors	Ability to judge the significance of information on risk factors
Health promotion	Being up-to-date with regard to the health determinants of the social and material environment	Ability to understand information on the determinants of health in the social and material environment and its significance	Ability to interpret and evaluate information on the health determinants of the social and material environment	Ability to make intelligent decisions regarding the health determinants of the social and material environment

Parents' health literacy affects their own quality of life and, due to their parental role and competence, also affects their child's health. Based on the results of international and domestic research on health literacy, it is clear that the health literacy indicators of our country in terms of health and health development competencies are particularly low. (Koltai & Kun, 2016; Keresztes, 2024). Given that the health status of children is affected by the mother's health literacy (Moravcsik-Kornyicki, 2021), and the mother's health competence is significantly related to the child's health status (Hack et. al., 2006; Sántha et. al., 2020), we considered it justified to find out about the health literacy of mothers raising young children.

In order to discuss the topic, it is also essential to conceptualize the concept of habit. Although many researchers have attempted to create a unified definition, so far it has not been possible to find a definition that fully covers the content of the concept of habit. At the same time, it can generally be said that it covers a process in which an automated action response appears as a result of a stimulus, based on the individual's possession of previously experienced stimulus-response associations (Gardner, 2015, Gardner & Rabar, 2019). In order to consider a habit as a stable, established action, the learning process must go through four stages: the first step is the decision to take a specific action, the second is the behaviour corresponding to the decision, the third step is the repetition of the behaviour, and as the last phase it is done in a way that helps the formation of new habitual associations. It is important to emphasize that the third stage in the process can be considered critical, where it can become important to maintain the motivation of the individual participating in habit formation, which may require the help, support, and example of an external person (Lally & Gardner, 2013). In the early years of life, the parent is the most suitable person to help in the habit-forming process and to maintain the child's motivation. In families where children grow up in such a way that habits are part of everyday family life, children are more cooperative with their parents, and the children's social competences are also more developed. Although more and more studies are aimed at examining health-related habits, only an insignificant part of them focus specifically on family life and young children (Csima et al., 2024).

The selection of the sample

During the pilot study, a semi-structured interview was conducted with 10 mothers (N=10), of which 9 conversations were conducted online using Microsoft Teams software, and one data collection took place in person. In the latter case, the family did not have internet service.

During the selection of the sample, it was an important aspect to ensure heterogeneity, in order to get to know the everyday life of families with different family structures and sociodemographic backgrounds. The heterogeneity of the sample is well reflected by the fact that among the mothers there were

mothers raising single infants, raising a single child attending an institution, living in a mosaic family, living in a large family, living in a mother's home, young childbearing, late childbearing, as well as abused.

In the study, we used convenience sampling, the mothers were invited to work together from a circle of acquaintances, from a maternity home and through an internet advertisement. The latter was necessary because education was an important aspect when selecting the sample, and during the recruitment of the mothers it became clear that in our immediate environment there are few mothers who have completed eight grades of primary school and are raising young children. That is why we looked for a Facebook group in which mothers are represented in significant numbers and published a post. In the post, we asked for the application of mothers open to the interview, who have at least one child under school age and whose highest education does not exceed the eight primary school grades.

We interviewed mothers with at least one child under school age. An exception to this was a mother whose children were already young adults. We considered it appropriate to include her in order to see how a mother belonging to an earlier generation thinks about her own education and care practices.

Another important criterion for the selection of the sample was heterogeneity according to educational level. We examined mothers with different sociodemographic backgrounds. Of the ten mothers, three had a university degree, two had a secondary school certificate and a trade, and five had completed eight grades.

The interviewed women were between 17 and 41 years old when their first child was born. The youngest mother completed eight primary school classes, the oldest has a degree. Seven of the mothers were in their twenties, six of whom gave birth to their first child by the age of twenty-five.

Researcher's questions

During the examination we pursued to answer the following questions:

- What habits are formed in the lives of young children during education and care in the family?
- To what extent and in what way are fathers involved in activities around young children?
- How does family health education manifest itself in everyday life?
- What characterizes the health literacy of the interviewed mothers?

Data recording and processing

Microsoft Teams was used for the digital recording and transcription of the interviews. In order to process the data, the interviewees' answers were

organised in Microsoft Excel tables, where each mother received a code to ensure anonymity. Data cleaning was followed by interpretation. In many cases, the mothers' answers were informative in themselves, but at the same time, we also compared the answers for each question, so we managed to make valuable findings in this way as well. The basis of the comparison was provided by the educational level and/or age of the mothers.

