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Bridging the health equity gap: The role of nonprofit organizations in the United States and Bangladesh

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ABSTRACT

Persistent health inequities continue to affect marginalized populations in both high-income and low-income countries, despite ongoing investments in public health systems. This study examines the critical role nonprofit organizations play in advancing health equity in the United States and Bangladesh, two countries with vastly different institutional capacities, economic conditions, and governance structures. Using an extensive literature-based methodology, the analysis explores how nonprofits expand access to healthcare, address social determinants of health, and advocate for systemic reforms that benefit disadvantaged communities. This study compares how nonprofit organizations in Bangladesh and the United States advance health equity through community-embedded service delivery, integration of social determinants, and advocacy. It contributes to a cross-national, theory-informed analysis that identifies shared mechanisms and context-specific constraints, offering practical policy lessons for governments and nonprofit leaders. Findings show that Bangladesh's nonprofits, particularly large organizations like BRAC, operate as primary service providers in low-resource settings, leveraging community health workers and integrated development programs to reach underserved populations. This study highlights the need for stronger government–nonprofit collaboration, diversified funding models, and expanded data systems to enhance equity outcomes. By comparing two distinct national landscapes, the research underscores nonprofits' indispensable contribution to building more inclusive, resilient, and equitable public health ecosystems.

Contribution/ Originality: This study compares how nonprofit organizations in Bangladesh and the United States advance health equity through community-embedded service delivery, integration of social determinants, and advocacy. It contributes a cross-national, theory-informed analysis that identifies shared mechanisms and context-specific constraints, offering practical policy lessons for governments and nonprofit leaders.

1. INTRODUCTION

1.1. Problem Statement

Health inequities continue to represent one of the most persistent and complex challenges confronting societies around the world. Despite significant advancements in medical technology, public health policies, and social welfare systems, disparities in access to healthcare and health outcomes remain widespread across both developed and developing nations. Governments often establish programs and allocate resources to promote public health and universal healthcare coverage, yet large segments of the population continue to experience structural barriers that prevent them from receiving adequate care.

Vulnerable populations such as low-income groups, women, racial and ethnic minorities, and those living in remote or rural areas are particularly affected. These groups frequently encounter economic constraints, social exclusion, and geographic limitations that restrict their access to preventive and curative services. The persistence of these inequities demonstrates that traditional, state-centered approaches alone are insufficient to achieve equitable health outcomes. Bureaucratic inefficiencies, limited funding, and uneven policy implementation further exacerbate these challenges, leaving critical service gaps unaddressed.

This situation underscores the growing importance of nonprofit organizations (NPOs) as complementary actors within the broader public health ecosystem. Nonprofits play a vital role in bridging gaps that governments and for-profit sectors often fail to fill. Through their mission-driven focus, local partnerships, and community-centered approaches, nonprofits can respond to needs that are context-specific, culturally sensitive, and often overlooked by national systems. They engage in advocacy for marginalized populations, provide essential health education, deliver direct medical services, and experiment with innovative service models that can later be scaled or integrated into public systems.

However, while the contributions of nonprofits to health equity are increasingly recognized, there remains a limited understanding of how these organizations operate to promote equitable access and outcomes, particularly across different socioeconomic and political contexts. Comparing practices between countries such as Bangladesh, where nonprofits often compensate for weak public infrastructure, and the United States, where they frequently complement a more complex but inequitable healthcare system, offers valuable insights into the diverse roles nonprofits can play in advancing public health equity. This study seeks to explore these dynamics and identify lessons that can inform more inclusive and sustainable health systems globally.

1.2. Purpose of the Study

The purpose of this study is to critically examine the multifaceted role that nonprofit organizations (NPOs) play in promoting public health and advancing social equity across diverse contexts. While public agencies often serve as the primary providers of healthcare, nonprofits have emerged as indispensable partners in bridging service gaps, addressing health disparities, and advocating for more equitable health outcomes. This study seeks to understand how nonprofit organizations contribute not only to expanding healthcare access but also to transforming the social and structural conditions that perpetuate inequities. Specifically, this research will investigate the mechanisms through which nonprofits engage in health promotion, preventive care, and community empowerment, with a particular focus on marginalized groups who are often excluded from mainstream health systems. The study will explore the strategic use of partnerships, policy advocacy, education, and innovative service delivery models that allow nonprofits to advance both access and equity. By incorporating comparative perspectives from both the United States and Bangladesh, the study aims to illuminate how contextual factors such as governance structures, resource availability, and cultural dynamics shape the effectiveness of nonprofit interventions. Examining these two contrasting settings will provide a richer understanding of the similarities and differences in how nonprofits operate within varying health systems and policy environments. Ultimately, this research aims to identify best practices, recurring challenges, and policy implications that can guide nonprofits, government agencies, and international partners in designing more equitable and sustainable health initiatives. The findings will contribute to a deeper understanding of how mission-driven organizations can act as catalysts for systemic change, especially in promoting health justice and reducing inequality at local and global levels.

1.3. Significance of the Study

This study holds significant value for scholars and practitioners in nonprofit management, public administration, and public health policy. It contributes to the growing literature examining the intersection between nonprofit organizations and equitable public service delivery. While many studies explore nonprofit participation in health

programs, a notable gap remains in comparative research analyzing how nonprofits function across different socio-political and economic contexts. By contrasting the experiences of nonprofits in Bangladesh and the United States, this study offers an important cross-national perspective that enhances understanding of nonprofit adaptability, institutional collaboration, and social impact.

The research also carries practical importance for policymakers, nonprofit leaders, and development practitioners. By identifying strategies that enable nonprofits to effectively engage with local communities, build trust, and deliver health services to marginalized groups, the study provides actionable insights for strengthening nonprofit capacity and sustainability. Furthermore, it highlights pathways for more productive partnerships between nonprofits and government agencies, an essential component of achieving collective goals in health equity.

In the context of the United States, where systemic inequalities persist despite advanced healthcare infrastructure, lessons drawn from nonprofit operations in resource-constrained environments like Bangladesh may offer innovative approaches to community engagement, low-cost intervention models, and grassroots mobilization. Conversely, insights from the U.S. can inform Bangladeshi nonprofits on how to enhance governance, accountability, and evidence-based decision-making.

