What makes a good Small Charities Challenge Fund application?

UKaid
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We're often asked by applicants what makes a good Small Charities Challenge Fund (SCCF) application.

There's no single answer to this, but in this document we have provided some examples of quality answers to some of the key questions in the form. These answers are intended as a guide only.

Commentary has been provided alongside the example answers to help explain why they are considered high quality. This should help you construct your own answers to the questions.

The answers have been taken, with permission, from an application submitted by new SCCF grant holder Carers Worldwide.

As well as the example application form, we also recommend you review our top tips document and other guidance before submitting an application.

1.2 Please describe your proposed project

Using a community empowerment approach, the project will pilot a holistic way of addressing the social and economic inclusion of 500 carers (90% women) of PWMIE/PWD in the sub-district of Savar, outskirts of Dhaka.

These carers are excluded from mainstream poverty alleviation programmes due to caring responsibilities and stigma.

Capacity building of partner staff, carers, local government and private sector personnel and other NGOs will raise awareness of the role and the needs of carers, thus reducing stigma and isolation, facilitating community inclusion of carers and PWMIE/PWD and promoting community care facilities.

The project will pilot for the first time in Bangladesh the CW model, which holistically addresses poverty and seeks to achieve systemic change.

The model has 5 elements:
1) Carers' support groups: creating social networks and supporting emotional wellbeing.
2) Health services: providing access to physical and mental health services, including counselling.
3) Respite: developing a range of alternative high quality care options, inc. community caring centres.
4) Employment, training and education: facilitating access to jobs/training/education that can coexist with caring responsibilities.
5) Advocacy: strengthening the collective voice of carers to advocate for their needs, leading to changes in policy and practice.

The model has operated effectively for four years in Nepal and India (see 3.14) and has proved successful, low cost and replicable. This pilot project will seek to ascertain the ways in which the CW model can be adapted for the Bangaldeshi context - political, cultural and demographic. It will pave the way for full scale implementation of an approach to achieve the social and economic inclusion of carers and their families that can be rolled out across the country through the network of NGOs with whom CDD currently work, and for whom they act as a training hub.

Careful piloting of the approach is necessary to ensure the appropriate model is developed for that next phase and will inform the development of a training module and materials, as well as engage NGOs and government authorities in the most impactful way moving forward. Carers will be organised into self-help groups to promote peer support, emotional wellbeing, access to services and the development of a collective voice to advocate for their needs. Carers will be assessed and matched with appropriate livelihoods options, and supported to initiate those livelihoods,

This sentence sums up succinctly what the project aims to do, how many people will benefit and where it will take place.

This sentence clearly summarises the problem the project aims to address.

These two paragraphs summarise the overall approach to resolve the problem.

In this section, the applicant has outlined the specific parts of the project clearly and simply.

Here the applicant is demonstrating evidence that the approach has worked before.

An explanation of how the pilot could potentially be replicated allows for the project to demonstrate potential for long term added value and sustainability.

thus lifting their households out of poverty, into long term economic security. Through structured feedback mechanisms and analysis of project progress and outcomes, a plan for scale up and roll out of the CW model in the most appropriate and cost-effective way for the Bangladesh context will be developed.

There will be an emphasis on engagement with existing local community, NGO and government structures in order to promote their involvement and ultimate sustainability and systemic change.

There is evidence that all key stakeholders will be involved in the project to ensure long term buy-in and greater sustainability.

3.4 Why is your project needed?

Bangladesh made commendable progress towards achieving its MDG goals, and poverty levels have reduced significantly in recent years. However, poverty pockets remain, attaining food security is a challenge and income inequality and economic inclusion of women remain concerns (MDGs Bangladesh Progress Report 2015). 31.5% of the population live BPL ($2 per day).

Carers of PWD/PWMIE and their families are at high risk of poverty. Recent surveys conducted by CDD estimate poverty levels of households containing a carer and PWD to be as high as 67% living in extreme poverty (less than $1 per day). Carers therefore represent one of the vulnerable groups currently left behind in Bangladesh's economic development. In addition, most carers are women: wives, daughters, sisters. This work goes unrecognised and unremunerated. 90% of project beneficiaries are women.

