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Committee

**Disability and
development**

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Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
2 Why DFID needs a strong commitment to disability	8
Leaving no-one behind	8
Getting value for money from UK aid	10
Delivering human rights objectives	11
3 Strengthening DFID's commitment to disability	12
DFID's current work on disability	12
DFID's future work on disability	13
A disability strategy	14
Stronger reporting and accountability	18
Announcements in the pipeline	20
4 Implementing DFID's commitments on disability	21
A central role for disabled people	21
Disabled People's Organisations	22
Disabled People's Organisations from the UK	23
DFID's internal organisation	24
Disabled staff	26
5 What a strong commitment to disability means for DFID's sector programmes	28
A realistic schedule for change	28
Characteristics of a good sector-wide response to disability	33
Avoiding perverse incentives	35
Ensuring help reaches disabled people in emergencies	35
6 Treatment and prevention of disabling conditions	38
The impact of treatment and prevention programmes	38
Unmet need for treatment and prevention	39
Cost-effectiveness of treatment and prevention	41
DFID's current treatment and prevention work	42
DFID's approach to prioritising its health portfolio	44
Preventative measures outside the health sector	46
Road safety	46
Armed violence	47
7 Influencing partners' commitment to disability	48
DFID's Partners	48
Multilateral agencies	48
Partner governments	50
Private sector	52

2 Disability and development

Helping Regulate the Private Sector	53
Creating other Incentives for the Private Sector	53
Other UK departments	54
Global development frameworks	54

8 Conclusion **58**

Formal Minutes	66
-----------------------	-----------

Witnesses	67
------------------	-----------

Published written evidence	68
-----------------------------------	-----------

List of Reports from the Committee during the current Parliament	71
---	-----------

Summary

Disability is an urgent development issue. Around one billion people—or 15% of the world’s population—are disabled. Disabled people are often the poorest of the poor. They are stigmatised and face discrimination in many forms—from a lack of access to basic services, to violence and abuse. This discrimination has serious repercussions for families, communities and ultimately national economies. It prevents disabled people sharing in many of the gains of international development work, and has been a major barrier to meeting the Millennium Development Goals.

UK Prime Minister David Cameron has shown international leadership in calling for “no-one [to be] left behind” in the next global development framework. The proposed framework explicitly mentions disabled people and recommends indicators to measure their inclusion. The UK should keep up the pressure for these proposals not to be diluted as the final framework is negotiated.

If the UK is to have authority during these negotiations, it should lead by example, matching its post-2015 aspirations with a strong commitment to disabled people in its own development programming. DFID has some impressive programmes, reinforced by recent initiatives by the Parliamentary Under-Secretary of State Lynne Featherstone MP. However, these programmes are small relative to DFID’s total work. A more ambitious commitment to disabled people from a donor of DFID’s size and influence could have a transformational impact.

An ambitious commitment will take time to realise. We would not expect DFID to alter all its programmes immediately, and recommend it take a phased approach, selecting some sectors and countries to focus on first. DFID should ensure its commitment can be sustained even as governments change and key individuals move on. To do this, it will need a disability strategy with clear targets and timescales; a larger team with a senior sponsor; and strong reporting processes to ensure accountability.

As a major donor, DFID is in a strong position to influence its partners’ policies on disability. It spends more than half its budget through multilateral agencies, and should make it a requirement that their programmes reach disabled people. Such agencies are also critical to DFID’s humanitarian work. Disabled people face particular problems in emergencies—both in getting to safety, and in accessing relief. DFID’s partners must address these problems as a priority, and DFID should put in place training and incentives to ensure they do so.

DFID rightly sees disability as a matter of equal rights and discrimination, not just a medical issue. We agree this should be the focus of its disability work. Nonetheless, there are significant development gains to be made by treating and preventing the conditions that cause disability. Yet treatment and prevention make up only a small part of DFID’s current health work: it should urgently review its spending in these areas, where it risks missing important opportunities. The prevention of disabling injuries should also be a priority in DFID’s major infrastructure investments such as road building.

Finally, and crucially, DFID should ensure disabled people have a central role in its work. It should step up its support for disabled people’s organisations. It should also ensure

disabled people participate fully in the design and delivery of DFID's own programmes. The more visible disabled people are in development work, the easier it will be to reverse the damaging patterns of discrimination that have, for so long, left disabled people behind.

1 Introduction

1. According to the World Bank, around one billion people—or 15% of the world’s population—are disabled.¹ Definitions of disability vary, but most agree that disability is not just about medical conditions. Rather, it is characterised by the discrimination and harmful social norms that people with such conditions have to contend with.² For the purposes of this inquiry, we have taken the same approach as the UN Convention on the Rights of Persons with Disabilities:

Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.³

This definition encompasses people with a wide range of impairments—physical; sensory; intellectual; and mental health—but with a common experience of stigma and exclusion.

2. Disability and poverty are closely linked. 80% of disabled people worldwide live in developing countries,⁴ where—according to DFID’s own research—they are more likely to fall into poverty, and have less opportunity to escape.⁵ Disability can lead to a vicious circle of poverty and ill-treatment, as witnesses from Kenya and India described:

I hear and experience cases where a mother who has given birth to a deaf-blind child [...] has to quit her job because she has to take care of her deaf-blind child. That becomes a double tragedy for the family, because that mother stops earning a very important income that would sustain the rest of the family members. As soon as the mother stops working, in most cases the husband may desert that family. That compounds the problems that such a family experiences.⁶

I know of a family in the slums of Bangalore that has a daughter with cerebral palsy. She had difficulty walking and both her parents worked hard to ensure their children attended school. Somehow they managed to get a second-hand wheelchair for her to go to school. [...] Unfortunately, [...] the school she wanted to go to was not accessible and did not have accessible toilet facilities. [...] Therefore, she dropped out of school. In poor communities, children like her, and children with multiple intellectual and psycho-social impairments, are left at home all day, making them vulnerable to abuse. When they become victims, they do not have access to justice and the stigma adds to this.⁷

1 World Bank/World Health Organisation, *World Report on Disability*, Geneva, 2011, p.29. As explained in the *World Report on Disability*, this estimate inevitably involves a number of assumptions and judgements.

2 For example, Mike Oliver, *The Individual and Social Models of Disability*, 23 July 1990; Philippa Thomas, *Disability, Poverty and the Millennium Development Goals: Relevance, Opportunities and Challenges for DFID*, Cornell, 2005, p3

3 United Nations, *Convention on the Rights of Persons with Disabilities*, Preamble paragraph e

4 Leonard Cheshire Disability Annex A ([DIS0077](#)) para 3.1.2

5 Philippa Thomas, *Disability, Poverty and the Millennium Development Goals: Relevance, Opportunities and Challenges for DFID*, Cornell, 2005, pp 5-6

6 Q2 [Mr Osundwa]

7 Q2 [Mr Chandrasekar]

3. Because disability is so closely connected with the challenges of eradicating poverty, we decided to undertake an inquiry into the UK Government’s approach to disability in its development work. Since we first announced our intention to hold the inquiry, the Department for International Development (DFID) Parliamentary Under-Secretary of State (PUSS), Lynne Featherstone MP, has made a number of promising statements on the importance of addressing disability. In September 2013, she told the United Nations (UN) she was “determined to make people with disabilities a key development priority”.⁸ This inquiry will explore how these aspirations are being put into practice.

4. Earlier this Parliament, we held an inquiry into Violence Against Women and Girls—another thematic issue which, like disability, affects many different sectors of DFID’s work.⁹ There are several similarities between the two issues—in particular, both are characterised by discriminatory social norms, and donors need to adapt their programmes to tackle this.¹⁰ We have drawn on the Violence Against Women and Girls inquiry in preparing this one, and comment on some further similarities at later points in the report.

5. We held three evidence sessions for the inquiry. Witnesses included disabled people from developing countries; experts in disability and development from the UN, academia, and Non-Governmental Organisations (NGOs); and the DFID Minister. We also held informal meetings so that we could hear from a wider range of stakeholders, including people with intellectual and psychosocial disabilities.¹¹ We received 80 submissions of written evidence from: disabled people’s organisations (DPOs), NGOs,¹² multilateral bodies and UN agencies, researchers, and Government departments in the UK and overseas. We were particularly pleased that 15 of these submissions came from DPOs in developing countries. We would like to thank everyone who was involved in the inquiry, especially those who gave evidence orally or in writing.¹³

6. This report sets out our analysis of, and recommendations for, the UK Government’s response to disability in its development and humanitarian work.

- Chapter Two explores how a stronger focus on disability would complement DFID’s wider objectives.
- Chapters Three and Four suggest practical steps DFID could take to build on its existing disability work: Chapter Three looks at incentives, and Chapter Four considers who should be involved.

8 DFID, [‘UK Commits to Tackle the ‘Great Neglect’ of Disability’](#), accessed 19 March 2014

9 International Development Committee, Second Report of Session 2013-14, [‘Violence Against Women and Girls’](#), HC 107-I

10 International Development Committee, [‘Violence Against Women and Girls’](#) para 14

11 Psychosocial disability is the term for the exclusion experienced by people who have suffered mental health problems.

12 Throughout this report, we draw a distinction between DPOs and NGOs. Technically, DPOs are just one type of non-governmental organisation. However, in the context of disability, the terms are treated as mutually exclusive – a DPO is made up of, and run by, disabled people; an NGO is not.

13 We are also grateful to all the experts who provided us with informal advice during the inquiry, including the Leonard Cheshire Disability and Inclusive Development Centre at University College London, the Centre for Global Mental Health, ADD International, Handicap International, Sightsavers, Motivation, Basic Needs, Dr S Miles, Dr D Chisholm, and others.

- Chapter Five considers how DFID's work across different sectors could best be made accessible to disabled people.
- Chapter Six deals with the treatment and prevention of conditions that cause disability.
- Finally, Chapter Seven examines how DFID could encourage the organisations that it works with to do more to address disability.

2 Why DFID needs a strong commitment to disability

Leaving no-one behind

7. Disabled people are among the poorest of the poor. One witness observed: “If one goes into the poorest urban slum or the most marginalized rural village and asks “who is the poorest person in your community”? one will almost invariably be directed to the household of a person with a disability.”¹⁴ Disabled people experience disadvantage on many fronts—from a lack of access to lifesaving services, to violence and abuse (Table 1). DFID’s Permanent Secretary, Mark Lowcock, has described this as a “key threat to reaching the Millennium Development Goals”.¹⁵ As one of our witnesses pointed out, if any country with one billion people had such low employment, education and health outcomes as the world’s disabled population, it would probably be at the top of international development priorities.¹⁶

8. The Prime Minister has said he wants to ensure “no-one is left behind” in future global development work.¹⁷ The Minister says this is already becoming an important guiding principle for DFID.¹⁸ Table 1 illustrates that disabled people have been left behind in progress towards the Millennium Development Goals: if DFID is serious that no-one should be left behind in future work, a strong commitment to disability will be essential.

9. DFID’s approach to disability is important not only because of its direct impact on the ground, but also because of the signal it sends to other donors. The US, Australia, and Germany have all done some work on disability,¹⁹ but their work only covers some countries and sectors, and is not on its own enough to mitigate the substantial disadvantages that disabled people face.²⁰ Galvanising support from other bilateral and multilateral donors will be key.²¹ Witnesses to the inquiry firmly praised the UK’s statements on leaving no-one behind,²² and said DFID should now lead by example, “moving that commitment into practice”.²³ Such a step could have a large multiplier effect:

14 Professor N Groce, [Disability and the Millennium Development Goals](#), United Nations, New York, 2011, p1

15 Mark Lowcock, speaking in 2007 when he was Director General for Policy and International Finance, quoted in DFID, [How to Note - Working on Disability in Country Programmes](#), 2007, p1

16 Bob McMullan, [Tales from an Imaginary Country](#), Leonard Cheshire Disability and Inclusive Development Centre, University College London, Working Paper Series: No.22, 2013

17 United Nations, [A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development: the Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda](#), New York, 2013, p7

18 Q135

19 USAID ([DIS0088](#)), Australian Government Department of Foreign Affairs and Trade ([DIS0063](#)), Q4 [Mr Chandrasekar]

20 Q92 [Prof Groce], USAID ([DIS0088](#)) para 11. For country/sector coverage please refer to: USAID '[Where we work](#)' and [DIS0088](#) para 9; Australia Department of Foreign Affairs and Trade '[Where we give aid](#)' and [Development for All: Towards a Disability-Inclusive Australian Aid Program 2009-2014](#); German Federal Ministry for Economic Cooperation and Development, [Action Plan for the Inclusion of Persons with Disabilities \(2013-2015\)](#), 2013, pp14-15.

21 Development Initiatives, [Investments to End Poverty](#), 2013, pp 68-69, illustrates the diversity of bilateral donors and the important role played by multilateral agencies.

22 For example, Vision Alliance ([DIS0013](#)) para 13, RESULTS UK ([DIS0021](#)) para 8.1, AbleChild Africa ([DIS0026](#)) para 2.8.1

23 Q127. See also the Joint National Association of Persons with Disabilities ([DIS0083](#)) para 4.

That focus on disability could be enormously influential, not just for those [...] people who you are investing in, but for showing the others who have done nothing on disability the impact that that can have. [...] You could then get more from your money than you were anticipating²⁴

Table 1: Key facts on disabled people's progress towards the Millennium Development Goals

Goal/target	Available evidence on disabled people in developing countries
1.B Achieve full and productive employment and decent work for all, including women and young people	- The unemployment rate is often 80%
2. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	- Any work is often low paid, outside the formal labour market .
3.2 Share of women in wage employment in the non-agricultural sector	- One third of all out of school children have a disability ²⁵
4. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	- Over 90 per cent of children with disabilities are out of school in Africa. ²⁶
5.B Achieve, by 2015, universal access to reproductive health	- Women with disabilities are almost half as likely to have jobs as men .
6.A Have halted by 2015 and begun to reverse the spread of HIV/AIDS	- Babies and children with disabilities may not get adequate nutrition , may not be immunised , or may not be considered valuable enough for healthcare ²⁷
7.C Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation	- Inadequate access to sexual and reproductive health services
Target 8.E. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	- Higher risk of forced sterilization, forced abortion and forced marriage
	- Many disabled people experience sexual assault or abuse during their lifetime .
	- Healthcare services may be inaccessible , disabled people may be turned away from HIV education , or denied equal access to services that could prolong their lives .
	- Disabled people face technical and social barriers to accessing clean water
	- Disabled people are twice as likely to find health care providers' skills and facilities inadequate, thrice as likely to be denied health care , and four times more likely to be treated badly in the healthcare system. ²⁸

Source: Simplified version of table from Professor N Groce, [Disability and the Millennium Development Goals](#) UN, New York, 2011, pp 17-26

Getting value for money from UK aid

10. The Coalition Government has made value for money a priority for DFID. DFID aims to “target [UK aid] at people and places who will benefit most from our money”.²⁹ We therefore sought evidence on whether investing in disability was good value for money.

11. Experts told us that the cost of excluding disabled people from development work is much greater than the cost of including them.³⁰ If disabled people are unable to participate in education and employment, the impact on their communities and economies is severe. A pilot study by the International Labour Organisation found that countries could lose up

25 Based on 2005 data. 57 million children are still out of school, so disabled children probably still disproportionately affected, and some estimates suggest the proportion has even increased (source, World Vision, [DIS0023](#), para 9 and [‘Of all the world’s children deprived of education, two fifths are disabled’](#), The Guardian, 18 March 2014)

26 Based on 2005 data.

27 Dr Tom Shakespeare ([DIS0002](#)) para 3.1

28 World Health Organisation, quoted in Dr Tom Shakespeare ([DIS0002](#)) para 3.2

29 DFID, [‘Increasing the Effectiveness of UK Aid’](#), accessed 22 March 2014

30 Q65. See also USAID ([DIS0088](#)) para 11

to 5% of their GDP if disabled people did not have equal access to employment—and this is before taking into account indirect losses such as social security payments, or caregivers’ lost wages.³¹ One witness described how an employment project for disabled people work in Malawi had helped the whole community:

One community leader, completely spontaneously, said to me, “It has made a huge difference. Now that disabled people are benefiting our community, the whole community has come out of poverty. [...] Before, they were dependent; they were drawing our resources. Now they are productive, it means the whole community has a better potential.” That, for me, represents what we mean by value for money.³²

12. Not only does investing in disability offer economic benefits, it also ensures these benefits reach some of the world’s poorest people. A strong commitment to disability would ensure DFID’s aid does indeed “target people who will benefit most”. Bob McMullan, who helped introduce a ‘disability-inclusive’ aid programme during his time as a minister in the Australian Government, told us:

The poorest of the poor are people with disabilities in developing countries, and if our development programmes are not targeting them, we are missing the point. [...] In terms of improving the lives of the poorest people, this is the value for money number one.³³

Delivering human rights objectives

13. The UK ratified the UN Convention on the Rights of Persons with Disabilities (CRPD)—a legally binding convention summarising disabled people’s rights—in 2009.³⁴ States that have ratified the Convention are required to “ensure that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities”. They must also “take all necessary measures to ensure the protection and safety of persons with disabilities” in humanitarian emergencies.³⁵ UK performance against the Convention is due for review in late 2014, and we plan to submit our report as evidence to inform this review.³⁶ A strong commitment to disability, put into action, would help demonstrate how the UK is meeting its objectives under the Convention.

31 International Labour Organisation, [The Price of Exclusion: the Economic Consequences of Excluding People with Disabilities from the World of Work](#), Geneva, 2009, Table 65 and p.4. Table 65 shows the result for South Africa was as high as 7% - although this result involved a large number of assumptions, so we have excluded this result for caution.

32 Q30 [Ms Wapling]

33 Q22 and Q30 [Mr McMullan]

34 United Nations Enable, [Convention and Optional Protocol Ratifications and Signatories](#), accessed 22 March 2014

35 United Nations [Convention on the Rights of Persons with Disabilities](#), New York, 2006, Articles 32 and 11.

36 United Nations Committee on the Rights of Persons with Disabilities, [‘Sessions for Convention on Rights of Persons with Disabilities’](#), accessed 22 March 2014

3 Strengthening DFID's commitment to disability

DFID's current work on disability

14. DFID currently funds a diverse range of projects and programmes designed to benefit disabled people (**Box 1**).³⁷ These include a good balance of both targeted programmes that respond to disabled people's specific needs—for example, supporting DPOs' campaigns for rights; and 'mainstream' programmes designed to be accessible for disabled people.³⁸ In addition, the Minister has expressed a particular interest in disability, and recently announced several new commitments. These include a pledge that all new DFID-funded school construction will be accessible to disabled children; initiatives to gather better data; and renewed support to the Disability Rights Fund (DRF), which helps small DPOs in developing countries.³⁹ Many submissions to the inquiry said these were very positive steps.

15. However, while valuable, these programmes make up only a small proportion of DFID's total portfolio. Available data indicates that in 2012-13 DFID spent £195 million on programmes designed to benefit disabled people—a little over 5% of its total bilateral programme expenditure.⁴⁰

37 DFID Annex B ([DIS0074](#))

38 This so-called 'twin-track' approach was endorsed by many of the submissions that we received, e.g. from the UN Special Rapporteur on Disability ([DIS0086](#)) para 6, Prof Michael Stein ([DIS0053](#)) para 10, Bond Disability and Development Group ([DIS0011](#)) para 7.3.

39 DFID ([DIS0054](#)) para 7

40 DFID Annex B ([DIS0074](#)), National Audit Office (NAO), [Briefing to Support the International Development Committee's inquiry into the Department for International Development's Annual Report and Accounts 2012-13](#), 2013, Figure 1 [total bilateral expenditure, less debt relief and technical cooperation]. Actual result = 5.5%, but this is probably a slight under-estimate, due to limitations in the data that DFID holds centrally. The new commitment on school buildings, while symbolically significant, is unlikely to change this percentage materially.

