United Nations Population Fund (UNFPA) is an international non-government organization. According to their website, it is the United Nations' sexual and reproductive health agency. The United Nations Population Fund was established in 1969 as a branch of the United Nation. Their headquarters are located in New York City, United States, and the agency has a multitude of branches. The UNFPA's network of offices stretches across the globe. They have six regional offices in Panama City, Panama; Istanbul, Turkey; Cairo, Egypt; Dakar, Senegal; Bangkok, Thailand; and Johannesburg, South Africa. Aside from these regional offices which are located on several continents, they have three sub-regional establishments in Kingston, Jamaica; Almaty, Kazakhstan; and Suva, Fiji along with eight liaison offices in typically more developed nations. The United Nations founded this branch of its organization after the 1969 General Assembly in which they declared, "parents have the exclusive right to determine freely and responsibly the number and spacing of their children," (About Us).

The United Nations Population Fund possesses a list of issues that it supports. These guide their organization in its initiative and include the following: 1. "Reproductive healthcare for women and youth," 2. "The health of pregnant women," 3. "Reliable access to modern contraceptives sufficient to benefit twenty-million women a year," 4. "Training of thousands of health workers to help assure at least 90% of childbirths are supervised by skilled attendants," 5. "Prevention of gender-based violence," 6. "Abandonment of female genital mutilation," 7. "Prevention of teen pregnancies," 8. "Efforts to end child marriage," 9. "Delivery of safe birth supplies, dignity kits and other live-saving materials to survivors of conflict and natural disasters," and finally 10. "Censuses, data collection and analysis," (UNFPA About).

In order to achieve these ambitious and worthy goals the United Nations Population Fund needs a large endowment of money which is cultivated by a mix of private donations, funds from national governmental partners of the United Nations, and joint programs with other non-governmental organizations such as multi-donor trust funds and national program partners. Their 2019 budget in totaled to $933,799,623 (UNFPA Programme Expenses). More than half of the entire budget, $559,727,968 (UNFPA Programme Expenses), was dedicated to integrated sexual and reproductive health services. These services included health services, policy advocacy, accountability, employees, and logistical expenses (UNFPA Programme Expenses). Another $189,925,879 is dedicated to gender equality which funds (in descending order of fund allocations) "protection rights," "ending harmful practices," "gender equality laws and policies," and "gender and sociocultural norms," (UNFPA Programme Expenses). The third largest portion of the budget

includes data collection which costs the United Nations Population Fund $86,776,474. Youth and adolescence category takes fourth out of five, far ahead of organizational effectiveness, which focuses on logistics and internal efficiency, in the UNFPA's funding at $82,938,577. The youth category has a majority of its piece of the pie allocated to skill development and capability enhancement, with others designated to leadership opportunities and other initiatives.

The United Nations Population Fund has a list of objectives, and they measure each one in different ways. Some of the objectives like, accidental pregnancies, sexual transmitted disease affliction, and unprofessional abortions avoided were measured by individual counts or estimations, along with a slew of other benchmarks and measurements that range from disability, violence, and sexual education. Additionally, the UNFPA also measures success in broader terms and addresses changes at national levels. The United nations Population Fund influences roughly 150 countries each year, and as seen previously, devotes a wealth of resources to see changes at a governmental level in the states it affects. Some examples of their results and impacts on countries at a societal or legal level include countries achieving set goals for sexual reproductive health, emergency plans for emergencies regarding pregnancies, and tools and skills for sexual assault survivors (UNFPA Global Results).

Although the United Nation's Population Fund has a range of efforts, causes, approaches, and people it supports in a wide array of countries, in this research essay I will focus on their first two objectives listed on their agenda. These include: "Reproductive healthcare for women and youth in more than 150 countries—which are home to more than 80 per cent of the world's population," and, "The health of pregnant women, especially the 1 million who face life-threatening complications each month" (About Us). These issues deal with health outcomes and objectives as well as gender, gender bias, and gender roles for people in developing nations or those impacted by humanitarian emergencies.

