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Original Article

Intersectoral Collaboration and Complex Health Emergencies: Insights From a Comparative Analysis of Public Space Regulation During COVID-19 in Four Canadian Provinces

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Abstract

Background: This paper contrasts and examines the perceptions of policy communities on the dynamics and factors shaping intersectoral collaboration in governance of health emergencies, drawing on the example of public space regulation during COVID-19 in four Canadian provinces, with the goal of exploring variation and perceived quality of policy responses.

Methods: We compared public space regulation in four Canadian provinces—British Columbia (BC), Nova Scotia (NS), Ontario (ON) and Québec (QC)—during COVID-19 from 2020 to 2022. The study was designed as a comparative, qualitative, and explanatory case study, utilizing in-depth interviews and documents. We conducted 103 interviews with a diverse range of stakeholders, including senior government and non-government leaders, reviewed selected policy documents, and media reports. We utilized multisite qualitative analysis to analyze our data and develop within- and cross-case themes.

Results: Respondents reported vastly different provincial approaches to intersectoral collaboration within government and with non-governmental stakeholders in the management of public spaces, ranging from higher (BC, NS) to lower (ON, QC) levels of collaboration in governance, as reflected in the access of government and non-government stakeholders to key decision-makers and decision-making forums and processes, the transparency of those processes, and responsiveness to their input. Institutional frameworks, political factors and organizational culture and capacity were the major distinguishing factors between these provincial approaches to collaboration. Disparities in access to decision-makers were reported, with business interests and certain civil society organizations experiencing easier access compared to other public interest groups.

Conclusion: Public health challenges are increasingly complex and intersectoral. Research on intersectoral collaboration must examine collaboration dynamics within and outside government holistically, rather than exploring these dynamics in siloes. Stakeholder engagement which combines institutional structures and inclusive stakeholder engagement within and outside government is crucial to managing complex policy processes during crisis and beyond.

Keywords: Canada, COVID-19, Health Governance, Intersectoral Collaboration, Interest Groups

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Introduction

Health emergencies, such as the COVID-19 pandemic, present governments at national, sub-national and local levels with complex health and public policy choices. In the case of COVID-19, policy responses in healthcare, public health and social policy varied extensively across the globe and even within countries.[1-3] Scholars have engaged in comparative analyses of the factors driving variation in pandemic policy decisions, as well as the processes through which governments at different levels arrived at these outcomes.[4,5] Within this domain, a fruitful area of research has emerged around how collaboration in governance structures and processes, across levels of government and between government and non-government actors, including interest groups, can help explain variation in policy processes and outcomes during health crises.[6-8] This research is particularly crucial given that health policy is increasingly complex and intersectoral, especially in health emergencies and amidst the climate crisis.[9]

Governance refers to structures and processes applied both formally and informally to distribute decision-making and accountability amongst actors that comprise a particular policy system.[10] Distinct from normative conceptualizations of governance (eg, "good" governance), research on health governance arrangements focuses on the "architecture of relationships" and the behaviors, actions and incentives of actors within this architecture in formal and informal ways.[10]

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Key Messages

Implications for policy makers

- Siloed approaches to strengthening intersectoral collaboration (within government or sectors, or with non-government stakeholders) do not reflect complex realities of how government and non-government actors traverse decision-making pathways.
- Need for more nuanced approaches to understanding both the perceived benefits and potential risks associated with different models of collaboration.
- Developing transparent approaches to engaging a diversity of non-government stakeholders (eg, industry, civil society organizations, faith communities, etc) is required to develop trust and confidence in decision-making.
- Balancing collaborative governance and conflict management is an area for further exploration, given the possibility for regulatory capture in intersectoral governance.

