

Beyond Child Survival: Positioning Parent–Child Relational Health as a Global Health Priority in the Global South

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ABSTRACT

Background: Global child-health policy increasingly incorporates responsive caregiving alongside survival, nutrition, and disease prevention. However, parent–child relational health has received limited explicit attention as a health-management concern, particularly in Global South settings where household, community, and service-system conditions shape caregiving.

Perspective: This article argues that parent–child relational health should be analysed as a pathway through which structural conditions influence early-childhood health and development. Locating relational outcomes primarily within parental behaviour can misclassify constraints arising from material insecurity, and caregiving arrangements as parenting deficits.

Framework: By synthesizing evidence and conceptual perspectives on child health, caregiving, relational processes, and structural conditions, this article developed the Global South Relational Health Framework (GSRHF) as its central conceptual contribution. The GSRHF comprises six connected domains: (1) structural conditions, (2) caregiving ecology, (3) parent–child relational processes, (4) early-childhood health and development, (5) lifelong health, and (6) population health equity. The framework specifies caregiving ecology as the link between upstream structural conditions and parent-child relational processes, thereby explaining how social, material, household, community, and service-system conditions may shape relational health and subsequent developmental outcomes. The framework also incorporates feedback across domains, allowing early relational and developmental experiences to influence later health trajectories.

Implications: The GSRHF is a testable framework which could be used to explore how the structural conditions and caregiving ecology affect parent-child relational processes, and whether this affects early-childhood and later health outcomes directly or indirectly via mediation and moderation across the proposed pathways, and to compare implementation through routine services with stand-alone parenting programmes.

Conclusion: The GSRHF provides a testable structure for determining when relational constraints require caregiver-level, health-service, or structural intervention, rather than treating parent–child relational health solely as a parenting responsibility.

Keywords: *Early childhood; Global health; Parent–child relational health; Nurturing care; Health equity.*

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1. Introduction

Global child health has achieved substantial reductions in mortality, yet survival and healthy development remain unequally distributed. In 2024, approximately 4.9 million children died before age five, with sub-Saharan Africa and Southern Asia accounting for more than 80% of these deaths (United Nations Inter-Agency Group for Child Mortality Estimation [UN IGME], 2026). At the same time, global early-childhood policy increasingly recognises that health extends beyond survival to the conditions required for children to develop and thrive. Responsive caregiving is consequently embedded within the nurturing-care agenda and supported by evidence showing that parenting interventions can improve caregiver–child interaction and cognitive, language, motor and socio-emotional outcomes (Jeong et al., 2021; World Health Organization [WHO], 2023). Despite this wider awareness of child health, there are significant conceptual deficits in the way that the impact of the conditions of families and children's relational experiences are articulated. Most child survival interventions have focused on prevention of disease, nutrition, and access to essential health services, as well as on mortality. Although these priorities are central, they do not address how children experience care in families or how material and social conditions affect the relationships that support health and development. A child can survive and receive health services, but the parent or caregiver's ability to provide consistent, emotionally available, and responsive care is limited. Therefore, survival indicators alone cannot sufficiently determine if the relational conditions that foster healthy development exist.

A remaining gap concerns where parent–child relational health is located within global health analysis and management. Early relational health scholarship establishes the developmental importance of safe, stable, and nurturing relationships and has called for stronger integration into paediatric research and practice (Dumitriu et al., 2023; Guyol & Javier, 2024). Recent research also highlights the importance of children's relational experiences in broader family, community, and societal contexts, instead of just in the context of individual parenting behaviour (National Academies of Sciences, Engineering, and Medicine [NASEM], 2025). However, parent–child relational health has received limited explicit attention as a health-management concern, particularly in Global South settings where household, community, and service-system conditions shape caregiving. Current child-survival and early child development strategies focus on key determinants of child health and development, but do not always identify how structural conditions affect caregiving provision and, in turn, how the children are cared for affects the relationships they have.