Maternal healthcare has a few different measures which the United Nations Population Fund uses to show the effectiveness of their programs and services to mothers and pregnant women across the world. The most broad-sweeping measure of their outreach attempts is United Nations Population Fund's number of total women and young people accessed with their sexual and reproductive services, which they have tallied at 41.6 million people in2018 to 2019 (UNFPA Global Results). This is an incredible leap in outreach from their 2018 campaign, which affected 24 million individuals in the same measure, but it did not double its first year's performance (UNFPA Data). Two of these services are extremely relevant and pressing to their causes: maternal deaths averted

and unsafe abortions averted. The UNFPA prevented 47,272 maternal deaths in 2018 and 2019 (UNFPA Global Results). Furthermore, the non-profit helped women avoid 3.9 million unsafe abortions in that same time period (UNFPA Global Results). According to the World Health Organization (WHO), the international organization estimates that 25 million unsafe abortions occur every year, which is just under half of the total abortions globally. (World Health Organization). The WHO also categorizes abortions into different tiers of safety. In North American and Europe, a vast majority of abortions are safe abortions and use modern techniques and equipment handled by WHO-standard professionals. However, in developing countries, "less safe," and "least safe," abortions were more common. "Less safe abortions," either failed to use modern methods which complied with the World Health Organization's parameters, or they used current abortion methodology by an untrained professional. "Least safe abortion," procedures include hazardous prescriptions or techniques by untrained individuals on the mother. "Less safe," and "Least safe," abortion procedures accounted for 31% and 14% of abortion procedures respectively across the globe (World Health Organization). These women who suffer from "less safe," and particularly "least safe," are at risk of uterine infections, blood loss, and other harmful effects from these practices.

Additionally, not only are abortions particularly dangerous, both in morbidity and mortality, to pregnant women if not executed properly by a health professional, but even when mothers decide to keep babies, mothers can still be at risk. According to the World Health Organization in their 2015 report *Strategies toward ending preventable maternal mortality,* over 800 women die very day from preventable causes around the world. However, there is not an equal distribution of effected mothers. For most developed or middle-income nations, maternal mortality levels reside in the range of 0-99 maternal deaths per 100,000 live births. In Western Europe, this almost all between 0 and 20 maternal deaths per 100,000 live births. In Sub-Saharan Africa, especially the central regions, this same metric is far more grim. Many countries, like Kenya, Ethiopia, and Tanzania have maternal mortality rates that range from 300 to 500 deaths per 100,000 live births. At the furthest end of the spectrum, nations like Chad, Niger, and Nigeria have maternal mortality rates of 1,000 deaths or greater for the same number of live births. This is an intense disproportion that affects a large number of people particularly in Sub-Saharan Africa, but other struggling areas of the world include parts of South America, South Asia, Southeast Asia, and parts of the Middle East, Afghanistan in particular. (Strategies…).

In a related measure, per their 2019 numbers, "7,918,898 women reached with sexual and reproductive health services, including antenatal and postnatal care, emergency obstetric and newborn care services in 52 countries, (UNFPA Humanitarian). The country which received the most care from this specific measure was the Syrian Arab Republic at 1,314,762 individuals. These numbers were listed in separate data and includes 2018 efforts.

The Journal of Adolescent Health evaluated the effects of vouchers for poor populations on sexual and reproductive health knowledge and outcomes. This involved pre-existing facilities and it offered vouchers to a treatment group for sexual and reproductive health care in Managua, Nicaragua. The study found that a few metrics improved considerably for those young women who received vouchers. This included a near doubling in use of sexual and reproductive health care services (34% for the treatment group and 19% for those without the vouchers). "Voucher receivers answered significantly more questions correctly that were related to knowledge of contraceptives and sexually transmitted infections than nonreceivers [sic.]," (Meuwissen). Furthermore, those with the vouchers and who were sexually active were more likely to use modern forms of birth control (Meuwissen). One thing that I failed to find about the study is how much the vouchers covered in expenses. This made it difficult to evaluate the cost-effectiveness of the voucher treatment.

