Appendix: Aspects of 'good' communication and collaboration found in included studies from searches 1 and 2 (n=40)

1: everyday interdisciplinary communication and collaboration among maternity care professionals (n14)	
First author, year	**Aspects associated with 'good' communication and collaboration**
Bahl, 2010	Situation awareness, information gathering, understand / analyze information, anticipation, consider all options available, implement / review decisions, informed consent, gather team, identifying resources, re-evaluation each step, documentation / debriefing, ensure maternal cooperation, tailor care to mother's expectation, communicate with mother, maintain dignity of mother, partner participation, calm, confident / assertive, able, clear communication with team members, aware of team capabilities, respect for team members, ability to question practice, stay calm in emergency situation, do not appear stressed, create confident atmosphere, clear firm instructions, take lead, know your limitations, open / honest about his / her ability, reflect on experience, gentle / show empathy.
Berridge, 2010	Influences of architecture on feelings of calm, warm, short, abrupt communication, team situation awareness (TSA).
Bristowe, 2012	Having a clear understanding of nature of emergency, being calm, respectful, management plan / required tasks (clinical situation awareness), awareness of team members' names / abilities (team awareness) / patient's needs (patient focus/involvement), having somebody to both lead in emergency / make that leadership explicit, communicated clear objective to team and delegated roles / tasks clearly, able to challenge seniors when necessary, presence of senior clinicians (emotional maturity), communicate loud enough for all to hear, giving direction to a particular recipient (preferably using their name), regular formal familiarization, explain roles / abilities / responsibilities in advance of emergencies (e.g., during handovers), use of video recorded role play to stimulate self-reflection, mnemonics should be very simple / accessible (e.g., in laminated form), ability to remain composed, patient centered care, communicate critical information, aware.
De Veer, 1996.	Trust each other, good preparation of meetings, record minutes of meetings, good chairperson for meetings, regular meetings, financial support for secretarial work, good distribution of information / appointments, one person responsible for dissemination of uniformity of case histories, support of other institutions, support of own professional group, willingness to co-operate, tolerance of others, respect for each other, feeling of shared responsibility, willingness to invest time, positive attitude, openness, wish to improve work climate and to meet others, shared responsibility.
Kennedy, 2008	Equally involvement in care plan, respected each other's opinions, communicated effectively, time to sit / brainstorm about what would works best for patient, committed to helping patient have what she wanted, commitment of nurses / midwives to working together and improving their relationship, laughter, association with one another, shared memories, express concern, trust.
Lyndon, 2014	(Doctors) Great rapport with nurses, effective intervention for performance issues -including formal proctoring/limitations on scope of practice-, teamwork training, persistent advocacy.
Mahera, 2002	Trust, confidence, clear communication, assisting women to negotiate / rethink their birth stories.
Murray-Davis, 2011	Easily accessible obstetricians, having midwives in senior clinical posts, informal mechanisms, shared space (like coffee room), personal relationships, shared goal/vision of providing women centered care, knowledge of professional roles, ability to reflect on practice, skilled, effective communication, confidence, respect for others, distribution of power.
Nielsen, 2012	Humor, respect for all levels of health care providers, diligence, support / promote values learned in team training, versing new employees formal / informal, leadership, trust, promoting team unity, (maintaining) horizontal relationships.
Pecci, 2012	Share expertise, (mutual) trust, interdisciplinary communication, competence, accountability, risk-taking, assertiveness, willingness / ability to challenge assumptions, critical self-reflection, opportunities for participation / building cohesion, effective communication, interdisciplinary education, commitment to culture of safety, interdisciplinary participation, flat hierarchy, effective leadership, robust communication techniques, clarity regarding consultation / referral in collaborative, being team focused (responsibility for care of women rests with team of professionals rather than single provider), clarity of responsibility (identity of supervising provider and team responsible for each case will be clear to all L&D staff at all times), interactions between partners will be respectful / constructive, excellence in patient care will be focus of communication, all providers will perform patient care, order entry / chart documentation, frequent physical presence on L&D area promotes communication / collaboration among providers, acceptable

	caseloads (well rested providers responsible for reasonable number of women in labor), no provider will be directly responsible for more than 3 women needing active management at any one time, maximizing continuity, informing all parties involved, frequent communication, good documentation, maximize use of skill by caring for women whose needs match, evidence-based care, all members of team are encouraged to express opinions / concerns, respectful communication, consideration of each patient's medical / social / cultural needs.
