HOUSE OF COMMONS

# International Development Committee

## Oral evidence: DfID's work on disability, HC 1880

Tuesday 23 April 2019

Ordered by the House of Commons to be published on 23 April 2019.

Watch the meeting

Members present: Stephen Twigg (Chair); Mr Nigel Evans; Mrs Pauline Latham; Paul Scully; Mr Virendra Sharma; Henry Smith.

Questions 42 - 74

### Witnesses

I: Professor Tom Shakespeare, Professor of Disability Research, London School of Hygiene and Tropical Medicine; Dr Ola Abu Alghaib, Director of Global Influencing and Research, Leonard Cheshire.

II: David Constantine, Founding Director, Motivation; Parmi Dheensa, Founder and Executive Director, Include Me TOO; Julian Eaton, Global Mental Health Advisor, Bond Mental Health and Psychosocial Disabilities Group.

III: Mosharraf Hossain, Director of Global Policy, Influencing and Research, ADD International; Juliet Milgate, Director of Policy and Global Advocacy, Sightsavers; Tom Palmer, Humanitarian Disability Adviser, Humanity and Inclusion.

# Examination of Witnesses

Witnesses: Professor Tom Shakespeare and Dr Ola Abu Alghaib.

Q42 **Chair:** Good afternoon, everyone. This is a session of oral evidence for the International Development Committee's inquiry into DfID's work on disability. We have three expert panels and roughly half an hour with each. Welcome, Ola and Tom. I will kick off by asking each of you to say something about DfID's disability strategy, by way of introduction. In particular, do you think DfID is using research and evidence as systematically and effectively as it should to inform the implementation of the strategy?

***Professor Shakespeare:*** We welcome the new strategy. It is really exciting to see DfID and the UK take a leadership position in disability and development. It is overdue, and it is terrific. We at the London School of Hygiene and Tropical Medicine were very pleased to see a focus on social protection. It reflects the growing importance of social protection in many low and middle-income countries. We were worried that it almost felt as if health had been diminished in importance. We hope that DfID does not forget that health and rehabilitation are pressing needs for many disabled people in the world. It does not stop there, but it starts there. Without it, people do not lead full, good lives, so we hope that is not forgotten by DfID country offices.

You asked if DfID is using research systematically. The answer has to be: as far as we know. We see an eagerness for evidence-based policy, and we and colleagues work with DfID, so we hope so. At the International Centre for Evidence in Disability, we are worried by the dominant focus on the Washington Group's six questions. The International Disability Alliance, DfID and many other multilaterals and bilaterals seem to be saying that this solves the problem. Our thinking is that the questions are not comprehensive. You will hear later about mental health, but they are particularly poor on mental health. There are ambiguities, for example the question on understanding: is that you understanding things or you being understood? Those are very different things and, in many languages, those are quite confused concepts. Cognition and empathy blur.

The thresholds for disability are wrong. Either you have "some difficulty", which is too low a threshold for disability and suddenly 25% of the population is disabled, with the effect that the differences between disabled and non-disabled people begin to disappear because there are too many people in the disability group; or you have to have "a lot of difficulty", which is too high a threshold and you have a prevalence of about 3%. I know we can talk for the rest of the week about the prevalence of disability, but it is a key issue. When we were writing the *World Report on Disability*, we felt 15%, based on the World Health Survey, was a good figure. It is higher than that in the UK, by our

figures. There are whole populations, for example albino people—many of us work in Tanzania and Kenya—who are not really covered by that, yet I would call them a disability group. They are hugely and viciously persecuted.

What do we do? We have the WHO multi-country disability survey. That is 45 questions, which is too many. You cannot do that. What we want to try at the London school is what we use in the UK and many European countries. Question 1: do you have a disability or long-term health condition? Question 2: does it affect your day-to-day activities? We are going to try those. We are going to compare that to what you get from the Washington Group and see if it ends up with a better prevalence estimate. Many of my colleagues are experts on data, so forgive me for pushing that point, but we still have not finished that question and we want to keep it open for the time being.

***Dr Alghaib:*** I would echo Tom's point congratulating DfID on the strategy, because it really came at a point when the global thinking about disability was still missing a lot of elements. It put together inclusion around disability at the right level, where Governments have an understanding of what to do to change their policies, laws and legal frameworks to respond to those needs. We also know from the evidence we gathered from the summit last year—on data, for example, to complement Tom's point of view—that there is still a lot of missing data that reflects the situation on the ground of persons with disabilities.

For example, from the global study we did reviewing 40 countries, we found that many countries did not use the Washington Group questions systematically. They used them in the national census, but figures were sometimes much lower when they did not use them on the demographic health or labour force surveys. There was no consistency of understanding for Governments of how many people we are talking about when we want to address disability. That is key. We are trying to inform Governments on what the Washington Group questions offer. Coming back to Tom's point, it is the only recognised international methodology, yet it only provides prevalence. It is not a diagnostic tool. It still misses certain types of populations, so there are still questions to be answered about its validity. Still, it is the only recognised one.

This is a recommendation for DfID about working on data. I will talk now about other evidence we have. Working on data is not only work on the Washington Group questions, and this is where we mix things up. We assume that, if Governments, development or humanitarian actors use the Washington Group questions, we are ticking the box of inclusion. That is a misunderstanding that leads to a lot of ignorance about how to understand other sources of data, which are equally important. For example, Governments' administrative data is important in humanitarian and development actions. If you are developing a small programme, the Washington Group questions will not help you, because you will not have

the resources to do national surveys. They will not be able to inform your thinking.

On data, we believe, based on the evidence we have gathered, that a lot of learning has been generated, but we are still missing the opportunity to monitor the conventional rights of persons with disabilities. We are almost 10 years away from 2030. The sustainable development goals were very successful in indicating disability allocations, but many countries are failing. We are still failing to provide countries with an understanding of how to monitor these two interlinked frameworks. When I talk about development and disability, what do I need to do beyond the Washington Group questions to ensure I am targeting people with disabilities in social protection, WASH programmes, and education and employment, across all sectors? That is key.

Another thing to end with is about intersectionality between gender and disability, between age, gender and disability, and between context and cultural-related issues. We know it causes additional discrimination for people with disabilities to have unequal access and impact. DfID has started to bring more attention to that, but more evidence is needed to understand what really works. What kinds of interventions do we need to do, advise on and test to ensure this intersectionality is addressed equally across our programmes?

**Chair:** Thank you very much. We are going to come back to some aspects of that in a moment.

Q43 **Paul Scully:** Specifically on social protection, Ola, is DfID's commitment in that area sufficient?

***Dr Alghaib:*** I will be very frank. Social protection, not just through DfID but globally, has been seen for disability more from the poverty alleviation angle. This is a risk to be considered. Yes, we want people with disabilities to be addressed equally in poverty alleviation programmes, but we want to make sure that social protection also looks at the interlinkages between social protection and access to other services. I will give you one example.

From evidence we have generated at Leonard Cheshire for children accessing education in many countries of operation, conditional cash transfer programmes are given to households on the condition that children go to school, but they do not consider that the education system is not inclusive for certain children. Automatically, this household is excluded from the programme and the child is at higher risk, and there are no other support systems around them. Addressing social protection is key, but looking at it with this comprehensive approach is equally key.