According to the UNFPA's 2019 annual report, the organization achieved 21,000 educated or trained midwives across 32 countries (UNFPA in 2019). Midwifes are important for their help in the delivery process of newborns, as well as their emotional intelligence for the mother. Traditionally midwives, usually women, held roles in their communities that are vital, especially if health infrastructure is low in the society or region (Patterson). Although, all is not equal. Some countries are in more need of midwives than others. For example, all midwifery needs in Brazil and Peru were met; South Africa, Zambia, Gabon, Liberia, and Nigeria range in the high ninetieth percentiles; meanwhile two bordering countries of the latter, Cameroon and Chad sit at just 11% and 8% of met midwifery needs respectively. From a cost-effectiveness point of view, midwifery stands as a convenient middle ground for health interventions. Modern health practices are good, but often expensive and unsustainable, meanwhile the increased cost, driven by demand, offers little options for poor populations. For example, cesarean operations during delivery are over-represented, or far more common than usual, in affluent populations and are underutilized in poorer populations (de Jonge). Many of these operations are unneeded and lack efficient allocations of resources. Not only could these be unneeded, but they could increase complications. "Evidence shows that health systems where midwives are absent have higher rates of unnecessary interventions and inequalities in care provision and outcome," (de Jonge). To be clear,

this refers to trained midwives. "Midwifery was associated with more efficient use of resources and improved outcomes when provided by midwives who were educated, trained, licensed, and regulate," (Renfrew) but this return is diminished if amateurs are involved. Even in a mixed team of midwives, with some professionals, and others not, the unskilled midwives lessen the likelihood of positive health outcomes (Renfrew).

According to the BMJ, a self-described multifaceted organization with a diverse role to its members and sponsors dedicated to health research, in its 2005 study on cost-effective analysis of treatments for mothers and newborns, the most cost-effective strategy for health outcomes affected local levels. The BMJ studies calculated cost-effectiveness by the cost of a given treatment in millions of dollars compared to the millions of disability adjusted life years averted from the treatment. These included informational programs and community care packages. Additionally, the study found that antenatal care was the second most cost-effective intervention used to improve health. A less effective, but still encouraged were birthing aided by health professionals in health facility settings like midwifes or doctors (BMJ 2005). This being said, the study also stressed the importance of medical facilities, and without proper medical infrastructure and resources in place, little could be done to improve health outcomes from recipients of the different proposed treatments.

All this said, I believe that there are a wealth of positive externalities that are not accounted for in their calculations. With more education and resources given to women and young girls, it is possible that the effects might have spillovers. Women could tell their friends or even daughters, and over time, there may be a great common knowledge in communities affected by UNFPA programs. Furthermore, in communities that benefit from midwife training, there could be even more positive externalities. These women can be employed at health institutions. Not only do midwives aid in safe delivery of newborn children, but the midwives also gain a wage-paying job that can be done for a long time, can be taught as a relevant skill to younger generations, and they can communicate to their community medical knowledge. All of these effects on the midwife, future midwives, and the community are not captured within the analysis of the United Nations Populations Fund evaluation of their midwifery program, which largely focuses on the mortality and morbidity that these midwives negate.

A strategy of the United Nations Population Fund to help women and families control for the number of children they want is by supplying contraceptives to couples and individuals. This can lead to the negation of unwanted pregnancies and limit the passing of sexually transmitted diseases. According to the organization, as of 2018 onward and using impact modeling, they have prevented unwanted 14.1 million pregnancies, averted 145 thousand HIV infections, provided 69.3 million of couple-years