Box 1 Examples of DFID funded disability programmes. DFID supplied us a list of 112 programmes⁴¹ that aim to benefit disabled people. This Box provides some examples to illustrate their diversity. For full details, please see DFID ([DIS0054](#)) and DFID's written evidence, Annex B ([DIS0074](#))

Targeted interventions to respond to disabled people's specific needs:

- Support to the Disability Rights Fund (£2 million from 2013—2016): providing small grants to help disabled people in 27 developing countries **advocate for their rights**.
- Funding for International Committee of the Red Cross **rehabilitation** programmes in regions affected by conflict⁴²
- Support to the NGO Basic Needs to provide **mental health services** and advocacy support in Ghana and India (£3 million for a range of programmes between 2010 and 2018)⁴³
- A new £2 million **research programme** to examine links between disability and poverty, and how they can best be tackled

'Mainstream' programmes designed to be accessible to disabled people:

- Helping disabled girls **attend school** in Kenya, Sierra Leone and Uganda, as part of the Girls' Education Challenge Programme
- Working with the Government of Ethiopia to develop **accessible water, sanitation and hygiene** (WASH) facilities, and develop statistics on disabled people's WASH needs
- Developing a **cash transfer programme** in Uganda (£10.6 million, 2009—2015): 12% of the beneficiaries are estimated to be disabled people
- Supporting Handicap International and HelpAge International to provide specialised advice on disabled and older people's needs following **Typhoon Haiyan** in the Philippines (over £300,000).

DFID's future work on disability

16. Under the leadership of the current Minister, disability is gaining a higher profile within DFID. DFID recently issued new guidance on business cases, which requires authors to consider how programmes affect disabled people.⁴⁴ DFID told us the Minister refused to approve some business cases until they increased their emphasis on disability, for example a £106 million water, sanitation and hygiene programme in Ethiopia.⁴⁵ We understand from DFID that the Minister has also challenged country offices to increase their work on disability.⁴⁶

17. These are very welcome steps. However their effectiveness is partly dependent on the current Minister's interest in disability—and on the assiduousness with which aspirations in the business case are subsequently monitored. DFID's current Country Operational Plans indicate the Department's commitment to disability is not yet consistent: we reviewed 27 Plans, and found only two mentioned substantive objectives for disabled people.⁴⁷

41 This excludes disability prevention programmes

42 DFID ([DIS0054](#)) Para 41

43 See also Basic Needs ([DIS0056](#)).

44 DFID Annex C ([DIS0075](#))

45 DFID Annex D ([DIS0092](#)) para 3

46 As above.

47 DFID, '[Operational Plans and Summaries 2013](#)', accessed 22 March 2014. The two countries are Afghanistan, the Occupied Palestinian Territories. A further 7 include implicit or scene-setting references, but not explicit objectives. The scarcity of objectives on disability may partly reflect that disability was not a criterion in the 2011 Bilateral Aid Review, when DFID decided on the priorities for its country-specific work.

18. Many witnesses gave their views on the sustainability and consistency of DFID’s work on disability, and two key points emerged: DFID should produce a disability strategy;⁴⁸ and should strengthen its reporting processes to ensure greater accountability.⁴⁹ We discuss below why we think these recommendations are important. DFID disagrees with us about the first point, so we consider it in some detail before exploring the second.

A disability strategy

19. One of the most consistent recommendations witnesses argued for in the inquiry was that DFID needs a disability strategy. A diverse range of experts all agreed on this recommendation—including the Executive Director of the Harvard Law School Project on Disability; a large number of NGOs and DPOs; and the UN Special Rapporteur on Disability.⁵⁰ A disability strategy would have several benefits. It would make DFID’s work on disability more systematic, by allowing it to set out objectives and timescales, and to allocate appropriate resources.⁵¹ And, perhaps even more importantly, a strategy would be a visible signal of DFID’s commitment to disabled people.⁵² Bob McMullan told us about his experience of introducing a disability strategy for Australian aid:

What I found surprising in what was then called AusAID was the extent to which [the strategy] sent a message inside the organisation and led to organisational change in the agency itself. [...] That overarching document [...] its existence and the way you go about setting it up, is the most important thing you can do.⁵³

20. **We were therefore surprised that the Minister ruled out the possibility of a disability strategy in her evidence to us.**⁵⁴

A potential objection—“Too many strategies”

21. Explaining why DFID was reluctant to introduce a disability strategy, the Minister said that “overloading our offices with lots of strategies means a lot more paperwork. [...] To have a list of different [vulnerable] groups all the time means it is quite difficult to answer this strategy on that, or that strategy on another”.⁵⁵ Rather than considering disability as a

48 Philippa Thomas (*Disability, Poverty and the Millennium Development Goals: Relevance, Opportunities and Challenges for DFID*, Cornell, 2005 pp11-12) notes that ‘policy’ is an ambiguous term within DFID – sometimes it is more a piece of research, than a definite statement of the Department’s intent. Here we are using the latter definition: we would expect the policy to make clear commitments and to set out how they will be implemented.

49 For example, Bond Disability and Development Group ([DIS0011](#) para 8.5 and Q47); Mr McMullan (Q21 and Q26); Ms Wapling (Q22 and Q37)

50 Q21 [Mr McMullan], Q22 [Ms Wapling], Equal Lives ([DIS0001](#)) para 7.3, International Service ([DIS0005](#)), Bond Disability and Development Group ([DIS0011](#)) para 8.3, Vision Alliance ([DIS0013](#)) para 14, AbleChild Africa ([DIS0026](#)) para 3.2, ADD International ([DIS0027](#)) para 6.1, Age International ([DIS0037](#)) para 22, Special Olympics ([DIS0038](#)) para 1.2, Plan ([DIS0042](#)) para 6.2, Human Rights Watch ([DIS0043](#)) para 13, International Federation of Leprosy Missions ([DIS0025](#)) para 5, Sightsavers ([DIS0050](#)) para 2, Professor Michael Stein ([DIS0053](#)) para 12, Leonard Cheshire Disability ([DIS0056](#)) para 3.6, UN Special Rapporteur on Disability ([DIS0086](#)) para 7, Joint National Association of Persons with Disability ([DIS0083](#))

51 Sightsavers ([DIS0050](#)) para 5, Prof Michael Stein ([DIS0053](#)) para 12, Leonard Cheshire Disability, Disability Rights Fund ([DIS0091](#)) para 3, Lorraine Wapling ([DIS0062](#)) para 3.2, ADD International ([DIS0027](#)) para 5.1

52 Q21 [Ms Wapling] Professor Michael Stein ([DIS0053](#)) para 12, Joint National Association of Persons with Disability ([DIS0083](#))

53 Q21 [Mr McMullan]

54 Q132

55 Q132 and Q 133

separate issue, DFID's preferred approach is to consider, on a country-by-country basis, all the different risks of exclusion in the round. For example, an office would consider whether disabled people were vulnerable to poverty at the same time as considering the risks to women, children, ethnic minorities, LGBT⁵⁶ communities, and others. DFID calls this a 'social appraisal' approach.⁵⁷

22. This approach is intuitively appealing. It appears to provide a simple framework which deals with all groups equally and comprehensively, and allows for the fact that different groups may experience exclusion in different contexts.⁵⁸ It provides space to consider overlaps between different groups—for example, the fact that disabled women often experience 'double discrimination'.⁵⁹ DFID also argues that social appraisal helps it devise more integrated responses to exclusion, rather than a string of "smaller special interest projects".⁶⁰ Some submissions to the inquiry agreed with DFID that social appraisal was the right approach to take, although they were in the minority.⁶¹

23. However, on balance, the evidence persuades us that social appraisal does not work for disabled people, unless it is accompanied by a more specific checks. Submissions repeatedly said that, in practice, donors tend to focus on the most obvious groups, and people with disabilities get forgotten.⁶² As one witness, a former DFID consultant, told us: "People have talked about social exclusion for a long time, and disabled people have not been included, so there is something that is still needed in order to persuade people who are working on social-exclusion or inclusion issues that disability is part of that debate."⁶³ An expert on humanitarian relief told us how, in emergency situations, social appraisals tend in practice to focus on women and children.⁶⁴ Another witness recalled a discussion of World Bank programmes in Bangladesh:

When I asked [...] "What are you doing to ensure that women and girls are included in these programmes?" he said, "We've got lots in there: we've got this; we've got this check, we've got this check and we've got this check." My second question was, "What about disabled people?" He agreed with me there was nothing and that was a problem.⁶⁵

56 Lesbian, Gay, Bisexual and Transgender

57 DFID ([DIS0054](#)) paras 12-14

58 Women's Refugee Commission ([DIS0061](#)) paras 12-14, World Food Programme ([DIS0108](#))

59 For example, Dr Rebecca Dingo ([DIS0044](#)) para 12, Gender and Development Network ([DIS0009](#)) para 2.1.

60 DFID ([DIS0054](#)) para 13

61 Q32 [Dr Miles], World Food Programme ([DIS0108](#)), Women's Refugee Commission ([DIS0061](#)) paras 12-14. The Women's Refugee Commission makes a particularly compelling argument, so we contacted them to discuss their position in more depth. The Council did not disagree that a disability strategy was needed in the short term, given the neglect of the issue – their position is rather that, in the long term, once disability has gained more traction among donors, the goal should be to consider all types of exclusion in a single strategy. (Source: note of informal discussion with WRC, 8 January 2014, [DIS0105](#)).

62 Q51 [Ms Shivji], Sightsavers ([DIS0050](#)) para 5.2, Joint National Association of Persons with Disabilities ([DIS0083](#)) para 2

63 Q33 [Ms Wapling]

64 Q51, Q81, Q82 [Ms Shivji]

65 Q52 [Mr Wainwright]

24. If some DFID country offices are already conducting thorough social appraisal analyses that include disabled people, a disability strategy should not mean substantial additional work for them, although we accept there will be some extra paperwork. On the other hand, if other offices have not fully considered disability in their analysis, our proposal provides a safeguard to ensure disabled people do not fall between the cracks—a safeguard that will ensure DFID’s commitment to disability is sustained even as key personnel change. Nor does our proposal imply that DFID should respond to disability with ‘small, special interest projects’—on the contrary, as outlined in paragraph 44 and Chapter 5, we would expect DFID’s strategy to foster linkages between different marginalised groups, and to ensure disabled people were fully accommodated within wider ‘mainstream’ programmes.⁶⁶

25. We recommend that DFID introduce a disability strategy. Disability should be a priority for DFID. Its current approach to social impact appraisal, which considers the risk of exclusion across a wide range of marginalised groups, is valuable—but not enough. There remains a danger that disabled people’s interests will be lost among those of groups who are more visible – all the more after the current Minister moves roles. By publishing clear objectives, and timetables, as it has done for gender, the Department can signal its commitment to disability, and help ensure this commitment endures even as key individuals move on. We also recommend that the disability strategy be supported by clear references to disability in all Country Operational Plans, and in the next Bilateral Aid Review.

A second objection—“Too little data”

26. DFID says that “much of [the evidence on development work with disabled people] is related to single programmes within specific countries and includes limited information about long term outcomes, which limits the ability to scale up or replicate programmes.”⁶⁷ In principle, we support DFID’s commitment not to rush into large-scale programmes without firm evidence. We recognise that better data would make for more targeted programmes, and could help persuade more sceptical partners why disability is a priority.⁶⁸

27. However, DFID’s caution risks lack of ambition. We asked several of our expert witnesses whether there was enough data for DFID to embark on large-scale programmes, and they agreed that there was.⁶⁹ There is evidence that ‘scale up’ is not out of reach : for example, Handicap International highlighted DFID’s inclusive education work in Rwanda, which it is currently piloting at district level with a view to national level scale up.⁷⁰ In addition, DFID’s current, stringent, evidence requirements risk ruling out programmes which could have substantial benefits. One NGO specialising in deafness told us:

66 Putting in place a policy on disability need not be to the exclusion of a focus on other marginalised groups. USAID, for example, has an extensive programme of work on LGBT-inclusive development, alongside its work on disability (source: USAID, ‘[Advancing LGBTI-Inclusive Development](#)’, accessed 23 March 2014).

67 DFID ([DIS0054](#)) para 4

68 See, for example, Dr Tom Shakespeare ([DIS0002](#)) paras 4.1 and 4.3, International Centre for Evidence in Disability ([DIS0010](#)) paras 5.2 and 5.3, Leonard Cheshire Disability Annex A ([DIS0077](#)) para 1.2.

69 Q 31, Q 102 [Prof Groce]. See also Lord Colin Low of Dalston ([DIS0020](#)) Annex.

70 Handicap International ([DIS0012](#)) para 1.4. The submissions identified many other programmes with strong potential for scaling – including award winning livelihoods programmes run by Leonard Cheshire Disability ([DIS0058](#)) para 3.19. In addition, Handicap International has produced a database of successful interventions that have been positively reviewed by beneficiaries, and have potential for scaling (www.makingitwork-crpd.org)

This is something that as a small charity, we really struggle with when applying to DFID for delivery funding. It seems obvious that treating hearing loss will enable pupils to stay in education, and people to stay in jobs. Otherwise, why would we have such good audiology services in the UK? And yet there are no longitudinal studies in Africa that actually prove this, and no small charity has the funds to commission such a study. So then we are stuck when we apply to DFID and can't prove a link between hearing loss and poverty.⁷¹

28. In addition, there is a risk that, if too much emphasis is placed on data gathering, research can easily become a substitute for action.⁷² One academic described her experience undertaking an expensive disability survey for a multilateral organisation in Iraq, only to find the results were never used for programming.⁷³ DFID has specifically designed some of its research programmes with a view to putting the results into action.⁷⁴ However, one of our witnesses, who recently led a DFID-funded research programme, said that some DFID teams took more interest in the results of disability research than others.⁷⁵

29. We welcome DFID's research into disability, and support its commitment to evidence-based programming. However, as we found in our report on Violence against Women and Girls, DFID should strike a balance between building an evidence base on disability, and implementing programmes. The scale and urgency of the challenge are such that DFID cannot wait for perfect data before embarking on large-scale disability programmes. Rather, DFID should take an ambitious but flexible approach. We recommend that DFID set challenging milestones for implementing more large-scale programmes. It should begin these programmes by piloting, as it has done in Rwanda, so that it can stop any projects that are not working, and rapidly scale up those that are. Similarly, we recommend DFID take a pragmatic approach to funding applications from disability-focussed civil society organisations, and should not let imperfect data prevent it funding promising projects with a clear potential—albeit unproven—benefit. We recommend that DFID continue to undertake research on disability, and monitor closely whether the research is put into practice by DFID and its partners.

Ensuring the strategy reaches the most marginalised

30. Several submissions to the inquiry emphasised that, even among disabled people, some groups are particularly prone to be marginalised. These include people with intellectual or psychosocial disabilities. These people are particularly exposed to stigma, violence and

71 Sound Seekers ([DIS0089](#))

72 Q89 [Dr Shakespeare], Q 91 [Prof Groce]

73 Q31 [Dr Miles]

74 For example, the PRIME mental health programme explicitly aims to show how successful approaches can be implemented and scaled up : Q103 [Prof Thornicroft] and '[PRIME](#)', accessed 23 March 2014; DFID's recent £2 million ESRC research programme aims to gather evidence on 'what works' in practice: ESRC Research Programme Call, [Disability, Inequality and Poverty](#), 2013.

75 Q 103 [Prof Groce]

poverty.⁷⁶ A witness from Palestine told us how, while children with physical disabilities could often access school, many with intellectual disabilities could not.⁷⁷

31. We also heard that there are significant overlaps between disability and ageing. First, older people suffer more from disability than any other age group: it is thought that 46% of people over the age of 60 are disabled.⁷⁸ Yet their conditions may be dismissed as part of the ageing process, and not even recognised as disability;⁷⁹ and they tend to be under-represented in the disability movement.⁸⁰ Second, even if they do not have impairments, older people face many of the same barriers as disabled people. Compared with younger age-groups, they are less able to escape poverty; less likely to access basic services such as healthcare and micro-finance; more vulnerable to abuse; and more exposed to the effects of conflict and disaster.⁸¹

32. We recommend that DFID’s disability strategy state specifically how DFID will reach people with intellectual and psychosocial disabilities through its programmes. We further recommend that DFID cover ageing in the same strategy as disability, given the strong overlaps between the two issues. It should, though, recognise that not all disabled people are older people, to ensure the focus on older people does not eclipse the priorities of disabled children or younger adults.

Stronger reporting and accountability

33. A disability strategy is unlikely to be effective unless it is backed by a strong mechanism to ensure accountability. A stark example comes from DFID’s work on education for disabled children. In 2010, DFID published a detailed guidance note for country offices, supplemented by a one-page summary in 2011. In 2012, NGOs surveyed usage of the guidance across six country offices in Africa. They found that only one office had put the guidance note into practice; three had not even read it. When asked why, one office explained that they faced many competing demands, and “they had not been asked to report on actions taken”.⁸²

34. Many submissions recommended that the best way to hold programmes accountable is by requiring them to disaggregate the numbers of disabled beneficiaries.⁸³ The Prime Minister has already signalled his commitment to disaggregated reporting, when he said

76 For example, Q94 [Prof Thornicroft and Prof Groce], Special Olympics ([DIS0038](#)) para 1.2 and 1.3, BasicNeeds ([DIS0064](#)), International Labour Organisation ([DIS0031](#)).

77 Q5 [Ms Abu Alghaib]. See also Special Olympics ([DIS0038](#)) para 1.3.

78 UN Population Fund and HelpAge International, [Ageing in the 21st Century](#), New York, 2012, p12. Assuming this figure was calculated based on the same data and definitions as the WHO use, it is likely to include people with less severe impairments, as well as those who experience severe difficulties.

79 For example, Q102 [Prof Groce], HelpAge International ([DIS0039](#)) para 6, Age International ([DIS0037](#)) para 13.

80 Q97 [Dr Shakespeare]

81 HelpAge International ([DIS0039](#)) paras 6, 9, 17-20; UN Population Fund and HelpAge International, [Ageing in the 21st Century](#), New York, 2012, pp 41, 42, 87, 95-98, 111, 135, 153-55

82 Global Campaign for Education Annex A ([DIS0101](#))

83 Q13 [Mr Chandrasekar], Q48 [Ms Frost], Leprosy Mission of England and Wales ([DIS0004](#)) para 8.5, RESULTS UK ([DIS0021](#)) para 5.4, Global Campaign for Education ([DIS0022](#)) para 1.5, World Vision ([DIS0023](#)) para 18, Human Rights Watch ([DIS0043](#)) para 13, Vision Alliance ([DIS0013](#)) para 14, Life Haven ([DIS0007](#)) para 12, Action to the Community Development Center ([DIS0109](#))

that the new post-2015 development framework should include targets disaggregated by disability.⁸⁴ DFID is currently supporting international efforts to develop such data in the education and WASH⁸⁵ sectors—including WASH data broken down by type of disability.⁸⁶ It will be important for it to make use of this data as soon as possible in key internal monitoring processes such as Annual Reviews, Project Completion Reviews and logframes.⁸⁷ It is unclear, however, how DFID plans to gather data on disabled beneficiaries in sectors other than education and WASH. Moreover, DFID's Results Framework, which summarises DFID's most important targets, does not include any disability-disaggregated targets, whereas it disaggregates many targets by gender.⁸⁸ Gathering data on disability is notoriously difficult,⁸⁹ but some of our expert witnesses recommended that the UN's Washington Group questions (Box 2) would offer a 'quick and dirty' approach in the short term.⁹⁰

Box 2: The Washington Group questions on disability

The Washington Group questions identify disability by asking whether individuals have difficulty performing certain basic tasks. Respondents specify the level of difficulty that they experience, on four-point scale from 'no difficulty' to 'completely unable'.

1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty with self-care, such as washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating (for example, understanding or being understood by others)?

The questions have their limitations: for example, they focus on medical conditions rather than environmental and social barriers that lead to disabled people's exclusion.

However, they are relatively quick, allow international comparisons, and avoid the trap of asking directly whether people are disabled – a question which tends to lead to under-reporting.⁹¹ As such, some key experts recommend the questions are a good pragmatic way to measure how far programmes are successfully reaching disabled people.

Source World Health Organisation/World Bank, *World Report on Disability*, Geneva, 2011, Box 2.2; Q102 [Dr Shakespeare], Dr Sophie Mitra ([DIS0094](#)) para 14, Leonard Cheshire Disability Annex A ([DIS0077](#)) para 2.

35. We welcome the Prime Minister's commitment to reporting disaggregated data on the number of disabled people who benefit from development programmes. We also commend the steps DFID is taking to make better data available. We recommend that

84 Among other factors. United Nations, [A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development: the Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda](#), New York, 2013, p29

85 Water, Sanitation and Hygiene

86 DFID Annex A ([DIS0071](#)) para 6, WaterAid ([DIS0018](#)) paras 1.5 and 3.13

87 All DFID country offices, business units and programmes are appraised through annual reviews, and programmes are also subject to review on completion. The review considers broad measures of progress against intended outcomes, as well as value for money, and risks. These reviews are supported by logframes, which show more detailed, frequent, results. Logframes break a programme's goals into detailed indicators, and track progress on these indicators over time.