Presentation of the results

The data gained from the responses of the interviewees was organised in categories based on content characteristics. The following topics were separated:

- contents related to health education and health literacy,
- habit formation,
- shortcomings and problems of the care and support systems around families,
- intergenerational relationships,
- parental roles, views, practices.

This study focuses on results related to health education, health literacy and habit formation.

Results related to health education, health literacy

The fact we consider one of the most important results of the analysis of the interviews is that the mothers with low education almost without exception reported that the quality of the pregnancy and the circumstances of the birth do not influence the life of the unborn child in any way or to any extent. This suggests that mothers do not have sufficient knowledge about this connection. It can be assumed that during the period of family planning and pregnancy, these mothers did not have the knowledge that would have made responsible parenting decisions possible. As a result, the possibility of quality experience of parental competence and parental efficiency is reduced, and in the absence of potential intervention, the optimal development of the child may be at risk (Fong et al., 2018).

The study also included examining the concept of health and illness of the mothers. During the interview, we asked the respondents to describe what a healthy newborn is like, and then they answered the same question about a sick newborn.

Answers regarding the child's health parameters often appeared when defining a healthy newborn. Among these were the right weight, „satisfactory breathing", a „shapely" body and the ability to move. The answers of the mothers with lower education almost invariably included remarks to the child's appearance (e.g. „beautiful pink", „beautiful foetal glaze", „with rosy cheeks"), among which there are also definitions that cannot be classified as

characteristics of a mature newborn. In a significant part of the responses, regardless of educational level, the respondents represented that a healthy child eats and sleeps, is calm, and signals its needs by crying.

Obviously the most characteristic symptom of a sick newborn that mothers mentioned was crying. This means that the respondents - regardless of education and age - perceive the importance of expressive crying. Among responses related to the sick newborn, problems mainly related to basic needs were found („improper breathing", „doesn't eat, drink, poop"), as well as symptoms such as fever, cough, vomiting, runny nose.

We also examined the perception of health and illness in relation to children of preschool age. Here, the assessment of the child's weight („not too thin", „appropriate weight", „not obese") and the child's mobility appeared in the answers. Intense but coordinated movement was formulated as a hallmark of health, while inactivity and lethargy were formulated as symptoms of illness. The child's speech activity and enjoyment of speaking is also an indicator of health, while the image of a quiet and withdrawn child was associated with illness. Among the criteria of health, more qualified mothers named the psychic and social components of health more often and more strongly than respondents with a low education. Mental maturity was also mentioned by educated respondents as an important criterion for health. Based on the parental accounts given in the interviews, it can be said that the responses of better qualified mothers showed a more holistic perception of health than those with only primary education. This statement correlates with earlier results published in this topic (Yin et al., 2009; Sørensen et al., 2015; de Buhr & Tannen, 2020;), that is the level of parents' health literacy is influenced by their educational attainment: in the case of parents with a higher-level education, we are more likely to find more favourable health literacy indicators.

Health literacy can also be linked to parents' knowledge of medication, nursing and the use of the health care system. Parents with limited health literacy more often make medication errors and overburden the health care system (Fong et al., 2018). Based on this, we examined the frequency and justification with which the mothers sought help in the event of their child's illness, and how understandable they considered the instructions of the care professionals were. The interviews revealed that mothers - regardless of education - trust a specialist if they notice an illness in their child. In the answers, visits to the doctor (general practitioner, paediatrician) and the nurse appeared mainly. Most of the answers did not reveal how long parents wait before using health care. A mother with a lower level of education reported that she sought medical help almost immediately when her child was diagnosed with the disease, because she felt inexperienced and felt safe doing so. The mother also recalled that the paediatrician laughed at her, "it's you back again" with her child. Behind the immediate contact, we can assume a lack of health literacy. In the case of children's illnesses, based on

the answers, in addition to the doctor and nurse, family members, friends and the Internet also serve as important information channels.

Difficulties inherent in caring for a sick child appeared in several answers, which are as follows:

- judge what medicine to give the sick child,
- decide when it is appropriate to give medicine to the child,
- judge what dosage should be used for each medicinal product,
- consider whether the medicine is more useful or more harmful to the child,
- notice if medical help should be sought in connection with the child's illness.