Reiger, 2009.	(Mutual) Trust, respect, accountability, sharing, support, civility, staff introducing themselves, being helpful / pleasant, getting a drink for everyone not just friends, showing newcomers where equipment was, pulling together as work team, admitting weakness /mistakes, taking responsibility / initiative, exercising common sense, being a team player, being open / honest, awareness not only of how others are feeling but self-awareness; especially ability to acknowledge vulnerability / assert competence, shared accountability, commitment, communication / confidence, competence / cooperation, personal qualities, skills needed, strong midwifery identity or consciousness as practitioners of normal birth, supportive, backing each other up / sharing professional knowledge, being a hard worker, willing to share the load, able to pick things up quickly, have "peripheral vision' as to what needs to be done, as well as someone with commonsense and who took initiative, team-oriented, collegial, humor, value of genuine love of calling, importance of coming to work for more than money, being aware of professional developments, political issues / research, skilled at being with women, having respect for birth process, knowing women (at least being very open to knowing them / not judging them is crucial in this understanding, being competent, reliable / accessible, consulted as equals about a woman's care, value opinions, pleasant / helpful, treating women courteously, share their knowledge / decision-making (not only with midwives but with women / families), understand, partnership, clear communication, being kept informed, effective leadership / sense of direction, clarity of roles / responsibilities, good organizational communication, integrating / preparing junior staff effectively, open to discussions / viewpoints different from theirs (both those of peers and patients), stay calm, listen / be patient, able to think independently, caring, kind / respectful, able to individualize care.
Simpson, 2006	Not always in a hurry, doesn't yell or scream, professional, courteous, patient, kind to patients, understands labor process, doesn't call to tell me to push pit or get her delivered at certain time, respect, asks my opinion, trust, knowledgeable, keeps up to date, nice to new nurses, proactive, helps patients stay on the labor curve, not afraid of pit, loving / caring toward patient, wants patients to have best possible outcome, selfless kind of attitude, like to be called an hour before, is at bedside, older, reliable, consistent, experienced, anticipates needs, knows me well, knows when to get concerned / when to get serious and push the panic button and feed the information to the physician, many interactions / experience with each other over time are the basis of professional trust and confidence.
Simpson, 2009.	Confidence in administrative support, (mutual) respect, interdisciplinary policy-making, discussion, education, strong administrative support for nursing judgment (these characteristics represent the antithesis of hierarchical relationships), collegial practice environments, opportunities for interaction, treat each other with kindness / consideration.
Van Kelst, 2013	Woman-centered; no unnecessary interventions, informed choice, continuity of care, midwifery education to support ability of midwives to fulfill role/provide woman-centered care, adequate staffing level, cultural change, information given antenatally / pre-conceptionally, objective / honest (not guiding) information enabling making right choices for themselves (for less afraid, empowered women), expose all options / should all be available for women to choose from, advocate normal birth, midwives as lead professionals in antenatal care, open discussion with management/obstetricians about type of care.
2: everyday communication and collaboration between maternity care professionals and parents-to-be (n26)	
First author, year	**Aspects associated with 'good' communication and collaboration**
Alkazalah, 2004	(Immediate / clear) Information (different options explained), speed (when of importance), empathy (e.g.: offer patients assistance in getting home after receiving bad news or have opportunity to arrange to have friend / family member at their side), privacy (especially when receiving bad news), getting information from sonographer immediately (rather than waiting for obstetrician to discuss implications of result / options), women strongly preferred terms 'baby' over 'fetus' when giving them bad news, enough time to ask questions, information regarding follow-up care.
Beake, 2013	Knowing midwife, friend/kin like relationship, helpful, safe, relaxed, comfortable, able to confide in, contact, talk about issues/worries/questions, knows your history/extended family, person-centered care, being there, sit with women, emotional social support, kind / nice, enthusiastic about anything, helps women develop confidence, trust, confidence in midwife, meeting in own environment / home, makes women feel really special, continuity, caseload care, relational continuity, practice midwife-led care,

	respond to women's needs.
Borders, 2013	Timely / thorough / truthful information for women, women in control of birth by more information about what is happening, given options about position changes / timing of pushing, direction provides women with anchor to cling to in pain / distress, excellent collaborative relationship with midwives / physicians / nurses, patience, provide overwhelming affirmation, giving / soliciting information, offering well-timed directives, support women for using their own ample power, imbuing women with confidence.
Brown, 2005	Continuity of midwife's care, knowing at least one of the midwives, positive interactions with caregivers, sensitive caregivers, being understanding; not being rushed (have time to spend), offering advice / support, helpfulness of advice and support, listen, acknowledge patients specific concerns, ask about their own health /recovery and about baby's health / progress.