This Perspective addresses that gap by conceptualising parent–child relational health as a pathway connecting structural conditions with early-childhood health and development. The conceptual synthesis led to the proposed Global South Relational Health Framework (GSRHF), a six-domain framework that comprises structural conditions, caregiving ecology, parent–child relational processes, early-childhood health and development, lifelong health, and population health equity. The framework shifts analysis from parenting behaviour alone to the conditions under which relational care is produced and identifies specific points for health-system intervention and empirical testing. Unlike nurturing-care approaches that identify the conditions required for children to thrive, the GSRHF specifies caregiving ecology and parent–child relational processes as analytically distinct intermediate domains through which structural conditions may influence child health, development and subsequent health equity.

2. Parent–Child Relational Health as a Global Health Priority

This Perspective argues that parent–child relational health is recognised as an upstream determinant of child health and health equity in the Global South. Although, global child-health priorities have expanded beyond survival towards enabling children to develop and thrive, responsive caregiving has become increasingly prominent because development is shaped on both material conditions and the quality of caregiver-child interactions (Jeong et al., 2021; World Health Organization [WHO], 2023). However, Current interventions do not always differentiate structural conditions, the organization of caregiving, and the relational processes that children experience. Structural factors like poverty and insecure work, housing, gendered caring responsibilities, and limited of access to health and social services are often analysed differently from parenting, making it difficult to examine how they influence caregiving arrangements, and ultimately, parent–child relational processes.

Parent–child relational health refers here to the quality, stability and reciprocity of interactions through which young children experience responsiveness, emotional security, protection and developmentally appropriate support. This shifts attention from isolated parenting behaviours to relationships as a health-relevant process. Early relational health scholarship similarly identifies safe, stable and nurturing relationships as foundational to healthy development (Dumitriu et al., 2023; Guyol & Javier, 2024). It also shows that caregiver–child interactions are potentially modifiable. A systematic review and meta-analysis of 102 randomised controlled trials across 33 countries found that parenting interventions improved children's cognitive, language, motor and socio-emotional development, attachment, and parenting practices (Jeong et al., 2021). However, relational health cannot be fully understood by parenting behaviour alone, as caregivers' capacity to sustain responsive care is shaped by health and community systems.

This perspective is important in the Global South, where poverty, food insecurity, insecure employment, migration, gendered care burdens, and uneven access to health and childcare services constrain caregiving. These conditions should not be interpreted as deficient parenting. WHO (2023) guidance on parenting interventions recognises that support for responsive caregiving must be embedded within broader systems capable of strengthening both child development and caregiver well-being. Parent–child relational health should therefore be located within a caregiving ecology extending beyond the parent–child dyad to households, extended families, communities, health services, and wider structural conditions. This is important where caregiving involves grandparents, siblings, and extended kin. Relational health should focus on functions such as responsiveness, continuity, reciprocity, emotional security, and protection rather than predetermined family structure.

The Global South context also differs substantially in household organization, caregiving practices, cultural understandings of childhood, and health-system capacity. Relational-health strategies and measures should be culturally and structurally grounded rather than transferred uncritically from high-income settings (Dumitriu et al. 2023). This shifts the policy focus from correcting parental behavior alone towards strengthening the conditions that sustain health-promoting relationships. Parent–child relational health is therefore simultaneously a household process, a preventive-health concern and a health-management issue. Emerging scholarship increasingly positions nurturing relationships as integral to children's health and well-being and calls for early relational health to assume a more prominent role in pediatric research and practice (Roby et al., 2024; Guyol & Javier, 2024).

These arguments support three analytical shifts: from discrete parenting behaviors to relational processes, from individual parental responsibility to shared structural responsibility, and from immediate developmental outcomes to life-course and population-health pathways. These provide the foundation for the Global South Relational Health Framework (GSRHF), which links structural conditions, caregiving ecology, parent–child relational processes, early-childhood health and development, lifelong health, and population health equity.