88 [DFID's Results Framework](#), 2013, p.6

89 For example, Leonard Cheshire Disability Annex A ([DIS0077](#)) para 2. See also UNICEF, [State of the World's Children 2013: Children with Disabilities](#), New York, 2013, Ch6.

90 Dr Tom Shakespeare ([DIS0002](#)) paras 4.1 and 4.3, Dr Sophie Mitra ([DIS0094](#)) paras 13 and 14

91 Q 102 [Dr Shakespeare], Dr Sophie Mitra ([DIS0094](#)) para 14, Leonard Cheshire Disability Annex A ([DIS0077](#)) para 2.3

DFID report results disaggregated by disability in all Annual Reviews, Project Completion Reviews and logframes. We also recommend that it disaggregate targets in its Results Framework by disability, as it does for gender. We recognise that collecting data on disability is not straightforward, and teams have many other demands on their time, so recommend a pragmatic approach in the short term—for example, using the Washington Group questions. In the medium term, we recommend DFID develop more precise data disaggregated by type of disability. Wherever possible, we recommend that DFID report results disaggregated to show people who belong to several marginalised groups at once (e.g. disabled women), to help tackle the ‘double discrimination’ that such people face.

Announcements in the pipeline

36. The Minister told us that DFID’s approach to disability is “work in progress”.⁹² During our evidence session, she indicated that DFID plans to announce further programmes to reach disabled people in more key sectors of its work.⁹³ She indicated these plans might affect both DFID’s bilateral programmes, and those delivered through multilateral organisations.⁹⁴ DFID has subsequently provided some additional information on these plans:

The thematic areas that DFID are looking into include general infrastructure, WASH and social protection. However, we still have substantial work to do before finalising what any new commitments might look like and we would welcome the Committee’s report as a useful source to influence the decisions that are being taken.⁹⁵

We welcome the news that DFID plans to introduce further programmes aimed at disabled people. We trust DFID will take our recommendations into account as it develops these plans, and we look forward to hearing an update in the Government’s response to this report.

92 Q133

93 Q136, Q154

94 Q167

95 DFID Annex E ([DIS0097](#))

4 Implementing DFID's commitments on disability

A central role for disabled people

37. There is strong consensus that if development work is to benefit disabled people, it must be done in partnership with them.⁹⁶ If disabled people do not have a central role, there is a risk that—as DFID's own guidance from 2007 points out—“aid modalities [will] [...] perpetuate existing power imbalances whereby non-disabled people control funding and make decisions on behalf of disabled people”.⁹⁷ Moreover, programmes designed with input from disabled people are likely to be more effective in meeting their needs: in one extreme example following the 2004 Indian Ocean tsunami, a disabled girl was given five wheelchairs, but not asked if she needed food or clothes.⁹⁸ Witnesses emphasised the importance of involving people with a range of disabilities, and from a range of backgrounds (e.g. women, older people, youth).⁹⁹ Several submissions also emphasise the need to engage with the families of disabled people—particularly those with more complex conditions—and to understand the views of their wider communities.¹⁰⁰

38. During our visit to Afghanistan, we saw first-hand the benefits of development programmes delivered by disabled people. We visited the Kabul Orthopaedic Centre, run by the International Committee of the Red Cross and Red Crescent, to which DFID contributes funds.¹⁰¹ The Centre provides rehabilitation services to people with injuries and disabilities.¹⁰² Most of the staff at the Centre—including the director— were themselves amputees, and so had an insight into their patients' circumstances.

39. DFID has taken some very encouraging measures to give disabled people a greater role in its work. It has consulted disabled people in the design of many of its WASH schemes, and plans to employ disabled staff in Ethiopia to advise on accessibility.¹⁰³ It has involved disabled people in the design of some of its cash transfer programmes, and modified one such programme in Zimbabwe in response to disabled people's feedback.¹⁰⁴ Between 2007 and 2012 it also set up a pioneering research programme run by disabled people in South

96 See, for example, Secretariat of the African Decade of Persons with Disabilities ([DIS0030](#)) para 2.1, Joint National Association of Persons with Disabilities ([DIS0083](#)), Bond Disability and Development Group ([DIS0011](#)) para 7.5, Equal Lives ([DIS0001](#)) paras 7.1 and 7.12, Prof Michael Stein ([DIS0053](#)) paras 7,8,9, Australian Government Department of Foreign Affairs and Trade ([DIS0063](#)), USAID ([DIS0088](#)) para 11, Action to the Community Development Center ([DIS0109](#)) para 14

97 DFID, [How To Note: Working on Disability in Country Programmes](#), 2007, para 8.4

98 UNICEF, [State of the World's Children 2013: Children with Disabilities](#), New York, 2013, p.53

99 For example, Q16 [Mr Chandrasekar], Q97 [Dr Shakespeare], Centre for Global Mental Health/CBM/Nepal Mental Health Foundation ([DIS0052](#)) para 7.2, Inclusion International ([DIS0080](#)), ADD International ([DIS0027](#)) paras 4.4 and 4.6.

100 For example, Inclusion International ([DIS0080](#)), Sense International ([DIS0057](#)) para 5.3.4, Leonard Cheshire Disability ([DIS0058](#)) para 5.2.6, Dr Rebecca Dingo ([DIS0044](#)) para 6.

101 [DFID Annual Report and Accounts 2012-13](#), p.98

102 ICRC, ['Kabul Orthopaedic Centre'](#), accessed 23 March 2014

103 DFID ([DIS0054](#)) para 26

104 DFID ([DIS0054](#)) para 33 and DFID Annex A ([DIS0071](#)) para 8

Africa.¹⁰⁵ However, such engagement does not yet seem to be a consistent feature across all programmes that aim to reach disabled beneficiaries.¹⁰⁶ Moreover, we have seen little evidence that disabled people are involved in DFID's central policy work. The Minister recently established an advisory group on disability—a welcome step; however, the group consists of NGOs rather than DPOs.¹⁰⁷

40. We warmly welcome the steps DFID has taken to give disabled people greater say in aspects of its work, in particular the fact that it modified some WASH and social protection programmes in response to disabled people's feedback. The challenge is to do this more consistently across DFID's whole portfolio. DFID is currently reviewing its programme management, and we recommend it take this opportunity to give disabled people more influence – from programme design through to evaluation and research. DFID should ensure people with all types of disability participate, and should adjust its communications to make sure they are reached. It should consult family and community members as well as disabled people themselves. More specifically, DFID should:

- **Ensure that disabled people play a prominent role in drawing up DFID's disability strategy, and help shape its Country Operational Plans.**
- **Seek to give more disabled people visible and senior roles in programme delivery—as already happens at the Kabul Orthopaedic Centre, which DFID helps fund.**
- **Invite DPOs from developing countries to join its disability advisory group, even if only in writing or by telephone.**

Disabled People's Organisations

41. Many submissions stress the important role of DPOs, which help challenge exclusion and press for better access to services and other rights.¹⁰⁸ DFID already provides support to around 400 DPOs across around 40 countries¹⁰⁹—most importantly through ADD International, the Disability Rights Fund (DRF) and Sightsavers.¹¹⁰ These organisations provide financial and capacity-building support to a wide range of DPOs, including some smaller organisations representing particularly marginalised groups.¹¹¹

105 DFID ([DIS0054](#)) para 44 and Equal Lives ([DIS0001](#)) para 6.1. See also Thisability ([DIS0072](#)).

106 DFID Annex A ([DIS0071](#)) para 9: systematic approach to beneficiary feedback is still being developed; and it is unclear how far this approach will routinely involve consultation with disabled beneficiaries.

107 Q147

108 For example, VSO ([DIS0066](#)) para 10, ADD International ([DIS0027](#)) para 4.1, Norwegian Association of Disabled ([DIS0024](#)) para 1.

109 DFID Annex F ([DIS0098](#))

110 This support currently comprises a £3.4 million (2011-2014) Partnership Programme Agreement with ADD International, a £2 million grant (2013-2016) to the Disability Rights Fund, and a £11.2 million (2011-2014) Partnership Programme Agreement with Sightsavers (this supports a number of objectives, including healthcare as well as disability rights).

111 DFID Annexe F ([DIS0098](#)), Q18 [Ms Abu Alghaib], Lakeside Cross Disability Self Help Group ([DIS0065](#)) para 1, Disability Rights Fund ([DIS0091](#)) para 1, ADD International ([DIS0027](#)) paras 2.1, 4.2, 4.4, 4.6, Sightsavers 'Social Inclusion', accessed 24 March 2014. See also Leonard Cheshire Disability Annex B ([DIS0079](#)) para 3.10 on the importance of capacity building. DPOs' current capacity varies enormously, from very small informal local groups, to larger more established DPOs, such as the Secretariat of the African Decade of Persons with Disabilities, which have experience dealing with international bodies such as the African Union ([DIS0030](#)).

42. Our evidence indicated one key respect in which DFID could improve its support to DPOs: disabled witnesses from Kenya and Palestine told us that, in their countries, it is “almost impossible” for DPOs to apply for funding directly from DFID, since information is not available in accessible formats, and grant conditions are complex and ill-suited to small DPOs.¹¹² DFID provided us with a list of the DPOs that it supports: this indicated that in some DFID focus countries such as the Occupied Palestinian Territories and Pakistan, DFID is not supporting any DPOs. It also showed that very few DPOs had obtained funding directly from DFID: the majority had applied through intermediaries such as NGOs or large civil society organisations.¹¹³ We accept that DPOs may be able to access alternative sources of funding in some countries.¹¹⁴ However anecdotal evidence suggests that there is still a strong need for further funds in many locations, and some DPOs are at risk of closing through lack of financial support.¹¹⁵

43. We strongly welcome DFID’s support for DPOs. However, we are concerned that it is hard for disabled people’s organisations to access funding directly from DFID. We recommend that DFID make its funding more accessible to DPOs. We do not wish to prescribe how DFID does this, but do recommend that it address the main barriers such as information that is not accessible, and complex grant conditions. We are also concerned that, if DPOs can only access DFID funding through intermediaries, DFID is missing a valuable opportunity to train its staff in local disability issues. While we recognise country offices have many calls on their time, we recommend that DFID seek to establish more direct contact with DPOs, which could be an efficient way to tap into local knowledge and networks.

44. In addition, some authors have argued that, if disabled people are successfully to challenge inequality and exclusion, they need to form alliances with other marginalised groups.¹¹⁶ This also helps tackle stigma, and makes it easier for disabled people to access self-help schemes from across the community.¹¹⁷ We have seen some encouraging evidence that organisations such as ADD International support such linkages, but this evidence is not widespread.¹¹⁸ **We welcome DFID’s current work to build DPO capacity and to reach out to marginalised groups, and encourage it to ensure this is standard practice in all its work with DPOs. We also recommend that, whenever DFID provides grants to ‘mainstream’ civil society organisations (for example, women’s organisations), it monitor whether they are including disabled people.**

Disabled People’s Organisations from the UK

45. We have been told that UK DPOs have little opportunity to participate in DFID’s work.¹¹⁹ Some such organisations have a track record of work in development— indeed

112 Q 19 [Ms Abu Alghaib and Mr Osundwa]. See also Action to the Community Development Center ([DIS0109](#)) para 10.

113 DFID Annex F ([DIS0098](#))

114 Q151

115 Q14 [Ms Abu Alghaib], Accessibility Organisation of Afghan Disabled ([DIS0069](#))

116 For example, Yeo, [Disability, Poverty and the New Development Agenda](#), London, 2005, pp 15, 17, 19-21, 26.

117 Q4 and Q18 [Mr Chandrasekar]

118 ADD International ([DIS0027](#)) para 5.4

119 Equal Lives Annex A ([DIS0099](#))

they have in the past undertaken work for DFID, including training and capacity building.¹²⁰ While DFID's primary aim should be to work with disabled people in developing countries, we recognise specialised input from the UK will sometimes be needed. UK DPOs have complementary experience to UK NGOs—for example, while NGOs may have experience of certain country contexts or of specialist fields such as sanitation, DPOs have direct experience of lobbying governments for disabled people's rights. **We encourage DFID to renew its links with UK DPOs, and to consider where their expertise might usefully complement that of NGOs.**

DFID's internal organisation

46. DFID's current work on disability is coordinated by a very small team of people (Table 2). They all have to balance disability work with other responsibilities, and have demonstrated considerable dedication in accommodating a growing disability workload over recent months. Table 2 shows the numbers of staff at each grade on the disability team. For comparison, it also shows the make-up of the gender team. We were very surprised to see the disparity in staff numbers between the disability and gender teams. We would not expect the disability team to be commensurate with that for gender, but, as a guide, the ratio of disabled people to women in the developing world is around 2:5.¹²¹ The teams for gender and disability are also supported by a wider network of 80 social development advisors, but these advisors are responsible for all aspects of social inclusion—women, children, ethnic minorities, etc.—so there remains, in practice, a risk that disabled people will not be their main focus (paragraph 23).

120 Equal Lives ([DIS0001](#)) para 2, Equal Lives Annex A ([DIS0099](#))

121 Rough estimate using World Bank data from 1999 that indicated 20% of people in developing countries have a disability (source: World Bank, [Poverty and Disability: a Survey of the Literature](#), 1999).

Table 2: Comparing DFID's staffing for disability and gender

It should be noted that the Conflict, Humanitarian and Security Division (CHASE), which handles DFID's response to emergencies, currently contains no disability specialists: disability work is undertaken by social development advisors.

Grade (most senior at the top)	DFID's disability team ¹²²	DFID's gender team
SCS	0.05	0.5 ¹²³
A1	0.05	3
A2	0.25	8.7
A2L	0.5	1.2
B1d	0.05	1
B1	0	3
B2	0	1.8
Graduate ¹²⁴	0	2
Total	0.90	21.2

Source DFID Annex A ([DIS0071](#)) para 4. A decimal fraction indicates the proportion of the working week devoted to disability/gender.

47. Evidence from Australia, the US, and the World Health Organisation suggest that, to build a sustainable commitment to disability, DFID will need a considerably larger team, including the following elements.

- **A Director-level sponsor with overall responsibility.** Many submissions recommended that highly visible, senior, leadership would help signal DFID's commitment to disability.¹²⁵ For example, if DFID produces a disability strategy, endorsement by senior officials will be important.¹²⁶ Dr Tom Shakespeare told us how endorsement from the lead of WHO was crucial in gathering support across that Organisation.¹²⁷
- **A substantial number of Social Development Advisors specialising in disability.** The Minister told us that most of DFID's current Social Development Advisors are not disability specialists¹²⁸—and, as can be seen from Table 2, they do not devote a

122 In addition, one staff member is currently on secondment to the Australian Department for Foreign Affairs and Trade, with a view to learning from Australia's work on disability (source: DFID, [DIS0054](#), para 47).

123 In addition, all SCS have some responsibility for gender equality, as this is one of the Secretary of State's priorities, and will shortly become a legal requirement under the International Development (Gender Equality) Act.

124 I.e. participants in DFID's one-year training programme for new graduates.

125 Dr Tom Shakespeare ([DIS0002](#)) para 2.1.1, Bond Disability and Development Group ([DIS0011](#)) para 8.4, RESULTS UK ([DIS0021](#)) para 5.5, Sightsavers ([DIS0050](#)) para 6.7, Leonard Cheshire Disability ([DIS0058](#)) para 3.7, Australian Department for Foreign Affairs and Trade ([DIS0063](#)), USAID ([DIS0088](#)) para 11

126 Global Campaign for Education ([DIS0022](#)) para 5.1, Lorraine Wapling ([DIS0062](#)) para 3.2

127 Q105 [Dr Shakespeare]

128 Q134

substantial share of their time to disability. In contrast, AusAID—a considerably smaller agency than DFID—had a team of full time staff dedicated to disability work.¹²⁹

- **A wider network of people to champion disability in every country office.** These staff members would devote a substantial proportion of their time to disability, liaising with government partners and DPOs, and providing guidance to country office staff.¹³⁰
- **Training for all staff – both general training on disability rights in a development context, and sector-specific training.**¹³¹ Some experts recommend that, where possible, this training should be delivered by disabled people.¹³²

48. We commend the dedication of DFID’s current disability team, but are concerned that DFID has no full-time disability specialists. To ensure its commitments to disability are sustainable, we recommend DFID develop a larger team, with more capacity, including: a senior sponsor; a complement of Social Development Advisors specialising in disability; and a wider network of people to champion disability in each country office. We further recommend DFID ensure all staff are trained in basic principles of disability rights and access to development programmes. It should consider making disability the theme for the next Social Development Advisor team conference. It should also ensure disability specialists are represented in its humanitarian division, as well as in its development work.

Disabled staff

49. We asked DFID to supply us with a breakdown of disabled staff, by grade. It told us 45 of its total staff had declared a disability. It also told us no locally appointed staff from its country offices had declared a disability.¹³³ These figures may partly reflect that staff are not required to disclose whether they have a disability or not¹³⁴—but nonetheless, they appear to be low compared with the numbers of disabled staff at many other major Government departments.¹³⁵ Evidence from a large UK DPO praises DFID’s disability recruitment policy,¹³⁶ but these figures suggest further action is needed.

50. We are concerned that DFID only employs 45 staff with a declared disability—and that no locally appointed staff in its overseas offices have declared they are disabled. A visible disabled workforce could be a powerful way to challenge stigma and discrimination, and to get a deeper understanding of the barriers that disabled people

129 Kelly and Wapling, [AusAID: Development for All Strategy: Mid-Term Review Report](#), Canberra, 2012, p 45. See also e.g. Lorraine Wapling ([DIS0062](#)) paras 3.4 and 3.5, Australian Department for Foreign Affairs and Trade ([DIS0063](#)).

130 Lorraine Wapling ([DIS0062](#)) para 3.4, The Leprosy Mission ([DIS0004](#)) para 8.1, Bond Disability and Development Group ([DIS0011](#)), RESULTS UK ([DIS0021](#)), Global Campaign for Education ([DIS0022](#)) para 5.4

131 For example, Leonard Cheshire Disability ([DIS0058](#)) para 3.14, RESULTS UK ([DIS0021](#)) para 6.7, USAID ([DIS0088](#)) para 10, Norwegian Association of Disabled ([DIS0054](#)) para 5.1

132 For example, World Vision ([DIS0023](#)) para 17

133 DFID Annex D ([DIS0092](#)) para 2

134 As above

135 Based on analysis of departmental Mid-Year Reports published on the [government website](#). Comparisons should be treated with caution, due to differences in reporting processes, but of 13 large departments that declared their workforce diversity, DFID appeared to have one of the lowest levels of disabled staff.

136 Equal Lives ([DIS0001](#)) para 4.4

face. DFID should investigate why it has not attracted more disabled staff, and should consider whether targets would help it redress the balance in some of its offices.

5 What a strong commitment to disability means for DFID's sector programmes

A realistic schedule for change

51. DFID has to strike a balance between many different priorities. In the long-term, we would expect all its programmes to be accessible to disabled people: but we recognise it is not realistic to do this immediately—a phased approach will be necessary.¹³⁷ Australia's experience provides a useful model of how to set ambitious targets without trying to do everything at once. Bob McMullan, the minister responsible for introducing Australia's strategy on disability and development, explained that the strategy focussed on just two sectors, and also on four countries.¹³⁸ This approach meant the agency's developing disability expertise was not spread too thinly, whilst still aiming for results on an ambitious scale.¹³⁹

52. DFID has taken an important symbolic step with its new commitment to make all directly-funded school buildings accessible to disabled children. We understand this announcement has already had a positive knock-on effect on other donors, with the World Bank now looking to make its new school buildings accessible too.¹⁴⁰ **However, while this commitment is welcome, it is well-known that accessible buildings are a relatively simple, low-cost, response to disability.**¹⁴¹ **If disabled people are to enjoy full access to programmes, donors also need to tackle more stubborn barriers such as information and stigma.**¹⁴² **We would now expect DFID to show more ambition. We recommend DFID choose one or two substantial sectors (e.g. health or education), and a small number of countries, to focus on. Within these chosen areas, it should then pledge to give disabled people full access to all its programmes.**

53. Over the course of the inquiry, we have heard compelling evidence of disabled people's needs across a wide range of sectors, so it will not be easy to choose where to start (Box 3). Our witnesses suggested two ways to handle this difficult decision: first, they emphasised that DFID should ask disabled people themselves which sectors to focus on.¹⁴³ Second, they proposed that DFID should also focus on sectors where it is already performing strongly, and countries where it already has good relations with the government: this provides a strong foundation to build on, and makes it easier to demonstrate what is possible.¹⁴⁴ **We**

137 For example, Q79 [Mr Wainwright], Bond Disability and Development Group ([DIS0011](#)) para 8.2, Norwegian Association of Disabled ([DIS0024](#)) para 3

138 Q 23 [Mr McMullan]. The sectors were education and infrastructure: AusAID worked to make these sectors accessible for disabled people throughout its work worldwide. The countries were Samoa, Cambodia, Papua New Guinea and East Timor: AusAID worked to ensure programmes in these countries were accessible, across multiple sectors. The strategy covered a five year period, after which the priorities would be reviewed. Source AusAID, [Development for All: Towards a Disability Inclusive Australian Aid Program, 2009-2014](#), pp 14-22.