protection with supplied contraceptive, and prevented 6.4 million transmissions of sexually transmitted infections (UNFPA Results). Interventions like these can have great number of externalities. If an individual uses contraceptives like a condom (male or female), not only does it reduce their risk of receiving sexually transmitted diseases, but it also lowers the chance of it happening to any one of their future partners. Furthermore, this can improve or protect people's productivity as laborers, for they are not afflicted with an ailment. Agricultural laborers, which make up a large portion of the least developed countries work force, can suffer greatly and in many ways financially from diseases like HIV and AIDS. Treating a member of a household with these illnesses have particular strain on the poor and can impose a cut of over 10% of income (Kwadwo). The greater than 10% estimate is in outstanding cases, but the average amount of household income that directly goes into treating the disease is estimated between 2.5% and 7% (Russell). Households also affected by AIDs and HIV saw lower agricultural investments. This can be due to reduced available funds (Kwadwo). Associated with agricultural losses as well, there is a possible "brain drain" associated by these morbid and lethal afflictions, because of a shortened lifespan, a lot of experience that could have been had in the agricultural field is cut short, and there is less time to train and teach younger generations in the household (Kwadwo). The indirect costs of these diseases accounted for the greatest burden at 69% (Russell) due to loss earning hours of the afflicted, and additionally, almost as many hours lost by the family health attendant (Russell). These diseases also increase absenteeism due to morbidity. Over an 18-month period, males and females afflicted with HIV/ AIDS missed an average of 297 days and 429 days of productive work respectively (Kwadwo). The deaths associated with the illnesses also affect households available labor and earnings permanently, and the death can cause further economic stress in the form of funeral rites and all associated costs of those ceremonies, indirect cost from grief and mourning in the form of missed days or less productive days (Kwadwo).

These diseases can also affect women differently and in a negative manner. While stereotypically being caregivers, industries or agricultural areas where women labor force is more prevalent can adversely affect their bargaining power and personal finances, along with the household's income. For example, in Rwanda, due to taking care of the sick, women could not farm and harvest beer bananas, a cash crop (Kwadwo). The forgone wages are a problem for these households, and in order to pay for direct costs and supplement lost or diminished incomes, families may need to draw on savings or sell assets. This adversely affects a family's current and future wealth and can limit investment and disallow advantageous loans to be taken out in the future. Lastly, couples can wait until they are in a more advantageous financial situation in order to have children and have better health outcomes for the child. There are

significant economic risks and consequences for both an individual and community that does not use contraceptive, especially in regions where disease is common and agrarian societies.

An important thing to consider is which type of contraceptive is given to a community. Uptake could be high where it is already common practice (e.g. hormonal treatments in Africa) (Darroch), but uptake, while a part of what could make an intervention vary in degrees of effectiveness, the health outcomes that the United Nations Population Fund focuses on lends itself to the use of contraceptives like condoms. It measures not only unwanted pregnancies averted through their interventions and couple-years using modern contraceptives, but it also is interested in sexually transmitted disease infections of individuals and communities. While options like sterilization and hormonal treatments can be effective in preventing unwanted pregnancies, they may not effectively protect against sexually transmitted diseases or infections. According to a study by Jared M. Baeten in 2001, oral contraceptives altered immune system responses to sexually transmitted to diseases—some for better and some for worse. However, the use of condoms diminished, "the risk of gonorrhea, chlamydia, genital ulcer disease, bacterial vaginosis, and pelvic inflammatory disease," (Baeten). Additionally, while hormonal treatments are popular in Africa, sterilization efforts remain a popular practice in many parts of the world, especially Latin America and Asia. According to a study by Willard Cates Jr. and Katherine M. Stone from 1992 that featured in *Family Planning Perspectives Vol. 24,* "Sterilization provides no protection against acquisition of bacterial or viral STDs in the lower genital tract," (Cates & Stone). This is bad in and of itself, however, because these women are less likely to seek out family planning initiatives once they are sterilized, they take measures to protect themselves from infection of dangerous diseases less often than those who are not sterilized (Cates & Stone). In countries where HIV is prevalent, it can be extremely cost-effective to distribute condoms or female condoms to the public and could even pay for itself. According to a study by Steven D. Pinkerton and Paul R. Abramson, continual condom use could diminish the transmission of human immunodeficiency virus by 90% to 95% (Pinkerton & Abramson). This effectiveness is vital in measuring the cost-benefit analysis of these interventions. Treating HIV can be costly and dealing with the indirect effects to income and wealth are also substantial. In a study that measured cost-effectiveness of condoms in South Africa and Brazil, given the average cost of treatment for a case of HIV, it would be advantageous for governments or non-governmental organizations to invest in female condoms for their populace. It would not even have to be a lot of the countries' women or youth. The study estimates that supplying 10% of sexually active women with these female condoms could pay for itself (Dowdy) This measure does not account for morbidity from other diseases either, meaning that there could be more positive externalities, especially in areas or regions where multiple