As another example, through the Aid Connect programme funded by DfID, we are now looking into the interlinkages between social protection and access to employment. In many countries, both contradict each other, so you need to show you are not capable to work to access social

protection. If you want to access work, you have additional costs. In the UK, the Access to Work programme supports and enables you to cover the additional costs of work. In many countries that is not the case. You have either/or. From my PhD research in Palestine, many households had made the choice not to allow their sisters or brothers to go to work, because they knew it was a precondition of poverty alleviation programmes that no one in the household is working.

We need further evidence, research and understanding about social protection in its wider perspective, as it is in the UK and many other countries. Without that, we will limit our thinking to poverty alleviation programmes that we know will not, in many cases, tackle the disability element.

Q44 **Paul Scully:** To be clear, in that first example about education, you were saying that cash comes with the condition of education, but they cannot get into education, so they do not get the cash in the first place.

***Dr Alghaib:*** Yes.

**Paul Scully:** It is not that they do that and then abuse the system.

***Dr Alghaib:*** No, it automatically excludes the family with a child with a disability, which puts additional barriers on the family itself, but also does not look at solving it for the child themselves. When I worked with the Government and the Ministry of Health in Morocco, we realised that many children were not getting their immunisations and vaccines, because they were out of the education system. They were not counted. Nobody knew they existed and nobody realised that this was a problem, until we started looking into the data of the children we were working with, trying to see why they had not been addressed. They were not in the databases of the schools or the Ministry of Health. The schools and the Ministry of Health were working on the assumption that all children are in the system, which is not true.

Q45 **Paul Scully:** If you have these anomalies and cracks in the system, to what extent is DfID working with Governments in other countries to smooth and work this out? Is it being proactive?

***Dr Alghaib:*** If you want my opinion about what is missing from the picture of DfID's work, there are huge investments in civil society work, which is crucial and needed to deliver programmes, for accountability and for voicing change. There is increasing good work around evidence, but what is missing is Governments. Whether we like it or not, they are the decision makers. They are the ones who are making wrong decisions, most of the time, on where to direct their changes, reforms and investment in disability. I would not say that that element is missing from the triangle, but it needs further thinking about how we enlighten them and provide them with technical guidance, because sometimes they are confused.

There were many cases in my work with Governments when the Minister would tell me, "I am confused. Let's go to the Washington Group. What do I use and how much would I cost me?" I worked with them on the international classification of functioning, which is this disability assessment question. They told me, "We were told it would cost us $5 million a year. I cannot go there. You need to give me something simple and easy to use, which does not require high-level technical expertise, so I can test it". There are these interlinkages between evidence and our practice, but Governments taking this on board is still missing. It needs further thinking.

Q46 **Paul Scully:** You are right; you do not get buy-in from those Governments and, as you say, there is a lot missing. Leonard Cheshire is running a number of projects—I think there is one in Kenya. I was at a different project, but these guys came back wowed by the project in Kenya. Is there anything more that DfID can do to have an influence on Governments that do not have buy-in?

***Professor Shakespeare:*** This is about the technical assessment to understand the extra costs of disability and the different components of a social protection system, not just a pension to compensate for you not working, but helping you get into work and connecting, for example, to a social health insurance system, so you get extra coverage as a result of being in the system. The amounts in the social protection programmes are still very low and will be low for the foreseeable future, but they could help, as Ola says, by levering people into education or a health system, which would meet their additional costs. We still do not have good data on the additional costs that disabled people face, whether of transport, getting to work, assistance in the home or whatever it might be.

***Dr Alghaib:*** In terms of practicalities, talking from my practice when working with Governments, I have only seen it working when Governments work with other UN agencies or the World Bank, for example. It is not always the money. DfID has the privilege, if I can use the word, of interlinking to those agencies that have additional buy-in from Governments. They need to come together and provide technical guidance, sometimes political pressure, and an easier translation of the evidence. In many cases the evidence is there, and it is used in the academic space or a little by civil society, but less so by Governments. They are still struggling to understand what to do about disability. In many cases they want to do something, but are scared to take the first step. The assumption is that it is too complicated and costly. It will probably give them more responsibilities that they will not be able to bear.

These good practices will also generate an understanding of what works at Government level. At programme level we have masses of evidence, but it is always small-scale and Governments are hesitant to immediately scale it up. This idea of transitioning small-scale programmes into

massive-scale programmes that would cover the Government space is key for Governments to buy into it.

***Professor Shakespeare:*** Through DfID's RED funding stream for PENDA, with our friends in DID and led by Sightsavers, we are trying to put together a portal where all the evidence that Ola suggests would be available. There are portals for education and other sectors so, if you want to know whether classroom assistants work, you can go and it will provide you the evidence and tell you that they do. We want to do something like that for disability and development, bringing together many people in this room and beyond. It is not owned by any university, NGO or DPO, but will be verified information available to Governments, so they have no excuse for saying to Ola, me or anybody else, "We don't know what works". Here is the evidence: this is what works.

There are huge gaps. DfID has been proactive in funding research to fill those gaps, but it will be ongoing for a while to come, I am afraid, for us and many other partners to try to fill those gaps. Policy briefs and creating easy-to-use access to research is important.

Q47 **Mrs Latham:** Tom, you gave evidence when we did a similar exercise a few years ago.

***Professor Shakespeare:*** Yes, I did. It is a privilege to be here.

**Mrs Latham:** Sexual and reproductive health and rights for people who are disabled are rarely mentioned in the DfID strategy. Should it have focused more on that?

***Professor Shakespeare:*** Let me declare an interest, because DfID has funded two sexual and reproductive health and rights projects, one of which the London school is part of. I am glad that disability is part of that, because it is about working with marginalised communities in uncertain settings and disabled people are definitely counted as part of that. We are trying to promote the ability to disaggregate. Notwithstanding the criticism I had of the Washington Group, it enables disaggregation to take place. With the What Works programme on gender-based violence, we have been able to disaggregate disability. All of those trials will have separate findings for disability.

One of the questions you asked us all is about communication with DfID, and our communication with DfID is very good. We have nothing but praise for Anne MacKinnon and Tim Conway, who are our focal people, but DfID is a big beast and there are many different parts to it. It is not always clear that the different parts talk to each other, and sometimes different parts talk to us, including sexual and reproductive health and rights, but better communication, both internally and with clients like us, would help. We very much hope to fill those gaps or some of those gaps in terms of sexual and reproductive health, but there are still loads of issues. As you know, exposure to violence and abuse, helping people to report violence and take criminal proceedings where appropriate,

problems with forcing involuntary sterilisation and just not accessing comprehensive sexuality education are real issues.

DfID's record on sexual and reproductive health and rights is very good. In a world where, I am afraid, the United States is not positive in this regard, Europe and Britain have an important part to play. I hope that, as a result of your report but also in its internal thinking, DfID realises that, every time it talks about sexual and reproductive health and rights, disability is part of it, and disabled women and girls, boys and men, are vulnerable and excluded. All sorts of problems occur as a result.