Ultimately, the study underscores the indispensable role of nonprofit organizations as collaborative actors in the pursuit of equitable public health outcomes. By bridging theory and practice, it contributes to both academic scholarship and the design of real-world strategies aimed at reducing disparities, promoting inclusiveness, and strengthening public trust in health governance.

2. LITERATURE REVIEW

2.1. Conceptual Foundations of Health Equity

Health equity is broadly defined as the elimination of avoidable, unfair, and systematic differences in health outcomes among populations (Baciu, Negussie, Geller, & Weinstein, 2017; Bouckley et al., 2025). It is grounded in the principle that everyone should have a fair and just opportunity to attain their highest level of health, regardless of social, economic, or environmental circumstances. Achieving health equity, therefore, extends beyond providing equal access to healthcare; it requires addressing the deeper structural and social factors that shape people's ability to live healthy lives.

Scholars argue that true equity in health demands both improvement of overall population health and the reduction of disparities between privileged and marginalized groups (Brownson et al., 2023). In this sense, equity is not merely a health policy objective but also a moral and ethical imperative rooted in justice and human rights. It recognizes that unequal distribution of resources, power, and opportunity leads to persistent gaps in health status across socioeconomic, racial, gender, and geographic lines.

Central to the concept of health equity is the understanding of social determinants of health (SDOH), the conditions in which people are born, grow, live, work, and age. These determinants, including income, education, employment, housing, gender, and race, play a more significant role in shaping health outcomes than healthcare access alone (Khor, Elsisi, & Carlson, 2023). Addressing these determinants requires multi-sector collaboration and policy interventions that target systemic inequalities rather than individual behaviors.

In this context, nonprofit organizations play an increasingly vital role in advancing health equity. Their proximity to communities, flexibility in program design, and mission-driven orientation allow them to respond to health disparities in ways that are culturally appropriate and socially responsive. By focusing on prevention, advocacy, and service delivery for vulnerable populations, nonprofits operationalize the concept of health equity at the grassroots level, turning theoretical frameworks into practical action.

Thus, the conceptual foundations of health equity provide an essential framework for understanding how nonprofit organizations contribute to closing the health gap. They not only complement government efforts but also act as change agents that challenge structural inequities and promote inclusive systems of care.

2.2. The Role of Nonprofit Organizations in Public Health

Nonprofit organizations (NPOs) play a central role in advancing public health objectives, particularly in contexts where governments and market institutions fail to meet the healthcare needs of vulnerable populations. As mission-driven entities, nonprofits prioritize social value over profit, focusing on equity, accessibility, and sustainability of health services (Salamon, 1999; Young, 2000). Their defining characteristics community orientation, flexibility, and trust within local populations- enable them to fill crucial gaps left by both state and private sector actors.

Scholars emphasize that NPOs operate at the intersection of public and private sectors, functioning as essential partners in achieving societal goals (Anheier, 2014). Their embeddedness within communities allows them to identify local needs more accurately and tailor interventions accordingly. Because of their smaller scale and organizational agility, nonprofits can innovate rapidly, pilot community-based solutions, and adapt to changing conditions capabilities often constrained within bureaucratic government structures (Nicholson-Crotty, 2009).

In Bangladesh, nonprofit organizations have long been pivotal in extending healthcare to underserved rural areas. Large-scale NGOs such as BRAC, Gonoshasthaya Kendra, and CARE Bangladesh have made significant contributions in primary healthcare, maternal and child health, nutrition, and disease prevention. BRAC's extensive community health worker network, for example, has been credited with reducing maternal mortality and improving immunization coverage through cost-effective, scalable models (Khatun, Stenlund, & Hörnell, 2004; Schurmann, 2009). These initiatives demonstrate how nonprofits can operationalize health equity by addressing both access barriers and social determinants of health.

In contrast, in the United States, the nonprofit sector's engagement in public health takes a somewhat different form. Nonprofit hospitals, community health centers, and specialized advocacy organizations contribute to the public good by providing medical care to uninsured or underinsured populations, conducting preventive health programs, and addressing health-related social issues such as housing, food insecurity, and substance abuse (Hadley, Marcial, Quattrone, & Bobashev, 2023). Under the community benefit mandate tied to their tax-exempt status, nonprofit hospitals are required to reinvest surplus revenues into programs that improve population health and reduce disparities. This legal framework not only reinforces their social mission but also differentiates them from for-profit healthcare providers.

Collectively, literature underscores nonprofits' unique ability to advance health equity across both developing and developed contexts. In resource-constrained environments such as Bangladesh, nonprofits act as primary providers, often substituting for weak state capacity. In wealthier nations like the United States, they serve as supplementary actors, bridging gaps within fragmented healthcare systems and advocating for systemic reform. In both settings, nonprofit organizations exemplify the principles of social justice and collective responsibility that underpin equitable health systems, positioning them as indispensable partners in global efforts to achieve universal health coverage and inclusive well-being

2.3. Historical Evolution of Nonprofits in Health Equity

The emergence of nonprofit organizations as key players in health equity is rooted in both history and necessity. In many parts of the Global South, including Bangladesh, nonprofits arose in response to state incapacity and market exclusion. BRAC, for example, began as a small relief initiative after the Bangladesh Liberation War of 1971 but rapidly transformed into the world's largest NGO by building scalable models for health, education, and economic empowerment (Banks, 2024; Schurmann, 2009). Its historical trajectory illustrates how nonprofits became trusted actors by filling life-or-death gaps during times of crisis. Similarly, Grameen Bank's pioneering microfinance initiatives linked women's empowerment with access to healthcare, showing the intertwined nature of poverty reduction and health equity. In the United States, nonprofit involvement in healthcare has an equally long lineage. Faith-based hospitals, charitable clinics, and community-based organizations expanded in the 19th and 20th centuries to address populations underserved by both government and private providers (Brownson et al., 2023). These

historical cases demonstrate that nonprofits emerge not as optional supplements but as essential institutional actors shaped by social crises, systemic inequities, and the persistent failure of markets and states to deliver equitable health outcomes.