Beyond Child Survival: The Unfinished Global Health Agenda

The reduction of preventable child deaths is a large global health success that is yet to be completed. In the past 35 years, the global under-five mortality rate has dropped by about 60%, reaching 37.4 deaths per 1,000 live births in 2024. However, it is estimated that over 4.9 million children died before the age of five in 2024, with over 80% of these deaths occurring in sub-Saharan Africa and Southern Asia (World Health Organization [WHO], 2026). Sustained investments in immunization, nutrition, maternal and newborn health, and infectious-disease control and accessible primary healthcare are therefore crucial. Children also need conditions that would facilitate their cognitive, emotional and social development. 102 RCTs in 33 countries demonstrate benefits of parenting interventions on cognitive, language, motor and socio-emotional development and attachment in the first 3 years of life (Jeong et al., 2021); evidence-based parenting interventions are recommended by WHO (2023) to enhance responsive care. Mortality data do not reflect if children live or not, but do reflect whether they have stable, responsive, and protective relationships. Likewise, poverty, caregiver stress, social protection conditions, and health-system conditions can influence caregiving, which may be overlooked in interventions targeting only the caregiver's behaviour. Child-health priorities should, therefore, focus both on mortality and on the relational conditions for development, in settings of high child mortality and moderate to high levels of inequalities in socioeconomic and health-system development in the Global South. Relational health should complement, rather than replace, established priorities for mortality and morbidity.

Parent–Child Relationships as an Early-Life Health Determinant

Parent–Child relationships have regulatory, developmental, and behavioural pathways to early health. Responsive interactions foster children's sense of safety, emotional regulation, distress management, communication, attachment, and learning (Jeong et al., 2021; Dumitriu et al., 2023). One of the major routes is stress management and emotional safety. Stable and responsive relationships offer predictability and support when a child is distressed, as young children need the caregiver to help them regulate (calm down). Safe, stable, and nurturing relationships can therefore enhance regulation and resilience (Dumitriu et al., 2023; Guyol & Javier, 2024). Relational processes also facilitate cognitive, language, and socio-emotional development by responding to their communication, sharing their attention, and stimulating them through play. Through a meta-analysis of 102 RCTs in 33 countries, Jeong et al. (2021) provided evidence of the modifiability of relational processes by reporting better outcomes for cognitive development (SMD: 0.32), language (SMD: 0.28), motor development (SMD: 0.24), socio-emotional development (SMD: 0.19), attachment (SMD: 0.29), and parent–child interaction (SMD: 0.39).

Parent–child relationships also affect preventive health because the care and nurturing that parents provide to children can impact children's nutrition, health care use, safety, and reactions to illness (Guyol & Javier, 2022). These pathways provide services that facilitate parent–child relational processes as the third domain of the GSRHF. Responsive interactions, however, are not innate qualities of parents; a parent's ability to engage in responsive interactions is influenced by the environment of care. This highlights the relevance of the previous GSRHF domain (care-giving ecology) to the production and sustainability of relational health.

3. Why Global South Requires Specific Attention

Parental behaviour is not the only explanation for parent–child relational health in the Global South. Poverty, food insecurity, insecure work, gendered care responsibilities and limited access to health and ECD services may influence caregivers' ability to provide regular care (Black et al., 2021; International Labour Organization [ILO], 2024). But, relationship quality is not a function of structural disadvantage, and family and community care resources vary in the Global South. Mothers, fathers, and other caregivers can perform caregiving, as seen in 51 LMICs (Rothenberg et al., 2024). This constitutes the second domain of the GSRHF, which is the caregiving ecology, which includes caregivers, family support, community resources, childcare arrangements, and services. These can serve as a buffer or alter structural influences prior to their impact on parent–child relational processes.

In addition, there is a need for contextual validation of relational-health measures since the expression of responsiveness and reciprocity may vary by cultural and caregiving contexts (Dumitriu et al., 2023; Lobo et al., 2026). How structural conditions are mediated or buffered within the context of caregiving ecologies is, instead, the key question rather than the question of structural determination of relational quality.