Implications for the public

This study examined intersectoral action during COVID-19 in four Canadian provinces, particularly regarding collaboration within and across government and non-government stakeholders on non-pharmaceutical interventions. Respondents perceived vastly different approaches to intersectoral collaboration across Canadian provinces, which we examined through perceptions on access of government and non-government stakeholders to key decision-makers and decision-making forums, and the transparency and responsiveness of those decision-makers and forums. Institutional frameworks, organizational culture and capacity and political support were the major factors shaping provincial approaches to collaboration. Non-government stakeholders reported higher levels of collaboration in British Columbia (BC) and government stakeholders reported similar approaches in Nova Scotia (NS), while in Ontario (ON) and Québec (QC), decision-making processes were viewed as less collaborative. This study contributes key learnings on collaboration dynamics that cut across sectors and levels of government, and around the challenge of unequal access by certain non-governmental stakeholders, raising questions about whose voices count in decision-making during health emergencies. Combining formal structures for stakeholder engagement, alongside inclusive relationship building, is crucial to managing complex policy processes during crisis and beyond. This study provides important insights on policy dynamics that ultimately impact health outcomes, public trust, citizen compliance, and other aspects of public policy related to health emergencies, such as economic recovery.

During crises, governance arrangements are subjected to strain and pressure, involving an expanded set of actors and competing incentives, with uncertainty playing a central role in shaping decision trajectories.[11] The concept of collaborative governance helps in unpacking health governance during crises, given the overlapping and intersecting sectors and jurisdictional dynamics at play.[12] The role of non-governmental actors, such as non-profit organizations or interest groups – "membership organizations working to obtain political influence"[13] – and their interactions with different levels of government is a crucially important aspect of collaborative governance.

Existing research on intersectoral collaboration in COVID-19 policy responses yields compelling insights. Subnational jurisdictions within federal contexts such as Canada, the United States, and India saw considerable heterogeneity in the nature and timing of public health measures and social policy in response to the pandemic.[14-16] The domain of intersectoral collaboration draws on diverse theoretical traditions, and scholars studying these dynamics have applied concepts such as polycentric governance, multi-level governance, governance capacity, and governance networks to examine how governments coordinated internally, ie, horizontally between sectors[8] and vertically at different levels of jurisdictional focus, identifying factors such as levels of regional and municipal autonomy,[17,18] individual and team innovations,[17,19] and past experiences with crisis.[11] Some literature is available on engagement between government and non-government actors representing different constituencies, including interest groups, during periods of crisis, termed as "viral lobbying" by Crepaz and colleagues.[20] Business interest groups in the European Union, for example, had far greater access to policy-makers during the pandemic compared with non-profit organizations, underscoring that representation during periods of crisis remains deeply unequal.[21] Access to decision-makers does not mirror active involvement in crisis response, however. In many countries, community organizations have been essential partners in managing food supply and safety, supporting access to testing and vaccination, and other safety net gaps, in many jurisdictions.[5,22,23]

Important gaps remain in our understanding of collaboration and intersectoral governance in health, particularly in the context of crisis. First, much of the existing work in this domain, including governance outside of crises, focuses on formal governance structures and institutional arrangements, with comparatively less attention to the dynamic processes and actor-based interactions through which collaboration is enacted in practice.[24] As Kork and colleagues observe, scholarly understanding through thick description of both the perceived and actual dynamics of collaboration in crisis governance also remains surprisingly limited. There is a need for in-depth exploration of the "context, purposes, choices, and motivations"[25] of those policy actors engaging in collaboration, an analytic approach that has been less commonly applied in health crises.[26] Second, relatively few studies have examined collaboration within and beyond government in an integrated, holistic manner, limiting our ability to understand intersectoral collaboration *as a system* rather than as a set of isolated sector-based arrangements. Approaching intersectoral collaboration in health from a system lens can yield crucial insights on *cross-cutting* values, behaviors and actions from the actors driving these processes. Further, public administration scholars have illustrated patterns of interest group engagement that cuts across levels of government, revealing a complex, network-oriented view of decision-making that foregrounds issues of power and access,[27] an analytic approach that has been less commonly applied in health crises.[26] Third, driving institutional arrangements, how

these evolved and differed across contexts, and what might be learnt from these experiences for future emergencies and intersectoral collaboration (ie, collaborations between two or more government policy domains, often involving public, private and/or non-profit sectors).[14] Fourth, relatively limited attention has been paid to how the intersections of institutional, organizational, and political factors shape the formation and functioning of intersectoral collaboration,[28] particularly during crisis. Finally, comparative explorations of intersectoral governance in federal and decentralized contexts have been sporadic; for health emergencies, this is a particular gap given the transboundary nature of health crises.[29]