types of prevalent sexually transmitted diseases are prevalent. Further on that same line of thinking, it does not address the missed opportunities for income and work. The more hazardous and costly the disease is to an individual, household, or nation the better the cost-effectiveness of the condom as a contraceptive.

All this being said, in order to match its aims of sexual and reproductive health for women and youths with efficient, cost-effective contraceptive, the United Nations Population Fund should focus on distributing male and female condoms to people who have unmet needs for the best possible health outcomes.

Emergency relief also plays an important part in reaching woman and youths with care. By their nature, emergencies are urgent situations where quick, efficient plans must be enacted swiftly. They definitionally involve the country of origin, as well as other countries that suffer their own shocks from crises. The amount of required funds are calculated by Humanitarian Response Plans and Regional Refugee and Resilience (UNFPA Emergency). The United Nations Population Fund constructs humanitarian emergency response funding for countries around the world. The organization states that it, "provides life-saving information, services and supplies in the area of sexual and reproductive health and rights and gender-based violence," (UNFPA Emergencies). Many of these humanitarian emergencies occur in Sub-Saharan African, the Middle Eastern, South Asian, and Southeast Asian countries, with some in eastern Europe. The UNFPA gives a document of which countries are in need of aid, how much aid is needed, and how much has been met. The following numbers are from their 2019 year. The amount of aid needed, in dollars, ranges from greater than 110 million in Yemen, to just 50 thousand in Serbia. Total, the amount of aid needed to fund all of the emergency interventions thoroughly is 561,927,916 dollars. The variance in which interventions are funded and by how much also ranges. UNFPA emergency responses contain a wide range of unfunded, like Mozambique's 12 million dollar emergency need; underfunded, which range from 1% to 99% funded campaigns and are the most common; funded, which include Serbia, Nepal, Mali, and Malawi; or even overfunded projects like Syrian Arab Republic, which has received 109% of its more than 38 million dollar emergency need, and it includes the Philippines, which has received 117% of its 1.6 million dollars in needs (UNFPA Emergencies). In totality, 53% of the organizations estimated need for its projects is met, which is more than 50%, but it still leaves lots to be desired. In the year 2020, the total amount of aid needed increased to 645,518,489 dollars, while only receiving just over 100 million dollars, 17%, of that much money needed to properly respond. One of the more frustrating aspects of the United Nations Population Fund is that I could not find how or why the organization allocated certain resources to one country as

opposed to another. The emergency funding, at large, comes from United Nations (UN) member states attributing "core" and "non-core" funds (UNFPA Donor Contributions). Core resources cover operational costs for the organizational, but they also cover costs for least developed countries in, "fragile or emergency situations" (What Do Core Resources Pay For).