2.4. Nonprofits and the Social Determinants of Health

A central theme in contemporary scholarship is that health equity cannot be reduced to clinical outcomes alone. The World Health Organization and public health scholars widely emphasize the social determinants of health factors such as income, education, housing, employment, and nutrition that structure inequities long before individuals encounter the health system (Baciu et al., 2017). Nonprofits are uniquely positioned to address these determinants because of their grassroots orientation and ability to mobilize both community trust and flexible programming. In Bangladesh, BRAC and other NGOs integrated microfinance with maternal health programs, ensuring that women not only received prenatal care but also gained economic agency to make decisions about family health (Khatun, Stenlund, & Hörnell, 2007). This dual approach recognizes that poverty and health disparities are mutually reinforcing. In the United States, food insecurity and housing instability are recognized as critical barriers to equitable health. Nonprofits have stepped into this gap by creating food banks, housing assistance programs, and holistic community health centers that target the root causes of health disparities (Bailey, Serrano, McGlone, & Kegler, 2023; Ogbolu et al., 2022). By integrating clinical and social services, nonprofits move beyond the limitations of fragmented government programs and demonstrate how sustainable equity requires interventions at multiple levels of the social structure.

2.5. Partnerships and Community Engagement

A recurring theme in the literature is the importance of partnerships and collaboration. Nonprofits rarely act alone; they rely on trust-building with communities and partnerships with government agencies and donors to maximize impact (Mosley, 2010; Ogbolu et al., 2022). For example, community health worker programs in Bangladesh illustrate how volunteers rooted in neighborhoods expand access to care, particularly for women and children (Alam & Ahmed, 2010; Alam, Oliveras, & Nazneen, 2014; Alam, Tasneem, & Oliveras, 2012). In the U.S., nonprofit coalitions have advanced health equity by serving as intermediaries between marginalized populations and public institutions (Bailey et al., 2023). The literature suggests that collaboration not only enhances effectiveness but is also essential for achieving sustainable equity outcomes.

Nonprofit organizations play a unique role in bridging the gaps created by weak governance structures and fragmented public-sector delivery systems. Their legitimacy often derives from community trust, local embeddedness, and the ability to adapt programs to cultural and contextual realities. Studies show that frontline nonprofit workers, especially community health workers, are critical intermediaries who translate public health goals into accessible, culturally resonant interventions (Abimbola & Topp, 2018). In the U.S., nonprofit hospitals face pressure to demonstrate measurable community benefits, and recent analyses highlight how effective governance practices enable nonprofits to align service priorities with documented local needs (Bateman, Katz, & Glassman, 2021). In Bangladesh, nonprofits such as BRAC have demonstrated how flexible organizational structures and strong community partnerships can expand health access even in remote, underserved areas (Chowdhury & Cash, 2021). Together, this literature underscores that nonprofit effectiveness depends not only on resources but also on governance quality, community relationships, and operational adaptability.

2.6. Theoretical Perspectives on Nonprofit Organizations

Several theoretical frameworks explain the existence and roles of nonprofit organizations. Market failure theory argues that nonprofits arise when private markets fail to provide sufficient public or quasi-public goods, such as healthcare or education (Salamon, 1999; Young, 2000). Similarly, government failure theory suggests that nonprofits

step in when government provision is inadequate or does not meet diverse community needs (Nicholson-Crotty, 2009). According to Froelich (1999), Hansmann's theory suggests that trust or contract failure theory highlights how nonprofits are often perceived as more trustworthy providers than for-profit firms because they lack a profit motive and are mission-driven. Finally, voluntary failure theory points out that nonprofits also face resource and accountability constraints, necessitating strong interdependence with government and markets (Grønbjerg, 1993). These theories provide a useful lens for understanding how nonprofits advance health equity, particularly in resource-limited settings such as Bangladesh, while also facing challenges common to the U.S. context.

2.7. Nonprofit Advocacy and Equity

Beyond service delivery, nonprofits play a critical role in advocating for structural changes that address inequities. Advocacy efforts often target policies that perpetuate disparities, allowing nonprofits to act as "voice" organizations for vulnerable populations (Mosley, 2010; Pekkanen, 2014). In Australia, advocacy nonprofits have kept equity concerns visible in national health debates (Musolino, Freeman, Flavel, & Baum, 2024). Similarly, in the United States, nonprofits increasingly work to address systemic inequities in healthcare access and the social determinants of health (Bailey et al., 2023). While advocacy can sometimes strain relationships with funders or government partners, literature consistently identifies it as a vital dimension of nonprofits' contribution to equity.

2.8. Challenges of Nonprofit Sustainability

Despite their importance, nonprofits face ongoing challenges in sustaining equity-focused programs. Resource dependency theory suggests that reliance on government contracts and donor funding creates vulnerability and limits autonomy (Froelich, 1999; Grønbjerg, 1993). Studies confirm that nonprofits struggle to diversify revenue streams, limiting their ability to sustain long-term initiatives (Lecy & Van Slyke, 2013). In Bangladesh, BRAC's scale is impressive, but scholars note its dependence on external donor support leaves it exposed to shifting aid priorities (Banks, 2024). U.S. nonprofits also face pressures to demonstrate measurable "community benefit" while competing for scarce funds (Hadley et al., 2023). These financial constraints pose a persistent challenge to nonprofits' equity commitments.

2.9. Deepening the Bangladesh–United States Comparison

The literature on Bangladesh emphasizes the extraordinary scale of organizations like BRAC, which have pioneered innovative models for community health, microfinance, and education (Banks, 2024; Khatun et al., 2007; Schurmann, 2009). BRAC's volunteer health workers, for example, illustrate how nonprofit-led initiatives can extend services into hard-to-reach rural areas (Alam & Ahmed, 2010; Alam et al., 2014; Alam et al., 2012). In contrast, U.S. nonprofits often operate within a more fragmented but resource-rich healthcare system, where hospitals and health foundations focus on filling service gaps, addressing disparities, and demonstrating measurable "community benefit" (Brownson et al., 2023; Hadley et al., 2023). While the contexts differ, both cases highlight nonprofits' flexibility, legitimacy, and ability to address needs overlooked by either government or market providers. Nonprofit organizations in Bangladesh and the United States operate within very different institutional, economic, and regulatory environments, yet both play essential roles in expanding health equity. In Bangladesh, nonprofits such as BRAC and Grameen Health operate as large-scale service providers, delivering primary care, maternal health programs, and rural outreach services that often exceed the government's capacity, especially in low-income and remote districts (BRAC, 2023; World Bank, 2022). These organizations function as critical partners to the government by piloting innovative health models, deploying community health workers, and reaching marginalized populations that public hospitals struggle to serve. In contrast, nonprofits in the United States operate in a highly regulated environment shaped by federal tax-exemption rules, state-level reporting requirements, and complex healthcare reimbursement systems (Internal Revenue Service, 2023; U.S. Department of Health & Human Services,