Drawing on a comparative analysis of decision-making in four Canadian provinces during the COVID-19 pandemic, the focus of this paper is to contrast and examine the perceptions of policy communities on the dynamics and factors shaping intersectoral collaboration in governance of public space regulation during COVID-19, and to explore how these might explain variation and perceived quality of policy responses across these provinces. The Canadian response to the pandemic was characterized by considerable variation in the nature and application of public health restrictions and measures across Canadian provinces, shaped by its federal institutional framework and decentralized approach to health emergencies,[14,30] and therefore offering a useful context for examining these issues. Public space regulation was one of the foremost concerns for governments across various stages of the pandemic when developing and implementing non-pharmaceutical interventions to limit COVID-19 transmission,[3,31] and is an instructive case as it involved a diverse group of stakeholders in and out of government. Public spaces broadly refer to those which individuals can access for free (eg, public parks, public recreation, faith-based spaces) or for a fee (eg, restaurants, entertainment, fitness, etc). Our focus in this paper is not to investigate the impact of governance of this policy domain on health or societal outcomes; rather, we seek to explore the dynamics of governance and what these arrangements might tell us about perceived strengths and weaknesses of various approaches to intersectoral collaboration during health emergencies, yielding valuable insights on the dynamics shaping policy choices, which in turn have wideranging impacts not only on health outcomes, but also on public trust, citizen compliance and other aspects of public policy related to health emergencies, such as economic recovery.

This study combines two theoretical approaches and applies them to the study of intersectoral collaboration at the subnational level during COVID-19. First, we use a framework developed on the interconnections of institutions, politics and organizations on governance, developed specifically for examining the influence of these factors on upstream decision-making during COVID-19 (Figure).[6,32] Second, we use analytic categories inductively derived from the collaborative governance literature,[33] particularly governance network theory[28,34] which conceptualizes policy-making as occurring through interactions among public and non-governmental actors. These categories capture key dimensions of dynamics: intra-governmental collaboration, cross-sector collaboration with non-governmental stakeholders, and the perceived impacts of these interactions on policy outcomes.[33,35]

Methods

This study is part of a comparative project involving four Canadian provinces—British Columbia (BC), Nova Scotia (NS), Ontario (ON) and Québec (QC)—which aimed to explore the institutional, political, organizational and governance-related factors shaping COVID-19 policy. The study was designed as a comparative, qualitative and explanatory case study[36] focused on the provincial response to COVID-19 in two policy domains – public spaces and testing – during the period between the early stages of the pandemic in 2020 up until early 2022. Four provinces in Canada were