Q48 **Mrs Latham:** Have the programmes you are aware of used any of their money or funding, or have you been able to use it, to ensure there is no discrimination against this basic right for people with disabilities?

***Professor Shakespeare:*** We have not yet used the money they have given us for research. It seems to me that the research programmes I was referring to include disabled people. With the other funding that we have received for research, we will be alive to all the rights of disabled people, including sexual and reproductive health and rights. I cannot answer for the other programmes; I am afraid I do not know, so it would be wrong of me to say something more general.

***Dr Alghaib:*** On that point, we are working with MSI on a project that is more about mainstream sexual and reproductive health. Our role as Leonard Cheshire is to come in with research and technical guidance specifically on disability. It is a five-year programme, and we are coming in to advise them at programme and policy level, and generate evidence to inform Government systems, but also the programmes themselves. They specifically indicated that in the allocation of budgets and activities. We will be working with them systematically on that.

***Professor Shakespeare:*** The DfID help desk has material on HIV and gender-based violence relevant to disability, so it has invested time and money to answer questions from country offices on how to work in that area, which is heartening.

Q49 **Mrs Latham:** That is good. You mentioned safeguarding issues earlier. Is there anything that DfID should be aware of, specifically related to people with disabilities, in terms of sexual exploitation and abuse?

***Professor Shakespeare:*** The evidence we published in the *Lancet* was that children with disabilities were three times as likely to be victims of violence generally, but including sexual violence and abuse. We must be aware that this is a priority population and any interventions in the area of safeguarding have to include that. Again, I am sorry that is general, but DfID is aware of those data.

***Dr Alghaib:*** This is something that we need to reemphasise, because DfID needs to invest more in this area. We know that it is a most vulnerable population, but there has not been enough evidence to say not just where the system fails, but what solutions could come in to ensure

the accountability mechanism is right and in place, where language, accessibility and access to information could be barriers.

Sometimes there are mechanisms in place. Coming back to our programme in Kenya, we had a very strong mechanism in place but, when we looked into it two years ago, we realised that many of the parents of the girls in the villages did not know that it existed. We had to invest further to ensure access to information is well established with all the workers who are in connection with those families to inform them and teach them how to use the system. It is not just something that looks nice from the outside, but we have to ensure it is used effectively.

***Professor Shakespeare:*** We did a review of access to child protection mechanisms and found that it was very poor for disabled children in sub-Saharan Africa.

Q50 **Mrs Latham:** Is there anything specific DfID should be looking at and taking note of in its policies towards safeguarding people with disabilities in relation to sexual and reproductive health?

***Professor Shakespeare:*** Involuntary sterilisation remains a pressing issue and a grievous violation. We ought to be thinking of long-term contraception. There is evidence from high-income countries of young women with intellectual disabilities being on long-term contraception and now, from the ECHO trial, we know there are HIV transmission risks for people on injectables. None of that has really been considered from a disability perspective. Whatever the topic is in sexual and reproductive health, taking a disability lens and asking how it affects disabled populations is critical. It should be mainstream.

**Mrs Latham:** It should be in every policy and at all levels.

***Professor Shakespeare:*** It definitely should.

Q51 **Chair:** Ola, in an earlier answer to Paul, you contrasted DfID's engagement with civil society to its more slightly more cautious approach with Governments. Are there other donors that do that side of things better? Is there anyone we could learn from, in terms of a better engagement at Government level, as well as civil society level?

***Dr Alghaib:*** There are mechanisms out there that need further looking into. For example, the UN Partnership to Promote the Rights of Persons with Disabilities is a mechanism that exists and should be supporting collaboration across countries, through UN agencies and Governments, but the space needs looking into further. I cannot tell you for a fact if there are good practices out there, but I feel it is an area that needs further review. We are 12 years away from the UN Convention on the Rights of Persons with Disabilities and, I am sorry to say, the evidence says that country changes are still not happening at the level of expectations, which means there is something wrong with all the investment. We know that investment on disability was not enough, but there was quite a lot of investment. To understand and analyse that

space, I would advise DfID to look at where the money went. That tells you a lot. Try to understand whether it went in the right direction and really changed things at the level that was anticipated by now.

**Chair:** Thank you both very much indeed for your evidence today. Please feel free to stay for the other two panels. I will invite Parmi, Julian and David to join us, and thank both of you for your evidence this afternoon.

## Examination of Witnesses

Witnesses: David Constantine, Parmi Dheensa and Julian Eaton.

**Chair:** For this second panel, again we have about half an hour and, essentially, we are seeking to cover one area with each of you. Whereas in the first panel both panellists were answering questions, each of us will have a specific set of issues to raise with each of you, in turn.

Q52 **Henry Smith:** Welcome to the panel. I will direct my first question to you, Parmi. The Include Me TOO survey results suggested that education is the biggest change that matters to young people with disabilities. Do you believe this issue is adequately addressed in DfID's disability strategy?

***Parmi Dheensa:*** There are inroads to improve inclusive education for disabled children and young people, but young people were telling us that it is also about recognising and not limiting their abilities or opportunities. Of the young people who responded about the thing they would like to see change as a result of their participation in and contribution to the Global Disability Summit, 33% wanted access to good, inclusive education, and 31% said they would like to see the removal of stigma and discrimination.

There are lots of cross-cutting themes that go through, so it is not just about looking at education on its own. It is about removing stigma and discrimination, and ensuring that every child can reach their potential regardless of what their additional needs and requirements may be. It is also ensuring they are not limited in their extracurricular activities. They shared with us that they wanted to ensure there was alignment between job opportunities and training, better partnership working and better pathways of support to employment and businesses.

They also had key concerns, just looking at education, about ensuring not just accessibility and inclusion, but attitudinal, systematic and cultural change at the same time. It is about ensuring they have a sense of belonging and are valued; they are not seen as depleting or taking on too many resources unnecessarily, because they are not valued in terms of what their contribution can be.

As for DfID, some areas can definitely be a lot stronger, with changes to the terminology, so it is not only about academic achievements, but supporting lifelong learning, so that everybody has something to contribute and an equal value. That is definitely one of the key messages that came from children and young people. They want to be able to contribute, whether in the academic world or education, in sports or by having the personal and transferable skills to become more independent. It is looking at it more holistically and ensuring that nobody is left behind or penalised because they are not able to reach a particular level in their education or ability to access academia.

Q53 **Henry Smith:** I have a couple of follow-up questions. Do you feel that DfID's Get Children Learning policy is sufficiently integrated into the disability strategy?

***Parmi Dheensa:*** There definitely seems to be a shift towards saying that we need to start looking at how we can be more inclusive, in terms of the strategy and the outcomes that DfID is focusing on. For example, at the Global Disability Summit, there definitely was a focus on inclusive education. As for whether we think they are moving in the right way, there is an element of saying that it is about looking at what we can learn from the UK here. In terms of DfID, it is about looking at all the good practice that is happening, because here in the UK we have lots of discrepancies within our own educational system. We cannot turn around and say, "We are a universal leader on this." We still have a long way to go when it comes to inclusive education. Inclusive access is about accessible resources and accessible curriculums. We know how many children and young people are being excluded here in the UK. With DfID, if our target is measuring by what the UK does, we need to look much more widely than the UK and at good practices globally. We should not be complacent regarding the areas where we fall short in the UK at the same time.