During the investigation, we also learned about the mothers' functional health literacy. Having shared two situations, we were curious as to what practical solution they would use in the given situation. In the first case, we asked what the mother would do if she noticed discharge in the eyes of her newborn child. Eight mothers would immediately take their newborn child to the doctor, one would first consult with the district nurse, then try to solve the problem by dripping breast milk into the eye, and if these efforts were unsuccessful, she would take her child to the doctor. One answer mentioned wiping with chamomile tea or water, which, if unsuccessful, would also be followed by a doctor's visit. It is clear from these that, regardless of age and education, the respondents would rather seek medical help in the case of an illness in a newborn child than apply home practices for recovery. Most mothers would treat the runny eye with eye drops obtained with a doctor's prescription.

The other practice-focused situation attempted to explore the mothers' theoretical and practical knowledge of fever relief. First, we asked them this open question:

> *"What would you do if your preschool age child's head felt warmer than usual?"*

Next, the mothers were placed in an imaginary situation expecting them to come up with a concrete solution:

> *"Suppose the doctor suggests a cooling bath for your child, how will you make this happen? Please, describe the process in details!"*

The first reaction of the mothers without regard to age or educational attainment was to take the child's temperature if their head felt warmer than usual. Depending on the measured value they would or would not do fever relief. Even less educated mothers were aware that the fever does not need to be treated immediately, however, a specific threshold above which this may become necessary was only found in the responses of respondents with a higher level of education. In these answers, the mothers indicated a

body temperature of 38.5 °C, above which, according to their knowledge, it becomes necessary to reduce the fever. It is important to highlight that the latest professional recommendations no longer set an upper limit above which fever is supposed to be reduced (Professional protocol of the Ministry of National Resources on the care of children with fever, 2011). Based on the results, none of the mothers interviewed possessed this knowledge. A mother with a low level of education named "giving the fever a rest" and "waiting" as the last option in the case of useless home treatments (medicines, poultices, cold baths). However, in the practical implementation of the cooling bath, education was not an advantage, and in several cases more accurate answers were received from mothers with a lower educational level than from respondents with a degree.

In order to learn about healthy lifestyle education in the family, we asked mothers what they do to keep their children healthy. Most mothers linked the foundation of the child's health to the consumption of fruit and vegetables, breathing fresh air and physical activity. In addition to these, strengthening the immune system with vitamins also appeared in the answers. Mothers use vitamins C and D, as well as complex children's vitamins (multivitamins) to maintain their children's health, except for the mothers with only basic schooling, who did not mention the use of vitamin preparations in their answers. It is important to note that a low level of education is often associated with a low socioeconomic status, which does not allow the purchase of high-priced vitamin supplements.

Results related to habits

An important recognition of the pilot study was that it was difficult for the mothers to interpret and answer questions about family habits. Questions directed at habits were answered briefly and superficially. The reason for this may be that the concept of habit and the content of the concept were not clear to them. In other words, the fact that few valid answers were given to such questions does not mean the absence of family habits, rather it can be assumed that identifying the habits and grasping their content may have caused a problem. We tried to keep this result in mind during the development of the measuring instrument representing the next phase of the research, so that it would enable the most detailed exploration of family habits. During the previously mentioned large-scale study (N=598), we developed a set of questions consisting of 30 items, which are suitable for exploring children's habits related to eating, hygiene, accident prevention, physical activity and daily routine (Csima et al., 2024).

In the pilot study, we tried to touch on several areas of family habits, so we sought to learn about habits related to dressing, eating, play activities and outdoor activities. To do this, it was also necessary to explore the extent to which the parents take responsibility for the decision in each educational

and care situation. We asked the mothers to judge who makes the decision in their family in matters of education and care.

Examining the distribution of decision-making between parents in child rearing issues, we found that joint decision-making is the most common, regardless of educational level. At the same time, some of the answers in the question of decision-making were characterized by a slight bias in favour of mothers („rather me" type answers were received to the question). In several cases, fathers were referred to as the person who ensures strictness and discipline in the field of child rearing. The father's disciplinary function was included in the responses of mothers with lower level of education.

In matters arising in the field of newborn and toddler care, mothers clearly claimed to have the right to decide. The role of fathers in matters related to childcare reflects more of a kind of advisory position, that is, mothers may seek the advice of fathers on certain issues, take their opinions into account, but they make the final decision. In two interviews, it was actually said that since the mother spends a significant part of her time with the child, definitely much more than the father, therefore the mother has the final say in matters of care.