The applicant has presented a clear case of why the project is needed, using specific and relevant statistics to back up their argument.

In the context of the SDGs, the Bangladesh Government has published its seventh Five-Year Plan, covering the period up to 2020. It recommends reducing income inequality, and specifically mentions "eliminating physical and social barriers" as a key strategy to achieving this goal. Family carers of PWMIE/PWD receive no support or respite and are excluded from mainstream society. The impact on their emotional wellbeing, physical and mental health are devastating. Caring responsibilities preclude carers from IGA. Families are hit by income loss of carer and PWMIE/PWD. Poverty is multidimensional.

This response shows the applicant's knowledge of the Sustainable Development Goals (also known as the Global Goals), particularly in a country setting. It also recognises the Department for International Development's (DFID) frameworks, where their project aligns with these, and DFID in-country recommendations.

Carers are hard hit by all aspects of poverty. Using DFID's sustainable livelihoods improvement framework, it is clear that the target carers are impoverished in physical capital (caring limits access to mainstream services eg. health services, higher education); social capital (carers are excluded due to stigma of caring for a PWMIE/PWD as well as limitations created by caring; women are excluded); human capital (beneficiaries have missed out on skills training, IGA and mainstream development programmes); natural capital (the area is prone to flooding; agricultural land is degrading due to climate change; target families are landless, a key factor in persistent poverty) and financial capital

In this section, the applicant has analysed the drivers of poverty for their target group. This helps us to analyse whether their interventions and approaches are the right ones to address these barriers.

(at least 67% of the carers earn <$1 a day; households are hit by additional financial demands of caring for a relative with disability or MI).

By addressing deprivation across all poverty dimensions, household incomes will be raised above the poverty line. Carers will be more resilient and less likely to fall back into poverty at a later date.

3.5 Who did you consult with when you designed this project?

This project proposal has been prepared through a process of: drawing on current practice and experience of CW in its work with carers across Nepal and India; drawing on CDD's extensive experience of working with PWDs/PWMIEs and as a training agency in the project area; ongoing reflection on and evaluation of those practices and experiences; consultations with carers, their relatives with disability and MI and other family members; meetings with relevant stakeholders in and around the project area, including health workers and doctors, SHG members, teachers, representatives from women's groups, community leaders, microcredit groups, members of political parties, local and district level Government representatives, local NGOs and members of national level network bodies involved with mental health and disability.

Group consultation meetings were facilitated by CW and by CDD staff using participatory approaches. These involved 50 carers (M:5 F:45). CDD staff have met with officials at the Upazila (sub-district) Social Welfare Office to discuss the project and also staff of two local non-profits – Access Bangladesh and Village Association for Social Development (VASD) – to sensitise them to the issues of carers, seek their input on appropriate beneficiaries and plan out potential livelihood options for carers.

CW has implemented large scale, multi-year projects elsewhere in South Asia (including one funded by UK Aid Direct in Nepal). These projects have focussed on identification, recognition, support and empowerment of unpaid family carers through partnership with local NGOs, capacity building of those NGO staff, facilitation of carer-specific services and mobilisation of local government and other stakeholders. The achievements of those projects have been significant. Learning and experience from those projects has directly informed the process of preparing this project proposal. CDD has recognised the value of adding support for carers to its existing work with PWDs and to the training modules it offers as a training provider for over 350 CSOs working with PWDs across Bangladesh.

CW and CDD have been partners since early 2016, and over the last year have collaborated in designing this project, combining

It is clear from this response that the applicant has consulted with beneficiaries, communities, health professionals, local government and network bodies. By doing so they can ensure the project design reflects the needs of the beneficiaries and is also appropriate for those working in that setting. Local government support encourages greater sustainability.

Consultation with other non-government organisations who can support the work of the project is key to prevent duplication of activities and to offer support over and above the project interventions.

the CW model (adapted to account for local context, demography, community attitudes and government policies and practice), CDD's extensive experience and the opinions of beneficiaries and local stakeholders.

3.6 What do you want to achieve with this project?

Family carers are marginalised, excluded and unaware of their rights. Through a structured but responsive approach of community engagement, empowerment and capacity building, based on prior experience and consultation with local carers and stakeholders, the project utilises a holistic package including access to basic services (health, education and government development programmes); emotional support through expertly facilitated SHGs; promotion of sustainable livelihoods; close interaction with government authorities and local NGOs.