4. A Global South Relational Health Framework

Existing nurturing-care and early relational-health scholarship establishes that responsive relationships are consequential for child development and that caregivers require supportive environments to provide nurturing care (Black et al., 2021; Dumitriu et al., 2023). However, translating this evidence into Global South health policy requires a framework that specifies how structural conditions become connected to relational experiences and how those experiences may subsequently contribute to health inequalities. Therefore, the evidence drawn from the previous sections, translated into the GSRHF by identifying the distinct concepts, but interconnected, which relational health is produced, experienced, and distributed (as shown in Figure 1). The structure is a framework that places parent–child relational health at the intersection of structural conditions and children's developmental and health trajectories. As illustrated in Figure 1, the GSRHF comprises six interconnected domains linked through dynamic and reciprocal pathways: (1) structural conditions, (2) caregiving ecology, (3) parent–child relational processes, (4) early-childhood health and development, (5) lifelong health, and (6) population health equity.

The GSRHF's distinctive proposition is that caregiving ecology and parent–child relational processes constitute analytically separable intermediate domains between structural conditions and child outcomes. Structural conditions do not determine relational health directly; their influence may be transmitted, modified, or buffered by the configuration of caregiving relationships, services, and support surrounding the child.

Structural Conditions

Structural conditions constitute the framework's upstream domain. They include household economic security, employment and working conditions, gender relations, housing, food security, social protection, healthcare accessibility, and broader political and institutional environments. Their relevance lies in their capacity to distribute the material resources, time, and security required for caregiving. The framework therefore rejects explanations that locate relational outcomes exclusively within parental competence. Global nurturing-care scholarship similarly recognises that caregivers' capacity to provide nurturing environments depends upon enabling family, community, service and policy conditions (Black et al., 2021). Structural conditions are linked to caregiving ecology within the GSRHF, because they affect who is available to give care, how the responsibilities of caregiving are divided between people, and whether families can make use of both formal and informal support.

Dynamic Feedback Pathways

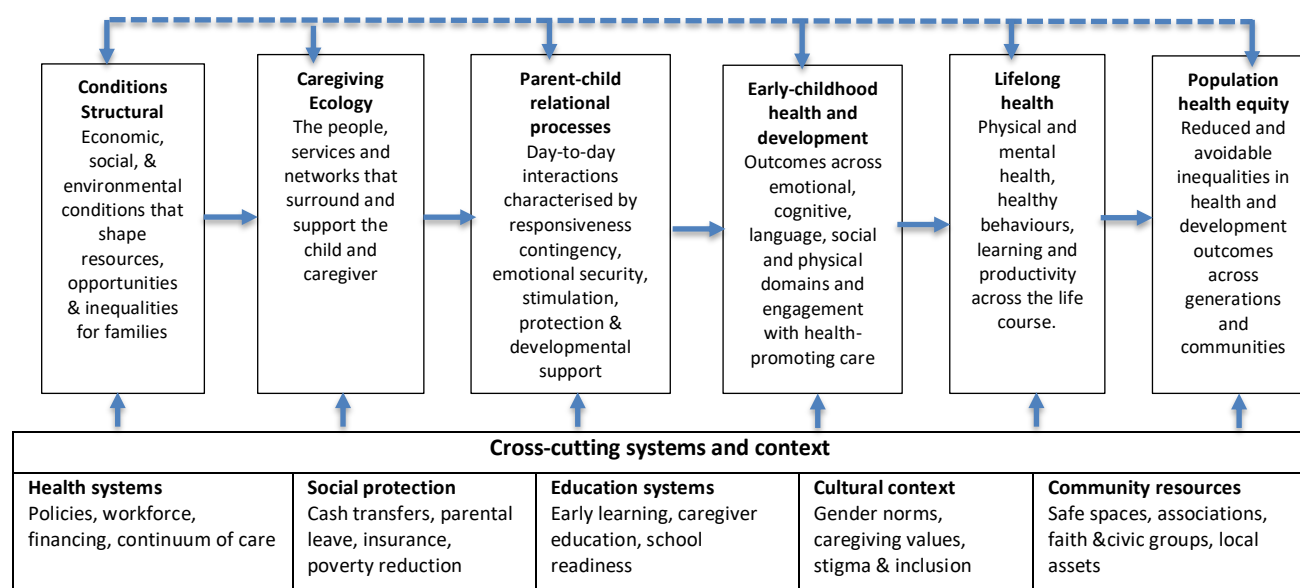


Figure 1. The Global South Relational Health Framework (GSRHF)