139 Q23 [Mr McMullan]

140 Q133

141 Lorraine Wapling ([DIS0062](#)) para 1.4, WaterAid ([DIS0018](#)) para 3.1

142 For example, World Vision ([DIS0023](#)) para 10, Dr Rebecca Dingo ([DIS0044](#)) para 6, Vision Alliance ([DIS0013](#)) paras 3,6,9, Nepal National Association of Service Providers in Physical Rehabilitation ([DIS0016](#)) para 2

143 Q92 [Dr Shakespeare]

144 Q23 [Ms Wapling], Q80 [Ms Frost], Q92

recommend that disabled people take the lead in deciding which the sector(s) DFID should to focus on initially. We further recommend that DFID play to its strengths, and select sectors and countries in which it has a strong track record. Although we recommend that DFID take a focussed approach to begin with, we also urge it to set out a long-term timetable showing how it will expand its commitments to more sectors and countries in due course.

Box 3: Testimony on some of the challenges that disabled people face across the spectrum of DFID's work

Health

"I will never forget the testimony of one disabled woman in West Africa, who reported that, when she presented at a hospital in the early stages of labour, health workers laughed at her and asked how on earth she could have managed to get pregnant."—witness to the inquiry speaking of his time at the WHO¹⁴⁵

Education

"She was no longer in school. She had hoped to pass junior secondary school three, and was determined to make it as far as the disability would allow. Then, she got pregnant. She told her interviewer, "Yes I have been mistreated sexually and physically and also insulted by my teachers and colleagues in school. When I decided to leave school it was because I was impregnated by some guys I didn't know. Because of my poor eyesight I can't remember them, so they denied responsibility." After she became pregnant the school refused to let her continue."
—the case of a girl with albinism and a visual impairment in Sierra Leone.¹⁴⁶

Employment and Social Protection

*"Persons with disability are always the last to be hired and the first to be discharged"*¹⁴⁷
—evidence from a disabled person in Afghanistan..

*"I was lucky to find support and to be able to continue my education and then get a job, as it is sadly not the case for all persons with disabilities, including [landmine] survivors, who remain the poorest amongst the poor because they often do not have access to such services and opportunities".*¹⁴⁸—evidence from a disabled person in Laos.

*"I am living by borrowing from other people and relatives here and there. I am just surviving."*¹⁴⁹
—recent research into stipends in Bangladesh.

Violence against Women and Girls

*"At the age of 16 this girl went to a jute field to fetch wood. There, the son of a powerful chairman of the village raped her. She went back to her home, bloodied and in a lot of pain, and after she reached home she collapsed. Her brother's wife asked her what had happened and the girl told her, using sign language. Later, she died. The girl's elder brother wanted to file a case against the chairman's son, but the chairman's people threatened him. He did file the case, but the police didn't take it on because the chairman was powerful. The police said that [the girl's death] was suicide. They threatened the girl's elder brother and made him sign that it was suicide.... Still, today, there has been no justice."*¹⁵⁰

—The story of a deaf girl in Bangladesh.

54. While much of our evidence suggested DFID should focus on particular sectors and countries to start with, this was not universal. For example, USAID has chosen **not** to focus on particular sectors, as it wanted to signal that disability was relevant to every sector, and it wanted the flexibility to take new opportunities in different sectors, and to exploit cross-sector links.¹⁵¹ We see the reasoning behind this approach, but on balance judge that a sector-specific focus, like Australia's, will make it easier for DFID to set ambitious and

¹⁴⁵ Dr Tom Shakespeare ([DIS0002](#)) para 3.3

¹⁴⁶ Plan UK ([DIS0042](#)) para 5.5

¹⁴⁷ Accessibility Organisation of Afghan Disabled ([DIS0069](#))

¹⁴⁸ Quality of Life Association ([DIS0049](#)) para 3.3

¹⁴⁹ Sightsavers, ADD International, HelpAge International and Alzheimer's Disease International, [We Can Also Make Change](#), Sussex, 2013

¹⁵⁰ Sightsavers ([DIS0051](#)) para 4.3

¹⁵¹ Telephone conversation with USAID, 3 February 2014

time-bound goals. We think DFID can put in place other checks and balances to ensure it does not suffer from a lack of breadth. A carefully worded disability strategy would signal that disability is relevant to all sectors. And even if DFID only focussed on one or two sectors, we would expect it to be alert to key linkages: for example witnesses highlighted how, if DFID focussed on education, a small, targeted intervention in nutrition, health or accessible transport may have a large multiplier effect on disabled children's learning.¹⁵² The evidence also suggests there would be some relatively "quick wins" across a diverse range of sectors (Box 4): it would be a mistake for DFID to focus slavishly on one or two sectors to the extent that it missed these opportunities.

55. We accept that once DFID has chosen to focus on one or two priority sectors, extensive work outside these focal areas could leave it overstretched. Nonetheless, to maximise the impact of its work, DFID should remain alert to important links between sectors, as USAID has done. It should also look out for "quick wins" across its whole portfolio, where a small intervention could have a large multiplier effect on disabled people's ability to participate.

152 Q27 [Dr Miles], Professor Michael Stein ([DIS0053](#)) para 11, Able Child Africa ([DIS0026](#))

Box 4 Examples of “quicker wins” that could improve disabled people’s access to services

Physical access:

- Small cash transfers to cover the costs of transport to and from school, work or clinics¹⁵³
- Extend DFID’s guidance on school infrastructure to other sectors such as health¹⁵⁴
- Support DPOs to carry out accessibility audits of key facilities¹⁵⁵

Access to information:

- Train DPOs to disseminate health information—for example on HIV/AIDS, and on vaccinations¹⁵⁶
- Provide EasyRead information on issues such as sexual and reproductive health. Such information has already been produced in the UK, and could be translated for other country contexts at relatively little cost.¹⁵⁷

Access to professional advice:

- Provide basic disability sensitisation training for professionals such as teachers, health workers and members of the judiciary.¹⁵⁸ This should include training on recognising and responding to abuse.¹⁵⁹ Where possible, such training should be delivered by people with disabilities.¹⁶⁰
- If people’s disabilities affect their communication, allow them longer appointments¹⁶¹

Overcoming cost barriers:

- Small cash transfers to cover user fees¹⁶²

Overcoming stigma and social norms:

- Ensure newly produced help sheets, publicity campaigns and textbooks include images of people with disabilities¹⁶³
- Ensure people with disabilities are among those trained to provide basic services such as HIV/AIDS counselling¹⁶⁴
- Ensure UK-sponsored media outputs include positive coverage of disabled people (working in collaboration with the BBC World Service)¹⁶⁵
- Provide technical support on the design of complaints procedures, to help disabled people report discrimination or abuse¹⁶⁶

153 World Health Organisation/World Bank, *World Report on Disability*, Geneva, 2011, p195 (affordability of transport) and p263 (transport as a barrier to accessing services)

154 Lord Low of Dalston ([DIS0020](#)) para 12, Action to the Community Development Center ([DIS0109](#)) para 4

155 Wateraid

156 StopAIDS [DIS0032](#), UNICEF, *State of the World's Children 2013: Children with Disabilities*, New York, 2013, p.24

157 Informal meetings with people with intellectual disabilities. EasyRead information is designed to be accessible to people with intellectual disabilities.

158 Q99 [Prof Groce and Dr Shakespeare], Dr Tom Shakespeare ([DIS0002](#)) para 1.3, The Guardian, [Societies Can't Be Inclusive Without Equal Access to Justice](#), 20 February 2014. In particular, the Kenya Hospices and Palliative Care Association ([DIS0056](#)) highlights the value of disability training for palliative care professionals.

159 International Network for Education in Emergencies, [Keeping Children Safe](#): Training for Child Protection, module 3

160 Dr Rebecca Dingo ([DIS0044](#)) para 15

161 WHO Draft Disability Action Plan

162 Accessibility Organisation of Afghan Disabled, Gender and Development Network para 4.3.6

163 UNICEF, [State of the World's Children 2013: Children with Disabilities](#), New York, 2013, p 12 and 24

164 Kampala Declaration on Disability and HIV/AIDS, 2008, p.2

165 Q11 [Ms Abu Alghaib] illustrates the role of the media in perpetuating stigma.

166 HelpAge International [DIS0039](#) para 10

Characteristics of a good sector-wide response to disability

56. The precise nature of DFID's response will of course depend on the sector(s) that it chooses to focus on. Our written evidence provides excellent examples of effective programmes from specific sectors, and it would be useful for DFID to refer to this as it develops its disability strategy. The evidence also contains some overarching messages with relevance to any sector.

Considering multiple levels of exclusion

57. A recurrent theme in the evidence we received is the importance of targeting exclusion at all levels—including information barriers; cost barriers; and discriminatory attitudes from service providers, community members and governments.¹⁶⁷ DFID's existing disability programming shows it is already addressing these barriers on a small scale:¹⁶⁸ the challenge will be to apply this approach sector-wide.

58. In particular, submissions emphasise that, if disabled people are to get full access to programmes in any sector, it is vital to tackle stigma.¹⁶⁹ They propose a variety of responses:

- At the **family** level, they recommend providing more support in caring for disabled children.¹⁷⁰
- At the **community level**, they recommend bringing disabled people and community members together, through for example community-based rehabilitation programmes;¹⁷¹ education; livelihoods programmes; sport; and disability training delivered by disabled people.¹⁷²
- At the **national level**, they recommend supporting national governments to run publicity campaigns; include disability as topic on the school curriculum; and foster disabled role models, including disabled parliamentarians.¹⁷³

167 Nepal National Association of Service Providers in Physical Rehabilitation (DIS0016) paras 2 and 4, Quality of Life Association (DIS0049) para 4.4, Vision Alliance (DIS0013) paras 3,6,9, Gender and Development Network (DIS0009) paras 4.2 and 4.3, Marie Stopes International (DIS0041) para 6

168 DFID Annex B (DIS0074) for example, programmes to tackle discrimination against people with leprosy in India, or to help disabled people have more say on local governance in Ghana

169 Q2 [Ms Abu Alghaib], Q59 [Ms Frost], Q94 [Prof Groce and Prof Thornicroft], USP Kenya (DIS0078) para 10, World Vision (DIS0023) para 10, Dr Rebecca Dingo (DIS0044) para 6, CBM (DIS0034), Centre for Global Mental Health/CBM/Nepal Mental Health Foundation (DIS0052) 2.1.3, Plan UK (DIS0042) para 3.4, Sense International (DIS0057) paras 4.2 and 4.3

170 Q22 [Mr McMullan], Q96 [Dr Shakespeare]

171 I.e. programmes that provide disabled people with practical assistance in living with their disability, in a low-cost way near to their homes and families

172 For example, Q95 [Dr Shakespeare]; National Association of Service Providers in Rehabilitation (DIS0016) para 3; UNICEF, *State of the World's Children 2013: Children with Disabilities*, New York; The Leprosy Mission (DIS0004) para 4.8; Special Olympics, '*Changing Attitudes*', accessed 28 March 2013; agreed minute of informal meeting with people with intellectual disabilities from CHANGE and Special Olympics, 30 Jan 2014. However, it is important that such programmes be designed so that they genuinely accommodate disabled people's needs – otherwise there is a risk that they will reinforce, rather than remove, existing stigma (Dr R Dingo, DIS0044, para 18).

173 For example, SAHARA (DIS0081), Q11 [Ms Abu Alghaib], agreed minute of informal meeting with people with intellectual disabilities from CHANGE and Special Olympics, 30 Jan 2014

59. Several submissions emphasised that tackling stigma takes time. They therefore said it was important that DFID provide long-term support. A DPO in Nigeria told us:

DFID needs to change focus in terms of short term programming for disability. This is in view of the fact that attitudes or habits do not change easily. Some of the programmes designed and implemented by DFID are short term and do not allow for an adequate incubation period, let alone maturity, in a country like Nigeria where there is a high bias against disability, which is perceived as a curse, and PWDs [People with Disabilities] are seen as outcast.¹⁷⁴

We recommend that, once DFID has decided which sectors and countries to focus on, it should consider in detail the steps needed to combat stigma in these chosen areas. This will allow it to tackle the root cause, as well as the symptoms, of disabled people's exclusion. We also note that overcoming stigma takes time. Echoing our findings on Violence Against Women and Girls, we recommend that programmes designed to tackle stigma last at least five years, with opportunities for further follow-up.

Tailoring the approach to the context

60. Many submissions also said that programmes need to be tailored to local circumstances.¹⁷⁵ This appears to be particularly true for education. Many of our submissions recommended that disabled children be educated in the same classes as those without disabilities (inclusive education);¹⁷⁶ but some said this was not always a suitable approach for those with more complex conditions.¹⁷⁷ During the inquiry we met, via video conference, a young man with intellectual disabilities from India: he told us how he had learnt much more after he moved to a special school.¹⁷⁸ Two of our witnesses were education specialists, and—while broadly supportive of inclusive education—they said that the answer was “not black and white”: the best approach might depend on the nature of children’s disabilities, local attitudes, resources, and existing facilities.¹⁷⁹ The Minister told us she agreed a flexible approach was best— and indeed, in 2007 DFID produced a Guidance Note with a similar view.¹⁸⁰ However DFID’s most recent guidance on school buildings states that “a growing body of evidence is [...] showing that inclusive schools are more cost-effective, and academically and socially effective, than special schools”.¹⁸¹ **We note that the education of disabled children is a complex area, and that the best**

174 Joint National Association of Persons with Disabilities ([DIS0083](#))

175 For example, Secretariat of the African Decade of Persons with Disabilities ([DIS0030](#)), CBM/Centre for Global Mental Health/Nepal Mental Health Foundation ([DIS0052](#)) para 3.3, Leonard Cheshire Disability ([DIS0058](#)) para 1.8.

176 For example, SAHARA ([DIS0081](#)), Sightsavers ([DIS0050](#)) para 6.6, RESULTS UK ([DIS0021](#)) para 6.2 – 6.6, Global Campaign for Education ([DIS0022](#)) para 6.3, CBM ([DIS0034](#)), Leonard Cheshire Disability ([DIS0058](#)) para 3.18, Lumos ([DIS0029](#)) para 3.1, Inclusion International ([DIS0080](#)), Special Education Professionals ([DIS0070](#)) para 4, Africa Network Campaign on Education for All ([DIS0068](#))

177 Agreed note of informal meeting with ADD International Bangladesh, 8 January 2014, RESULTS UK ([DIS0021](#)) para 6.6. See also UNESCO, [Salamanca Statement and Framework on Special Needs Education](#), 1994: this framework strongly advocates inclusive education, but says that “owing to the particular communication needs of deaf and deaf/blind persons, their education may be more suitably provided in special schools or special classes and units in mainstream schools” (para 21).

178 Agreed minute of informal meeting with CBM India, 30 January 2014

179 Q39 [Ms Wapling], Q41 [Dr Miles – different approaches for educating deaf children]

180 Q162, DFID, [Guidance Note: Education for Children with Disabilities: Improving Access and Quality](#), 2007, pp 2, 4, 5

181 DFID, [Policy on Standards of Accessibility for Disabled People in DFID Financed Education Construction](#), 2014, p1

approach is not “one size fits all”: DFID’s recent guidance on school buildings does not capture these complexities, but we trust its forthcoming guidance on inclusive education will take a more nuanced approach.

Avoiding perverse incentives

61. DFID is making increasing use of payment by results, in sectors including education, to encourage programmes to increase their reach and effectiveness.¹⁸² We understand the reasons for this approach. However, there is a danger that it will, unintentionally, discourage staff from including disabled people, and instead prioritise the ‘low-hanging fruit’.¹⁸³ Some of DFID’s payment by results programmes include additional checks and balances to ensure disabled people are not left out (for example, the Girls’ Education Challenge), but this is not universal.¹⁸⁴ **We note that disaggregated reporting is particularly important in programmes that use payment by results, or else these may create perverse incentives not to include disabled people.**

Ensuring help reaches disabled people in emergencies

62. Disabled people (and, similarly, older people) face particular risks in emergencies. Recent research suggests only 20% of disabled people could evacuate without difficulty in the event of a disaster.¹⁸⁵ Even if disabled people manage to evacuate, they may be denied asylum in neighbouring countries on the grounds of their disability,¹⁸⁶ or may be unable to access shelters and refugee camps.¹⁸⁷

63. DFID works with a number of specialist NGOs to help target assistance to disabled people in emergencies. For example, it provided Handicap International with around £300,000 for work with ‘vulnerable’ groups—including disabled people—following Typhoon Haiyan in the Philippines.¹⁸⁸ During our recent visit to the Middle East, we saw first-hand an impressive rehabilitation programme for disabled people in the Zaatari refugee camp,¹⁸⁹ run by Handicap International with DFID support.

64. Witnesses praised DFID’s work with specialist disability NGOs in emergency settings¹⁹⁰—but said these agencies could not meet the needs of disabled people on their own.¹⁹¹ For example in the region of Syria, available evidence suggests the international response to

182 For example, linking education sector funding to the number of pupils completing a given level of education; or paying bursaries conditional on children attending school a certain number of days each week: DFID, [Education Position Paper: Improving Learning, Expanding Opportunities](#), 2013, pp 10, 11. See also [Payment by Results](#), 2013.

183 Q38 [Ms Wapling]

184 DFID Annex D ([DIS0092](#)) paras 7-11. For example, we have seen no evidence of checks and balances over the use of conditional bursaries in Pakistan.

185 Handicap International ([DIS0012](#)) para 2.5

186 UNICEF, [State of the World's Children 2013: Children with Disabilities](#), New York, p52

187 UN Enable, '[Disability, Natural Disasters and Emergencies](#)', accessed 28 March 2014

188 DFID ([DIS0054](#)) para 39

189 The largest camp for Syrian refugees, located in Jordan

190 Q63 [Mr Wainwright]

191 Handicap International ([DIS0012](#)) para 2.3, Women’s Refugee Commission ([DIS0061](#)) para 16

disabled refugees has been inconsistent.¹⁹² The accessibility of camps varies ; and there have also been difficulties in identifying disabled people’s needs outside of camps.¹⁹³ Aleema Shivji, UK Director of Handicap International, told us that many of the most crucial steps to reach disabled people did not require detailed specialist expertise, and could readily be carried out by ‘mainstream’ agencies with suitable training.¹⁹⁴ Such steps include:

- ensuring that disabled people participate in disaster preparedness work;¹⁹⁵
- gathering data on the locations of disabled people, and their needs;¹⁹⁶
- making simple modifications to refugee camp design;¹⁹⁷
- reaching out to disabled refugees who are not living in camps;¹⁹⁸
- working in partnership with local DPOs.¹⁹⁹

65. DFID has supported Handicap International to carry out some limited training of non-specialist agencies,²⁰⁰ and Ms Shivji said there would be scope to do this more widely, but “because there is no accountability around it, people do it if they have the sense that they want to, but there is not really a systematic coverage of it”.²⁰¹ As a major donor, DFID is in a strong position to push for more systematic coverage.²⁰² It has been working with the UN Office for the Coordination of Humanitarian Affairs (OCHA) to improve data on emergencies, and could build on this by requiring all its partner agencies to report data on the proportion of disabled people reached.²⁰³ Submissions also said there were

192 DFID Annex D ([DIS0092](#)) paras 20-22; see also Women’s Refugee Commission (New York), [Disability Inclusion in the Syrian Refugee Response in Lebanon](#), 2013, and [Unpacking Gender: the Humanitarian Response to the Syrian Refugee Crisis in Jordan](#), 2014, p13.