This will result in the achievement of the project outcome statement, which is: 500 carers have increased household incomes and are included in support groups, able to identify health issues and recognise the vital role they are playing for the cared for individuals.

This will be realised through a holistic package of outcomes and outputs, as follows:

- Outcome 1 - 67% of carers and their households living above the poverty line.
- Outcome 2 - 25 carers support groups promoted with 100% of carers enrolled and attending meetings regularly.

Additionally, 100% of beneficiaries will report improved wellbeing. 500 carers and families will have access to appropriate, high quality and timely medical advice and counselling and 350 will be in direct receipt of those services. 200 carers will be trained and engaged in a sustainable livelihood, compatible with their caring responsibilities and 150 other carers will be facilitated to access government financial support and programmes.

We expect to see significant change in community, government and NGO awareness of the existence of carers, their critical contribution to the disabled and mentally ill relatives for whom they care and society as a whole, and the varied impacts on them as a result of unsupported caring. It is hoped that this will leverage the support of all these stakeholders in moving forward an agenda that will address the needs of carers – social, emotional, medical and economic – resulting in their full engagement in co-production and roll out of a full scale programme working with and for carers across the region and nationally, fully involving carers themselves in the design and implementation and resulting in establishment of carer-specific services as well as long-term systemic changes in policy and practice.

A recap of the issue the project is hoping to resolve, as well as a reminder of the organisation's experiences in this area, sets the tone well for this answer. A detailed but clearly expressed summary of planned activities, with specific and clear targets for outcomes is outlined.

The applicant has also highlighted the additional benefits that it is hoped the project will have.

3.7 How will you achieve your objective?

The project and its objectives are underpinned by a comprehensive training and capacity building programme delivered by CW to equip staff of CDD with the understanding, knowledge and skills they need to engage with carers to meet their needs.

The training will cover identification of carers and assessment of their current situation and needs; ways to promote meaningful inclusion of carers; ways to engage families, communities and local stakeholders in recognition of carers; livelihoods assessment and promotion of caring compatible livelihoods. Carers will be organised into self-help groups to promote peer support, emotional wellbeing, access to health services and the development of a collective voice to advocate for their needs. These groups will form the core of the project, through which carers will be able to express their issues and needs, find common solutions, act collectively with the support of the CDD CFs to approach local services and government authorities and establish themselves as a visible presence in their communities.

The project area is ill-served by public services such as healthcare. In addition to difficulties faced by the majority, carers are particularly hard hit due to the constraints they have due to caring responsibilities. For example, they cannot wait a long time at the health centre and lack resources to buy expensive medicines/ treatments. Many cannot access appropriate, timely medical care and there is no psychological support or counselling. Yet we know carers are disproportionately affected by conditions such as back pain, high blood pressure, anxiety and depression and need physical and mental health support. Through medical assessment camps and sensitisation of government doctors on the typical medical issues facing carers, along with their service access issues, carers will be better able to access the care they need to address their physical and mental health needs. The project's three CFs will undergo barefoot training counselling and will start to offer those skills in the project villages to meet the emotional needs of carers as well as address the anticipated high incidence of anxiety and depression.

Carers of PWMIE/PWD and their families are at high risk of poverty. In addition to poverty caused by loss of income, the financial burden on families to pay for treatment is crippling. Carers are a significant loss to the workforce: most carers are aged 18 to 54 years, the most productive age for engaging in paid work. Carers will be assessed to find appropriate livelihoods, based on their interest, local appropriacy, sustainability and their caring responsibilities. They will be facilitated to access existing government training and support for livelihoods initiation and those experiencing the most severe levels of poverty will be supported directly by the project. Alternative community-based

An overview of the objectives and a succinct breakdown of how the programme would be delivered in-country is outlined at the beginning of this question.

In this section, the applicant has succinctly explained each problem and what activities will be undertaken to address that problem. There is a logical flow between the answers so that the reader can see how each activity can contribute to the outcome.

care options (centre and home based) will be explored. Households will be lifted out of poverty, into long-term economic security.