2022). U.S. nonprofit hospitals and community health centers focus heavily on addressing insurance gaps, social determinants of health, and community benefit obligations under federal law. While Bangladesh's nonprofits compensate for limited state capacity, U.S. nonprofits supplement a large but inequitable healthcare system, especially for uninsured and underrepresented populations. Despite their differences, nonprofits in both countries share a mission-driven commitment to improving health outcomes and reducing disparities through service delivery, advocacy, and community engagement (National Council of Nonprofits, 2023; World Health Organization, 2021).

2.10. Global Learning and Cross-National Insights

An emerging body of literature argues that lessons from nonprofits in the Global South can inform practices in advanced economies. For example, community-based approaches from Bangladesh could inspire U.S. nonprofits to engage more effectively with marginalized populations (Ogbolu et al., 2022). At the same time, U.S. innovations in data equity, performance measurement, and accountability systems offer tools that could enhance the transparency and sustainability of nonprofits in Bangladesh (Raza, 2023; Wang et al., 2025). This bidirectional flow of knowledge suggests that nonprofit organizations are not only critical actors within their local contexts but also participants in a broader global conversation on advancing health equity.

Health inequities do not arise randomly; they are deeply embedded in social and structural determinants that shape people's ability to access care, maintain healthy living conditions, and achieve long-term well-being. Scholars have long argued that unequal exposure to poverty, discrimination, and environmental risk systematically produces poorer outcomes for disadvantaged groups (Marmot, 2017). In both Bangladesh and the United States, these factors manifest differently but lead to similarly persistent disparities. Research on social determinants of health emphasizes that income, education, neighborhood safety, and social capital strongly predict health trajectories, often more than clinical care itself (Braveman & Gottlieb, 2014). In settings like Bangladesh, gender norms, economic vulnerability, and geographic isolation further intensify barriers, limiting women's access to maternal health, nutrition, and emergency care (Bowen & Murshid, 2016). This foundation strengthens the argument that nonprofit organizations must address both medical and non-medical drivers of inequity to achieve meaningful and lasting health improvements.

2.11. Technology, Innovation, and Data Equity

The role of nonprofits in leveraging technology to promote equity has become increasingly prominent in the 21st century. Digital platforms, mobile health tools, and big data analytics provide nonprofits with the means to reach underserved communities more efficiently.

In Bangladesh, mobile health technologies (mHealth) are used by community health workers to monitor maternal health, schedule vaccinations, and disseminate health information in remote villages where state health infrastructure remains weak (Alam et al., 2014; Alam et al., 2012). These interventions not only increase access but also improve accountability by making health data visible in real time. In the United States, nonprofit hospitals and health coalitions have invested heavily in electronic health records and data-driven community needs assessments to identify disparities at a granular level (Hadley et al., 2023). However, scholars warn of the equity risks embedded in technology.

Raza (2023) note that algorithmic bias in machine learning models may reproduce racial and gender inequities if nonprofits and policymakers do not adopt frameworks for data equity. Wang et al. (2025) propose that nonprofits can act as leaders in implementing data audits to ensure fairness in the design and use of health technologies. The literature suggests that nonprofits serve as both innovators and watchdogs in the realm of health equity technology, championing innovation while ensuring it does not exacerbate the very disparities they seek to overcome.

2.12. Nonprofits, Gender, and Intersectionality

Gender equity remains one of the most important domains where nonprofits have advanced health outcomes. In Bangladesh, nonprofits such as BRAC have pioneered female-led volunteer health worker programs that not only deliver care but also challenge patriarchal norms by empowering women to assume leadership roles in their communities (Alam & Ahmed, 2010). These women serve as trusted health intermediaries, bridging cultural gaps that might otherwise prevent families from seeking care, particularly in maternal and child health. Their work demonstrates how nonprofits advance both gender equity and health equity simultaneously. In the U.S., nonprofits have increasingly incorporated intersectionality into their programming, recognizing that women of color, immigrant women, and low-income women experience compounded disadvantages in the health system (Bailey et al., 2023). For example, nonprofit advocacy organizations have pushed for policies that address racial bias in maternal care, responding to disproportionately high rates of maternal mortality among Black women. Musolino et al. (2024) further show that nonprofits play a crucial role in advocacy, ensuring that gender and intersectional concerns remain visible in national policy debates. Taken together, the literature suggests that nonprofits do more than provide services; they reshape social norms and policy discourses by centering gender justice as a necessary component of health equity.

2.13. The Future of Nonprofits in Global Health Governance

As globalization has reshaped development and health policy, nonprofits are increasingly central actors in global health governance. Multilateral organizations such as the World Bank, WHO, and bilateral donors like USAID often rely on nonprofits to implement health equity programs, recognizing their flexibility and grassroots legitimacy (Ogbolu et al., 2022). However, this reliance introduces complex dynamics of accountability. Nonprofits must answer simultaneously to international funders, local governments, and the communities they serve, often producing tensions in mission alignment (Froelich, 1999; Grønbjerg, 1993). For example, BRAC's reliance on donor funding has enabled it to scale programs across Bangladesh, but shifting aid priorities exposes it to vulnerabilities that threaten long-term sustainability (Banks, 2024). In the U.S., nonprofit hospitals face pressures from both federal regulations and community expectations to prove their community benefit, balancing service provision with advocacy (Hadley et al., 2023). Lecy and Van Slyke (2013) argue that the future of nonprofits in governance will depend on their ability to diversify revenue streams while maintaining legitimacy among stakeholders. Ultimately, nonprofits are likely to remain indispensable actors in health governance worldwide, but their effectiveness in advancing equity will hinge on how well they navigate resource dependency, accountability, and global-local power dynamics.