193 DFID Annex D ([DIS0092](#)) paras 20-22

194 Q57, 58, 61 [Ms Shivji]

195 CBM ([DIS0034](#)). See also Smith, Jolley and Schmidt, *Disability and Disasters: the Importance of an Inclusive Approach to Vulnerability and Social Capital*, paper submitted to the Global Thematic Consultation on Addressing Inequalities, 2012, p9.

196 Q59 [Ms Shivji]

197 Q62 and Q64 [Ms Shivji]

198 Q57 [Ms Shivji]

199 Sightsavers Annex B ([DIS0051](#)), Handicap International ([DIS0012](#)) para 2.8, CBM ([DIS0034](#)), Disasters Emergency Committee ([DIS0084](#)) recommendation 8. This should include host country DPOs in refugee situations (Women’s Refugee Commission, [DIS0061](#), paras 18-19).

200 For example, DFID, [‘Typhoon Haiyan: UK Disaster Response Update’](#), accessed 31 March 2014

201 Q62 [Ms Shivji]. See also Disasters Emergency Committee ([DIS0084](#)) para 7.

202 For example, the Independent Commission for Aid Impact recently reported that DFID was the largest donor to the crisis in the Philippines following Typhoon Haiyan ([Rapid Review of DFID’s Humanitarian Response to Typhoon Haiyan in the Philippines](#), 2014), and DFID is the second largest donor to the UN’s 2014 Syrian crisis appeals (UN Office For the Coordination of Humanitarian Affairs, [Funding to 2014 Response Plans](#), accessed 28 March 2014 – analysis excludes donations from EU).

203 DFID Annex D ([DIS0092](#)) paras 13-15, Q62 [Ms Shivji], Office for the Coordination of Humanitarian Affairs, [Humanitarian Response Indicators Registry](#), accessed 25 March 2014. Some of the indicators already include disaggregation by disability, others would need further development to allow meaningful reporting (for example, some do not distinguish between different excluded groups such as children, ethnic minorities and disabled people).

opportunities to reach more disabled people by creating central pools of expertise within the UN system,²⁰⁴ and by further strengthening the available guidance.²⁰⁵

66. We welcome DFID’s support for specialist agencies to help disabled people in recent emergencies. However, if DFID is to reach disabled people in need throughout its humanitarian work, it must also use its influence on UN agencies and large humanitarian NGOs. We recommend that, as a condition of funding, DFID should require all its humanitarian partners to say how they will reach disabled people, and to report the number of disabled people they have helped. To enable partners to reach more disabled people, DFID should increase its support for specialist organisations to provide training for non-specialists. We also recommend that DFID urge the UN to create a central pool of disability experts, similar to the current pool for gender; provide funds for the pool; and encourage other donors to do the same. In addition, we recommend DFID press the UN to endorse cross-sector guidelines on best practice for reaching disabled people in emergencies.

204 Age International Annex A ([DIS00104](#)), Women’s Refugee Commission ([DIS0061](#)) para 24: a similar system, called GenCap, is currently being developed for gender.

205 Women’s Refugee Commission ([DIS0061](#)) para 16. While some international guidance already exists (e.g. the [Sphere Project](#)), its use is voluntary.

6 Treatment and prevention of disabling conditions

67. As we noted earlier, disability is not a purely medical issue, but is instead characterised by discrimination towards disabled people. Most of this report therefore focuses on increasing disabled people's equal access to programmes across the whole of DFID's portfolio—rather than on treating or preventing medical conditions. Nonetheless, we received powerful evidence that – if DFID is to minimise the adverse impact of disability on development—it is essential to consider treatment and prevention issues too.

The impact of treatment and prevention programmes

68. For the purposes of this report, we use 'treatment' to cover a wide range of healthcare programmes that address disabling conditions—from surgery through to rehabilitation.²⁰⁶ The direct impacts of such treatment and prevention are powerful—whether surgery that restores sight, provision of artificial limbs that enable people to walk, or the administration of life-changing psychiatric therapy. As highlighted in a recent report by Save the Children, access to better basic healthcare at birth can prevent an entire lifetime of disability.²⁰⁷ Sometimes, treatment for disabling conditions can be a matter of life and death. One of our witnesses told us:

I became spinal-cord-injured in 2008. In a low-income country, I would most likely be dead by now, not because I needed life-saving surgery or anything, but because I needed catheters and I needed to avoid pressure sores. It is those very basic things from which many, many people die and which reduce life expectancy.²⁰⁸

69. Moreover, witnesses emphasised that besides its direct health benefits, treatment of disabling conditions also has important indirect impacts. It can enable people to access other rights such as education, and to participate more fully in their communities.²⁰⁹ One submission described the benefits of a rehabilitation programme providing mobility devices:

When I am on my tricycle, I don't feel at all like a disabled person. This tricycle makes me forget my disability. It is my aeroplane that flies me to every destination.²¹⁰

Access to community-based rehabilitation and care services can also save children from being placed in institutions, which, as evidence from Lumos highlighted, can have devastating consequences for their safety and long-term psychological well-being.²¹¹

206 In this report, we use 'rehabilitation' to mean measures that help people with impairments to "achieve and maintain optimal functioning in interaction with their environments" (*World Report on Disability*). Examples include advice on self-care; and the provision of assistive devices such as wheelchairs and hearing aids.

207 Save the Children, [Surviving the First Day: State of the World's Mothers](#), 2013

208 Q86 [Dr Shakespeare]

209 For example, Nepal National Association of Service Providers of Physical Rehabilitation ([DIS0016](#)) para 2, AbleChild Africa ([DIS0026](#)) para 2.3.2, Motivation ([DIS0017](#)) paras 2,4,5,6,10, David Constantine MBE ([DIS0087](#)), BasicNeeds ([DIS0064](#)) para 3.1

210 Motivation ([DIS0017](#)) para 6

70. For people with mental health problems, treatment can sometimes make the difference between freedom and imprisonment. On our visit to Burma, we saw first-hand how a family had resorted to tying up their son, who had a mental health problem, to stop him harming himself. In Indonesia alone, a recent estimate suggested that 18,000 people with mental health problems are kept in chains.²¹²

71. In addition, treatment and prevention of disabling conditions can have an indirect economic impact. For example, a recent study for the World Economic Forum suggested the global economy would lose \$16 trillion due to mental illness over the next 20 years.²¹³ . By preventing or treating disabling conditions, donors can achieve substantial development gains: for instance, research in India estimated every \$1 spent in treating Neglected Tropical Diseases (Box 5) yields a return of \$20 to \$30.²¹⁴

Box 5 Two Significant Causes of Disability: Neglected Tropical Diseases and Non-Communicable Diseases

Neglected Tropical Diseases (NTDs) are a group of infectious conditions that thrive in hot, humid conditions. Examples causing disability include:

- Trachoma—causes blindness
- Leishmaniasis—an infection transmitted by sandflies that causes death or disfigurement
- Lymphatic Filariasis—causes severe, disabling, swelling of lower parts of the body
- Schistosomiasis—causes learning difficulties in children, and ultimately also organ damage
- Soil transmitted helminths—can lead to chronic weakness and to intellectual disability²¹⁵

Non-Communicable Diseases (NCDs) comprise:²¹⁶

- Cancer
- Cardiovascular condition
- Diabetes
- Chronic respiratory conditions

Non-Communicable Diseases frequently lead to disability: for example, it is thought that one person undergoes an amputation every 20 seconds due to diabetes.²¹⁷

Unmet need for treatment and prevention

72. Our evidence showed that, in developing countries, treatment and prevention for many disabling conditions is extremely scarce: Table 3 illustrates the scale of unmet need, and Figure 1 shows, in particular, the shortage of funding for mental health care in low income countries.

211 It is estimated that 8 million children worldwide live in some form of institution. The risks include impaired brain development, mental health problems, and abuse: Lumos ([DIS0029](#)) paras 1.3, 2.2.1, 4.3.

212 Centre for Global Mental Health ([DIS0052](#)) para 2.1.2

213 World Economic Forum and Harvard School of Public Health, [The Global Burden of Non-Communicable Diseases](#), Geneva, 2011, p29

214 Chu BK and colleagues, [The Economic Benefits Resulting from the First Eight Years of the Global Programme to Eliminate Lymphatic Filariasis \(2000-2007\)](#), PLOS Neglected Tropical Diseases, 2010.

215 UK Coalition against Neglected Tropical Diseases, *Annual Report 2012*, pp 9-10

216 World Health Organisation, [Global status report on noncommunicable diseases 2010](#), Geneva

217 Q78 [Ms Shivji]. See also Age International Annex A ([DIS00104](#)).

Table 3 Treatment and prevention of disabling conditions – unmet needs

Rehabilitation	<ul style="list-style-type: none"> - 70 million people worldwide need a wheelchair: only 5—15% have access to one.²¹⁸ - Less than 3% of the hearing aid needs in developing countries are met annually (estimated by hearing aid producers)²¹⁹ - In many low-income countries, there is statistically less than one physiotherapist for the entire population.²²⁰
Mental health care	<ul style="list-style-type: none"> - Funding for mental health services in developing countries is extremely limited (Figure 1) - Only around 10% of people with mental health problems in low and middle income countries receive the treatment they need: in Nigeria the figure is as low as 2%.²²¹
Dementia	<ul style="list-style-type: none"> - It is estimated that 135 million people will be living with dementia by 2050—70% of them in developing countries.²²² The scale of the problem is such that the Prime Minister has called for it to be “at the heart of the development agenda”.²²³ - The unmet need for care is hard to quantify, but is likely to be particularly acute in low and middle income settings.²²⁴
Neglected Tropical Diseases	<ul style="list-style-type: none"> - The proportion of people receiving the medical assistance they need is very low for most NTDs—e.g. only around 13% for trachoma²²⁵ - Interventions tend to focus on disease prevention rather than treatment—yet treatment can stop people being disabled for life.²²⁶
Non-Communicable Diseases	<ul style="list-style-type: none"> - NCDs account for over 10% of all years lived with disability in low-income countries.²²⁷ - The <i>Global Status Report on NCDs</i> found a third of low-income countries have no funding for NCD prevention and control.²²⁸
Neonatal health care	<ul style="list-style-type: none"> - Over 2% of years lived with disability in low-income countries are due to neo-natal conditions.²²⁹ - The presence of a skilled attendant substantially reduces the risk of death and disabling conditions for newborns, yet every year, 40 million women give birth without a skilled attendant, and 2 million give birth completely alone.²³⁰

218 World Health Organisation, '[Governments to agree increased focus on people with disabilities in development strategies](#)', 20 September 2013, accessed 28 March 2014

219 World Health Organisation/World Bank, *World Report on Disability*, Geneva, 2011, p102

220 Q88 [Dr Shakespeare]

221 Q86 [Prof Thornicroft]

222 Alzheimer's Society and Alzheimer's Disease International ([DIS0035](#)) para 2.1

223 Alzheimer's Society and Alzheimer's Disease International ([DIS0035](#)) para 3

224 World Health Organisation and Alzheimer's Disease International, [Dementia: A Public Health Priority](#), 2012, Geneva, pp 39, 50, 52, 55, 56

225 UK Coalition against Neglected Tropical Diseases, *Annual Report 2012*, pp 9-10

226 [NTDs: Disease Control is about Much More than Drugs](#), The Guardian, 9 January 2014.

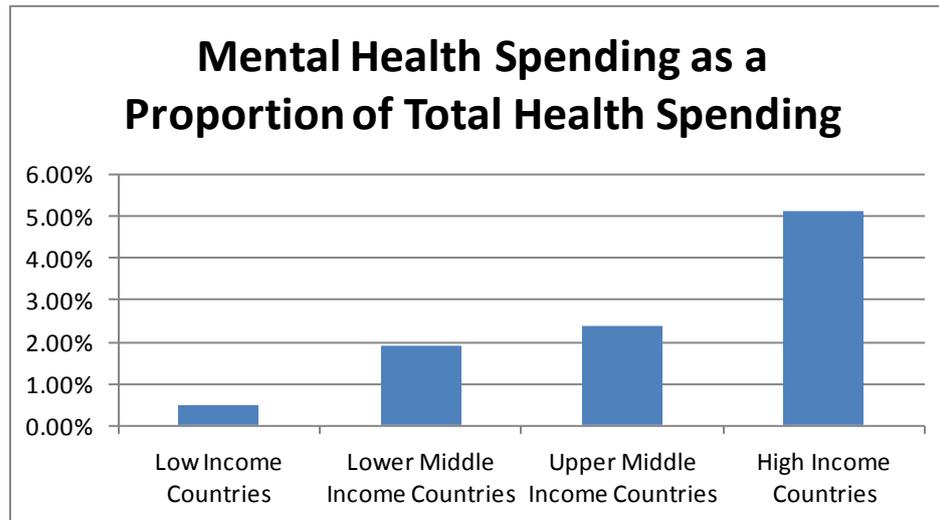
227 World Health Organisation, '[Regional Estimates for 2000-2011](#)', *YLL Estimates: World Bank Income Groups*, accessed 29 March 2014

228 World Health Organisation, [Global Status Report on Non-Communicable Diseases 2010](#), Geneva, p73

229 World Health Organisation, '[Regional Estimates for 2000-2011](#)', *YLL Estimates: World Bank Income Groups*, accessed 1 April 2014

230 Save the Children, [Surviving the First Day: State of the World's Mothers](#), 2013, p40.

Figure 1: Mental Health Spending Variations



Source World Health Organisation, [Investing in Mental Health: Evidence for Action](#), Geneva, 2013, p.15

Cost-effectiveness of treatment and prevention

73. An emerging evidence base suggests many treatment and prevention measures meet international cost-effectiveness benchmarks. Commonly, treatments are considered very cost-effective if the cost for an extra year of healthy life is less than the average annual per capita Gross Domestic Product of the country in question (this is broadly similar to the approach that NICE uses in the UK).²³¹ The following measures all fall comfortably within this threshold:

- Many responses to Neglected Tropical Diseases—these are often extremely inexpensive (some cost just a few pounds per healthy year saved)²³²
- Treatment and rehabilitation for deaf people (e.g. treating ear infections; screening and providing hearing aids)²³³
- Surgery for trachoma and cataracts, provision of spectacles for people with refractive errors²³⁴
- Treatment for epilepsy and depression²³⁵
- A range of measures to tackle cancer and cardiovascular disease²³⁶

231 D Chisholm and colleagues, [What are the Priorities for the Prevention and Control of Non-Communicable Diseases and Injuries in Sub-Saharan Africa and South-East Asia](#), British Medical Journal 2012;344:e586.

232 World Health Organisation, [Working to Overcome the Impact of Neglected Tropical Diseases: First WHO Report on Neglected Tropical Diseases](#), Geneva, 2010, p18 18

233 D Chisholm and colleagues, [What are the Priorities for the Prevention and Control of Non-Communicable Diseases and Injuries in Sub-Saharan Africa and South-East Asia](#), British Medical Journal 2012;344:e586.

234 As above

235 As above

236 As above

- A range of interventions to improve newborn health, for example, the presence of skilled birth attendants.²³⁷

74. Less data exists for some treatment and prevention measures—in particular, we have not seen any detailed analysis on the cost-effectiveness of wheelchair provision, or of basic care for conditions such as spinal cord injuries. However, anecdotal evidence to the inquiry repeatedly indicated such measures could often achieve substantial impacts for very low costs.²³⁸ This is particularly true of community-based rehabilitation, which our witnesses said can be a low-cost way to reach large numbers of people in remote locations, especially when integrated in wider work to strengthen health systems.²³⁹ One witness told us of a community based rehabilitation programme that had halved the mortality rate for children with spina bifida in one area of Uganda.²⁴⁰ Electronic technologies increasingly offer another route to reach many people relatively cheaply.²⁴¹

75. There may also be opportunities for DFID to secure improvements in cost-effectiveness—particularly in the case of assistive devices such as wheelchairs and hearing aids. International guidance such as the WHO’s *Guidelines on the Provision of Manual Wheelchairs in Less Resourced Settings*—suggests several ways to obtain such devices at low cost. One is to develop local production capacity. Another is to buy in bulk—although it is important to ensure that the devices are suitable for the local context; accompanied with facilities for training and repair; and procured as part of a sustainable plan for strengthening rehabilitation services in-country, including local production.²⁴² USAID is already working to provide more assistive devices, so there may be opportunities to join forces.²⁴³ When we questioned the Minister about opportunities to buy in bulk, she countered that manufacturers might be willing to offer devices free in order to develop overseas markets.²⁴⁴ However we are sceptical that this will happen quickly, widely, or sustainably, enough to meet the scale of global demand.

DFID’s current treatment and prevention work

76. **DFID is already taking some welcome steps to help treat or prevent the conditions that cause disability.** This includes:

- **Rehabilitation:** funding a diverse range of programmes, e.g. the International Committee of the Red Cross (rehabilitation in conflict settings); Motivation (mobility impairments); Sightsavers and Vision Aid (visual impairments); Interburns; and

237 T Adam and Colleagues, [Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries](#), *BMJ*, 2005;331:1107.

238 Q100 [Dr Shakespeare]

239 Q100 [Dr Shakespeare and Prof Groce]. Integration in wider community health systems both helps ensure sustainability [Prof Groce] and helps reduce stigma (agreed minute of informal meeting with the Centre for Global Mental Health)

240 Q95 [Dr Shakespeare]

241 WHO/World Bank, *World Report on Disability*, Geneva, 2011, pp1 18-119

242 WHO, [Guidelines on the Provision of Manual Wheelchairs in Less Resourced Settings](#), Geneva, 2008, pp 40, 45, 117, 120. WHO/World Bank, *World Report on Disability*, Geneva, 2011, para 117-118. See also Soundseekers Annex A ([DIS0107](#)) for similar considerations with respect to hearing aids.

243 USAID ([DIS0088](#)) para 9

244 Q191

Healthprom (early years care for a variety of disabilities, in order to reduce institutionalisation).²⁴⁵

- **Mental health treatment**—primarily through two innovative programmes:
 - The PRIME research programme, which aims to put cost-effective treatments into practice, in partnership with ministries of health in South Africa, Uganda, Ethiopia, India and Nepal.²⁴⁶ The programme budget is £6 million over six years.²⁴⁷
 - Support to the NGO BasicNeeds in Ghana and India. The programme encompasses treatment, access to basic services, and empowerment. The programme budget is around £2.5 million over 7 years (Ghana) and £500,000 over 4 years (India).²⁴⁸ DFID is also funding the Ghanaian Government to strengthen mental health services.²⁴⁹

DFID stands out as one of the only international donors to work on mental health.²⁵⁰

- **Prevention.** These programmes include a £50 million programme to tackle blinding trachoma (2012-2018), and a £31 million programme to eliminate lymphatic filariasis (2009-2017).²⁵¹ More widely, many of DFID's healthcare programmes contribute to disability prevention, among other objectives—for example, its maternal health programmes reduce the risk of conditions such as fistula;²⁵² its neonatal health work helps prevent disabilities resulting from complications at birth; and it is working to eradicate or control several conditions such as polio, measles, and rubella that cause both death and disability.²⁵³
- **Health system strengthening**—this aims, among other goals, to help partner countries prevent the onset of Non-Communicable Diseases.²⁵⁴

77. These programmes are valuable—but they represent a very small share of DFID's overall health budget. For example, DFID's evidence to the inquiry suggests it spends less than 1% of its total budget on Neglected Tropical Diseases, and less still on mental health.²⁵⁵ In addition, the geographic coverage of DFID's mental health work is limited: a

245 DFID ([DIS0054](#)) para 41, DFID Annex B ([DIS0071](#))

246 Centre for Global Mental Health

247 DFID ([DIS0054](#)) para 44, DFID Annex B ([DIS0071](#))

248 DFID Annex B ([DIS0071](#)), Basic Needs ([DIS0064](#)) paras 2.1, 3.1 and 3.3. DFID also supports some smaller mental health programmes, for example a £76,000 programme with a local civil society organisation in Ghana (see for example DFID Annex B, [DIS0071](#)).

249 DFID, '[Ghana Health Sector Support Programme 2012-2018](#)', accessed 25 March 2014

250 Agreed minute of informal meeting with Jagannath Lamichhane and Dr Mary de Silva, 30 January 2014

251 DFID Annex B ([DIS0071](#))

252 A hole in the birth canal which, if untreated, leads to severe discomfort and often intense stigma and isolation.

253 DFID ([DIS0054](#)) para 36, DFID Annex B ([DIS0071](#)), DFID, '[Development Tracker: Population Policies/Programmes and Reproductive Health](#)', accessed 1 April 2014.