Browne, 2014	Humor/laughter to set a particular tone, diffuse potentially anxiety provoking environment, sense of calm / unhurriedness, share yourself / humanize yourself, make quick connection, women central (as whole person), build trust, rapport to enable women to open up / talk, continuity of midwifery, knowing women, giving women time / space to ask / answer questions, listening to answers, checking for accuracy in understanding, relax between appointments, not look busy to women, convey the importance of woman (not the computer), balancing interactions; 'nice stuff'/'risk stuff', asking women about work / family life / books / classes, visits are about women (not midwives), reframe language / terminology of risk, use possibility instead of risk, focusing on / guarding the 'normal/healthy' aspects, awareness of language, reprioritizing structure of visits, having no absolute agenda, encouraging women to direct conversation / take cues from women / lead interaction during appointments / be active participants in care, clinical tasks integrated into conversation, instilling confidence, reassure women, transferring faith, share knowledge through storytelling, decrease anxiety, how to amount information, strategizing, increase sense of control regarding decision making / feeling needs have been met, connection over surveillance, vigilance, working with each women's story, help women draw on own resources/strength.
Burns, 2013	Language / practices facilitating communication / building confidence, know woman, friendly 'chat', women centered care, open-ended questioning, opportunities for women to lead / dominate discussions, assessing situation, asking questions, checking in, ask about other aspects of women's life, take time to socially engage / know women's story, know women as individual / equal / autonomous human being, friendly, form connections, (prioritize) listening, body language, smiling, don't look grumpy, soft tone of voice, sense of calmness, sense of having 'all the time in the world' to spend with women, encouraging, soft / gentle manner, challenging women's negative perceptions, redirected maternal constructions / reframing unfavorable representations, normalizing infant behavior, using verbal / non-verbal language to convey confidence, woman's knowledge sought / prioritized, gather woman-led information, 'tuning in' to women's feelings / preferences, 'hands-off' breastfeeding support (or if indicated by women 'hands-on'), prioritize relationship building, sharing many suggestions / options, avoid merely giving instructions, respect / facilitate self-determination, authentic / genuine relationship-based professional support style, relational / partnership approach, share power / responsibility, mutual respect, (demonstrate) trust, taking time, sharing experience, positive confidence building encouragement, protect woman's dignity, sit through feed, continuity of care, non-judgmental, affirming communication style, confidence in women's bodies / own knowledge, encouraging women to tune in to their body / infant, communicated belief in normalcy of breastfeeding, facilitated assistance.
Bylund, 2005	Women's involvement in decision-making.
Eri, 2010	Be taken seriously, attentiveness, individualized care, being believed / heard, humbleness from staff.
Eri, 2011	Being informed, asking questions in a concrete / simple way, calm women, normalizing situation, reassure woman that her experiences are normal, give women feeling of security, reassurance, have humble attitude, giving advice in concrete terms, strive toward agreed decision (or even better, let them make decision themselves by giving women time / opportunity to decide for themselves).
Forti, 2013	Midwives using mobile technologies
Fraser, 1999	Empower woman, being good listener, being able to ask anything, explaining things step by step, intuitively knowing what is needed, smiling, friendly, caring, outgoing, personable, reassuring, nice, taking time, being involved in decision making, cheerful, enable her feel special, help her relax, be in control, when necessary be woman's advocate with doctor, only female caregivers, be cared for by same midwife, good at job, being nice, know about them (mothers, including detailed reading of their notes / being briefed by their colleagues), tell mothers when change of midwife would happen and introduce them if possible, treated as individuals, involved in decisions about own care, improved labor unit environment / the atmosphere on the postnatal wards (compared with previous experiences in the same hospital), postpartum care in community,

	provided they could negotiate pattern of visits made by midwife, being informed, knowledgeable midwives, ability of caregivers to discern what was needed by responding to nonverbal cues, instill mothers with confidence (especially when they are in labor).
Goodall, 2009	Personalized information (rather than just risk information) in understandable format, healthcare professionals aware of how their communication is framed / what message this framing conveys (whether directly or indirectly).
Hunter, 2006	Reciprocity, individualized approach to care, patients being receptive to midwifery advice, establishing rapport with clients, determine boundaries for 'give / take', balanced exchange, affirmation / validation of midwife's role, midwifery work is legitimated, midwife is in control of reciprocal exchange, feeling appreciated by woman, getting to know woman by providing continuity of care, creating authentic / trusting relationships.
Jonkers, 2011	Need for maternal health care providers to be sensitive to needs / sociocultural contexts of immigrant women.
Lerman, 2007	Adequate information, constructive communication, good relationships, interpersonal characteristics of caregivers, willingness of caregivers to engage patients as informed collaborators in own care.
Matthias, 2007	Strong relationship, helping to cope, respect to having home birth, having plan of action, sense of control, knowledge tantamount to control, supporting, help to understand, reassure, give ideas, suggests possible solutions (citing example in which these solutions worked), information, evaluate, emotional support, listening empathetically, friendship.
Matthias, 2009	Honest, straightforward, trustworthy, calming, time, strong relationships (parents / caretakers), helping to cope, offer way to reappraise potentially negative situation, help shape expectations, creating action plan, trust.