2.14. Implications for Policy and Practice

The literature points to several implications. First, nonprofits must balance service delivery with advocacy to achieve both immediate and structural equity gains (Mosley, 2010; Pekkanen, 2014). Second, sustainability requires innovative funding mechanisms and stronger government–nonprofit partnerships (Froelich, 1999; Lecy & Van Slyke, 2013). Finally, comparative perspectives suggest nonprofits in diverse contexts can learn from one another: lessons from Bangladesh's large-scale programs may inform U.S. approaches to underserved populations, while U.S. practices in accountability and data management may strengthen nonprofits globally (Banks, 2024; Raza, 2023). Together, this literature affirms that nonprofits are indispensable actors in advancing public health equity.

2.15. Service Delivery, Community Trust, and Access

One of the strongest contributions nonprofits make is their ability to expand access to care by building trust with marginalized populations. Studies across multiple countries show that nonprofits reach groups that government systems struggle to serve, including low-income families, rural communities, and ethnic minorities (Ahmed, Khan, & Ahmed, 2021; Asad & Heller, 2022). Community-based approaches such as the use of local health workers, neighborhood clinics, and home-visit programs strengthen ties between providers and residents, improving both

uptake and continuity of care (Afulani, Riley, & Vwalika, 2021; Biswas, Rahman, & Kabir, 2019). In Bangladesh, NGOs have played an indispensable role in maternal and child health, nutrition, and family planning, creating scalable models that the government often later adopts (Islam & Biswas, 2020). Meanwhile, in the United States, nonprofit hospitals and community health centers contribute significantly to reducing unmet medical needs by offering free or sliding-scale services to uninsured or underinsured patients (Patel & Kearns, 2021). These interventions demonstrate how nonprofits strengthen equity not simply through service delivery but through trust-building practices that increase healthcare utilization among underserved populations (Barros & Victora, 2020; Dini, 2022).

2.16. Governance, Participation, and System Strengthening

Beyond direct service provision, nonprofits contribute to health equity by influencing governance structures, advocating for reforms, and ensuring community participation in decision-making. Civil society organizations often act as intermediaries between the state and the public, enabling marginalized groups to voice concerns and shape health policies (Feruglio & Nisbett, 2018; Sheikh, George, & Gilson, 2019). This participatory governance is especially important for equity, as it addresses power imbalances that traditionally exclude low-income and minority populations from policy processes (Rifkin, 2014). In the United States, nonprofits play a similar advocacy role by pushing for Medicaid expansion, influencing community health needs assessments, and promoting equity-oriented hospital governance (Johnson & Williams, 2022). These efforts strengthen system capacity and embed equity principles into national and local health institutions.

2.17. Sustainability, Funding Challenges, and Long-Term Equity Outcomes

Community-based approaches that leverage local resources and actors are widely recognized for their potential to reduce health inequities in low- and middle-income countries (LMICs). One key strategy involves the deployment of community health workers (CHWs), who serve as bridges between formal health systems and underserved populations. Evidence from a systematic review indicates that CHW programs often improve access to care and health services for disadvantaged groups, although persistent structural barriers can limit their full impact (Ahmed et al., 2022). Research on nonprofit hospital community benefit strategies increasingly emphasizes the role of equity-oriented practices in shaping how resources are allocated to underserved populations. Equity-oriented primary care interventions aim to reduce health disparities by tailoring care to the social and structural determinants that disproportionately impact marginalized groups. A comprehensive review demonstrates that when primary care systems integrate equity principles such as prioritizing culturally safe care, expanding access, and addressing socioeconomic barriers, patient outcomes improve and trust in health services increases (Ford-Gilboe et al., 2018). This evidence underscores the ethical imperative for administrators and policymakers to embed equity not just in rhetoric but in operational strategies that actively bridge gaps in care and empower underserved populations. While community benefit reporting is mandated for tax-exempt hospitals, evidence suggests considerable variation exists in how comprehensively hospitals integrate health equity into their benefit strategies (Singh, Santos, Puro, & Cronin, 2026). Hospitals that adopt more robust equity-focused plans tend to invest more in community health improvement and preventive care services that address the social determinants of health. These investments reflect not only organizational stewardship of resources but also a commitment to addressing systemic disparities that disproportionately affect marginalized groups. By linking strategic equity planning with actual spending patterns, this research highlights that nonprofit hospitals can be both efficient and ethically responsive to community needs. From a public administration perspective, such alignment between policy goals and operational outcomes is crucial for advancing social justice and maintaining public trust in nonprofit institutions. Yet despite these constraints, many nonprofits continue to innovate by using data-driven models, forming coalitions, and leveraging technology to extend their impact (Fahey & Hino, 2020). The literature shows that nonprofit strength lies in adaptability, responding quickly to crises such as COVID-19 while maintaining a commitment to equity and targeted outreach (Smith & Judd,

2021). Ultimately, nonprofits in both Bangladesh and the United States exhibit remarkable resilience in promoting health equity, but their long-term effectiveness depends on sustainable financial models, supportive government partnerships, and continued investment in community-led approaches (Barros & Victora, 2020; Khatun et al., 2007). This evidence supports the ethical argument that nonprofit hospitals should prioritize equity not only in rhetoric but in measurable investment strategies, an imperative consistent with principles of justice and beneficence in public health administration.

3. RESEARCH DESIGN

3.1. Purpose of the Present Study

Building on the problem statement and literature review, the central purpose of this research is to analyze how nonprofit organizations contribute to public health and social equity in two distinct national contexts, Bangladesh and the United States, and to identify the strategies and conditions that enable or constrain their effectiveness. The comparative approach clarifies context-sensitive lessons that may be transferable across settings.

3.2. Research Design Overview

A comparative case study design is suitable for this investigation because it allows in-depth, contextually rich analysis of how nonprofits operate within different institutional environments (Ragin, 2014; Yin, 2018). The design utilizes existing empirical research, policy and program evaluations, NGO reports, and secondary data to produce a cross-case synthesis. Using Bangladesh and the United States as contrasting cases offers leverage for theory-building: Bangladesh represents a lower-income, weakly capacitated public health system where nonprofits often serve as primary service providers; the United States exemplifies a high-resource but fragmented system where nonprofits typically act as complementary providers and advocates (Brownson et al., 2023; Ogbolu et al., 2022).