254 DFID [Health Position Paper: Delivering Health Results](#), 2013, p20

255 DFID Annex B ([DIS0071](#)), 213-14 data. Total health budget taken from DFID's [Development Tracker - Aid by Sector](#), accessed 26 March 2014 [final 2013-14 result may change as additional health funding is allocated, but this is unlikely to be material]. Save the Children also highlight that, while DFID's spending on maternal, newborn and reproductive health is substantial, only a small proportion of this funding is devoted to newborn care ([Surviving the First Day: State of the World's Mothers](#), 2013, p53).

mental health service users' group from Kenya wrote to us highlighting the shortage of international support for mental health in their country.²⁵⁶

DFID's approach to prioritising its health portfolio

78. Even when interventions meet international cost-effectiveness standards, DFID cannot fund them all, and must make tough choices. DFID last undertook a full review of its health portfolio in 2009, and made further revisions as part of the Bilateral Aid review in 2011. These reviews worked on a country-by-country basis, and took into account factors such as the following:²⁵⁷

- International guidelines on the cost-effectiveness of different interventions in low-resourced settings, primarily the World Health Organisation's CHOICE guidelines.²⁵⁸
- The Millennium Development Goals, which place particular emphasis on nutrition (MDG 1), maternal and neo-natal health (MDG 4 and 5), and HIV/AIDS, malaria and TB (MDG 6).
- The priorities of country governments.
- The work of other donors.

79. **We are pleased that, in choosing how to spend its health budget, DFID takes into account a range of important factors, particularly international guidelines on cost-effectiveness. However, we are concerned that DFID's approach to health spending may under-state the importance of treating and preventing the conditions that lead to disability.** A full review of DFID's approach to prioritising health programmes is outside the scope of this report, but we have a number of specific concerns:

- International cost-effectiveness guidelines focus on health outcomes. They do not consider broader impacts, for example on an individual's human rights and access to services.²⁵⁹ In the case of disabling conditions, these impacts are often particularly severe (Table 1, Box 3, paragraphs 7, 11, 69, 70)
- International cost-effectiveness guidelines focus on specific conditions in isolation. They do not allow for the fact that disabling conditions tend to lead to further health complications—for example, people suffering from Neglected Tropical Diseases

256 Users and Survivors of Psychiatry in Kenya ([DIS0078](#)) paras 2, 5, 8

257 DFID Annex D ([DIS0092](#)) paras 26 and 27, DFID [Health Portfolio Review Report 2009](#), p 6,7,16,17,18,30. DFID Bilateral Aid Review in Health guidance: [How to Estimate the Costs and Benefits of Health Related Activities](#), p 1,2,5.

258 CHOosing Interventions that are Cost Effective, '[WHO-CHOICE](#)', accessed 29 March 2014. 258. The CHOICE guidelines' message on measures to treat and prevent disability is complex. While many such treatment and prevention measures fall within the CHOICE cost-effectiveness threshold, fewer make the list of *very* best buys: for instance, treatments for conditions such as mental health and non-communicable diseases tend often to be more expensive than those for some common infectious diseases.

259 D Chisholm and colleagues, [What are the Priorities for the Prevention and Control of Non-Communicable Diseases and Injuries in Sub-Saharan Africa and South-East Asia](#), British Medical Journal 2012;344:e586.

(NTDs), Non-Communicable Diseases (NCDs), or HIV/AIDS are more likely to develop mental health problems—and vice versa.²⁶⁰

- Experts have pointed out a number of technical difficulties in the definition of the cost of an additional year of healthy life, in practice, are likely to undervalue interventions that tackle disability.²⁶¹
- Cost-effectiveness data is only available for a limited number of conditions, which risks skewing the analysis: for example, the WHO's CHOICE guidelines do not cover the effectiveness of some forms of rehabilitation (e.g. provision of wheelchairs or basic care); of most types of NTD prevention; or of ways to manage dementia.²⁶²

80. We recommend DFID issue a guidance note to clarify that, in making difficult decisions on health spending, it is important to look beyond narrow measures of cost-effectiveness. The value of programmes that treat and prevent disabling conditions lies not only in their medical impact, but also in their ability to increase people's opportunities and potentially lift them out of poverty. While we were not in a position to do a full cost-benefit analysis of DFID's health programmes, we have seen some persuasive evidence that DFID should increase its spending on disability treatment and prevention. **We recommend DFID thoroughly appraise the case for spending more in the following areas. If DFID decides not to increase its spending, it should explain its reasons to the Committee.**

- **Mental health care**
- **Rehabilitation and basic care, e.g. for people with spinal cord injuries**
- **Provision of assistive devices, potentially joining forces with USAID or other major donors to buy in bulk**
- **Neglected Tropical Diseases**
- **Non-Communicable Diseases**
- **Newborn Health**

We also recommend DFID gather detailed data on the cost and impact of all its treatment and prevention work, so as to improve the international evidence base on cost-effectiveness.

81. Specifically on dementia, DFID told us that it was awaiting guidance from the Department of Health—the lead department—before embarking on further programming.²⁶³ The evidence base on dementia is less extensive than for some other

260 *NTDs: disease control is about much more than drugs*, The Guardian, 9 January 2014; Kolappa and colleagues, [No Physical Health without Mental Health: Lessons Unlearned?](#), Bulletin of the World Health Organization 2013;91:3-3A; World Health Organisation Executive Board, [HIV/AIDS and Mental Health: Report by the Secretariat](#), 2008.

261 Arnesen and Nord, [The Value of DALY Life: Problems with Ethics and Validity of Disability Adjusted Life Years](#), British Medical Journal 1999, 319:1423. For example, some versions of the calculation give less weight to conditions affecting older people.

262 CHOosing Interventions that are Cost Effective, '[WHO-CHOICE](#)', accessed 29 March 2014

263 Q190

causes of disability, but the submission from Alzheimer’s International pointed to several steps that the UK could already take—funding research; building developing countries’ capacity to respond to dementia; and tackling stigma.²⁶⁴ **Dementia is a growing cause of disability in developing countries, and the Prime Minister has called for it to be “at the heart of the development agenda”:**²⁶⁵ **we urge DFID and the Department of Health to update the Committee on their plans to accomplish this.**

Preventative measures outside the health sector

82. Causes of disabling injuries are extremely diverse,²⁶⁶ and a complete assessment was outside the scope of this inquiry. Nonetheless, we did receive evidence on some common causes of disabling injuries, and steps that DFID can take to help prevent them.

Road safety

83. Road traffic accidents leave tens of millions of people injured or disabled every year.²⁶⁷ Safely designed roads, with footpaths, cycle lanes, and safe crossings, not only help prevent disability, but also make access easier for road users who are already disabled. Our 2011 report, *DFID’s Role in Building Infrastructure in Developing Countries*, found that:

The multilateral development banks are responsible for the overwhelming majority of donor-funded road-building projects in developing countries. MDB-funded roads should be designed with safety as a paramount concern. DFID should work harder to ensure that road safety design is an essential part of the multilateral road-building projects it funds. We agree with the Global Road Safety Partnership that, when making decisions to invest in infrastructure, DFID should make a life-cycle risk analysis of the expected road crash death and injury scenarios that can be expected, and then require stipulations to be put in place to manage these risks as part of the funding packages.²⁶⁸

Our report also recommended that DFID reinstate a pledge to provide £1.5 million funding to the Global Road Safety Facility (GRSF).²⁶⁹

84. In response to our report, DFID reinstated its donation to the GRSF. It says it has used its position as a GRSF board member to press for a greater emphasis on road safety in World Bank programmes, and those of other multilateral development banks. DFID says the World Bank has recently approved a policy that it will only approve lending to programmes that address road safety.²⁷⁰ **We welcome DFID’s response to the recommendations on road safety in our 2011 report on DFID’s Role in Building**

264 Alzheimer’s Disease International ([DIS0035](#)) paras 4.1, 4.2, 4.6, 4.8

265 Alzheimer’s Society and Alzheimer’s Disease International ([DIS0035](#)) para 3

266 See for example WHO, [Violence and Injury: the Facts](#), p 3 for common causes of injuries.

267 WHO, [‘Violence and Injury Prevention: Road Traffic Injuries’](#), accessed 30 March 2014

268 International Development Committee, Ninth Report of Session 2010-12, [DFID’s Role in Building Infrastructure in Developing Countries](#) HC 848-I, para 79

269 As above, para 80

270 DFID Annex D ([DIS0092](#)) para 28

Infrastructure in Developing Countries. We also welcome the news that the World Bank will only approve loans to programmes that address road safety. DFID should keep up the pressure on the World Bank to meet its road safety commitments, requiring that all new programmes are supported by a full life-cycle risk analysis, and by monitoring mechanisms to ensure risks are successfully mitigated. We also recommend that it require other multilateral development partners—including development banks and the European Union— to introduce similar road safety policies, as a condition of future UK funding.

Armed violence

85. Handicap International’s submission draws attention to the large number of disabilities that result from armed violence: it reports that an estimated two million people live with firearms injuries sustained in non-conflict settings over the past decade.²⁷¹ The World Health Organisation says that some groups at risk of violence receive little attention from donors—for example, young men are particularly at risk of armed violence; and violence against older people also tends to be neglected (1 in 20 older people suffer abuse).²⁷² **Given the links between armed violence and disability, we welcome DFID’s research programme on urban violence in developing countries—the Safe and Inclusive Cities programme (£4.5 million, 2012-2017).**²⁷³ We recommend DFID develop further programmes to tackle armed violence, and target all groups at risk of violence, including young men and older people.

271 Handicap International ([DIS0012](#)) para 3.2. See also World Vision ([DIS0023](#)) para 20.

272 WHO, [Preventing Violence and Reducing its Impact: How Development Agencies Can Help](#), Geneva, 2008, p25

273 DFID [Development Tracker - Safe and Inclusive Cities](#), accessed 26 March 2014

7 Influencing partners' commitment to disability

DFID's Partners

Multilateral agencies

86. DFID spends over 50% of its budget through multilateral agencies.²⁷⁴ As a substantial donor, it is well placed to influence the agencies' policies on disability. The evidence we have gathered paints a mixed picture of multilateral agency performance. There have been some positive steps. For example, UNICEF, the WHO and the World Bank have done some leading work to collate and improve disability data.²⁷⁵ The World Bank sponsors the Global Partnership on Disability and Development, which helps donors share knowledge and collaborate on disability.²⁷⁶ However, several of our witnesses said multilaterals' performance was inconsistent.²⁷⁷ Recent reports from Uganda and the Philippines suggest World Bank programmes have sometimes missed easy opportunities to include disabled people, such as building a ramp up to a water borehole.²⁷⁸

87. Our witnesses said DFID could play a "critical role"²⁷⁹ in making multilateral agencies' development work more accessible to disabled people:

If someone as big as DFID says, "You have to have something linked to disability, you have to report on it and it has to be reportable," so it has to be something that they are held accountable to, you put that in and they have to do something about it. There are people within these agencies who are desperate for those kinds of conditions to be added, because it would enable them to work within their own agencies to improve things. I have requests saying, "If there could be more conditionality linked with disability, we would be really happy."²⁸⁰

In addition, the World Bank—one of the multilateral agencies to which DFID contributes most²⁸¹—is currently reviewing its development policies.²⁸² The Bank looks likely to

274 NAO, [Briefing to Support the International Development Committee's Inquiry into the Department for International Development's Annual Report and Accounts 2012-13](#), p6 [multilateral aid + bilateral support delivered through multilateral organisations]. Multilateral agencies include the World Bank and other international financial institutions; the European Union; UN agencies; global funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the International Committee of the Red Cross.

275 For example, the *World Report on Disability* (WHO/World Bank 2011), and [State of the World's Children 2013: Children with Disabilities](#) (UNICEF). See also World Bank Group ([DIS0048](#)) para 4.

276 World Bank Group ([DIS0048](#)) para 6

277 Q44 [Mr McMullan], Q48 [Ms Shivji], Q52 [Mr Wainwright]

278 Ngirabakunzi and Malinga, [The Impact of NUSAF II in the Lives of Persons with Disabilities in Northern Uganda](#), 2013; Life Haven, Inc. ([DIS0007](#)) and Benjamin S Bernardino ([DIS0008](#))

279 Q44 [Mr McMullan]

280 Q44 [Ms Wapling]

281 NAO, [Briefing to Support the International Development Committee's Inquiry into the Department for International Development's Annual Report and Accounts 2012-13](#), p 7

282 Q54 [Mr Wainwright]. This review includes, among other elements, a review of the Bank's Safeguard policies, which aim to avoid unintended adverse consequences for at risk groups ([Review and Update of the World Bank Safeguard Policies](#); accessed 30 March 2014).

introduce some new checks on disability—a very encouraging step: but it is unclear how far-reaching they will be.²⁸³ This is therefore a good time for DFID to exert its influence.

88. DFID spends more than half of its budget through multilateral agencies. It should exert its substantial influence to ensure this budget is accessible to disabled people. We recommend that DFID require its multilateral partners to demonstrate that they are reaching disabled people, by reporting disaggregated data: the current policy review at the World Bank provides one good opportunity to do this. When DFID conducts its 2015 Multilateral Aid Review, we recommend it include criteria on disability. DFID should also require its partners to show how disabled people—including DPOs and disabled parliamentarians—are participating in programming, from design through to evaluation.

89. As well as its influence on multilateral partners' own development programmes, DFID also has an influence on their wider work—including two areas with particularly profound effects for disabled people: Poverty Reduction Strategy Papers, and trade policy.

Poverty Reduction Strategy Papers

90. Poverty Reduction Strategy Papers (PRSPs) set out a country's priorities for development, typically over a three year period. They are drafted by the country, with input from the World Bank, International Monetary Fund and other donors.²⁸⁴ Poverty Reduction Strategy Papers have a material impact on the allocation of development funds²⁸⁵—yet a number of submissions have raised concerns that PRSPs place little emphasis on the rights of disabled people.²⁸⁶ We reviewed the most recent PRSPs for DFID focus countries, and found that, while most mentioned some plans for disabled people's access, few considered their rights across all sectors, and there was little evidence that access would be systematically monitored as it is for gender.²⁸⁷ **We recognise that the PRSP process is led by country governments. However, we would expect the World Bank to discuss with governments how they plan, through their PRSP, to meet their obligations under the UN Convention for the Rights of Persons with Disabilities. DFID should press the World Bank to do so. DPOs participate in PRSP process, and we recommend DFID help them to do this, for example by providing economics training, by sharing relevant research on disability and poverty, or by advising on effective monitoring techniques to ensure that any PRSP commitments on disability are duly translated into practice.**

283 Q54 [Mr Wainwright]

284 International Monetary Fund, '[Poverty Reduction Strategy Papers](#)', accessed 30 March 2014

285 See for example, Organisation for Economic Cooperation and Development Assistance Committee [Guidelines on Poverty Reduction](#) Paris, 2001, pp 13-14; World Bank, '[Country Assistance Strategies](#)', accessed 30 March 2014; European Commission, [Support to Sector Programmes](#), Brussels, 2007 pp 20-21.

286 Equal Lives ([DIS0001](#)) para 5.6, Disability Rights Fund ([DIS0091](#)) para 2, Inclusion International ([DIS0080](#))

287 We reviewed the most recent available plans for Afghanistan, Bangladesh, Democratic Republic of Congo (DRC), Ethiopia, Ghana, Kenya, the Kyrgyz Republic, Liberia, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Sierra Leone, Sudan, Tajikistan, Tanzania, Uganda, Yemen and Zambia. Approaches to disability varied significantly, from Zambia – with an extensive plan covering all sectors – to the DRC, which only includes one reference to disabled people, as part of a long list of vulnerable groups. (Source: IMF, '[Poverty Reduction Strategy Papers](#)', accessed March 2014.

EU Trade Policies

91. STOPAIDS' submission to the inquiry drew attention to two proposed new EU trade agreements that could set back progress on access to low-cost Anti-Retroviral Therapy (ART) for HIV/AIDS.²⁸⁸ **HIV/AIDS is closely associated with conditions that cause disability.** The virus can lead to a range of disabling conditions, and so can the side-effects of treatment.²⁸⁹ HIV/AIDS can also lead to mental illness.²⁹⁰ Furthermore, the average age of people with HIV/AIDS is increasing, which heightens the risk of disability, since older people have weaker immune systems, and are more prone to other illnesses that can compound the effects of HIV/AIDS.²⁹¹ **This makes the provision of affordable Anti-Retroviral Therapy (ART) all the more urgent. We recommend that, in any forthcoming trade negotiations, the UK press the EU to retain existing flexibilities that facilitate the production of affordable generic ART.**

Partner governments

92. DFID delivers a substantial portion of its bilateral assistance through direct budget support²⁹² to partner governments: this amounted to around 10% of its bilateral aid in 2012-13.²⁹³ Most²⁹⁴ DFID partner governments have ratified the UN Convention on the Rights of Persons with Disabilities. However, implementation is slow, for example:

- Submissions from DPOs in developing countries reported their governments had problems implementing commitments on employment quotas; literacy; and healthcare.²⁹⁵
- Experts in mental health from developing countries highlighted the persistence of laws that deprive people of their rights to vote, and even potentially of their freedom, if they have mental health problems.²⁹⁶

This puts DFID in a difficult position: on the one hand, it needs assurance that its funding is reaching disabled people and that governments are respecting their rights. But on the

288 The EU-India Free Trade Agreement, and the EU-Thailand Free Trade Agreement. STOPAIDS ([DIS0032](#)); STOPAIDS '[Access to Medicines](#)', accessed 30 March 2014, STOPAIDS Annex A ([DIS0103](#)).

289 WHO, [Disability and HIV Policy Brief](#), Geneva, 2009

290 WHO Executive Board, [HIV/AIDS and Mental Health: Report by the Secretariat](#), Geneva, 2008.

291 UNAIDS, [HIV and Aging](#), New York, 2013

292 Direct funding to a partner government's exchequer, in support of its poverty reduction programmes.

293 NAO, [Briefing to Support the International Development Committee's Inquiry into the Department for International Development's Annual Report and Accounts 2012-13](#), p 6

294 22 countries out of 27 that could have signed (source: UN, '[Convention and Optional Protocol Signatories and Ratifications](#)', accessed 30 March 2014).

295 For example, Accessibility Organisation of Afghan Disabled ([DIS0069](#)), Action to the Community Development Center ([DIS0109](#)) para 8, Quality of Life Association ([DIS0049](#)) para 2.4. On literacy and healthcare, see also Children's Book Project Tanzania ([DIS0067](#)) Executive Summary and para 5, Nepal National Association of Service Providers of Rehabilitation ([DIS0016](#)) para 3

296 Pan African Network of People with Psychosocial Disabilities ([DIS0096](#)), Mental Health Society of Ghana ([DIS0095](#)). See also Users and Survivors of Psychiatry Kenya ([DIS0078](#)) 10.b.vi.

other hand, one of the main principles of budget support is that donors should not impose their priorities on recipient countries.²⁹⁷

93. We explored this dilemma with our witnesses. One commented that—in light of the slow progress that partners had made—this might be a special case for “positive conditionality”.²⁹⁸ We put this to Lynne Featherstone MP, but she responded that conditionality was unlikely to achieve sustainable progress—this required genuine buy-in from the partner government; moreover, there was a risk that conditions could be perceived as creating a “master-servant relationship”.²⁹⁹

94. On balance, we are persuaded by the Minister’s arguments on sustainability and unequal relationships. Nonetheless, we think DFID should be engaging more actively with partner governments, to press for disabled people’s rights. Currently, DFID’s main approach is to support DPOs. DPOs are widely recognised as powerful advocates for disability rights³⁰⁰—but several sources emphasised that DFID had responsibilities too: as the Global Campaign for Education puts it,

Donors have the right—indeed the duty—to discuss disability rights obligations with developing country governments (and vice-versa). This has nothing to do with imposing an agenda on weaker countries, or deviating from the principle of country ownership.³⁰¹

95. The evidence suggested a range of approaches for DFID, and the rest of the UK Government, to take:

- There would be scope for greater dialogue with partner governments and ministries on disability rights issues. In particular DFID could offer **capacity building support** in key areas such as data collection and governance.³⁰² More specifically, some evidence highlighted that in many countries, the social protection ministry is responsible for disabled people’s affairs: this an obstacle to implementing disability-inclusive policies across other portfolios such as education and health.³⁰³ There might therefore be an opportunity for the UK to share its experience ‘mainstreaming’ disability across multiple ministries.³⁰⁴

297 DFID, [Partnerships for Poverty Reduction: Rethinking Conditionality](#), 2005, paras 2.2 and 2.3

298 Q53 [Ms Frost]. See also Equal Lives ([DIS0001](#)) para 5.4

299 Q 176

300 For example, VSO ([DIS0066](#)) para 10, ADD International ([DIS0027](#)) para 4.1, Norwegian Association of Disabled ([DIS0024](#)) para 1.