In relation to clothing habits, several mothers noted that comfort and practicality are important aspects when choosing clothes. Most of the interviewed mothers reported that they take their child's taste and needs into account when dressing. This applies to the colour of the clothes, the pattern on the clothes. The „matching" of the colour of the clothes and the display of the child's gender through clothing are also emphasized, especially in the case of children of preschool age. A Gypsy/Roma mother pointed out that, although their own culture and traditions do not allow it, she still dressed her daughters in shorts and miniskirts, according to fashion. She also reported that this generated several conflicts between her and the grandparents.

Children's clothing includes choosing the appropriate attire for the weather/season. Many mothers find it difficult to judge how well the child should be dressed. A mother with primary education said that she makes her daughter wear a hat even when the other children have stopped, because 'her daughter is prone ear pain' and 'medicine is getting more expensive' and this is how she protects her daughter. In addition, she noted that the days when the child is sick "are lost", implying that she is not reported to work and does not receive any government health care during the time she is at home with the child. One of our respondents shared with us that if the child does not see that he needs warmer clothes, he is allowed to dress according to his own ideas, so it happened that the child went to kindergarten wearing slippers and shorts at two degrees above zero.

We managed to collect little information about the acquisition of clothes. A mother talked about how she prefers to look for cheaper clothes, but she always buys new shoes for her child because "it's important to her".

In several conversations, the mothers mentioned sleepwear habits, but the answers revealed that while in one family, the child is given different clothes to wear at night and in the daytime from birth, in another family, the child always puts on a clean set of clothes in the evening, which will be daytime wear the day after.

Regarding outdoor activities, most mothers considered it important that the child should spend time outdoors every day if possible. The length of time spent in the fresh air was primarily determined by the weather, with rain, wind and cold weather appearing as the biggest deterrents.

The parents' own eating habits and diet, as well as the nutrition provided to the child, serves as a model for the child, and also strongly determines the appearance of overweight in the lives of family members (Fong et al., 2018). During the examination of eating habits, it was striking that a mother with basic schooling classed the three main meals as daily meals, that is, she considers this to be necessary rather than the five meals a day that the majority of educated mothers named. Several mothers pointed out that due to work and tasks, they cannot have meals together during weekdays, and several also pointed out that although they try to keep a system, the timing of the meals also varies. This suggests that the formation of habits related to meals in the examined families is contingent and not very consistent.

When exploring the habits related to the child's play activities, only two mothers mentioned shared playtime with the child as a habit in their answers. Both have a low level of education and live in mother's homes. The other mothers with a low level of education, without exception, emphasized the number of toys in their answers: "they give the child all the toys", "they have a lot of toys", "they have toys all over the place". In the latter case, it was not revealed whether shared playtime appears in the life of the family, and if so, in what form and frequency.

The responses of the more educated mothers were characterized by the fact that they categorized the toys ("board, developmental, plastic, logical, dolls") and pointed out that the children were not restricted in their play activities. Exceptions to this were „aggressive", „dangerous" games and watching cartoons, in which case parental control appeared. A mother complained that her children have all the toys of the world, but she feels that they are not tied down by the many gadgets:

> *„I strongly see that uh... we have a lot of toys, that's a fact, but... but no, they never need them. Not the toys. So that I don't, I don't know, I don't know. I don't know what to do, but... but they prefer my company or our company" (answer of a 28-year-old mother with a secondary school certificate and a profession).*

Summary

In our study, we presented the results of a pilot study aimed at exploring the educational and care practices, habits, and health literacy of families raising young children. One of the defining tasks of education is the development of health value. If we make use of the early childhood years and put emphasis on health-related habits, through this we can hope for individual and social benefits in the later years of life. We know little about the everyday life and daily routines of Hungarian families raising young children, so we focused our attention on learning about the practices and habits of child-rearing and care taking place in the family. Semi-structured interviews were conducted with 10 mothers, one part of which specifically examined parental health literacy and family habits. The data collected during the pilot study provided a lot of valuable information, and this is especially true for parental health literacy and health education in the family. The set of questions prepared for the interview contained nine questions specifically related to the mentioned topics. We examined the health literacy of the parents with both knowledge-focused and practice-focused questions, which were related to child raise and care. During the interviews we received answers to what significance the mothers attributed to the circumstances of pregnancy and childbirth from the point of view of the child's later life. We learnt about their ideas attached to the meaning of the concepts of health and illness and effort was also made to unveil their knowledge about the care of an ill child.