3.3. Research Questions

This study addresses the following refined research questions.

1. Through what mechanisms do nonprofit organizations expand access to healthcare services for marginalized populations in Bangladesh and the United States?
2. What strategies do nonprofits employ to reduce health disparities and promote equitable outcomes in these two settings?
3. How do institutional context, funding models, and governance structures shape nonprofits' capacity to deliver equitable health programs?
4. What interventions and policy arrangements appear most promising for scaling nonprofit-driven equity gains while preserving accountability and sustainability?

3.4. Justification of Method

Comparative qualitative synthesis is particularly useful here because.

- It allows the researcher to trace causal mechanisms (how and why nonprofit interventions produce outcomes) rather than merely correlating variables.
- It exposes contextual moderators (e.g., regulatory frameworks, donor dependence, social norms) that influence program effectiveness.
- It fosters cross-national learning and theory development, identifying which strategies are context-specific versus more generalizable (George & Bennett, 2005; Lijphart, 1971).

Given the study's emphasis on practice and policy, a qualitative comparative method that integrates program evaluations, grey literature (NGO and donor reports), and peer-reviewed studies yields actionable insights for both scholars and practitioners.

4. DATA COLLECTION, ANALYTICAL APPROACH, AND FINDINGS

4.1. Data Sources

This investigation synthesizes published and publicly available sources, including.

- Peer-reviewed journal articles and systematic reviews (selected from the literature review).
- NGO program evaluations, annual reports, and internal assessments (e.g., BRAC program documentation).
- Policy documents and guidance from international organizations (e.g., WHO, World Bank) and national public health agencies.
- Publicly available administrative and programmatic data referenced in the literature (e.g., immunization coverage statistics, maternal mortality trends cited in the studies).

Using multiple, complementary sources improves validity through triangulation, where independent documents and datasets corroborate thematic findings (Denzin, 1978; Patton, 2015).

4.2. Analytical Approach

The analysis proceeds in three stages.

1. Thematic extraction: For each case (Bangladesh and the U.S.), key programmatic strategies, governance arrangements, funding structures, and observed outcomes were extracted from the literature and coded into thematic categories (e.g., community engagement, workforce strategies, funding diversification, advocacy).
2. Mechanism tracing: Within each theme, the analysis identifies plausible causal pathways that explain how specific nonprofit activities lead to intermediate outputs, such as increased clinic attendance, and longer-term outcomes, like reduced child mortality.
3. Cross-case synthesis: Themes and mechanisms are compared across the two cases to identify convergent patterns (strategies that work across contexts) and divergent patterns (context-specific enablers or constraints).

Throughout, the analysis pays attention to the contextual moderators' political will, donor priorities, governance capacity, and socio-cultural norms that alter the strength or direction of observable effects.

4.3. Findings Synthesis of Evidence

4.3.1. Access Expansion through Community-Embedded Delivery

Both cases indicate that nonprofits expand access most effectively when interventions are embedded in communities. In Bangladesh, BRAC's network of community health workers and its microfinance-linked health programs have repeatedly demonstrated improved coverage of primary care, immunizations, and maternal health services (Alam & Ahmed, 2010; Khatun et al., 2007). These interventions succeed because they leverage existing social ties, create trust, and offer low-cost, culturally sensitive delivery pathways.

In the U.S., community health centers, nonprofit clinics, and mobile outreach programs extend services into underserved urban and rural communities, often reducing access barriers related to transportation, insurance coverage, and language (Bailey et al., 2023; Hadley et al., 2023). The mechanism is similar: proximity and trust fostered by local staffing and community partnerships, yet the institutional context differs. U.S. nonprofits operate within reimbursement systems and regulatory frameworks that condition their scope of services (e.g., Medicaid policies, community benefit requirements for nonprofit hospitals).

4.3.2. Integrating Social Determinants into Program Design

Nonprofits that couple clinical services with interventions targeting social determinants (housing, nutrition, economic empowerment) achieve more durable equity gains. BRAC's integrated model linking health, nutrition, and microcredit illustrates how tackling economic vulnerability complements clinical care, leading to measurable improvements in child growth and maternal wellbeing (Banks, 2024; Khatun et al., 2007). Similarly, U.S.-based

nonprofits that provide food security programs, housing stabilization, or employment support alongside clinical referrals have improved health outcomes among high-need populations (Ogbolu et al., 2022).

Mechanism: By reducing socioeconomic constraints, nonprofits increase patients' ability to follow preventive regimens and reduce exposure to health risks, making clinical interventions more effective.

4.3.3. Workforce Strategies: Community Health Workers and Volunteer Networks

A recurring success factor in both contexts is investment in community-level workforce models. Volunteer and paid community health workers (CHWs) act as cultural brokers, health educators, and frontline service deliverers. Studies show CHW programs in Bangladesh have improved maternal and child health indicators while creating local employment and social capital (Alam et al., 2014; Alam et al., 2012). In the U.S., CHW programs have been effective for chronic disease management, linkage to care, and reducing emergency department utilization when supported with training and sustainable funding (Bailey et al., 2023).

However, workforce sustainability depends on training, supervision, remuneration, and institutional recognition factors that are often underfunded.

4.3.4. Advocacy and Policy Engagement as Catalysts for Structural Change

Nonprofits not only deliver services; they also act as advocates for policy change. In the U.S., nonprofit coalitions have influenced Medicaid expansions, community health financing, and local health policy through evidence-based advocacy and coalition-building (Mosley, 2010; Patton, 2015). In Bangladesh, NGOs have worked with government partners to pilot scalable programs and inform national policies, sometimes leading to the institutionalization of NGO-originated innovations (Ogbolu et al., 2022; Schurmann, 2009).

Mechanism: Advocacy translates grassroots insights into policy reforms that institutionalize successful interventions, thereby amplifying impact beyond the NGO's direct service footprint.

4.3.5. Funding Models and Sustainability: A Persistent Constraint

Resource dependency is a central limiting factor. Nonprofits in Bangladesh often rely on donor funding and grants; while such funding allows rapid scale-up, shifting donor priorities create vulnerability and discontinuities (Banks, 2024; Froelich, 1999). In the U.S., nonprofits must navigate a mixed funding environment, including charitable donations, government contracts, and insurance reimbursements, which can encourage mission drift or program fragmentation (Lecy & Van Slyke, 2013). The evidence suggests that diversified revenue models, blending earned income, stable government contracts, philanthropic endowments, and social enterprises, correlate with better program continuity and capacity to pursue equity goals.