301 Global Campaign for Education Annex A ([DIS0101](#))

302 Q122 [Ms Mohammed], Sightsavers ([DIS0050](#)) para 2, Sightsavers Annex C ([DIS0051](#)), Norwegian Association of Disabled ([DIS0024](#)) para 4.1, Inclusion International ([DIS0080](#)). See also Leonard Cheshire Disability Annex B ([DIS0079](#)) para 3.6.

303 Q5 [Ms Abu Alghaib], Nepal National Association of Service Providers in Physical Rehabilitation ([DIS0016](#)) para 3. See also Sense International ([DIS0057](#)) para 5.8

304 Q44 [Dr Miles]: until the 1970s, the education of children with intellectual disabilities was handled by the Department of Health.

- The Foreign and Commonwealth Office (FCO) leads the UK's work on human rights. It should make disabled people's rights a **key message for travelling ministers**, as it has done for gender and LGBT rights.³⁰⁵
- The UN has recently launched a fund to support countries in implementing the Convention—the **UN Partnership to Promote the Rights of Persons with Disabilities**.³⁰⁶ DFID is considering supporting the Partnership, but has not yet made a decision.³⁰⁷

96. **Many DFID partner countries have been slow to implement the UN Convention on the Rights of Persons with Disabilities. We agree with the Minister that it might be counter-productive to make aid conditional on implementing the Convention. However, we recommend the UK take other steps to press for disabled people's rights—for example, by supporting civil service capacity building, and by sending key messages with Foreign Office travelling ministers. DFID should also consider supporting the UN Partnership to Promote the Rights of Persons with Disabilities. If it decides not to support the Partnership, it should use the funds for other work to promote disabled people's rights, and should report back to the Committee on its plans.**

Private sector

Investing in the Private Sector

97. Under the Coalition Government, DFID has placed a new emphasis on building relationships with the private sector: one of the six goals of DFID's Business Plan is to boost wealth creation, including 'making DFID more private sector friendly'.³⁰⁸ DFID's support for private sector companies includes:

- Ownership of CDC Group, which invests UK funds in private sector companies in developing countries³⁰⁹
- Funding for the Private Infrastructure Development Group (PIDG), which creates incentives for private companies to invest in infrastructure projects in developing countries (£68 million in 2012-13)³¹⁰
- High Level Prosperity Partnerships with Tanzania, Ghana, Mozambique, Cote d'Ivoire and Angola. Under these partnerships, DFID will provide capital to local businesses, in sectors such as power and agriculture.³¹¹

305 Q175

306 UN Development Programme ([DIS0046](#))

307 Q177

308 [DFID Business Plan 2011-15](#). Subsequent revisions of the plan do not contain this exact wording, but retain the overall goal of greater private sector engagement.

309 CDC Group, [Key Facts: an Introduction to the UK's DFI](#), accessed 30 March 2014

310 DFID [Annual Report and Accounts 2012-13](#), p 99. Provisional funding figure.

311 DFID, ['Policy Paper: High Level Prosperity Partnerships in Africa'](#), accessed 30 March 2014

DFID’s engagement with the private sector creates exciting possibilities for its work on disability. A recurrent theme in our evidence has been the importance of disabled people finding sustainable work and getting access to credit—submissions from disabled people across the world, representing a variety of conditions, regularly mentioned this as a key concern.³¹² **We recommend that DFID require its private sector partners to report on the number of disabled people they employ, and – for services such as credit—the number of disabled people they serve. Reporting requirements should be proportionate—we accept DFID would not want to impose a heavy burden on very small companies. However it should, as a minimum, require such reporting from larger companies supported through CDC Group, the Private Infrastructure Development Group, and the High Level Prosperity Partnerships.**

98. CDC Group and PIDG both set basic health and safety requirements for the companies in which they invest.³¹³ However, these do not require compliance with all relevant international standards set by the International Labour Organisation, World Bank and World Health Organisation.³¹⁴ Industrial accidents are a significant cause of disability.³¹⁵ **We recommend DFID require all partner companies to produce action plans stating how they will work towards international health and safety standards. If DFID is working with very small businesses, it should provide financial support for any necessary adjustments to meet these recommendations.**

Helping Regulate the Private Sector

99. DFID also says that it expects private sector organisations will, in some countries, play an important role in the delivery of public services such as health and education.³¹⁶ DFID aims to help national governments regulate such organisations.³¹⁷ **Wherever private sector organisations are responsible for delivery of key public services, we recommend that DFID work with partner governments to ensure appropriate regulations are in place for disabled people’s access.**

Creating other Incentives for the Private Sector

100. During the inquiry we have explored a number of ways to encourage private sector organisations to take on disabled staff—for example, subsidising training³¹⁸ or arranging

312 For example, Q4 [Mr Chandrasekar], Accessibility Organisation of Afghan Disabled ([DIS0069](#)), Quality of Life Association ([DIS0049](#)) paras 2.3 and 2.5, Development and Ability Organisation ([DIS0006](#)),. See also Mencap ([DIS0045](#)).

313 CDC Group, [Code of Responsible Investing](#), pp 9-10, PIDG - Handbook, pp 36-37

314 CDC encourages companies to meet ILO/WHO standards, but this is not a requirement (CDC Group, [Code of Responsible Investing](#), p.11). PIDG only requires companies to take account of international standards where local health and safety laws do not exist (PIDG Handbook, p. 37).

315 Dr Rebecca Dingo ([DIS0044](#)) para 13

316 DFID, [Education Position Paper: Improving Learning, Expanding Opportunities](#), 2013, pp 13, 16, 19 and [Health Position Paper: Delivering Health Results](#), 2013, pp 18-19

317 DFID, [Education Position Paper: Improving Learning, Expanding Opportunities](#), pp 13, 16, [Health Position Paper: Delivering Health Results](#), pp 8, 18

318 Agreed minute of informal meeting with ADD International Bangladesh. See also [Motivation Annual Review 2012](#), p12

short internships.³¹⁹ To complement these, we have also discussed the possibility of a ‘Kite Mark’ recognition scheme similar to FairTrade. Under such a scheme, employers would have to show they met criteria on accessibility and equality; numbers of disabled employees; and health and safety. They would then be allowed to mark their products with a logo recognising their good employment practices, and this would potentially command a premium in UK markets.³²⁰ Like FairTrade, the scheme would be run independently from DFID—but DFID could provide financial support, as it does to the FairTrade Labelling Organisation.³²¹ Given its contacts in countries such as Bangladesh,³²² DFID would also be well placed to undertake initial enquiries as to the scheme’s feasibility. **We recommend DFID investigate the feasibility of a Kite Mark standard to recognise disability-inclusive employers. It should report back its findings in its response to this report.**

Other UK departments

101. Around 13% of UK ODA³²³ is delivered by other departments, foremost the Foreign and Commonwealth Office (FCO).³²⁴ The FCO’s recent work on human rights includes a number of positive steps to promote disabled people’s rights, including lobbying in countries such as Mozambique and Ghana,³²⁵ funding for disability NGOs in Russia, and support for disabled children’s education in North Korea.³²⁶ However, what the FCO lacks is a process to ensure disabled people are included in all its development and human rights work—for example, if the FCO is funding women’s organisations, it should ensure these include disabled women. **It is important that all UK Official Development Assistance (ODA) is accessible to disabled people, no matter which department is responsible. We recommend all departments that spend ODA put in place measures to monitor the number of disabled people who benefit from their development programmes. This is particularly important for the Foreign and Commonwealth Office, which spends most UK ODA outside DFID, and is the lead department on human rights issues.**

Global development frameworks

102. The evidence to the inquiry was clear that the Millennium Development Goals had had a decisive influence on the last fifteen years’ development agenda. The evidence recognised the Goals’ enormous beneficial impact on extreme poverty, gender equality, child mortality, and communicable diseases.³²⁷ But witnesses also said the Goals had had

319 Q12 [Ms Abu Alhaib]

320 The Fair Trade scheme does include some conditions on disabled access (see e.g. [Fairtrade Standard for Hired Labour](#) p 15 and 16), but this is not its main focus. There would be scope to introduce a more targeted scheme with stringent criteria on the numbers of disabled people employed. DFID’s website includes more information on its Partnership Programme Agreement support to the Fairtrade Labelling Organisation (www.gov.uk/dfid).

321 DFID, [‘Programme Partnership Arrangements’](#), accessed 30 March 2014

322 For example, through the [‘Responsible and Accountable Garment Sector Challenge Fund’](#) (accessed 30 March 2014)

323 Official Development Assistance

324 DFID, [Statistics on International Development 2013](#), p 61

325 DFID Annexe A ([DIS0071](#)) para 10

326 [Human Rights and Democracy: the 2012 Foreign and Commonwealth Office Report](#), pp 158 and 203

327 E.g. Q110

unintended, adverse, consequences for disabled people. There is no mention of disability either in the Goals or specific indicators; even the health indicators focus on mortality, rather than disability prevention.³²⁸ The submissions argued this lack of attention meant disabled people had been left behind in development, to the extent that their “living conditions may actually be declining in relative terms”.³²⁹ **The post-2015 development framework is currently being deliberated upon by UN General Assembly members. It is vital that this framework secure better outcomes for disabled people than the Millennium Development Goals.**

103. The final framework will not be settled for over a year, but a key milestone was the publication, in May 2013, of the Report of the High-Level Panel on the Post-2015 Development Agenda, which the Prime Minister co-authored (Box 6). The report contains two particularly important developments for disabled people:

- The principle that “no-one [should be] left behind”:

The next development agenda must ensure that neither income nor gender, nor ethnicity, nor **disability**, nor geography, will determine whether people live or die, whether a mother can give birth safely, or whether her child has a fair chance in life.³³⁰

- The principle that results should be disaggregated by factors including disability, and no goal would be considered met unless it was met for all groups.³³¹

328 UN, '[Official List of MDG Indicators](#)', accessed 25 March 2014

329 Lorraine Wapling ([DIS0062](#)) para 1.1

330 United Nations, [A New Global Partnership: Eradicate Poverty and Transform Economies through Sustainable Development: the Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda](#), New York, 2013, p7 [emphasis added]

331 As above, p29

Box 6 : Developing the Post-2015 Development Framework*Milestones so far:***May 2013:** Report of the High-Level Panel of Eminent Persons on the Post 2015 Development Framework (co-authored by the UK Prime Minister)**September 2013:** Report by the UN Secretary General (echoed findings of High Level Panel)*Next steps:***September 2014:** ‘Open Working Group’ of General Assembly members will present recommendations on post-2015 framework**September 2014:** Economic experts will publish report on financing the new framework**Late 2014:** Secretary General will publish synthesis report, summarising preceding reports, to feed into final negotiations**September 2015:** UN summit on post-2015 development framework**1 Jan 2016:** New framework comes into effectSource [UN website](#) (multiple pages, accessed 30 March 2014)

These principles were very warmly welcomed in evidence to the inquiry, and the Prime Minister widely credited for leading the way with this shift of emphasis: “the UK has really been up front in trying to push these issues to make sure that we do have an inclusive agenda”.³³²

104. Amina Mohammed, Special Advisor to the UN Secretary General on Post-2015 Development Planning, said there was an “amazing [...] consensus” around the principle of ‘leave no-one behind’,³³³ and it is encouraging that recent international statements continue to refer to disabled people’s rights.³³⁴ However Ms Mohammed also recognised there was a risk the consensus would be diluted as “the rubber hit the road” in the final stages of the negotiations.³³⁵ Submissions to the inquiry have emphasised that, if the unintended consequences of the Millennium Development Goals are to be avoided, it is essential that the final framework maintains an explicit focus on disability, as opposed to a general statement on ‘marginalised groups’.³³⁶

105. We strongly endorse the High-Level Panel’s emphasis on leaving no-one behind in the next global development framework. We also welcome the proposal to disaggregate data by disability, and consider no goal met unless it is also met for disabled people. The Prime Minister has shown impressive leadership in bringing disability into the post-2015 development process, and we now urge the UK to use all diplomatic channels to ensure this momentum is sustained until the goals are finally agreed.

332 Q110

333 Q112

334 For example, [Progress Report of the Open Working Group of the General Assembly on Sustainable Development Goals](#), paras 143, 192, and the UN [Commission on the Status of Women Outcome Document](#), 2014

335 Q114

336 Bond Disability and Development Group ([DIS0011](#)) para 4.2.

106. The Post-2015 Development Framework, while crucial, is not the only international framework with a serious impact on disabled people. The Hyogo Framework for Disaster Risk Reduction is also being revised for post-2015. Aleema Shivji, UK Director of Handicap International, told us that the initial drafts included specific references to disabled people's needs, but it was important to keep up the pressure.³³⁷ **We recommend that DFID press for the next framework on disaster risk reduction to include explicit references to disabled people, rather than simply vulnerable groups.**

8 Conclusion

107. The post-2015 development framework offers hope that disabled people will finally get the prominence they deserve on the global development agenda. But this will only be possible with sustained political pressure, and the UK's position will only be credible if it leads by example in its own development work. Disabled people experience some of the most extreme poverty in the world, but—as the evidence to this inquiry has shown—there are also realistic opportunities for donors to turn the situation around. This, as one of our witnesses said, is “a powerful combination of circumstances”,³³⁸ and we cannot afford to miss it.

Conclusions and recommendations

1. We were surprised that the Minister ruled out the possibility of a disability strategy in her evidence to us. (Paragraph 20)
2. We recommend that DFID introduce a disability strategy. Disability should be a priority for DFID. Its current approach to social impact appraisal, which considers the risk of exclusion across a wide range of marginalised groups, is valuable—but not enough. There remains a danger that disabled people’s interests will be lost among those of groups who are more visible – all the more after the current Minister moves roles. By publishing clear objectives, and timetables, as it has done for gender, the Department can signal its commitment to disability, and help ensure this commitment endures even as key individuals move on. We also recommend that the disability strategy be supported by clear references to disability in all Country Operational Plans, and in the next Bilateral Aid Review. (Paragraph 25)
3. We welcome DFID’s research into disability, and support its commitment to evidence-based programming. However, as we found in our report on Violence against Women and Girls, DFID should strike a balance between building an evidence base on disability, and implementing programmes. The scale and urgency of the challenge are such that DFID cannot wait for perfect data before embarking on large-scale disability programmes. Rather, DFID should take an ambitious but flexible approach. We recommend that DFID set challenging milestones for implementing more large-scale programmes. It should begin these programmes by piloting, as it has done in Rwanda, so that it can stop any projects that are not working, and rapidly scale up those that are. Similarly, we recommend DFID take a pragmatic approach to funding applications from disability-focussed civil society organisations, and should not let imperfect data prevent it funding promising projects with a clear potential—albeit unproven—benefit. We recommend that DFID continue to undertake research on disability, and monitor closely whether the research is put into practice by DFID and its partners. (Paragraph 29)
4. We recommend that DFID’s disability strategy state specifically how DFID will reach people with intellectual and psychosocial disabilities through its programmes. We further recommend that DFID cover ageing in the same strategy as disability, given the strong overlaps between the two issues. It should, though, recognise that not all disabled people are older people, to ensure the focus on older people does not eclipse the priorities of disabled children or younger adults. (Paragraph 32)
5. We welcome the Prime Minister’s commitment to reporting disaggregated data on the number of disabled people who benefit from development programmes. We also commend the steps DFID is taking to make better data available. We recommend that DFID report results disaggregated by disability in all Annual Reviews, Project Completion Reviews and logframes. We also recommend that it disaggregate targets in its Results Framework by disability, as it does for gender. We recognise that collecting data on disability is not straightforward, and teams have many other

demands on their time, so recommend a pragmatic approach in the short term—for example, using the Washington Group questions. In the medium term, we recommend DFID develop more precise data disaggregated by type of disability. Wherever possible, we recommend that DFID report results disaggregated to show people who belong to several marginalised groups at once (e.g. disabled women), to help tackle the ‘double discrimination’ that such people face. (Paragraph 35)

6. We welcome the news that DFID plans to introduce further programmes aimed at disabled people. We trust DFID will take our recommendations into account as it develops these plans, and we look forward to hearing an update in the Government’s response to this report. (Paragraph 36)
7. We warmly welcome the steps DFID has taken to give disabled people greater say in aspects of its work, in particular the fact that it modified some WASH and social protection programmes in response to disabled people’s feedback. The challenge is to do this more consistently across DFID’s whole portfolio. DFID is currently reviewing its programme management, and we recommend it take this opportunity to give disabled people more influence – from programme design through to evaluation and research. DFID should ensure people with all types of disability participate, and should adjust its communications to make sure they are reached. It should consult family and community members as well as disabled people themselves. More specifically, DFID should:
 - Ensure that disabled people play a prominent role in drawing up DFID’s disability strategy, and help shape its Country Operational Plans.
 - Seek to give more disabled people visible and senior roles in programme delivery - as already happens at the Kabul Orthopaedic Centre, which DFID helps fund.
 - Invite DPOs from developing countries to join its disability advisory group, even if only in writing or by telephone. (Paragraph 40)
8. We strongly welcome DFID’s support for DPOs. However, we are concerned that it is hard for disabled people’s organisations to access funding directly from DFID. We recommend that DFID make its funding more accessible to DPOs. We do not wish to prescribe how DFID does this, but do recommend that it address the main barriers such as information that is not accessible, and complex grant conditions. We are also concerned that, if DPOs can only access DFID funding through intermediaries, DFID is missing a valuable opportunity to train its staff in local disability issues. While we recognise country offices have many calls on their time, we recommend that DFID seek to establish more direct contact with DPOs, which could be an efficient way to tap into local knowledge and networks. (Paragraph 43)
9. We welcome DFID’s current work to build DPO capacity and to reach out to marginalised groups, and encourage it to ensure this is standard practice in all its work with DPOs. We also recommend that, whenever DFID provides grants to ‘mainstream’ civil society organisations (for example, women’s organisations), it monitor whether they are including disabled people (Paragraph 44)

10. We encourage DFID to renew its links with UK DPOs, and to consider where their expertise might usefully complement that of NGOs. (Paragraph 45)
11. We commend the dedication of DFID's current disability team, but are concerned that DFID has no full-time disability specialists. To ensure its commitments to disability are sustainable, we recommend DFID develop a larger team, with more capacity, including: a senior sponsor; a complement of Social Development Advisors specialising in disability; and a wider network of people to champion disability in each country office. We further recommend DFID ensure all staff are trained in basic principles of disability rights and access to development programmes. It should consider making disability the theme for the next Social Development Advisor team conference. It should also ensure disability specialists are represented in its humanitarian division, as well as in its development work. (Paragraph 48)
12. We are concerned that DFID only employs 45 staff with a declared disability—and that no locally appointed staff in its overseas offices have declared they are disabled. A visible disabled workforce could be a powerful way to challenge stigma and discrimination, and to get a deeper understanding of the barriers that disabled people face. DFID should investigate why it has not attracted more disabled staff, and should consider whether targets would help it redress the balance in some of its offices. (Paragraph 50)
13. DFID has taken an important symbolic step with its new commitment to make all directly-funded school buildings accessible to disabled children. However, while this commitment is welcome, it is well-known that accessible buildings are a relatively simple, low-cost, response to disability. If disabled people are to enjoy full access to programmes, donors also need to tackle more stubborn barriers such as information and stigma. We would now expect DFID to show more ambition. We recommend DFID choose one or two substantial sectors (e.g. health or education), and a small number of countries, to focus on. Within these chosen areas, it should then pledge to give disabled people full access to all its programmes. (Paragraph 52)
14. We recommend that disabled people take the lead in deciding which the sector(s) DFID should to focus on initially. We further recommend that DFID play to its strengths, and select sectors and countries in which it has a strong track record. Although we recommend that DFID take a focussed approach to begin with, we also urge it to set out a long-term timetable showing how it will expand its commitments to more sectors and countries in due course. (Paragraph 53)
15. We accept that once DFID has chosen to focus on one or two priority sectors, extensive work outside these focal areas could leave it overstretched. Nonetheless, to maximise the impact of its work, DFID should remain alert to important links between sectors, as USAID has done. It should also look out for “quick wins” across its whole portfolio, where a small intervention could have a large multiplier effect on disabled people's ability to participate (Paragraph 55)
16. We recommend that, once DFID has decided which sectors and countries to focus on, it should consider in detail the steps needed to combat stigma in these chosen areas. This will allow it to tackle the root cause, as well as the symptoms, of disabled

people's exclusion. We also note that overcoming stigma takes time. Echoing our findings on Violence Against Women and Girls, we recommend that programmes designed to tackle stigma last at least five years, with opportunities for further follow-up. (Paragraph 59)