The United Nations Population Fund does self-evaluation. Associated with their data, they have a "technical notes tab," which lists how they get their data, how its data is calculated, and the parameters that their data accomplish. One thing about the formatting that I thought was strange is that its numbers and statistics on their websites are cumulative for the years 2018-2021. Initially, when I first viewed this, I assumed these numbers to be yearly numbers, especially since the organization opted to give numbers in yearly reports. This leads to permanently increasing numbers for their programs. Most of their data comes from their own branches that they collect themselves at a country level. This type of aggregation is important, but as always, there's more to be desired for greater specification of data, and it might prove difficult to properly allocate resources to regions, states, and territories that are in more in need than other places in the same country. Furthermore, on the matter of country data, the United Nations Population Fund reports that it operates in 150 countries worldwide, however it receives data from 127 countries. Most countries are accounted for; however, 23 countries do not contribute any data to their sets. The UNFPA supplies a map of countries and marks them with different distinctions. One of these distinctions in the map's legend is "No UNFPA programme [sic.] or data not reported.," (UNFPA Global Results). This metric also includes countries that have reached the organizations goals without the aid of the United Nations Population Fund. Another downfall in their own statistics is that for latter years, some key findings that the organization presented were only achieved in 2018 and have not been improved upon since. These measures include: "Health service providers trained on the minimum initial service package," "Women and girls who were offered prevention and/or protection services and care related to child, early and forced marriage in partnership with UNFPA," "Marginalized girls reached with health, social and economic asset-building programmes," "Communities that developed advocacy platforms to eliminate discriminatory gender and sociocultural norms that affect women and girls," "Women and girls who were offered prevention and/or protection services and care related to female genital mutilation in partnership with UNFPA," and, "Women and girls subjected to violence who were provided with access to essential services packages." Because the organization runs cumulative measures of their impact, this means that there have been no changes in these fields of interest for women's and adolescent health.

Overall, the United Nations Population Fund does a fairly good job at evaluating themselves. They provide lists of donor countries, who and what their money goes to, and statistics on what has improved with their aid. This mostly relies on impact modeling for more abstract things like diseases, but endeavors like numbers of midwives trained can be enumerated. This being said, their numbers are loftier than what their yearly accomplishments are due to the cumulative aggregation of their statistics from 2018 and onward. From an economics perspective, I would like to commend them on their worthy solutions to problems regarding women, pregnant, women, and youths on an array of problems that affect those populations. Local community interventions, community resources, and midwife training are all practices that are cost-effective and things that the UNFPA puts a lot of money and emphasis into. Furthermore, not only are these interventions cost-effective in their own right, but the strategies may also contain positive externalities that can aid recipient communities further. Their ability to distribute contraceptives and make safe ones available to less developed, agrarian communities is not only commendable, but can be extremely cost effective, especially in places where sexually transmitted diseases and HIV/ AIDS are prevalent. I think that United Nations Population Fund should increase their efforts in supplying contraceptives, especially to rural areas.

One thing I would like to see is the humanitarian emergency page improve. I would want to see where the money comes from, specifically on the pages, how it is prioritizing some countries over another, how it justifies any funds that are allocated over their target goal listed in their graphic, and the cost-effectiveness of their strategies in humanitarian relief. The humanitarian emergency funds lack money, but with some cost-effectiveness analysis, it could optimize its use of donations and funds to best accommodate the most people. I think that opposed to some causes being fully funded, while others having extremely little, there could be some type of middle ground that takes in account severity and cost-effectiveness. For example, if two situations are both dire, but one is cheaper to fix, it should take priority. However, I fear this could oversimplify disastrous occurrences and humanitarian emergencies. It is hard to compare events. Additionally, timing could matter for when they allocate resources versus when a crisis occurs. Obviously, a downside to this is that not all humanitarian emergencies are created equal. Some are massive in scale, financial need, and severity, while others are less serious temporally, monetarily, or dangerous. The emergency funds tab also lists that these emergency plans' funding estimates are made in correspondence to the Humanitarian Response Plans and Resilience Plans, but the United Nations Population Fund fails to list these resources, standards, or methods or any links to these guidelines.