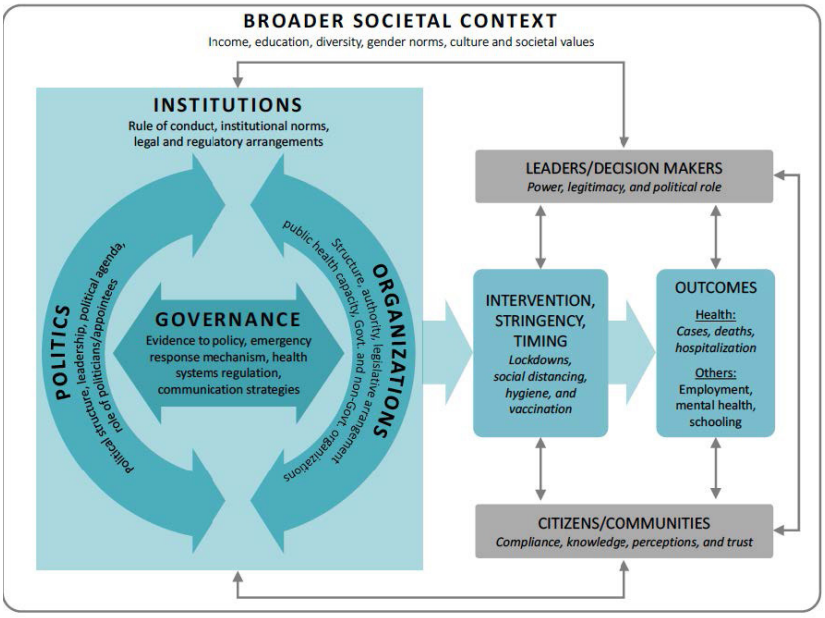

Figure. Framework on Institutions, Politics, Organizations and Governance, and Health Emergency Response.[6,32]

selected purposively to reflect a diversity of institutional, political and health systems contexts, geographies, and other factors (Table 1). In this paper, we draw on findings from research within this project that focused on public spaces. Research on the testing domain and on organizational dynamics in the COVID-19 response have been published separately.

Ethics approvals were received from each university involved in the study.

Data Collection

We used two qualitative data sources for this analysis – in-depth interviews and documents. Research teams located within each provinces oversaw and conducted data collection and analysis for their respective jurisdictions. Interviews were conducted between December 2022 to February 2024 with senior decision-makers and organizational leaders in and outside of government. Purposive sampling was used to identify individuals with direct and also diverse experiences in decision-making and policy implementation related to the COVID-19 response working in government, quasi-government organizations and non-government organizations (eg, industry associations, representative organizations, non-profit organizations). Stakeholder categories were defined a priori by the project team to ensure coverage of key groups across provinces, while preserving flexibility to incorporate context-specific actors relevant to particular settings (eg, perspectives on the First Nations Health Authority in BC). A priori knowledge, document review and snowball sampling were used to identify potential respondents. 103 interviews were conducted in total (Table 2). Respondent categories were largely consistent across the provinces. Interviews lasted approximately 60-80 minutes and were audio-recorded, with a few exceptions where respondents requested that verbatim notes were taken instead of a recording (n = 2). Interviews were conducted in English in BC, NS, and ON; in QC, interviews were conducted in French. A semi-structured interview guide was used across all four sites and adapted for each context. Interviews were transcribed and de-identified to ensure participant confidentiality. Relevant sections of transcripts in French were translated into English by two bilingual members of the QC team.

Document review consisted of policy documents and news media reports in English and French, and were selected and analyzed using the READ (Ready materials, Extract data, Analyse data, Distil) approach.[38] These documents were used to shed light on the policy timeline, key junctures, policy actors, and content of measures for regulation of public space, both to inform interview preparation and to triangulate with interview data. Documents published between January 2020 to June 2022 were collected from government websites, news portals, non-government organization websites, and through Google and PubMed database searches. Approximately 180 documents were included, such as public health orders, news media, reports, press releases, and letters produced by government or non-government organizations. Documents in this analysis were included if they had substantive content pertaining to regulation of public space and excluded if they pertained only to domains that were not public spaces, per the definition in our study (eg, agricultural industry).