Q54 **Henry Smith:** That leads very neatly to my next question. I know that Include Me TOO does a lot of work here in the UK. How do you feel our international development efforts could take lessons from the experience that Include Me TOO has of the educational experience, particularly, of disabled young people internationally?

***Parmi Dheensa:*** It is about listening to DPOs, disabled people's organisations, on their shared, learned experience. Many fantastic young disabled people who are activists have had experience that we can learn from internationally. It is about working alongside NGOs that are supporting families and carers. One area that was highlighted in the strategy and in the policy was a recognition of institutionalism, how excluded children and young people can be, and how that can also be lifelong exclusion. Once they are in the system, it is very difficult, in terms of having them taken from there. We have heard, here in the UK, about what has been happening with assessment and treatment units. It is important to look at lessons that can be learnt here in the UK while, at the same time, looking at some of the strengths.

We have had some great programmes in the UK. It is great that resources are being put into advancing disability inclusion and advancing, for example, inclusive education from early years, hopefully all the way through into higher educational lifelong learning. What ends up happening is that, when the resources are no longer there, that tends to disappear. Here in the UK, we have had some fantastic initiatives, for example the early support programme. When it is resourced, it really makes a difference, by wrapping services around families, making sure they understand diagnostic assessments, making sure the child gets the support they need, and having a holistic approach to meet their healthcare, social and educational needs. Without resources, it does not necessarily continue.

The other element is that we have to make sure the transition from childhood to adulthood is not the poor relation in the life journey. What usually ends up happening is that there can be a lot of support when they are children but, when they move into adulthood, we find that everything from social and financial support to opportunities tends to reduce quite dramatically. Once again, there have been fantastic programmes, looking at inclusive play. Children and young people also want relationships and friendships outside school. They want to be able to foster those. Sadly, because of stigma and discrimination, as we know, there are high levels of bullying. That happens internationally, as well as in the UK. It is about fostering those relationships, breaking down the stigma and discrimination these young people face, and working with those who have lived experience, as well as with NGOs.

Whether it be in the voluntary community sector or whether it be through support from Government funding, there are several programmes that have worked extremely well. We have had good employment programmes. We have had inclusive programmes. There is the DPAC model, which supports childcare and young people providers to look at how they can be more inclusive and ensure that there is accessible provision for disabled children and young people, so they are not seen as the other and they can get involved in what their non-disabled peers end up benefiting from.

It is about bringing people together and sharing the journey we have gone through over the last 10 years, what has worked over the last 10 or 20 years and what we need to revise. Instead of pulling down infrastructures that previous Governments have, sometimes successfully, delivered in the community, it is about how we build upon what works instead of tearing it down due to politics et cetera. There have been some great initiatives that have really supported the communities and the various young people and children we are talking about today.

Q55 **Chair:** Julian, mental health is a cross-cutting issue in the DfID disability strategy. DfID says that it wants mental health to be considered in all its activities and, therefore, it would not be the right approach for it to have a specific policy marker for mental health. Do you agree with that?

***Julian Eaton:*** I agree with the first half of that, not the second half of it. There is no question that the only way to do mental health well is to recognise its cross-cutting nature. We have a clear priority of DfID on vulnerable groups. In almost every case, those particular vulnerable groups have a higher risk of having mental health problems themselves. It would be inappropriate just to focus on mental health as a health issue in a vertical programme under DfID health. At the same time, that does not mean you cannot measure it or you should not have a clear focus and agenda that is evidenced-based and has a clear budget allocation, for example. Yes, it should be cross-cutting but we also need to be clear about what we think we can achieve within each of those different cross-cutting sections.

Q56 **Chair:** Thank you for that. In a letter to us, DfID said there are no specific codes for tracking spending in the area of mental health. What sort of measures do you think DfID should be putting in place to track spending that is to do with mental health?

***Julian Eaton:*** First of all, it is untenable not to track something. If you value it, you need to track it. We know the amount of attention and focus on a topic tends to follow the degree to which people are judged around their success on it. There is a huge momentum in global mental health at the moment, which is very exciting and we need to build on it. DfID has demonstrated some real progress in the strategy and work on learning across the organisation. We have heard of some of the limitations of some of the existing measures. The Washington Group, for example, has a very, very poor means of addressing psychosocial disability, which is not included at all in the short set, which tends to be all that people use. The long set often does not often get a look-in.

There are very good measures that can be used across a variety of purposes, whether you want to screen or do much more in-depth measurement of need or a wide variety of needs. They just need to be used properly. Tom mentioned earlier the importance of making evidence accessible. Global mental health as a discipline now has a 20-year track record of building up this evidence. DfID is starting this work and really needs to work with the people who have been doing it for some time, in order to access that evidence and put it in the hands of the people who are going to be doing the work at country level.

Q57 **Chair:** Can you give us one or two concrete examples of ways in which the data gap left by the Washington Group's questions could be filled, particularly as it relates to mental health?

***Julian Eaton:*** Okay. The Washington Group is only trying to do one thing. First of all, even if it was perfect on mental health, it would not be able to achieve a lot of the other things we are trying to measure. The main thing about it is that it has a desire to do something very, very briefly and very quickly. It attempts to pick up the functional impacts of physical and sensory impairments, which cannot be done so easily for the much more diffuse social impacts of certain mental health problems. That

does not mean it is not important. You often get this conflation between what is easy to measure, which tends to be overvalued, and what is important but quite complex to measure. It has not been able to quickly and easily address asking questions in a very simple way, but that is not to say it is not important. It does cognition relatively well, even within the short set. In the long set, the two questions there, one on depression and one on anxiety, are sensible because they are the most common diagnoses, but they are diagnoses, and this came up against a lot of opposition from the disability community because they were specifically asking about people's diagnoses rather than asking about the functional impact on their lives of having mental health problems. That is an issue.

One issue with the way mental health is kind of everywhere, but is also a very discrete problem for some people causing profound disability, is that you have to find the balance between not everyone reporting not feeling well-being—which is important to them, and something they value and want to do something about, so we should be in the business of thinking about it—and not leaving out people, for example, with very severe schizophrenia, who have extremely high rates of unemployment and are not able to access services, or even access legal rights like voting in many countries. We need to find that balance by doing both. There is not something perfect in between. You need to address well-being across the range and to have specific, focused programmes that address people with very severe conditions that lead to profound psychosocial disability.

Q58 **Chair:** As you will know, we are determined to focus on safeguarding throughout the work of this Committee. Are there particular issues with regard to safeguarding for people with mental and psychosocial disabilities that either the Committee or DfID should be aware of?

***Julian Eaton:*** Only that, as with other disabilities, people with psychosocial disabilities are at particularly high risk of abuse and violence against their body. That is also true of people with intellectual disabilities. Where people are seen as not having power, they are much more likely to be the victims. That is the main thing. You talked about measuring earlier. If you do not do proper measurement and understand the vulnerable groups you have in your community, you cannot target resources to the people who have particular needs. That is very true of safeguarding as well.