4.3.6. Data Use and Evidence-Based Programming

Nonprofits that invest in rigorous data collection and evaluation are more effective at both demonstrating impact and informing program improvement. In the U.S., data-driven community health needs assessments and outcomes tracking inform hospital community benefit strategies (Hadley et al., 2023). In Bangladesh, monitoring and community feedback mechanisms in BRAC programs enable iterative refinement of interventions (Khatun et al., 2007). Conversely, a lack of capacity for data collection constrains accountability and reduces donors' willingness to invest long-term.

4.3.7. Gender and Intersectional Approaches

Programs that explicitly incorporate gender and intersectional analyses addressing how race, class, and gender interact produce more equitable results. In Bangladesh, female CHWs both increase women's access to care and shift local gender norms (Alam & Ahmed, 2010; Alam et al., 2014). In the U.S., nonprofits targeting maternal health

disparities among Black women have used culturally competent models that show promise in reducing adverse outcomes (Bailey et al., 2023; Musolino et al., 2024).

5. DISCUSSION

5.1. Interpretation of Key Findings

The findings highlight several convergent themes across Bangladesh and the United States.

- Community embeddedness is pivotal. Trust and localized presence allow nonprofits to bypass structural barriers and increase service uptake.
- Integration of social determinants strengthens clinical interventions and addresses root causes of inequity.
- Human resource models, particularly CHWs, are instrumental in operationalizing equity at scale but require stable investment.
- Policy engagement and advocacy convert localized successes into systemic reforms, offering pathways to sustainability beyond individual programs.
- Funding diversification and robust data systems are necessary conditions for scaling and sustaining equity-focused programs.

While these mechanisms are similar across contexts, their operationalization differs depending on institutional environments. Bangladesh's nonprofits act sometimes as parallel service systems where government capacity is weak; this allows NGOs to innovate rapidly and directly influence large populations (Banks, 2024). In the U.S., nonprofits are more embedded within regulatory and financing structures (e.g., Medicaid, philanthropy), shaping both their opportunities and constraints (Brownson et al., 2023).

5.2. Contributions to Practice

For practitioners, comparative synthesis suggests practical strategies.

- Prioritize community-based workforce investments and formalize CHW roles with training and compensation.
- Design programs that integrate social services (Housing, food security, livelihoods) with clinical care.
- Invest in data capacity to demonstrate impact and support continuous improvement.
- Engage in strategic advocacy to institutionalize successful pilots within public systems.

5.3. Contributions to Theory

The analysis contributes to nonprofit theory by demonstrating how theories of market and government failure interact with resource dependency and trust-based mechanisms to shape nonprofit effectiveness. Specifically.:

- Where government capacity is low, nonprofits can substitute for state provision (Supporting government failure theory).
- Trust-based advantages, including contract failure and trust theory, are essential mechanisms through which nonprofits gain access and effectiveness in marginalized communities.
- Resource dependency constrains long-term impact unless revenue streams are diversified; thus, sustainable equity requires structural adaptation of funding models (Froelich, 1999; Lecy & Van Slyke, 2013).

6. POLICY IMPLICATIONS AND RECOMMENDATIONS

Drawing from the comparative findings, the following actionable recommendations are proposed for policymakers, nonprofit leaders, and donors. Each recommendation is framed to be practical and evidence-based, oriented toward improving equity outcomes while respecting organizational realities.

6.1. For Governments

1. Institutionalize CHW Programs: Create funding streams, accreditation, and supervision mechanisms for community health workers to ensure stable compensation and integration with primary health systems. This will help scale successful NGO models into public programming.
2. Flexible Partnership Frameworks: Establish formal mechanisms for rapid contracting with nonprofits during service gaps, including streamlined procurement and performance-based grants, such as public–private NGO partnerships.
3. Support Data Interoperability: Provide technical assistance and funding to enable nonprofits to adopt interoperable data systems that align with national health information systems, increasing accountability and enabling scale-up.

6.2. For Nonprofit Managers

1. Adopt Integrated Service Models: Where possible, integrate social determinants interventions into health programs (e.g., combine maternal health with livelihood support).
2. Strategic Diversification of Revenue: Pursue blended finance approaches combining grants, earned income, government contracts, and social enterprises to reduce vulnerability to single-funder shifts.
3. Invest in Capacity Building: Prioritize investments in monitoring and evaluation units, staff training on gender and intersectionality, and leadership development to sustain long-term equity commitments.

6.3. For Donors and International Agencies

1. Long-term, Flexible Funding: Fund multi-year, flexible grants that enable nonprofits to adapt and respond to local needs, rather than short-term project cycles that promote short-termism.
2. Capacity Strengthening: Provide resourcing for NGO data systems, governance strengthening, and local leadership development areas that are often underfunded but are crucial for sustainability.
3. Facilitate Cross-National Learning: Support knowledge exchanges between NGOs in low- and high-income countries to transfer community-driven innovations and accountability practices.

7. THEORETICAL IMPLICATIONS

7.1. Defining a Theory

A theory is a structured set of concepts, definitions, and propositions that explains or predicts phenomena by specifying relationships among variables (Dubin, 1978; Kerlinger, 1973). Good theories organize knowledge into coherent frameworks that clarify why and how certain outcomes occur. Whetten (1989) emphasizes that strong theory must define what factors are involved, how they relate, and why those relationships matter. Bacharach (1989) adds that effective theories possess conceptual clarity, internal logical consistency, and empirical testability. These characteristics enable theories to guide research design, interpretation of findings, and generalizable applications across contexts.

7.2. Major Theories Relevant to This Study

The literature on nonprofit organizations and health equity draws on several foundational theories; the major theories informing this study include.

a) Contract-Failure / Trust Theory (Hansmann, 1979).

Hansmann argues that nonprofits emerge where information asymmetry is high, and beneficiaries must trust providers, especially in sectors like health, where vulnerable populations cannot easily assess quality. Nonprofits' non-distribution constrains signals of mission-driven behavior, which builds credibility and promotes service uptake.

b) Resource Dependence Theory (Pfeffer & Salancik, 1978).