17. We note that the education of disabled children is a complex area, and that the best approach is not "one size fits all": DFID's recent guidance on school buildings does not capture these complexities, but we trust its forthcoming guidance on inclusive education will take a more nuanced approach. (Paragraph 60)
18. We note that disaggregated reporting is particularly important in programmes that use payment by results, or else these may create perverse incentives not to include disabled people. (Paragraph 61)
19. We welcome DFID's support for specialist agencies to help disabled people in recent emergencies. However, if DFID is to reach disabled people in need throughout its humanitarian work, it must also use its influence on UN agencies and large humanitarian NGOs. We recommend that, as a condition of funding, DFID should require all its humanitarian partners to say how they will reach disabled people, and to report the number of disabled people they have helped. To enable partners to reach more disabled people, DFID should increase its support for specialist organisations to provide training for non-specialists. We also recommend that DFID urge the UN to create a central pool of disability experts, similar to the current pool for gender; provide funds for the pool; and encourage other donors to do the same. In addition, we recommend DFID press the UN to endorse cross-sector guidelines on best practice for reaching disabled people in emergencies. (Paragraph 66)
20. DFID is already taking some welcome steps to help treat or prevent the conditions that cause disability. DFID stands out as one of the only international donors to work on mental health (Paragraph 76)
21. These programmes are valuable—but they represent a very small share of DFID's overall health budget (Paragraph 77)
22. We are pleased that, in choosing how to spend its health budget, DFID takes into account a range of important factors, particularly international guidelines on cost-effectiveness. However, we are concerned that DFID's approach to health spending may under-state the importance of treating and preventing the conditions that lead to disability. (Paragraph 79)
23. We recommend DFID issue a guidance note to clarify that, in making difficult decisions on health spending, it is important to look beyond narrow measures of cost-effectiveness. The value of programmes that treat and prevent disabling conditions lies not only in their medical impact, but also in their ability to increase people's opportunities and potentially lift them out of poverty. We recommend DFID thoroughly appraise the case for spending more in the following areas. If DFID decides not to increase its spending, it should explain its reasons to the Committee.
 - Mental health care

- Rehabilitation and basic care, e.g. for people with spinal cord injuries
- Provision of assistive devices, potentially joining forces with USAID or other major donors to buy in bulk
- Neglected Tropical Diseases
- Non-Communicable Diseases
- Newborn Health

We also recommend DFID gather detailed data on the cost and impact of all its treatment and prevention work, so as to improve the international evidence base on cost-effectiveness. (Paragraph 80)

24. Dementia is a growing cause of disability in developing countries, and the Prime Minister has called for it to be “at the heart of the development agenda”: we urge DFID and the Department of Health to update the Committee on their plans to accomplish this. (Paragraph 81)
25. We welcome DFID’s response to the recommendations on road safety in our 2011 report on DFID’s Role in Building Infrastructure in Developing Countries. We also welcome the news that the World Bank will only approve loans to programmes that address road safety. DFID should keep up the pressure on the World Bank to meet its road safety commitments, requiring that all new programmes are supported by a full life-cycle risk analysis, and by monitoring mechanisms to ensure risks are successfully mitigated. We also recommend that it require other multilateral development partners—including development banks and the European Union—to introduce similar road safety policies, as a condition of future UK funding. (Paragraph 84)
26. Given the links between armed violence and disability, we welcome DFID’s research programme on urban violence in developing countries—the Safe and Inclusive Cities programme. We recommend DFID develop further programmes to tackle armed violence, and target all groups at risk of violence, including young men and older people. (Paragraph 85)
27. DFID spends more than half of its budget through multilateral agencies. It should exert its substantial influence to ensure this budget is accessible to disabled people. We recommend that DFID require its multilateral partners to demonstrate that they are reaching disabled people, by reporting disaggregated data: the current policy review at the World Bank provides one good opportunity to do this. When DFID conducts its 2015 Multilateral Aid Review, we recommend it include criteria on disability. DFID should also require its partners to show how disabled people—including DPOs and disabled parliamentarians—are participating in programming, from design through to evaluation. (Paragraph 88)
28. We recognise that the PRSP process is led by country governments. However, we would expect the World Bank to discuss with governments how they plan, through their PRSP, to meet their obligations under the UN Convention for the Rights of Persons with Disabilities. DFID should press the World Bank to do so. DPOs

participate in PRSP process, and we recommend DFID help them to do this, for example by providing economics training, by sharing relevant research on disability and poverty, or by advising on effective monitoring techniques to ensure that any PRSP commitments on disability are duly translated into practice. (Paragraph 90)

29. HIV/AIDS is closely associated with conditions that cause disability. This makes the provision of affordable Anti-Retroviral Therapy (ART) all the more urgent. We recommend that, in any forthcoming trade negotiations, the UK press the EU to retain existing flexibilities that facilitate the production of affordable generic ART. (Paragraph 91)
30. Many DFID partner countries have been slow to implement the UN Convention on the Rights of Persons with Disabilities. We agree with the Minister that it might be counter-productive to make aid conditional on implementing the Convention. However, we recommend the UK take other steps to press for disabled people's rights—for example, by supporting civil service capacity building, and by sending key messages with Foreign Office travelling ministers. DFID should also consider supporting the UN Partnership to Promote the Rights of Persons with Disabilities. If it decides not to support the Partnership, it should use the funds for other work to promote disabled people's rights, and should report back to the Committee on its plans. (Paragraph 96)
31. DFID's engagement with the private sector creates exciting possibilities for its work on disability. We recommend that DFID require its private sector partners to report on the number of disabled people they employ, and – for services such as credit—the number of disabled people they serve. Reporting requirements should be proportionate—we accept DFID would not want to impose a heavy burden on very small companies. However it should, as a minimum, require such reporting from larger companies supported through CDC Group, the Private Infrastructure Development Group, and the High Level Prosperity Partnerships. (Paragraph 97)
32. We recommend DFID require all partner companies to produce action plans stating how they will work towards international health and safety standards. If DFID is working with very small businesses, it should provide financial support for any necessary adjustments to meet these recommendations. (Paragraph 98)
33. Wherever private sector organisations are responsible for delivery of key public services, we recommend that DFID work with partner governments to ensure appropriate regulations are in place for disabled people's access. (Paragraph 99)
34. We recommend DFID investigate the feasibility of a Kite Mark standard to recognise disability-inclusive employers. It should report back its findings in its response to this report. (Paragraph 100)
35. It is important that all UK Official Development Assistance (ODA) is accessible to disabled people, no matter which department is responsible. We recommend all departments that spend ODA put in place measures to monitor the number of disabled people who benefit from their development programmes. This is particularly important for the Foreign and Commonwealth Office, which spends

most UK ODA outside DFID, and is the lead department on human rights issues. (Paragraph 101)

36. The post-2015 development framework is currently being deliberated upon by UN General Assembly members. It is vital that this framework secure better outcomes for disabled people than the Millennium Development Goals. (Paragraph 102)
37. We strongly endorse the High-Level Panel's emphasis on leaving no-one behind in the next global development framework. We also welcome the proposal to disaggregate data by disability, and consider no goal met unless it is also met for disabled people. The Prime Minister has shown impressive leadership in bringing disability into the post-2015 development process, and we now urge the UK to use all diplomatic channels to ensure this momentum is sustained until the goals are finally agreed. (Paragraph 105)
38. We recommend that DFID press for the next framework on disaster risk reduction to include explicit references to disabled people, rather than simply vulnerable groups (Paragraph 106)

Formal Minutes

Tuesday 1 April 2014

Members present:

Sir Malcolm Bruce, in the Chair

Fabian Hamilton
Michael McCann

Fiona O'Donnell
Chris White

Draft Report (*Disability and Development*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 107 read and agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report (in addition to that ordered to be reported for publishing on 8 and 15 January, 4 and 25 February, 5 March and 1 April 2014).

[Adjourned till Tuesday 8 April at 9.30 am.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at [Disability and Development](#).

Tuesday 14 January 2014

Question number

Mahesh Chandrasekar, International Policy and Campaigns Manager, Leonard Cheshire Disability, **Edwin Osundwa**, Country Representative for Kenya, Sense International, **Ola Abu Alghaib**, Regional Disability Rights, Handicap International, **Bob McMullan**, former Australian Parliamentary Secretary for International Development Assistance, **Lorriane Wapling**, disability and development consultant at AusAID and DFID, and **Dr Susie Miles**, Senior Lecturer in Inclusive Education, University of Manchester

[Q1-45](#)

Tuesday 21 January 2014

Tim Wainwright, Co-chair, Bond Disability and Development Group, **Aleema Shivji**, Director, Handicap International, **Barbara Frost**, Chief Executive, WaterAid, **Professor Nora Groce**, Director, Leonard Cheshire Disability and Inclusive Development Centre, University College London, **Dr Tom Shakespeare**, Senior Lecturer, Norwich Medical School, and former disability specialist, the World Health Organization, and **Professor Graham Thornicroft**, Professor of Community Psychiatry, King's College London

[Q46-108](#)

Tuesday 4 February 2014

Amina Mohammed, Special Adviser of the UN Secretary-General on post-2015 Development Planning, **Lynne Featherstone MP**, Parliamentary Under-Secretary of State, Department for International Development, **Liz Ditchburn**, Director of Policy Division, DFID, **Jen Marshall**, Head of Profession for Social Development, DFID, and **Jo Cooke**, Social Inclusion and Civil Society Specialist, DFID

[Q109-204](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at [Disability and Development](#). DIS numbers are generated by the evidence processing system and so may not be complete.

- 1 [Equal Lives \(DIS 0001\)](#)
- 2 [Equal Lives Annex A \(DIS 0099\)](#)
- 3 [Dr Tom Shakespeare \(DIS 0002\)](#)
- 4 [David Blunkett MP \(DIS 0003\)](#)
- 5 [The Leprosy Mission \(DIS 0004\)](#)
- 6 [International Service \(DIS 0005\)](#)
- 7 [Development and Ability Organisation \(DIS 0006\)](#)
- 8 [Life Haven Inc \(DIS 0007\)](#)
- 9 [Benjamin S. Bernardino \(DIS 0008\)](#)
- 10 [Gadn \(DIS 0009\)](#)
- 11 [International Centre for Evidence in Disability \(DIS 0010\)](#)
- 12 [Bond Disability and Development Group \(DIS 0011\)](#)
- 13 [Handicap International UK \(DIS 0012\)](#)
- 14 [Handicap International Annex A \(DIS 0100\)](#)
- 15 [Vision Alliance \(DIS 0013\)](#)
- 16 [National Association of Service providers in physical rehabilitation \(DIS 0016\)](#)
- 17 [The Motivation Charitable Trust \(DIS 0017\)](#)
- 18 [WaterAid \(DIS 0018\)](#)
- 19 [Lord Low of Dalston, CBE \(DIS 0020\)](#)
- 20 [Results UK \(DIS 0021\)](#)
- 21 [Global Campaign for Education \(DIS 0022\)](#)
- 22 [Global Campaign for Education Annex A \(DIS 0101\)](#)
- 23 [World Vision \(DIS 0023\)](#)
- 24 [Norwegian Association of Disabled \(DIS 0024\)](#)
- 25 [Ablechildafrica \(DIS 0026\)](#)
- 26 [Add International \(DIS 0027\)](#)
- 27 [Add International Annex A \(DIS 0093\)](#)
- 28 [Africa Network Campaign on Education for All \(DIS 0028\)](#)
- 29 [Lumos \(DIS 0029\)](#)
- 30 [Lumos Annex A \(DIS 0102\)](#)
- 31 [International Labour Organization \(DIS 0031\)](#)
- 32 [Stopaids \(DIS 0032\)](#)
- 33 [Stopaids Annex A \(DIS 0103\)](#)
- 34 [CBM \(DIS 0034\)](#)
- 35 [Alzheimer's Disease International and Alzheimer's Society \(DIS 0035\)](#)
- 36 [Age International \(DIS 0037\)](#)
- 37 [Age International Annex A \(DIS 0104\)](#)
- 38 [Special Olympics \(DIS 0038\)](#)
- 39 [Helpage International \(DIS 0039\)](#)

- 40 [Children’s Book Project for Tanzania \(DIS 0040\)](#)
- 41 [Marie Stopes International \(DIS 0041\)](#)
- 42 [Plan UK \(DIS 0042\)](#)
- 43 [Human Rights Watch \(DIS 0043\)](#)
- 44 [Dr Rebecca Dingo \(DIS 0044\)](#)
- 45 [Mencap \(DIS 0045\)](#)
- 46 [UNDP \(DIS 0046\)](#)
- 47 [Livability \(DIS 0047\)](#)
- 48 [The World Bank Group \(DIS 0048\)](#)
- 49 [Quality of Life Association \(DIS 0049\)](#)
- 50 [Sightsavers \(DIS 0050\)](#)
- 51 [Sightsavers Annex A \(DIS 0051\)](#)
- 52 [Mental Health Innovation Network, CBM, Nepal Mental Health Foundation \(DIS 0052\)](#)
- 53 [Michael Stein \(DIS 0053\)](#)
- 54 [Department for International Development \(DIS 0054\)](#)
- 55 [Department for International Development Annex A \(DIS 0071\)](#)
- 56 [Department for International Development Annex B \(DIS 0074\)](#)
- 57 [Department for International Development Annex C \(DIS 0075\)](#)
- 58 [Department for International Development Annex D \(DIS 0092\)](#)
- 59 [Department for International Development Annex E \(DIS 0097\)](#)
- 60 [Department for International Development Annex F \(DIS 0098\)](#)
- 61 [Kenya Hospices and Palliative Care Association \(DIS 0056\)](#)
- 62 [Sense International \(DIS 0057\)](#)
- 63 [Leonard Cheshire Disability \(DIS 0058\)](#)
- 64 [Leonard Cheshire Disability Annex A \(DIS 0077\)](#)
- 65 [Leonard Cheshire Disability Annex B \(DIS 0079\)](#)
- 66 [Global Partnership for Education Secretariat \(DIS 0060\)](#)
- 67 [Africa Network Campaign on Education for all \(DIS 0068\)](#)
- 68 [The Children’s Book Project for Tanzania \(DIS 0067\)](#)
- 69 [YSO UK \(DIS 0066\)](#)
- 70 [Basicneeds \(DIS 0064\)](#)
- 71 [Australian Government, Department of Foreign Affairs and Trade \(DIS 0063\)](#)
- 72 [Lorraine Wapling \(DIS 0062\)](#)
- 73 [Women’s Refugee Commission \(DIS 0061\)](#)
- 74 [Women’s Refugee Commission Annex A \(DIS 0105\)](#)
- 75 [Inclusion International \(DIS 0080\)](#)
- 76 [Office for the Coordination of Humanitarian Affairs \(DIS 0085\)](#)
- 77 [Disability Rights Fund \(DIS 0091\)](#)
- 78 [David Constantine MBE \(DIS 0087\)](#)
- 79 [UN Special Rapporteur on Disability \(DIS 0086\)](#)
- 80 [Disasters Emergency Committee \(DIS 0084\)](#)
- 81 [Joint National Association of Persons with Disabilities, Nigeria \(DIS 0083\)](#)
- 82 [Manusher Jonno Foundation \(DIS 0082\)](#)
- 83 [Sahara \(DIS 0081\)](#)

- 84 [ThisAbility Consulting \(DIS 0072\)](#)
- 85 [USP Kenya \(DIS 0078\)](#)
- 86 [USAID \(DIS 0088\)](#)
- 87 [USAID Annex A \(DIS 0106\)](#)
- 88 [New Horizons Foundation of the Blind \(DIS 0090\)](#)
- 89 [Soundseekers \(DIS 0089\)](#)
- 90 [Soundseekers Annex A \(DIS 0107\)](#)
- 91 [Accessibility Organization for Afghan Disabled \(DIS 0069\)](#)
- 92 [Lakeside Cross Disability Self Help Group \(DIS 0065\)](#)
- 93 [Ariam Gebremariam, Sadpd Regional Office \(DIS 0030\)](#)
- 94 [Dr Sophie Mitra \(DIS 0094\)](#)
- 95 [Pan African Network of People with Psychosocial Disabilities \(DIS 0096\)](#)
- 96 [Mental Health Society of Ghana \(DIS 0095\)](#)
- 97 [International Federation of Anti Leprosy Associations \(DIS 0025\)](#)
- 98 [Special Educational Professionals \(DIS 70\)](#)
- 99 [World Food Programme \(DIS 0108\)](#)
- 100 [Action to the Community Development Center, Hanoi, Vietnam \(DIS 0109\)](#)
- 101 [Foreign Commonwealth Office \(DIS 0110\)](#)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/indcom.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2013–14

First Report	Global Food Security	HC 176 (626)
Second Report	Violence Against Women and Girls	HC 107 (624)
Third Report	Scrutiny of Arms Exports and Arms Control (2013): Scrutiny of the Government's UK Strategic Export Controls Annual Report 2011 published in July 2012, the Government's Quarterly Reports from October 2011 to September 2012, and the government's policies on arms exports and international arms control issues	HC 205 (CM 8707)
Fourth Report	Multilateral Aid Review	HC 349 (694)
Fifth Report	ICAI's Annual Report 2012-13	HC 566 (946)
Sixth Report	Implications for development in the event of Scotland becoming an independent country	HC 692
Seventh Report	The Closure of DFID's Bilateral Aid Programmes: the case of South Africa	HC 822
Eighth Report	The Future of UK Development Cooperation: Phase 1: Development Finance	HC 334
Ninth Report	Democracy and Development in Burma	HC 821

Session 2012–13

First Report	DFID's contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria	HC 126 (609)
Second Report	Scrutiny of Arms Exports (2012): UK Strategic Export Controls Annual Report 2010, Quarterly Reports for July to December 2010 and January to September 2011, The Government's Review of arms exports to the Middle East and North Africa, and wider arms control issues	HC 419 (CM 8441)
Third Report	The Development Situation in Malawi	HC 118 (641)
Fourth Report	Tax in Developing Countries: Increasing Resources for Development	HC 130 (708)
Fifth Report	DFID's programme in Zambia	HC 119 (759)
Sixth Report	Afghanistan: Development progress and prospects after 2014	HC 403 (862)
Seventh Report	UK Aid to Rwanda	HC 726 (949)

Eighth Report	Post-2015 Development Goals	HC 657 (1065)
Ninth Report	Department for International Development's Annual Report and Accounts 2011–12	HC 751(1098)
Tenth Report	Pakistan	HC 725
Session 2010–12		
First Report	Appointment of the Chief Commissioner of the Independent Commission for Aid Impact	HC 551
Second Report	The 2010 Millennium Development Goals Review Summit	HC 534 (HC 959)
Third Report	Department For International Development Annual Report & Resource Accounts 2009–10	HC 605 (1043)
Fourth Report	The World Bank	HC 999 (1044)
Fifth Report	The Future of CDC	HC 607 (1045)
Sixth Report	Scrutiny of Arms Export Controls (2011): UK Strategic Export Controls Annual Report 2009, Quarterly Reports for 2010, licensing policy and review of export control legislation	HC 686 (CM 8079)
Seventh Report	The Humanitarian Response to the Pakistan Floods	HC 615 (1435)
Eighth Report	The Future of DFID's Programme in India	HC 616 (1486)
Tenth Report	The Closure of DFID's Bilateral Aid Programme in Burundi	HC 1134 (1730)
Eleventh Report	Financial Crime and Development	HC 847 (1859)
Twelfth Report	Working Effectively in Fragile and Conflict-Affected States: DRC and Rwanda	HC 1133 (1872)
Thirteenth Report	Private Foundations	HC1557 (1916)
Fourteenth Report	Department for International Development Annual Report and Resource Accounts 2010–11 and Business Plan 2011–15	HC 1569 (107)
Fifteenth Report	South Sudan: Prospects for Peace and Development	HC 1570 (426)
Sixteenth Report	EU Development Assistance	HC 1680 (427)