The other fact is that many of the same people often have multiple risks, so people with other disabilities, people who are very poor or people who are in warzones also have higher risk of mental health problems. There is often this overlapping nature of risk where the same people have a cluster of risk together. Therefore, with regard to safeguarding, you know you are going to have people with psychosocial disabilities who also have a number of other risks associated with violence against their body.

Q59 **Chair:** One of the contexts in which we have looked at this as a Committee is the situation where people are refugees. The two that come to mind from the work of the Committee over the last few years are

meeting Syrian refugees in Lebanon and Jordan and, more recently, Rohingya refugees in Bangladesh. Can you draw upon any evidence of either good practice or gaps in provision, particularly with regard to the psychosocial support for refugees?

***Julian Eaton:*** To DfID's credit, it is leading on this. The first Global Ministerial Mental Health Summit was held in London last year and the next one is going to be in Holland, and the focus is going to be mental health and psychosocial support in emergency settings. The UK is one of the countries leading on a funding group for mental health and psychosocial support in emergency settings. It has been a bit easier to track spend on this area than on some other cross-cutting issues in DfID. That is really positive. There are some very good examples of work in this area. The area of mental health and psychosocial support in emergency settings has a longer track record than mental health in long-term development. It is so patently a need. More money has been devoted to it for longer. We are better at measuring it. The international organisations that devote their attention to emergency response have for a long time demarcated resources to mental health and psychosocial support. We some really good learning on that.

Practical examples are: thinking across the spectrum, including the huge proportion of the population who are distressed by an emergency, but not diving in with professionals to solve their problems, which we know does more harm than good; recognising the importance of local infrastructure and the value contributed by the people who are normally turned to for emotional support in distress, so the priests, the grandmothers, the people who are there; but also not forgetting that there are people with much more severe problems, for example people locked up in institutions, who often stay locked up in institutions, not being fed when there is a very rapid emergency and staff run away. Learning has meant we have been able to traverse that range, from the general needs of a population right through to making sure there are specific interventions for people with very severe needs.

Q60 **Mrs Latham:** David, you have been sitting waiting very patiently. We have a cross-cutting commitment to ask you about. What could DfID do to ensure its particular cross-cutting commitment to assistive technology meets the growing demand, given an ageing population and other factors?

***David Constantine:*** First, thank you to DfID for taking disability so seriously. I have been in the sector for 28 years, and last year was the first time that this has been so high on the agenda. The Secretary of State has signed it off and it is fantastic to see. It is also fantastic to see that assistive technology and innovation was part of the four themes. We were really disappointed when we saw that it was a cross-cutting issue, because our experience of cross-cutting issues is that within two or three years they are forgotten about. This is a key thing for us. It needs much greater investment and, like you said on mental health, it absolutely

needs keeping up there. It may not be a pillar, but without assistive technology, you are going to leave a huge raft of people behind.

Five of us in the room today would not be here without our assistive technology. We would not be doing our jobs. We would not be getting out of bed, in my case. It is crucially important, whether it is a pillar or a cross-cutting issue. Lord Bates said in the previous hearing that it was key that the cross-cutting issues stay as important at this high level, in how they are addressed, as the pillars.

Q61 **Mrs Latham:** Do you think DfID has the right data to deliver this, in terms of particularly older people who will need more assistive technology as they get older? It also affects younger people who are disabled from birth. Lots of us are getting older and lots of us acquire disabilities, but an awful lot of people have them at the beginning of their lives. Is it something they have enough data on?

***David Constantine:*** I do not think so, no. It needs to be done. As you heard from Tom and Ola, a lot of work has been done on disaggregated data. When you get into that kind of detail, I do not think DfID has that kind of data.

Q62 **Mrs Latham:** Do you have any solutions as to how they could get it?

***David Constantine:*** I do not, apart from doing a lot more research. I would warn DfID against spending an awful lot of money and time on research, fulfilling people's PhDs and writing papers when it comes to very practical needs. You can write a paper about the need for wheelchairs, prosthetics and orthotics or hearing aids. Does it help an organisation in the field, the Government of that country or a local organisation producing AT to actually make things and provide them responsibly? Not really. There needs to be a huge amount more investment in the actual delivery and innovation, and looking at what is still available, what is low cost but good quality and appropriate for those settings.

There are many Governments—India is one; Kenya another—who really want to start their own production. Kenya, for example, has a need for 120,000 wheelchairs per year. There are 5,000 being delivered every year in a population of 49 million. They are not meeting the need in any form, whether it is made locally, shipped in or donated. DfID is way behind on considering assistive technology. There is an awful lot of catching up, of many years, to do. Six or seven years ago, DfID was proudly saying it had put so many ramps into schools in east Africa, but where were the children with the mobility tools to get to school?

Q63 **Mrs Latham:** Particularly if they have three or four kilometres to walk.

***David Constantine:*** Exactly, and over rough terrain. There is a need for the development of products but there are a lot of things around. That takes investment and it takes the right skills for training on how to deliver them responsibly. When you are dealing with AT, you can do harm

as well as you can do good. You can give someone the wrong spectacles, the wrong hearing aid or the wrong prosthesis. You will have a problem, especially for children as they are growing. It is important that the right product is provided in the right way. While there is research needed on what the need is, we know there is a massive need out there. Investment is needed into those practical solutions and the correct delivery of them.

Q64 **Mrs Latham:** You mentioned in your written evidence that assistive technology is essential to achieving DfID's objectives under each of its pillars, although it is not a pillar in its own right. How can DfID practically ensure this is captured in the programming?

***David Constantine:*** I commend DfID for doing the programmes AT 2030 and ATscale, which were announced last year at the Global Disability Summit. Again, that is the first time anything nearly as practical as that has ever been talked about or done. What happens after ATscale? Is it going to just stop? Will it have reinvestment? I know more money has gone in recently, but it is a long-term game. You either start using an assistive device early on in life or, as you said, you come to it later in life, but it is a long-term need. In 2030, we are all going to be 11 years older. Do you think our need for assistive technology will be any less? No, it will not. The WHO estimated, and I am sure you heard, that a billion people in the world need some form of AT now. By 2050, that will double to 2 billion. There is a huge need out there. DfID needs to catch up. Ensuring it goes right across every pillar is crucial. Without it, people cannot live a fulfilling life. Without it, the commitment to "leave no one behind" will never be met. We are all going to need it at some time, whether we consider ourselves to have a disability or not.

DfID has an opportunity in these particular programmes. The disability theme is key and has only just come around, after all these years. What about the bilateral funding, the larger pots of money, that DfID gives to, for example, the WHO and UNICEF? They could be made to commit to take disability seriously, but also the assistive technology side of things, so that, when they are working in the field with member countries, they are insisting to those Governments that people's needs for assistive technology are met within those countries. Four years ago, the WHO created the Global Cooperation on Assistive Technology, the GATE movement, which created a list of 50 essential devices that Governments should be providing. They can pay lip service to that but, if DfID stepped up beyond ATscale and said, "Okay, every bit of funding we give bilaterally to Governments has a commitment to it that you will start to look at the correct provision of AT and the right products within that list of 50, and the right way of providing them," that would be a good start. You can provide them very badly or with no service or assessment of any kind, and you will do harm.