3.10 Is there a link to your host government's national or district level priorities?

The project will complement other poverty reduction initiatives in Bangladesh and links directly with the Bangladesh government's priorities.

In the context of the SDGs, the Bangladesh Government published its seventh Five-Year Plan, covering the period up to 2020. This targets a poverty incidence of 18.6% by 2020, with an extreme poverty level of 8.9%. It recommends reducing income inequality, mentioning "eliminating physical and social barriers" as a key strategy to achieving this goal. Without inclusion in the mainstream and economic empowerment, carers and their families, including the vulnerable disabled and mentally ill relatives for whom they care, are going to miss out completely on the positive effects of development activities being implemented by the Bangladeshi government and other NGOs in pursuit of the Global Goals. With the national government's renewed focus on tackling "poverty pockets", increasing economic involvement of women and increasing access to microcredit and training for IGA, the project specifically links with those areas.

This commitment by national government also means that the local political environment will be conducive to taking on new challenges and responding to the project's focus on carers as a vulnerable group and one which needs to be included in order to meet the government's poverty reduction and development targets at district and national level. In its seventh FYP, the government recommends reducing poverty by investing in milk production and agriculture to increase food security and supporting women and landless families through skills development and access to micro-credit and IGA. These recommendations are built into the project, linking project activities and aims closely with the context.

In addition to government priorities, the project also supports DFID Bangladesh's strategic priorities, which include "strengthening the ability and opportunity of people to earn..." By adopting an individualised approach, promoting IGA that can coincide with caring responsibilities and facilitating alternative care options in the community, the project will ensure that carers are once again able to do just this; earn a regular and reasonable living that is compatible with caring.

This answer is detailed and informed. It makes clear reference to national level priorities and how the proposal will link to those priorities.

3.13 How will you address gender inequality issues with this project?

Bangladesh is a male-dominated society and women are vulnerable. Bangladesh is ranked 119 out of 159 countries (Gender Inequality Index 2015). Women in Bangladesh face discrimination, so female carers are doubly marginalised due to being both a woman and a carer. Disabled women and those experiencing anxiety or depression are especially vulnerable. Gender awareness will be integrated into all training activities for carers, community and stakeholders.

Having CFs who are women encourages identification and participation of female beneficiaries. 90% of direct beneficiaries are female, reflective of the fact that most caring in Asian society is done by women. According to the 2013 Report of the UN Special Rapporteur on extreme poverty and human rights, heavy and unequal care responsibilities are a major barrier to gender equality and to women's equal enjoyment of human rights, and in many cases condemn women to poverty. CW and CDD will actively promote inclusion of women. Staff will support women's participation in carers' groups and encourage them to voice their concerns. Staff will talk to family members to ensure women are able to attend meetings as they do not have control over their own mobility. Where needed, women only SHGs will be promoted to facilitate community acceptance and women's freedom to become involved.

Women's confidence, involvement and leadership will be promoted through specific training activities, already used by CDD in SHGs of other projects. Having women in group leadership roles will ensure the needs of women are fully represented in advocacy efforts.

Generating an income will challenge the double discrimination women carers face, giving them greater independence. Research shows economic empowerment reduces gender-based violence. Earning members of the family dominate decision making in Bangladeshi families, so earning an income will promote women's status in the family.

The choice of IGA for women will take account of their protection needs and community norms. The differing needs and priorities of men and women will be identified and analysed through individual carer assessments at the start of the project. Men-only forums will be promoted where appropriate. Male members of staff will ensure specific issues of stigma and self-esteem experienced by male carers are addressed and community acceptance of their role is increased. Quantitative (attendance) and qualitative (level of participation, engagement and decision making) data will be collected and disaggregated by gender. The theory, strategy and approach underpinning the project are led by the philosophy of

The applicant has an excellent response to the question, not only recognising that women are discriminated against, but that as carers they are doubly marginalised. Efforts to mainstream gender equality are clearly outlined in the project activities, from participation to leadership, empowerment and accountability. The applicant has also recognised how important it is in this context to involve men in the dialogue.

'leave no one behind.' The small number of beneficiaries and close contact with target families ensure this can be a reality.