Based on the interviews, the everydays of families raising young children present a varied image. Holistic health concept – though not unknown for mothers with less education – is more typical of top qualified mothers. As for questions targeting family habits we expected more detailed answers. While recording the interviews we had the impression that the concept and/or content of the habit was difficult to grasp and not quite clear for the mothers. It can be assumed that the few valid answers do not mean the absence of family habits, rather it can be said that these habits function like automatism in everyday life, thus it is difficult for them to rise to a conscious level that requires interpretation. In the future, we consider it advisable to examine the issue of habits with the help of specific, practice-oriented, situation-related questions.

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References

Professional protocol of the Ministry of National Resources on the care of children with fever (2011). A Nemzeti Erőforrás Minisztérium szakmai protokollja lázas gyermekek ellátásáról – *Egészségügyi Közlöny, 61*(7), 1311-1317.

Ainsworth, M. D. S. & Bell, S. M. (1974). Mother-infant interaction and development of competence. In Connoly, K. & Bruner, J. (Eds.), *The growth of competence.* Academic Press.

Bowlby, J. (1969). *Attachment and Loss: Vol. 1. Attachment.* (1982, 2nd edition). Hogarth Press.

Camilli, G., Vargas, S., Ryan, S. & Barnett, W. S. (2010). A korai oktatási beavatkozások kognitív és szociális fejlődésre gyakorolt hatásának metaanalízise. *Teachers College Record, 112 (*3*),* 579-620. https://doi.org/10.1177/016146811011200303

Csima, M., Podráczky, J., Keresztes, V., Soós, E., & Finánczy, J. (2024). The Role of Parental Health Literacy in Establishing Health-Promoting Habits in Early Childhood. *Children, 11(*5*),* 576-590. https://doi.org/10.3390/children11050576

Danis, I. (2020). A csecsemő- és kisgyermekkori lelki egészség támogatásának indokoltsága - egy új fókusz a kora gyermekkori intervencióban. In Danis, I., Németh, T., Prónay, B., Góczán Szabó, I. & Hédervári-Heller, É. (Eds.), *A kora gyermekkori lelki egészség támogatásának elmélete és gyakorlata I. Fejlődéselméletek és empirikus eredmények* (pp. 20-44). Semmelweis Egyetem EKK Mentálhigiéné Intézet.

Danis, I. (2021). *21. századi babaszoba. A szülőség, a szülő-gyermek kapcsolat és a kora gyermekkori lelki egészség vizsgálatának társadalmi indokoltsága és elméleti háttere.* Semmelweis Egyetem Egészségügyi Közszolgálati Kar Mentálhigiéné Intézet.

de Buhr, E., & Tannen, A. (2020). Parental health literacy and health knowledge, behaviours and outcomes in children: a cross-sectional survey. *BMC Public Health*, *20*, 1-9. https://doi.org/10.1186/s12889-020-08881-5

Egyed, K. (2011). Az evolúció ajándéka: az agyi plaszticitás és a rugalmas fejlődés. In Danis, I., Farkas, M., Herczog, M. & Szilvási, L. (Eds.), *Biztos Kezdet Kötetek I.: Génektől a társadalomig: a kora gyermekkori fejlődés színterei* (pp. 166-205). Nemzeti Család- és Szociálpolitikai Intézet.

Finánczy, J., Podráczky, J., Nyitrai, Á. & Csima, M. (2021). Az egészségműveltség vizsgálatának megalapozása a koragyermekkori nevelésben dolgozók körében. Új Pedagógiai Szemle, 71, (11-12.) 19-38.

Fong, H. F., Rothman, E. F., Garner, A., Ghazarian, S. R., Morley, D. S., Singerman, A., & Bair-Merritt, M. H. (2018). Association between health literacy and parental self-efficacy among parents of newborn children. *The Journal of pediatrics, 202,* 265-271. https://doi.org/10.1016/j.jpeds.2018.06.021

Gardner, B. (2015). A review and analysis of the use of "habit" in understanding, predicting and influencing healthrelated behavior. Health Psychology Review, 9(3), 277-295. https://doi.org/10.1080/17437199.2013.876238

Gardner, B. & Rebar, A. L. (2019). Habit formation and behavior change. In *Oxford research encyclopedia of psychology*. https://doi.org/10.1093/acrefore/9780190236557.013.129

Heck, K. E., Braveman, P., Cubbin, C., Chávez, G. F. & Kiely, J. L. (2006). Socioeconomic status and breastfeeding initiation among California mothers. *Public Health Rep. 121*(1) 51-59. https://doi.org/10.1177/003335490612100111

Heckman, J. J., Masterov, D. V. (2007). The Productivity Argument for Investing in Young Children. *Review of Agricultural Economics, 29*(3), 446-493. https://doi.org/10.1111/j.1467-9353.2007.00359.x

Heckman, J. J., Peter J. & Klenow, J. (1997). *Human Capital Policy*. University of Chicago.