DfID has a real opportunity if it takes a step back and takes a bigger picture look at what it is doing. AT 2030 and ATscale are great starts and

I really commend them for doing this. It is very exciting, but there is a whole lot more that could be done.

Q65 **Mrs Latham:** DfID, in its evidence to this Committee, mentioned market-shaping initiatives, like making advance market commitments to first create the demand, then the supply. Could this technique work with assistive technology and what other market techniques could DfID apply to this area?

***David Constantine:*** It could, but you still need it on the ground. With the market shaping, it is about talking to suppliers and procurers, and getting mass procurement together, but on the ground it still takes an individual prescription of a product, whether it be a limb, a wheelchair or a hearing aid. There is driving down these big commitments to procurement and getting the right products, but then there is getting it down to the person who requires it responsibly and correctly. You need to look at all levels. That could work.

Personally, until last year, I had never heard of market shaping. I have been at meetings where it has been explained. I am not aware of how else you would do it, but look at the models they put together in ATscale. This has been proven in the pharmaceutical and antiretroviral area. It certainly can work. We have seen them go down from thousands of dollars to tens. That could happen with AT. The difference between a $50 wheelchair and $150 wheelchair, even though that may seem cheap to us, is a massive difference to that user on an everyday basis. That goes for every piece of AT. It needs to be low cost but it does not need to be so cheap that it is poor quality. People deserve better than a donated thing just because they cannot afford it.

**Chair:** Thanks very much to our three panellists. As I said to the previous panel, please feel free to stay if you wish to, to hear the third and final panel. I will invite Juliet, Mosharraf and Tom to join us.

## Examination of Witnesses

Witnesses: Mosharraf Hossain, Juliet Milgate and Tom Palmer.

**Chair:** Welcome. Again, we have around half an hour. There are three lines of questioning, one to each of you.

Q66 **Paul Scully:** I will come to you, Tom, if I may, at the beginning. There are many aspects to disability in conflict situations. Does DfID's strategy take a comprehensive approach to this issue in terms of both its approach to the humanitarian response and its programmes in conflict and post-conflict situations?

***Tom Palmer:*** Thank you very much for the opportunity to speak. First, we should definitely welcome the fact that humanitarian action is a pillar in the strategy. This follows on well from DfID's commitment at the World

Humanitarian Summit in 2016 on the Charter on Inclusion of Persons with Disabilities in Humanitarian Action. DfID has included a number of very practical measures under this pillar in its delivery plan, which should be welcomed, in terms of the work it is doing on data, building on the work that DfID has supported on humanitarian inclusion and testing the Washington Group questions in humanitarian settings. As we have heard, they are not a perfect solution but they fill an important gap, certainly in humanitarian settings, where it is such a resource and time-scarce environment. We are looking forward to seeing DfID follow through on the work it is doing with the UN on including an indicator for payment by results, to ensure that UN agencies are collecting and disaggregating data, and including it in their assessments and planning.

We also recognise and value DfID's commitment to generating evidence, because this is an emerging area for humanitarian actors, sharing lessons and funding innovation. We should recognise that a lot of this requires a fundamental change in how humanitarian actors perceive persons with disabilities. Usually, there is an assumption that persons with disabilities first and foremost need healthcare, but the needs of persons with disabilities go way beyond that. In humanitarian action, all essential services need to be inclusive of persons with disabilities. There is an assumption that persons with disabilities are recipients of aid alone, when we know that persons with disabilities can be active agents in humanitarian action, and organisations representing persons with disabilities can be really positive partners in humanitarian action. There is a gap perhaps, under the humanitarian pillar, in what DfID sets out to do working with DPOs in conflict and disaster situations. There are some really good examples where humanitarian actors have worked with DPOs to ensure that humanitarian action is more inclusive. That is something we would encourage DfID to articulate more on.

There is also a good response in the delivery plan about trying to ensure that any applications for funding from DfID consider disability and include measures to remove barriers for persons with disabilities to access humanitarian assistance. We would urge DfID to continue the work it is doing with the OECD DAC on the marker, to ensure the guidance comes out on how the disability policy marker can be used in practice so that, in humanitarian contexts, there are enough examples and guidance for DfID's own programme managers to use that marker more effectively. That is going to require training as well.

We would encourage DfID to look at that marker and at systematically scoring funding proposals and applications on disability and inclusion, alongside other risk factors and issues around gender and age, to ensure that intersectionality is considered at that stage as well. Looking at DfID's rapid response facility, it is important, during the pre-vetting of partners, that DfID considers to what extent those potential partners are prepared to include persons with disabilities in their actions. Preparedness, I would urge, is perhaps lacking in the strategy under the humanitarian pillar. We know that for every pound spent on preparedness, you save nine in the

response. That applies to disability and inclusion as well, to ensure that DfID is ready to include persons with disabilities in its actions and that the organisations it supports to provide the response and protection are also ready. That includes preparedness for working with DPOs.

Q67 **Paul Scully:** Tom, I believe you are seconded in-country to DfID Syria at the moment. What efforts is the team there making to mainstream disability inclusion among its programmes?

***Tom Palmer:*** This has been a great opportunity for humanitarian inclusion to work directly as seconded staff, me and a colleague, with the DfID Syria team. Already, we have learned a great deal about how DfID can make use of these external resources going forward. From the outset, there is a temptation to look towards getting quick wins and working directly with DfID's implementing partners on the ground. We have an imperative to ensure that the humanitarian programming arm is more inclusive. There is a need to balance that against the longer-term investment in the capacity of DfID's own staff, working directly with their programme managers, advisers and social development advisers to ensure that this work can continue beyond a temporary secondment like we have at the moment.

We have, directly with implementing partners, been focusing a lot on data, ensuring they understand the importance of collecting data on persons with disabilities, they know how to do that and they know how to use that data, both in reporting to DfID for accountability purposes, and to understand how they can adapt their programming for it to be more inclusive. There are lots of signs of progress. DfID's downstream partners, the INGOs and the local organisations, are doing a lot, with DfID's leadership but also with their own initiative, to include persons with disabilities in their programming.

We would encourage DfID, on a country-by-country basis, to do more to develop theories of change. DfID recognises that the general theory of change that accompanies the strategy is not necessarily applicable in conflict situations. We know that theories of change have to be contextualised because change happens in different places in different ways. In the humanitarian system, things work differently than in the development system. In order for DfID to integrate all the different cross-cutting elements, in terms of mental health, assistive devices, tackling stigma and discrimination, that needs to be articulated in a very robust and concrete way, based on contextualised analysis of the risk factors in a particular location. That is going to change dependent on whether it is a disaster, a conflict situation, an acute crisis or a protracted crisis that goes on for years and years.

We would be really encouraged to see that protection risk analysis in humanitarian response strategies going forward. We are currently working with DfID Syria as it updates its humanitarian response strategies and thematic strategies on livelihoods, education, et cetera, to ensure that disability inclusion is mainstreamed within all those

strategies. In terms of the demand from DfID staff for support, we can see that, for this disability inclusion strategy to have traction with DfID's programme managers and advisers in country, they need to know how it articulates with all the other strategies and priorities that are on their desk.