3.17 Please describe how you will try to ensure your project is as effective as it can be

The cost per head is of £100 per direct beneficiary is justifiable as we are accessing – for the first time – an excluded, hard to reach population, supporting DFID's policy of Leave No One Behind.

The approach, based on experience, consultation and beneficiary feedback from CW projects in Nepal & India, is effective. It holistically addresses lack of awareness, poverty, access/quality of services alongside building local capacity through proven training processes. Working with carers benefits whole families, reduces impact of MI/disability and returns people of productive age to work. 500 carers will benefit directly from the project along with 500 PWMIE/PWD and approximately 1,250 other family members (average family size 4.5 members) due to increased household income and social inclusion. Family carers provide the bulk of care for PWMIE/PWD, saving state and NGO sector huge amounts of money.

However, lack of support for their caring role and crippling poverty results in carers becoming users of health and MH services themselves, increasing demand for those services. Unsupported, carers become unproductive and unable to care. Costs to health services, local communities, NGOs and government of caring for PWMIE/PWD, without support of family-carers, is neither feasible nor sustainable. This project therefore represents significant VFM in terms of preventive cost saving to government and civil society. Our holistic approach ensures all facets of poverty and exclusion are addressed, leading to realisation of outputs and outcomes. Milestones and targets are monitored quarterly and annually to ensure the project is on track and allow necessary adjustments.

Working with government agencies and building local capacity through proven training processes will enable sustainability and successful policy engagement work. Capacity building of a core of CDD staff will produce a ripple effect in the project area in terms of skills and knowledge, maximising chances of meaningful government and community engagement to achieve outputs and outcomes.

Robust beneficiary feedback mechanisms will also contribute to effectiveness of the project as it will allow for adaptations in implementation to take place during the project lifetime if necessary. At the end of this pilot project, analysis of the project's learning and results which it is anticipated will lead to recommendations and writing up of an approach to enable future

Overall, this section on value for money is comprehensive. The applicant has given a clear justification and rationale for the cost, demonstrating the benefits it will bring. They have included the long-term impact on stakeholders other than the beneficiaries. The applicant is providing a justification for the cost per beneficiary and demonstrating that the approach they are proposing is effective.

This section sets out clearly the costs of not carrying out the intervention.

This section highlights the long-term impact the project will have on sustainability.

This example demonstrates that the applicant will ensure the project reflects beneficiary needs and by adapting and learning the project will be more effective.

scale up, the development of training resources and the delivery of a training module to other NGOs will also increase project impact.

4.1 What would the successful outcome of the project look like?

The project will complement other poverty reduction initiatives in Bangladesh and support DFID Bangladesh's strategic priorities. Staff of the local partner CDD will be trained and equipped to work effectively with the carers of PWD/PWMIE, facilitating the meeting of their needs in order to promote their own wellbeing and inclusion as well as the quality of life of those for whom they are caring.

500 carers will have access to a local support group and these groups will be creating a network of increasingly empowered carers, learning to advocate for their own needs. 500 carers will have access to improved medical services and counselling, able to have their own physical and mental health needs met in order that they may experience improved health and be in a better position to continue to care, with 70% directly accessing services. The combination of SHGs and improved medical provision will result in 100% of carers reporting improved wellbeing.

200 carers will be engaged in new livelihoods, which they are able to pursue alongside their caring responsibilities and 300 other carers will have the information and support they need to access government and private livelihood opportunities. Alternative caring options will have been piloted in the form of community centre-based care and home-based care, with recommendations drawn up for future roll out of the most appropriate models. In addition to the successful outcomes for project beneficiaries, the project will leave a legacy in the form of: an extensive published report on the situation and needs of unpaid family carers (produced from the baseline survey); a project design co-produced by CW, CDD and the project's key stakeholders and beneficiaries as a result of this pilot project, that will be appropriate to the Bangladesh context and which will contain recommendations for scaling up and rolling out of carers' programmes nationally; plans and recommendations for a training module on carers which can be rolled out by CDD in its capacity as a national disability training hub.

These project legacies will ensure that the inputs required for this pilot project will reach far beyond the project life time, project area and beneficiary group, with the capacity to positively impact the lives of thousands of unpaid family carers across Bangladesh.

This answer provides a very clear explanation of what will be seen at the end of the project period.

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