The United Nations Population Fund fails to create a counterfactual for their involvement, strategies, and outcomes explicitly. The international organization calculates a lot of their numbers via impact modeling and not raw number collection. This makes sense in a lot of cases in trying to measure objectives of interest like the prevented spread of sexually transmitted diseases. It is tough just to ask people if they would have spread the disease without their interventions with contraceptives, and even if they could, reporting could be skewed—no one wants to transmit a disease. The United Nations Population Fund is not transparent on how they calculate these, at least on their website. One thing that I would like to point out however is that one of their biggest and seemingly most successful endeavors, when regarding to the, "reproductive healthcare for women and youths," was contraceptive interventions. Strategies around the world vary widely in approaches to contraceptives. In Latin America and the Caribbean sterilization is the most common practice as well as Asia. In Africa, the most common approach to contraceptives is hormonal treatments, while in North America and Europe, the most common approaches to control are oral medication and condoms (Darroch). However, the use of contraceptives have increased across the world and desired and actual family sizes have decreased in recent decades from 5 to 2.5 people (Darroch). This is more pronounced in developing countries, however, developing countries are not all alike. For example, there has been a steep drop in fertility rates in East Asian countries, but fertility rates in Sub-Saharan Africa have decreased less and seem more resilient (Darroch). Part of this could be due to institutional changes like China's one child policy, and the lack of much change could be due to external factors like child morbidity and mortality, cultural values, and agricultural industries being more prominent in less developed countries. Regardless, the trend is generally on the down swing for fertility while contraceptive take up and strategies have increased in that same window of a handful of decades. I would surmise that some of the increase in developing countries use in contraceptives could be because of this worldwide increase, and some of the numbers attributed to the United Nations Population Fund's endeavors like diminished sexually transmitted disease spread or unwanted pregnancies averted could be because of this shift.

However, this is tough to argue. Although the number of people using contraceptive practices has increased around the world, in different fashions, and in varying degrees, there is still a vast unmet need for contraceptives in developing countries. According to Jcqueline E. Darroch from the Guttmacher Institute and her paper, "Trends in contraceptive use," the were, "some 222 million women in developing countries have unmet need for modern contraceptives, resulting in 54 million unintended pregnancies and 79 thousand more maternal deaths than if they used modern methods," (Darroch). The demand is not only high for contraceptives; it is also unmet. By supplying communities in less developed

countries with opportunities to receive teaching and get access to modern contraceptives and practices, the United Nations Population Fund is helping fill a need in communities across the world. That being said, I don't know if the United Nations Population Fund is matching contraceptive practices with the ones that are most common in the area, like hormonal treatments to Sub-Saharan Africa, or if they only provide certain types like oral medication and condoms.

I think the effects of the United Nations Population Fund is profound—as it should be as an international organization and entity with funding that some countries could only dream. With the vast amount of resources given to it by countries around the world and its age, there are high expectations for it to be well organized, well maintained, and effective. It is hard to put a price on life, although some times as economists, in a cold way, we have to. That being said, this program saves lives daily through preventions like informational trainings for youths, contraceptive supply or reactionary measures that improve health outcomes like training midwives, or providing care for pregnant women or those who have recently delivered children. I cannot tell you how impressive in size this organization is, and it is just one branch of the United Nations. I also think that the organization of the United Nations Population Fund makes sense geographically as well. It would be easy to maintain and operate offices in developed countries, but I don't think it would be as effective. The fact that their biggest offices are in the areas that need it most like Latin America and the Caribbean, Sub-Saharan Africa, South, East, and Southeast Asia, and the Middle East shows, to me, that they care about local interventions and have solid bases of operations in places where help and aid is traditionally most needed. Personally speaking, if a friend or family member wanted to donate to the causes that the United Nations Population Fund sought to support, I would recommend them as an option, but I would have reservations donating to them with my own money. I think the United Nations Populations Fund's commitment to sexual and reproductive healthcare to women and youths is both a worthy cause and one that is done particularly well. Countries fund United Nations worldwide, and the United States is no exception. According to the Council on Foreign relations, the United States of America contributed ten billion dollars to the United Nation in 2018 (Shendruk). That is a lot of money coming from American taxes already. I would personally encourage more local endeavors to help people in my home community, but I understand that their needs are far different than many people around the world, and could also be more expensive problems to answer, as opposed to supplying clean water via chlorine tablets, or curing worm infections via cheap pills. Its just my opinion that I would rather help my own community grow, flourish, and improve through charitable donations rather than anywhere else in the world.

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