We do not want disability to become just another item on a long list of priorities that have been passed down. DfID needs to understand and make the linkages between the commitments it has made—for example the grand bargain at the World Humanitarian Summit. These are shared commitments between donors and humanitarian actors on localisation, participation and reducing reporting requirements. All those elements have implications for disability inclusion. DfID staff will be much more inclined and responsive to these requests on disability inclusion if they see how they articulate with the initiatives they are already working on, so it becomes habitual and routine in their work. Working towards the minimum standards that DfID has set itself to achieve this year, it will be important that it is not just another piece of work put on the desk of someone who is already working at 120%, but it is integrated into the work they are already doing.

Q68 **Chair:** I will move to Juliet and some questions on health. In your written evidence to us, you highlight the lack of specific actions on health system strengthening and universal health coverage in the disability strategy. Tom Shakespeare made a similar point about health and the strategy in his evidence earlier on. Is there a risk here that disabled people are being left behind in DfID's work on access to healthcare?

***Juliet Milgate:*** Thank you very much for your question. I will just say thank you very much to the Committee for inviting Sightsavers and the Bond Disability and Development Group to attend here today. The disability strategy and delivery plan, in our view, do not compel health advisers at DfID to take account of the needs of people with disabilities. In the delivery plan outside of mental health, which we have already discussed, the only concrete action on health is the publication of a health systems position paper by 2023.

For us, universal health coverage is absolutely essential. DfID talks about it within the context of the strategy, but unfortunately does not have any concrete actions attached to it. The purpose or goal of universal health coverage is to ensure that everyone has access to the health services they need and that in accessing these health services they are not pushed into further poverty.

Progress on universal health coverage covers two domains. The first is coverage. What population are you covering? Who are you reaching? For us, that means people with disabilities. Secondly, it is about health intervention coverage. What health interventions are being provided? We talk about the access to the essential package of health services. We know from the WHO that more than 50% of the global population already do not have access to basic health services. This is a huge coverage gap.

The second aspect of universal health coverage is financial risk protection. That is ensuring that the necessary finances are in place so that, when you access health services, you can afford them and you are not pushed into poverty.

To deliver this strategy of universal health coverage through the paper, you need to invest in health systems. Health system investment is critical. A recent ICAI review of the work that DfID has been doing on maternal and child health in DRC in 2018 highlighted that, while DfID was delivering maternal health interventions incredibly well, it was much less effective at understanding what it meant to support an effective, functioning health service and to effect policy change at national level. It needs to focus on investment in health systems and do this through the paper.

That requires investment in governance, creating the right health infrastructure at national level; investment in human resources for health, so recruitment, retention and remuneration; supporting national health financing policies; supporting Governments to develop national statistical capacity and information; investing in quality health services, because there is no point in attending a health service if you come out in a worse state than you went into it; and investing in health information and resource.

Q69 **Chair:** You mentioned the proposed health system strengthening position paper. Are you being consulted on that? Is there any engagement with Sightsavers and others on that?

***Juliet Milgate:*** Yes. The DfID team is engaging through the Action for Global Health network on the health system strengthening position paper. DfID, under the disability strategy, is also required to engage with disabled people's organisations, so I very much encourage it to engage in that method as well. The health systems strategy has been in development for some time. We would welcome further consultation on it. We have some concerns about its current framing around universal health coverage. At the moment, it lacks specific priorities and actions on health systems. We would like to engage further with the Department on this, but it is engaging on it, yes.

Q70 **Chair:** Are you able to tell us a little more about what your concerns are?

***Juliet Milgate:*** The health position paper has some really strong, positive things. It understands the impact of an ineffective health system on the well-being and health of people with disabilities. It recognises the need for a multi-sectoral approach and recognises the "leave no one behind" principle, but it conflates an understanding of universal health coverage with health systems. One is a vision and a strategy, and the other is the system to deliver that strategy. There is a bit of confusion there. Because it does not set itself priorities for what it wants to achieve in health systems, it is very difficult to measure the extent to which it is having an impact on the lives of people with disabilities and, in fact, the

lives of anyone, since you do not really understand what the priorities are in the health system.

Q71 **Chair:** Can I ask about some issues relating to prevention of impairment? We received some evidence that the causal link between certain neglected tropical diseases and disabilities is not really addressed in the disability strategy. Do you agree with that criticism? If you do, what should DfID be doing in this area?

***Juliet Milgate:*** As the Committee may know, the phrase "prevention of disability" within the disability sector is incredibly challenging.

**Chair:** That is why I did not say that. That is why I did not frame the question in that way.

***Juliet Milgate:*** To go on with that and to clarify why we think prevention of disability is an issue, it conflates prevention of health conditions, which is the role and responsibility of a functioning health system, with prevention of disability as a human rights issue.

Yes, I have read the evidence that the Leprosy Mission presented on neglected tropical disease. Sightsavers engages in neglected tropical diseases but not in leprosy. The Leprosy Mission is better positioned than we are to engage on that. I will say that we see neglected tropical diseases as a litmus test for universal health coverage and promoting equity. Neglected tropical diseases, as you know, are diseases of poverty that affect more than 1.5 billion people globally. They affect people living in impoverished conditions with poor access to water and sanitation, and can lead to chronic impairments, which are long term and often irreversible. They also link to stigma and social exclusion.

What does DfID need to do? At the moment, in contexts where neglected tropical diseases are prevalent, the health systems are simply not up to the job of meeting the needs of people. Effective prevention strategies exist but, as David was saying, access to rehabilitation services or palliative care is not in place. Morbidity management is core as well. As I said, it is a good litmus test for universal health coverage because to finish the job on neglected tropical diseases requires us to structure health services such that they reach the poorest, the lowest wealth quintile, the people who are affected by neglected tropical diseases.

The health position paper is a critical method for delivering this. This year in September, a high-level meeting on universal health coverage will be held under the auspices of the General Assembly. DfID is the leading global actor on both neglected tropical diseases and universal health coverage. It is critical that the UK has a voice in the negotiations that are leading up to that. It is critical that we engage, because the outcome document or the political declaration from that will shape the direction of international health dialogue and discussion for many years. The UK has an important role to play in contributing to that because of our leading expertise and support on neglected tropical diseases.

Q72 **Chair:** On the issue of healthcare system strengthening and universal health coverage, I think we have seen through all the evidence today and the written evidence the importance of disabled people's organisations having their voices heard. Can you point to any positive examples of a country that is succeeding in strengthening its healthcare system with support from donors and is giving a voice, as part of that, to disabled people's organisations?

***Juliet Milgate:*** I recently returned from Bangladesh, which provides a very good example of this. It has made significant progress on the achievement of the millennium development goals because it is particularly engaged and focused on maternal and child health and nutrition outcomes. The disability sector within Bangladesh is vibrant and engaged, and, importantly, really provides scrutiny of how the Government operates, the systems and health systems it delivers for the people of Bangladesh, and the governance and framework of that, in empowering communities to engage and disabled people's organisations to participate. Recently, the civil society there, led by Sightsavers and other organisations, did a shadow VNR report scrutinising the work that was being done by the Government in their achievement of the SDGs. Bangladesh is a very good example of that.