McKay, 1990	Look / listen, respond to expressed needs of laboring woman, validate that sounds she is making are normal and may help her cope with pain / distress, support, explain, when they indicate help is needed; it should be offered.
Munro, 2013	Strong / mutually respectful relationships of care providers, clear understanding of team members' roles / responsibilities, resolving financial / legal / regulatory barriers, policy changes to resolve differences in scope of practice / inequitable funding, considered creating mixed models of shared primary maternity care between physicians / midwives, increased inter-professional collaboration with midwives, creating postpartum call group between nurses, local breastfeeding support counselor / midwives to facilitate quick in-home breastfeeding support for new mothers, including mutual learning, lightened workload, providing choice of care to women, strong relationships between the midwives / hospital staff, trust in skills, building trust by midwives' integration, participation in formal teambuilding activities / department meetings / in-service education / informal activities / sharing a cup of tea with nurses / building friendships with staff outside the hospital, open communication, shared decision making, flexibility / adaptability in approaches to care, local professional development / in-service education, enhancing confidence / competence of all maternity care providers, creation of demonstration projects to secure funds for non-physician members of collaborative team as solution to lack of appropriate remuneration structures, create conditions / structures necessary to support policies / guidelines, alleviate differences in models of care between rural midwives / physicians, alternative payment scheme for midwives / physicians working in shared care practice, on-call funding for maternity care for rural physicians to mitigate burn-out, consider expanding / adapting inter-professional education programs that instill maternity provider students with benefits / tools of collaboration, ongoing dialogue, key stakeholders to collaboratively establish standards of care for each community.
Persson, 2011	Being met as individual, support from staff, support from family and capacity and health of woman and baby, being given relevant information, being prepared for time after birth, having someone to turn to, knowing who to ask, having partner and / or significant others close at hand, being assured that own (mother) physical health was good, having planned follow-up regarding baby's health after discharge, all information given must be consistent, being met with sensitive / flexible attitude (caring staff), positive staff attitude to partner, being involved in postnatal ward, being listened to / taken seriously by staff, be met with encouragement, given positive acknowledgement that all was going well (they were 'doing things right'), peace / quiet after the birth (staff showing calm demeanor), having time by listening / giving explanations, being given consistent advice (in clear manner throughout the whole chain of care by all categories of staff), being offered postpartum talk with delivery midwife, being prepared before birth, acknowledge partner and include in preparation for parenthood by staff from beginning of pregnancy, having opportunity to ask questions, get help if necessary, have someone to contact / ask when questions arose, know where to get help 24 hours a day, partner given opportunity to stay overnight at hospital, return visit to hospital, home visit / telephone call soon after discharge, practical help from staff to allow them to get some sleep, staff should show sensitive / flexible attitude towards new parents, women found it easier to ask questions / relax at home; experiencing it as a secure environment.

Risa, 2011	Awareness of each midwife's own communication style, attentiveness to woman's implicit concerns, fulfilling her need for understanding, increased awareness of any emotional concerns, paying attention to her descriptions of subjective experiences, recognition of bodily changes / symptoms, openness to both emotional / psychological issues, take advantage of different professional competencies in multidisciplinary team, time / space for pregnant women to address / express their feelings /concerns, awareness of one's own communication style and adjust it to allow mother's voice to be heard and so enable her to participate more fully in own antenatal care, attentiveness towards clients to meet individual needs.
Schölmerich, 2014	Increasing multidisciplinary meetings / training/education, revising financial reimbursement system, implementing shared maternity notes system for all levels of care, adapting obstetric guidelines to explicitly facilitate shared care, decreasing expertise gap between providers / clients, frequent contact with community midwives in multidisciplinary meetings, mutual respect / trust between community midwives / obstetricians, women might help facilitate coordination between separate organizations, more frequently scheduled face-to-face meetings with midwives, hospital-based caregivers to discuss / improve coordination practices / care pathways for women, shared knowledge, training of resident obstetricians including time spent at community midwifery practices, exploring ways of making provider-information more accessible, facilitating more dialogue, increasing health literacy for women.
Siassakos, 2011	Specific sentences might make difference between adequate / inadequate amount of information.
Sinivaara, 2004	More time with patients.
Wheatley, 2008	Being explained, provided with information about potential complications, respected, having patience, availability responding to queries, attentiveness, getting direct attention.
Williams, 2010	Supportive, feeling comfortable, having relationship with one midwife, continuity of care, treated as individual, available midwives when needed to answer questions / offer reassurance, feeling comfortable, relaxed, at ease, orientation towards birth as natural / normal process, cared for by women, trust, confidence, feeling in control, empowered, feeling special, midwives know your history.