Caregiving Ecology

The caregiving ecology represents the relational and service environment within which parent–child interactions occur. It includes parental and non-parental caregivers, extended-family support, childcare arrangements, community networks and relevant services. Multi-country evidence demonstrates that mothers, fathers and other caregivers contribute differently to children's stimulation and socioemotional caregiving across LMIC settings (Cuartas et al., 2020; Rothenberg et al., 2024). The GSRHF therefore treats the availability and configuration of caregiving support as analytically distinct from the quality of parent–child relational processes.

Parent-child Relational Processes

At the centre of the framework are parent–child relational processes: responsiveness, reciprocity, emotional security, continuity, protection and developmentally appropriate interaction. These processes constitute the framework's principal proximal pathway. They are neither predetermined by socioeconomic circumstances nor reducible to parenting style. Rather, they emerge through repeated interactions occurring within the caregiving ecology. Evidence that parenting interventions can improve parent–child interaction alongside cognitive, language, socio-emotional, and attachment outcomes supports the modifiability and developmental relevance of these relational processes (Jeong et al., 2021).

Early-childhood Health and Development

The fourth domain, early-childhood health and development, captures proximal outcomes including emotional regulation, socio-emotional development, communication, cognitive development, and engagement with health-

promoting care. Many factors, including relational processes, affect these outcomes. The framework does not assume that this domain is necessarily a predictor for "lifelong health" but connects the two. While early-childhood outcomes can affect subsequent health trajectories, other family, educational, socioeconomic, and health experiences during childhood can modify those pathways.

Lifelong Health

Lifelong health is the possibility of continuing with early developmental and health processes throughout life. In the GSRHF, it reflects the idea that early relational and developmental contexts can contribute to later physical, mental, and social health, yet maintaining an openness to change in life course trajectories. The framework does not assert that early relational experiences have a determining effect on adult health; rather, it sees early relational processes as one possible route by which conditions might build up, be broken off, or be altered over time.

Population Health Equity

Finally, population health equity locates relational health within global health rather than solely developmental psychology. When structural inequalities systematically constrain caregiving resources for populations, relational opportunities may become another pathway through which social disadvantage is reproduced across generations. Conversely, strengthening family resources, community support and responsive health systems may interrupt this pathway. Relational health therefore represents a potential point of intervention between structural determinants and individual developmental trajectories. Crucially, GSRHF incorporates feedback pathways. Child health and developmental difficulties can increase caregiving demands; caregiver-child interactions can influence caregivers' well-being; and population-level evidence can reshape health and social policy. The framework, therefore, represents relational health as a dynamic rather than unidirectional pathway. Its principal contribution is the specification of caregiving ecology and relational processes as intermediate domains through which structural conditions may influence child development, thereby generating pathways that can be examined through mediation, moderation, and longitudinal analysis.

5. Unsolved Questions on Parent - Child Relational Health Issues and Dynamic Feedback Pathways

The GSRHF provides answers to three unanswered questions about parent-child relational health. First, while the family, community, culture, and society can all affect relational health, the divisions among these are not yet always analytically distinct (NASEM, 2025). The framework thus differentiates between the ecology of caregiving, and parent-child relational processes, acknowledging that the quality of parent-child relations can be affected by the availability and configuration of caregivers and services (Rothenberg et al., 2024).

Second, evidence from low- and middle-income countries suggests that parenting and family interventions can have positive effects, but the pathways through which broader conditions and interventions can have positive effects remain poorly understood (Bosqui et al., 2024). The GSRHF suggests caregiving ecology and parent-child relational processes as intermediary processes between the structural conditions and the health and development of early childhood, offering propositions that can be explored by mediation, moderation, and longitudinal studies.

Lastly, the relational processes are not fixed but dynamic. Parent-child relationships can change over time as parent needs and supports change, due to the changing needs of children and changes in caregivers' well-being (NASEM, 2025). The framework therefore includes feedback loops among relational processes, child development, conditions of caring, and wider systems, rather than one-way relationships.