**Chair:** That is a perfect segue into our third line of questioning.

Q73 **Mr Sharma:** Mosharraf, you served as a country director in Bangladesh for over 20 years. What factors contributed to ADD International's success in implementing inclusion in Bangladesh over the past two decades? What learning can DfID replicate across the programmes?

***Mosharraf Hossain:*** I met you when you visited Bangladesh 10 years ago. The crucial point is this. People with disabilities have a high potential not only to change their own life but to change society and to contribute in the economy if they are given opportunities. Disabled people are at the forefront and are the change-makers of what we have achieved in Bangladesh during the last two decades and more. At ADD, we work exclusively with disabled people to build their capacity and strengthen their voice so their issues can be raised everywhere.

I can give you an example. In the previous month of this year, six disabled people from Bangladesh met in the CRPD to raise the issue and ask the Bangladesh Government to promote and protect their rights and reduce exclusion. Exclusion is a social and economic disease. These factors affect people with disabilities in my country and people with disabilities in Asia, Africa and Latin America. In Bangladesh, we worked in partnership with DfID, even when there was no disability strategy, to empower people with disabilities at the grassroots level. As they had a strong voice, disabled people took a lead role in changing their home, their society and even the policy of their country.

Bangladesh is an incredible country. At this moment, it has 11 million people with disabilities, which is one-sixth of the UK population. The land

is a mosaic of problems and solutions. However, we are now moving towards being a middle-income country and the British people are a genuine partner in our progress. For a long time, Bangladesh has had three favourable conditions for disability inclusion, but especially now: the high political commitments; a national action plan on disability, which was enacted by the Government in March 2006; and, in 2013, the Government passed the disability rights Act. Bangladesh is one of the 20 countries to enact CRPD. Bangladesh has always been at the forefront in taking these issues forward. There is a strong civil society and grassroots disabled people's organisations throughout the country.

When I was the country director, we supported disabled people in 29 districts, which is nearly half of the country. Other NGOs, like Sightsavers, also work in the country. In that way, civil society is working with the UK Department for International Development. The local disability organisations and the Government there work in collaboration and co-operation to take this issue forward. That helped us to support disability inclusion in our country. Disability was not included in the main MDG framework, but Bangladesh has included disability in the PRSP, the poverty reduction strategy paper. The disability movement is very strong. Over the last two decades, it started gradually and, as Juliet said, is now vibrant. It played a crucial role in taking the issues forward. We are helping, supporting and collaborating with them so disability issues are included in the long-term strategy, and to develop disability-inclusive policy and a disability-focused strategy. The Government has responded to these things.

DfID has a big role. Even when there was no disability strategy, DfID supported the disability programme. I implemented three projects in Bangladesh for promoting disability rights at the grassroots level and the national level, and strengthening the democratic process. In Bangladesh, disabled people participate in local elections and national elections. They even run for office in local government. It is not only about the economic outcome; they also work for the political, social and civil rights of disabled people. We implemented a very successful project, the economic empowerment project, and DfID supported that programme. There are local mechanisms, like the Manusher Jonno Foundation, and they are also supporting local NGOs in that way. There is a lot of collaboration and working together to take this forward.

Q74 **Mr Sharma:** ADD International suggested that DfID could engage more effectively with the DPOs on the ground. How could DfID encourage its country offices to do this?

***Mosharraf Hossain:*** I can tell you of some issues I have identified. Let me start from here. Last year, DfID gave us hope by pledging to put disability at the heart of what DfID does, mobilising the global actors for disability inclusion in the Global Disability Summit and launching an ambitious disability inclusion strategy. I firmly believe that, if these commitments are translated at the country level, it will engage more

disabled people in each country. First, DfID needs to make sure the four pillars and the deliverables are included in the country-level strategies because, if the documents of the country programmes are not disability inclusive, this issue will be forgotten. That is the starting point. The country office will develop its strategies, and several times I have participated in that process in the past, but that has to be done systematically so the country strategy becomes disability inclusive.

Secondly, resources are very important. Looking at DfID investment, at this moment, there are 24 active projects according to development markers. Out of these 24 projects, five projects are focused on disability. If disability is at the heart of what DfID does, all social development projects should include disability issues. Of course, that has not happened in the past because it was not a commitment before, but from now, from today, whatever project DfID undertakes, disability should be a focus. Then we can see the mainstreaming of disability everywhere. In Bangladesh, across these 24 projects, the investment is £818 million over several years. From my rough estimate, there is no more than £5 million or £8 million for disabled people. That is less than 1%. DfID has to be ambitious in allocating resources.

One of our economists, the director of the Centre for Policy Dialogue, Mustafizur Rahman, said that we need to allocate an uneven amount of resources to ensure equality of people with disability. People with disabilities are deprived generation after generation, so we have to allocate more resources for the equality of these people. In 2006, on international disability day, Kofi Annan, UN Secretary General, said that we need to redouble our efforts for the development of people with disabilities. From our experience of working with five countries in Asia and Africa, I believe the allocation of resources for disabled people should be quadrupled or quintupled in each country if we want no one left behind by 2030. If we are on a level playing field, if we become equal, no one is left behind. You need more resources, so we can be in the same way as we have three people here.

I strongly recommend that DfID plays a leading role in this area. DfID has to be bold in allocating resources to achieve the objectives of the ambitious strategy that has been developed. Why is it important to invest in disabled people? First, countries like Bangladesh should give importance to international co-operation to realise the purpose and objectives of CRPD; that is article 32. There is an urgent need to ensure social protection, employment and assistive technology to reduce poverty. Those are the needs of each country in Asia and Africa.

Secondly, if investment increases to create jobs, ensure access to education and skill development, people with disabilities will be developed as human resources, who can contribute not only to improve their own family but to the growth of the economy. As the employment of people with disabilities increases, aid will reduce in those countries.

The third point is on the delivery of disability-inclusive strategies. Quick delivery needs smart people. I completely agree with the ICAI recommendations to recruit more disabled people and have staff with real experience in disability inclusion. DfID Bangladesh has had a disability focal point for a long time. One of my ex-colleagues with a disability is working there as an employee. That practice has to be in every country office of DfID, but one or two people is not enough. If we really want no one to be left behind, everyone has a responsibility to take the issue forward. I suggest DfID staff, whether in health or the private sector, should be educated and trained on disability inclusion. My fourth point—

**Chair:** I hope your fourth point is your final point.

***Mosharraf Hossain:*** Let me conclude. Finally, the foundation of the disability movement is nothing without us. I am impressed that 100 disabled people participated in the Global Disability Summit. I contacted a range of people before coming here and they confirmed that the DfID Bangladesh office engaged their views, as DfID representatives directly and through their partners. They say that there is a significant change in DfID practices after the summit. However, it is not a step change. We have to ensure that DfID works for the step change that should be promoted, for us, the 800 million disabled people living in the world who are deprived of their economic and political rights. DfID has a big role, and can play a leadership role in bringing others along and taking this issue forward. Thank you.

**Chair:** Thank you very much. That is a brilliant final answer to end this evidence session. I am immensely grateful to all three of you, but in fact to all eight of the fantastic witnesses we have had before us over the last hour and a half or so. We are very, very grateful.