Data Analysis

The first step in data analysis was reviewing documents in order to (1) map key organizations involved in the response from within and outside of government; (2) identify potential respondents for in-depth interviews; (3) construct a timeline of major epidemiological and policy milestones; (4) develop an emerging understanding of policy processes and stakeholder perspectives. The second step involved a group-based approach to analyzing interview data at two levels – provincial and cross-provincial. In this phase, thematic analysis was used to interpret our data, beginning with coding

Table 1. Political Organization and Characteristics by Province

Province	Population 2020	Political Structure 2020-2022	Role and Independence of Public Health Officials[37]
BC	5.1 million (StatCan 2026)	NDP (2018-2022) Majority government, 57 out of 87 seats (Elections BC 2026)	CMOH offers advice as senior public servant but also has independent mandate to report to the public and/or legislature. Typically exercises relatively strong independent communications role in practice.
NS	984 000 (StatCan 2026)	Liberal Party (2013-2021) Reduced majority, 26 out of 55 seats Conservative Progressive Party (2021) Majority government, 31 out of 55 seats (NS Legislature 2026)	CMOH operates in traditional senior public servant role, supporting and advising government on technical and high-level policy issues. Typically has a strategic or day-to-day role in managing public health functions. May have a statutory mandate to issue independent reports but does not usually exercise a strong public advocacy role in practice.
ON	14.7 million (StatCan 2026)	Progressive Conservative Party (2018-2022) Majority government, 76 out of 124 seats (Legislative Assembly of ON 2026)	CMOH operates in traditional senior public servant role, supporting and advising government on technical and high-level policy issues. Typically has a strategic or day-to-day role in managing public health functions. May have a statutory mandate to issue independent reports but does not usually exercise a strong public advocacy role in practice.
QC	8.5 million (StatCan 2026)	CAQ (2018-2022) Majority government, 74 out of 125 seats (National Assembly of QC 2026)	CMOH operates in a traditional senior public servant role, supporting and advising government on technical and high-level policy issues. Typically has a strategic or day-to-day role in managing public health functions. May have a statutory mandate to issue independent reports but does not usually exercise a strong public advocacy role in practice.

Abbreviations: BC, British Columbia; NS, Nova Scotia; ON, Ontario; QC, Québec; NDP, New Democratic Party; CAQ, Coalition Avenir Québec; CMOH, Chief Medical Officer of Health.

Table 2. Interview Respondents

Province	No. of Interviews				
	Total	Government (Senior Civil Servants, Public Health, Health/Hospitals, Elected Officials)	Business Associations	Civil Society Groups	Academics
BC	18 (2021–2022; pilot study, BC only) 31 (2022–2024)	35	8	4	2
NS	14	14	-	-	-
ON	16	12	3	-	1
QC	24	19	2	-	3

Abbreviations: BC, British Columbia; NS, Nova Scotia; ON, Ontario; QC, Québec.

all interview transcripts using CAQDAS software (NVivo and Dedoose) through a combined inductive and deductive approach, the latter drawing on theoretical frameworks described above.

Interviews with QC participants were coded in their original French-language version. Coded segments were then translated to English by one fully bilingual member of the research team (SU) and validated by another fluently bilingual team member (LG). The extensive experience of both these team members in research on QC and Canadian health systems assured the accuracy of translated terms and concepts of their comparability with terms employed in English-language provinces. Recognizing that translation could pose challenges for capturing the full meaning of data from QC participants, the aforementioned steps, and transparency about those decisions, helped ensure these interview perspectives were integrated as accurately and meaningfully as possible into the analysis.[39]

A multisite qualitative analysis approach was utilized with the following steps. First, all four teams used a shared codebook for pilot coding of five transcripts, drawing on a codebook developed during formative research on this topic in BC[40] and site-based adaptations of the codebook through line-by-line coding.[41,42] Codebooks from each site were compared across contexts and led to the development of a shared codebook across all sites. De-identified datasets were also merged for cross-case comparison to aid overall theme development. Datasets that emerged from coding were shared to support theme development within and across sites. For this specific analysis, three members of the analysts examined codes pertaining to collaboration within government, collaboration with non-governmental actors, institutional arrangements, political factors and organizational dynamics from each site and developed cross-site themes. Inductive thematic saturation for this specific analysis was achieved through sustained engagement with coded data, providing a foundation for the development of core analytical arguments presented here. Data saturation was met when thematic consistencies emerged across and within the cases about the patterns and implications of collaborative governance within government and between government and non-government actors. These themes were then discussed and finalized through repeated team meetings with the cross-provincial team. Member checking was conducted with selected respondents and findings were modified based on feedback where the research team viewed such changes as appropriate.[43]