Heckman, J. J. & Schultz, H. (2007). Invest in the Very Young. In Tremblay, R. E., Boivin, M. & Peters FDeV, (Eds.), *Encyclopedia on Early Childhood Development* (online). http://www.child-encyclopedia.com/importance-early-childhood-development/according-experts/invest-very-young (2024.12.09.)

Johnson, M. H. (2005). Sensitive periods in functional brain development: Problems and prospects. *Developmental Psychobiology, 46*(3), 287–292. https://doi.org/10.1002/dev.20057

Lally, P., & Gardner, B. (2013). Promoting habit formation. *Health Psychology Review, 7*(1), 137-158. https://doi.org/10.1080/17437199.2011.603640

Keltner, B. (1990). Family characteristics of preschool social competence among black children in a head start program. *Child Psychiatry and Human Development, 21*(2), 95-108. https://doi.org/10.1007/BF00706118

Keresztes, V. (2024). Óvodáskorú gyermeket nevelő szülők egészségműveltsége. In Dezső, R. A. & Ábrahám, G. (Eds.), *Kezdő kárpát-medencei neveléstudományi kutatók antológiája: In memoriam Szivák Judit (*pp. 84-94). Magyar Tudományos Akadémia Pécsi Területi Bizottsága.

Kliewer, W. & Kung, E. (1998). Family moderators of the relation between hassles and behavior problems in inner-city youth. *Journal of Clinical Child Psychology, 27*(3), 278-292. https://doi.org/10.1207/s15374424jccp2703_5

Koltai, A. J. & Kun, E. (2016). A magyarországi egészségértés nemzetközi összehasonlításban. *Egészségfejlesztés, 57*(3), 3-20. https://doi.org/10.24365/ef.v57i3.62

Moravcsik-Kornyicki, Á. (2021). *A pre-, peri- és posztnatális egészség területi egyenlőtlenségeinek és különbségeinek hosszú idősoros elemzése (1997-2019).* Doktori disszertáció. PTE Egészségtudományi Kar, Egészségtudományi Doktori Iskola

Nyitrai, Á. & Darvay, S. (2013). A mese és a játék jelenléte a kisgyermekes családok életében. *Iskolakultúra, 23* (11), 73-85. (Online) https://www.iskolakultura.hu/index.php/iskolakultura/article/view/21445

Pleasant, A. & Kuruvilla, S. (2008). A tale of two health literacies: public health and clinical approaches to health literacy. *Health promotion international, 23*(2), 152-159. https://doi.org/10.1093/heapro/dan001

Sántha, Á., Nagy, M. & Erdei, R. J. (2020). The Health Literacy of Ethnic Hungarian Mothers in Eastern Europe. *Italian Journal of Sociology of Education, 12*(3), 91-111.

Schweinhart, L. J. (2016). Lessons on sustaining early gain from a life-course longitudinal study. In Reynolds, A. J. & Rolnick, A. J. (Eds.) *Sustaining early childhood gains.* Cambridge University Press.

Sørensen, K., van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, S. & Brand, H. (2012). Health literacy and public health. A systematic review and integration of definitions and models. *BMC Public Health. 12*, 1-13. https://doi.org/10.1186/1471-2458-12-80

Sørensen, K., Pelikan, J. M., Röthlin, F., Ganahl, K., Slonska, Z., Doyle, G., ... & Brand, H. (2015). Health literacy in Europe: comparative results of the European health literacy survey (HLS-EU). *The European journal of public health, 25*(6), 1053-1058. https://doi.org/10.1093/eurpub/ckv043

World Health Organisation (1948). First World Health Assembly.

Yin, H. S., Johnson, M., Mendelsohn, A. L., Abrams, M. A., Sanders, L. M. & Dreyer, B. P. (2009). The health literacy of parents in the United States: a nationally representative study. *Pediatrics, 124*(3), 289-298. https://doi.org/10.1542/peds.2009-1162E