6. From Individual Parenting to Matched Responsibility

The GSRHF locates parent-child relational processes between caregiving ecology and early-childhood health and development. This positioning means that a relational difficulty cannot automatically be attributed to parental behaviour. Parenting interventions can improve caregiver-child interaction and developmental outcomes (Jeong et al., 2021; WHO, 2023), but the appropriate intervention depends on where the constraint occurs within the framework. A constraint located primarily within parent-child relational processes, such as difficulty interpreting or

responding to a child's signals, may warrant caregiver-focused support. A constraint within the caregiving ecology, such as limited caregiving support or discontinuity between family and services, requires intervention at the family, community or service level. Constraints arising from structural conditions, including material insecurity or restricted access to services, require responses directed at those conditions rather than additional parenting instruction. This distinction prevents structural constraints from being classified as parental deficits. The GSRHF defines this allocation as matched responsibility: intervention is assigned according to the location and source of the constraint. Caregivers address relational interactions within their capacity; health services respond to needs within preventive and clinical care; social and early-childhood systems address constraints within their mandates; and policy addresses conditions affecting access and resource distribution. Where a constraint crosses these domains, referral and coordination connect the responsible actors. Matched responsibility, therefore, provides an operational rule for the framework: locate the constraint within the GSRHF, identify the mechanism through which it affects relational health, and assign intervention to the actor capable of modifying that mechanism.

7. Implications for Global Health Management and Policy

Within the GSRHF, health systems serve as a cross-cutting influence by identifying relational needs, offering the appropriate kind of support, and referring cases that go beyond the health sector. Regular maternal and child health services can help to promote responsive caregiving and detect relational difficulties (World Health Organization, & United Nations Children's Fund, 2023). Concerns that have been identified should be situated within the context of relational processes, the caregiving ecology, or structural conditions to determine the appropriate responses or referrals. Assessment should likewise include relational processes such as responsiveness and reciprocity, using indicators that have been validated in each context (Dumitriu et al., 2023). The resulting health-management pathway is therefore: identify relational need → locate the primary constraint within the GSRHF → respond or refer → document the action → evaluate outcomes. This connects health-system action directly to the six-domain framework while maintaining the distinction between relational processes, caregiving ecology, and structural conditions.

8. Research Agenda for the Global South

Future research needs to examine the proposed GSRHF pathways in a variety of caregiving and cultural settings. It should investigate whether the relational processes are similar across different kinds of caregiving arrangements and whether the caregiving ecology acts as a mediator or moderator of the relationships between structural conditions and child outcomes (Cuartas et al., 2020; Rothenberg et al., 2024; Lobo et al., 2026). Implementation research should also compare the relational support given through regular child-health services with that provided by standalone parenting programmes (Jeong et al., 2021; WHO, 2024). Through such studies, it will be possible to find out if the six-domain framework is empirically supported and contextually applicable.

9. Conclusion and Recommendations

The key contribution of this Perspective is the proposed Global South Relational Health Framework (GSRHF), a six-domain framework to situate parent-child relational health in global health agendas. The framework ties together structural conditions, caregiving ecology, parent-child relational processes, early-childhood health and development, lifelong health, and population health equity. The framework sees caregiving ecology and the various relational processes as the means by which structural conditions can affect children's health and advocates for shared responsibility by connecting interventions with the origin of the constraints in question. The GSRHF must undergo empirical testing in a variety of contexts in the Global South.

Research needs to test the proposed pathways and develop indicators that are valid in the context regarding relational health. Relational-health support should be incorporated into maternal and child health as well as early-childhood programmes, including referral systems that deal with constraints relating to care, services and the structure of systems. The GSRHF should also be adapted and tested in a variety of cultural and health-system settings in the Global South.

Ethical Considerations

Since there were no human or animal participants in this conceptual synthesis, ethical approval was not necessary. The framework was based on the published literature, with all the evidence properly cited and acknowledged.

Conflict of Interest

There is no conflict of interest. Nothing to disclose.

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