This theory explains how nonprofits' actions are shaped by their dependence on external resources. Funding environments influence strategic decisions, program design, and long-term sustainability. Nonprofits develop partnerships, advocacy roles, and diversified revenue streams to reduce uncertainty.

c) Institutional Theory (DiMaggio & Powell, 1983).

Institutional theory highlights how organizational behavior is shaped by rules, norms, and cultural expectations. Nonprofits adapt their practices in response to regulatory pressures, professional standards, and the desire to mirror "legitimate" models. This helps explain similarities in health programs across contexts.

d) Social Determinants of Health Framework (Braveman & Gottlieb, 2014; Marmot, 2017).

These frameworks emphasize the upstream social and economic forces that shape health outcomes: poverty, gender inequity, education, and environment. They argue that health equity cannot be achieved solely through clinical services but requires addressing structural inequities.

e) Participatory Governance / Community Engagement Theory (Rifkin, 2014).

This theory emphasizes the importance of community involvement in decision-making and service co-production. Nonprofits using participatory models achieve higher trust, stronger ownership, and better alignment with local needs, especially in Bangladesh and marginalized U.S. communities.

7.3. Theory Synthesis and Proposed Integrated Model

Based on the literature and research questions, this study proposes an integrated theoretical model explaining how nonprofit organizations contribute to health equity in Bangladesh and the United States.

Dependent Variable (Y):

Health Equity Improvement

Measured by reductions in disparities, increased access to services, and improved outcomes for marginalized communities.

Independent Variables (X_1–X_4):

- X_1: Funding Stability

Stable, diversified funding enables nonprofits to sustain long-term health interventions and expand access to underserved communities (Froelich, 1999).

- X_2: Governance Capacity

Effective boards, leadership structures, and transparent oversight increase accountability and program quality, supporting equitable outcomes (Anheier, 2014).

- X_3: Community Engagement

Participation of local communities in program design and implementation enhances trust, cultural relevance, and service uptake (Bowen & Murshid, 2016).

- X_4: Service Accessibility

The ability to reach rural, low-income, or minority populations through clinics, mobile services, or health education directly strengthens equity (BRAC, 2024; Centers for Disease Control and Prevention, 2023).

Integrated Theory Formula:

$Y = F(X_1, X_2, X_3, X_4)$

Where:

- Funding stability (X_1).
- Governance capacity (X_2).
- Community engagement (X_3).
- Service accessibility (X_4).

Jointly predict and strengthen health equity improvement (Y).

Figure 1 illustrates the proposed integrated theoretical model showing how funding stability, governance capacity, community engagement, and service accessibility jointly influence improvements in health equity.

Figure 1. Factors impacting health equity improvement.

8. CONCLUSION

8.1. Brief Summary

This study set out to examine how nonprofit organizations in Bangladesh and the United States contribute to bridging the health equity gap, particularly for populations historically excluded from mainstream health systems. Drawing on a comprehensive secondary analysis, the findings show that nonprofits play indispensable but contextually distinct roles in advancing equitable access, improving service delivery, and influencing systemic reforms.

Three central insights emerge from the comparative evidence. First, the most durable gains in health equity are achieved when nonprofits work through community-embedded models grounded in trust, proximity, and cultural understanding. Whether through Bangladesh's large-scale community health worker networks or the United States' community health centers and outreach initiatives, nonprofits expand access by meeting people where they are and tailoring interventions to local realities.

Second, nonprofits are most effective when they integrate social determinants of health, such as gender dynamics, food security, housing stability, and economic vulnerability, into program design. The Bangladesh case illustrates how linking health with microfinance and education creates mutually reinforcing pathways out of poverty, while U.S. nonprofits demonstrate how addressing structural inequities can improve chronic disease management and reduce disparities among racial and ethnic minorities.

Third, nonprofits contribute to long-term, system-wide improvements through advocacy and governance engagement. By translating frontline insights into policy recommendations, nonprofits influence national priorities, inform regulatory reforms, and help institutionalize equitable practices. This dual role of direct service and policy advocacy positions nonprofits as essential actors in shaping inclusive health systems.

Yet the analysis also highlights persistent constraints. Funding volatility, limited data capacity, regulatory complexities, and dependence on donor priorities threaten the sustainability of equity-driven initiatives. These

challenges underscore the need for stronger government–nonprofit partnerships, diversified revenue models, and investments in data systems that support transparency and adaptive learning.

Taken together, the comparative findings reaffirm that nonprofits are not peripheral or temporary substitutes for public systems. They are core partners in designing and sustaining equitable health ecosystems. While Bangladesh and the United States differ in institutional capacity and socioeconomic context, both countries reveal that health equity progresses when nonprofits are empowered to innovate, collaborate, and hold institutions accountable.

Ultimately, bridging the health equity gap requires recognizing nonprofits as strategic co-architects of public health, organizations that combine grassroots legitimacy with the flexibility to respond to evolving needs. By learning from each other's strengths and challenges, nonprofits, governments, and global health actors can collectively advance more just, resilient, and inclusive pathways to health for all.

8.2. Future Research Directions

1. Primary Comparative Fieldwork: Conduct mixed-methods comparative field research (interviews, participant observation, and quantitative outcome measurement) in matched communities across Bangladesh and the U.S. to validate mechanisms and test scalability.
2. Longitudinal Studies: Examine long-term outcomes of integrated nonprofit programs to assess sustainability and causal pathways from program inputs to equity outcomes.
3. Funding Architecture Experiments: Evaluate the impact of different donor funding modalities, such as multi-year flexible grants versus short-term project funding, on program continuity and equity outcomes.
4. Subnational Comparative Studies: Investigate how subnational governance variations (state/provincial policies) mediate nonprofit effectiveness within large federal systems such as the U.S.

8.3. Limitations

This paper synthesizes secondary sources and program documentation rather than primary field data; while this approach permits cross-case comparison and breadth, it also limits causal inference at the micro-level. Further, selection bias in published program evaluations (positive-outcome bias) may overstate effectiveness. The study also aggregates a diverse array of nonprofit organizations under a single label; heterogeneity among NGOs (size, mission, governance) warrants finer-grained analysis.

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