



**REPUBLIC OF KENYA
COUNTY GOVERNMENT OF NAKURU
DEPARTMENT OF HEALTH SERVICES**



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STANDARD OPERATING PROCEDURE	
THE ESTABLISHMENT AND EXECUTION OF SUPPORT GROUPS	
Prepared by: Name:	Date:
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Approved by: Name:	Date:
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Valid for two years:	
Review Date:	

1.0 Introduction

Strengthening the health system is a crucial approach to improving health care. Nakuru County, through the sixteen primary care networks (PCNs), is in the process of establishing, strengthening and the guidance for the formation and management of support groups.

The purpose of a support group is to provide an opportunity for people to share personal experiences, feelings, and coping strategies to attain higher levels of well-being and improve their quality of life.

The support group will also allow the clients/members to be reviewed, screened, refilled prescriptions and referred by the clinical team.

2.0 Objective

To guide the formation and management of support groups, ensuring access to and quality care for the beneficiaries.

3.0 Scope

This Standard Operating Procedure (SOP) covers the formation and management of NCD support groups in the County by the Multidisciplinary teams (MDTs) through Primary Care Networks (PCNs).

4.0 Definition of terms

- **Support group:** A group of people with everyday health-related experiences and medical concerns who provide emotional and moral support for one another.
- **Multidisciplinary Team (MDT):** A dynamic team of healthcare workers with different skills and expertise who jointly assess, plan, and manage health conditions.
- **Transfer/Referral of Lab Samples:** This involves collecting and transporting samples from clients to the laboratory hub.

- **Health products and technologies:** This encompasses the provision of pharmaceuticals, medical supplies, Nutraceuticals, and diagnostics through a functional supply chain system.
- **Primary Care Network:** An administrative region comprising of Primary care facilities (HUBs-Level 4 and Spokes-Level 2 and 3 health facilities) established to deliver access to essential health services.
- **Non-communicable diseases: for this SOP,** it refers to Diabetes and Hypertension.

4.0 Steps in the Establishment Process

4.1 Step One - Formation

The MDTs undertake the following;

- Determine Membership /Eligibility
- Clustering of individuals with similar health needs.
- The size will be approximately 50 beneficiaries.
- The MDTs will identify and map the beneficiaries /clients.
- Sensitize Health Care Workers (including CHP) and beneficiaries.
- Set goals and aspirations of the group.
- Define the activities of a support group.
- Identify beneficiaries with special skills within the group that can benefit the larger group.

4.2 Step Two – Planning and Governance

The MDT will guide the Support group to:

- Develop group norms, including:
 - a. Meeting venue
 - b. Meeting times
 - c. Frequency of meetings (preferably monthly basis)
- Nominate leaders, determine their tenure and assess their roles

- The secretary of the Support group will be the facility in charge and the chairperson will be a support group member.
- Agree on mechanisms to monitor and review the effectiveness of support group progress.
- Development of a calendar of discussion topics.

4.3 Step Three - Implementation

Clinical Care Activities

- Review of the clients/patients
- Collection of Lab samples
- Refill of prescriptions
- Referral of cases that require senior review
- Documentation of services offered

Education Activities

- Health education and psychosocial support
- Dissemination of health-related materials
- Peer-to-peer discussions
- Activity report

4.4 Step Four- Monitoring and Evaluation

- Review the implementation and progress of Support Groups
- Documentation of best practices.

5.0 Roles of the MDTs in the Support Groups

- Awareness creation

- Clinical care: Regular and planned review, Lab investigations, refill of prescriptions and referral of cases requiring further management.
- Continuous and structured engagement of the CHPs.
- Develop and maintain the NCD database within the PCN.
- Ensure effective upward and downward referral of patients and services within the PCN.
- Support regular outreaches to the spokes.
- Management of HPTs.
- Nutrition assessment and counselling.
- Pharmacovigilance
- Documentation and dissemination of best Practices.