Supplementary file 3: Summary of interventions according to the TIDiER checklist: Integrated models of care

Study ID	**Ameh 2017**		**Rawat 2018***	**Havlir 2019**	
Intervention groups	**Intervention**	**Control**	**Intervention**	**Intervention**	**Control**
Name of intervention	Integrated chronic disease management (ICDM) model	Standard care in clinics where ICDM model was not piloted	Implementation of national policy to integrate HIV care into all PHC facilities	Integrated care: Baseline HIV and multi-disease testing plus annual testing, universal ART and patient-centered care	Usual care: Baseline HIV and multi-disease testing and national guideline-restricted ART, hypertension and diabetes care as per country standard of care
Aim of the intervention	To improve management of patients with HIV, TB, hypertension, diabetes, COPD, asthma, epilepsy and mental health conditions at PHCs	Not reported	To provide comprehensive HIV care (prevention, diagnosis, treatment initiation and follow-up) at PHC facilities	To remove patient-level barriers and maximise the efficiency of the health system To overcome barriers of universal access to HIV treatment and to be able to reach UNAIDS goals	Not reported
Physical and informational materials used	Not reported	Not reported	Not reported	Treatment guidelines ART tablets SMS reminders	National treatment guidelines
Procedures, activities and processes used in the intervention	Facility reorganisation: designated chronic care area; supply of critical medicines; pre-packaging of medication	Not reported	Policy to integrate HIV care into PHC clinics Training of nurses in comprehensive management of HIV: Nurse initiated	Community health campaigns (CHCs): Multi-disease testing for HIV, diabetes and hypertension; counselling and clinic appointments for participants with	Community health campaigns: Multi-disease testing for HIV, diabetes and hypertension; counselling and clinic appointments for participants with positive

	Clinical management support: use of guidelines to manage chronic diseases (PC101); human resources audit; capacity building; appropriate referral Ward-based outreach teams to ensure individual responsibility and "assisted" self-management Health promotion and population screening		Management of ART (NIMART) Training of nurses through the Practical Approach to Lung Health in South Africa (PALSA PLUS) Additional staff to strengthen drug delivery systems	positive tests; HIV positive participants received blood tests (CD4, t-cell count, HIV/RNA levels) and one-time round trip transportation voucher for first clinic visit Home-based testing for participants that did not attend CHCs Linkage to ART: HIV positive participants not on ART received appointments to initiate ART within a maximum of 7 days; clinic staff introduced themselves in person or by mobile phone; participants could contact hotline via phone or text message for questions or support; phone/SMS reminders about clinic visits Patient-centered care for HIV, diabetes, hypertension: 3-month visit intervals; flexible clinic hours; reduced waiting time at clinics;	tests; HIV positive participants received blood tests (CD4, t-cell count, HIV/RNA levels) and one-time round trip transportation voucher for first clinic visit ART, diabetes and hypertension treatment: provided in accordance with national guidelines

				welcoming staff; ART to all HIV positive participants; if not eligible for ART according to national guidelines, trial provided Truvada; hypertension and diabetes treated according to standard algorithms	
Who provided the intervention	Nurses	Nurses	Nurses	CHCs: Study team in collaboration with the local health units and the Ministry of Health in Uganda and Kenya Patient-centered care: government clinics augmented by trial staff	CHCs: Study team in collaboration with the local health units and the Ministry of Health in Uganda and Kenya Care in clinics: Clinic staff, augmented by additional staff funded by trial to mitigate staff shortages
Modes of delivery	Not reported	Not reported	Practical implementation of policy varied across clinics: Either disease-specific nurses in separate consulting rooms (co-location), or one nurse that provided comprehensive care for all diseases in single consultation room	Face-to-face, via telephone or text message	Face-to-face

Location of the intervention	Primary healthcare facilities	Primary healthcare facilities	Primary healthcare clinics: 37 urban clinics 65 rural clinics 30 clinics from former homeland	CHCs: Under large tents in all communities, or home-based Patient-centered care: At clinics	CHC: Under large tents in all communities, or home-based ART, diabetes, hypertension care: At clinics
When and how much the intervention was delivered	Unstable HIV and hypertension patients: follow-up every month Stable HIV and hypertension patients: follow=up every 2-3 months Routine referral of all patients to doctor: Every 6 months	Not reported	Not reported	CHCs: lasted 2 weeks at baseline, annually and at 3 year endpoint during weekdays, evenings and weekends Clinic visits: 3-month intervals	CHCs: lasted 2 weeks at baseline and at 3 year endpoint during weekdays, evenings and weekends Clinic visits: not reported
Tailoring of the intervention	Not reported	Not reported	Modular structures and pharmacy renovations to address space concerns in some clinics	Not reported	Not reported
Modifications of the intervention	Not reported	Not reported	Not reported	The end point of the trial was reduced from 5 years to 3 years	Control clinics implemented ART guidelines that were specific to Uganda and Kenya; during the trial, the threshold for eligibility for ART in these countries expanded from a specific CD4+ T-cell count (ranging from <350

					to <500) to universal treatment (regardless of CD4+ T-cell count)
Assessment of intervention adherence/fidelity	Not reported	Not reported	Not reported	Not reported	Not reported
Intervention delivered as planned	Not reported	Not reported	Not reported	Not reported	Not reported

*No control intervention described

HIV human immunodeficiency virus, TB tuberculosis, COPD chronic obstructive pulmonary disease, PHC primary healthcare clinics