In line with reflexive qualitative praxis,[44] the research team considered, individually and collectively, how our preexisting assumptions about governance of the COVID-19 pandemic, particularly as residents of each province who experienced the policy decisions we were studying, shaped our choices during data collection and analysis. The aim was not to bracket-out our interpretive role, but to ensure our experiences and assumptions were not unduly influencing the direction and conclusions of the study.[45] Our within and cross-provincial reflexive dialogues surfaced, for example, the value of soliciting input from non-government stakeholders and challenged preconceptions about the stringency of each provincial response, borne of our own experience of living through restrictions to public space in these settings.

Results

Provincial governments in Canada included in this study were perceived by respondents to have adopted vastly different approaches to collaboration *within and outside* government in the management of public spaces (summary of policy decisions in Table 3), ranging from relatively higher levels of collaboration (BC, NS) to lower levels of collaboration (ON, QC) (Table 4). We conceptualize levels of collaboration based on two factors: (1) access of non-decision-makers to decision-making forums and processes, and (2) transparency and responsiveness of decision-makers to non-decision-makers. The first factor was assessed by identifying key decision-makers in each province (eg, cabinet, provincial health officer) and determining the proximity of non-decision-makers within and outside of government to those decision-makers, including the forums (eg, working groups, tables) and quality (eg, direct one-on-one communication versus reliance on interlocutors) of those interactions. The second factor was assessed based on the degree to which non-decision-makers had access to information about the processes of and justifications for decision-making and the extent to which decision-makers solicited and responded to information shared by non-decision-makers within and outside of government. Provinces with higher levels of collaborative governance were those where non-decision-makers had more sustained and direct access to key decision-makers and more information about and input on decision-making processes. These dynamics were taken as an indication that multiple sectors and levels of government, as well as non-government

Table 3. Major Public Space Measures/Clusters by Province, 2020-2022

Province	Date	Description
BC	March 16 – April 8, 2020	Initial response: closures, physical distancing, restrictions on gatherings
	May 7 – June 30, 2020	First summer restart: re-opening, expansion of service areas (patios)
	September 9 – December 30, 2020	Response to second wave: restrictions on gatherings, mask order, enforcement penalties strengthened, complete shutdown of nightclubs, New Year's shutdown
	March 29 – April 30, 2021	Third round of heightened restrictions: "Circuit Breaker," non-essential services restricted, cancellation of religious services, masks in fitness facilities
	May 25 – July 5, 2021	Second summer restart: increased gathering capacity, emergency state lifted, extended liquor services, religious gatherings allowed
	August 12 – December 29, 2021	Response to fourth wave: vaccine-related orders, mask mandate in all indoor spaces, gathering capacity limited, full return to school delayed
	March 10 – March 22, 2022	"Back to Normal": lifting of restrictions on gatherings, masks, vaccines
NS	March 15 – April 15, 2020	Initial response: closures, physical distancing, restrictions on gatherings
	May 1 – July 3, 2020	First restart: re-opening of businesses
	November 24, 2020 – February 7, 2021	Response to second wave: gathering restrictions, mask order, holiday restrictions
	May 28 – September 15, 2021	Phased reopening: public space, gathering restrictions lifted
	December 13, 2021 – January 26, 2022	Response to third wave: restrictions on sports and schools, gathering limits
	February 14 – March 21, 2022	Re-opening: Provincewide restrictions eased
ON	March16 – April 26, 2020	Initial response: closures, physical distancing, cancellation of major events
	May 1 – August 14, 2020	Re-opening plan: business restrictions eased, increased fitness facility capacity
	September 8, 2020 – May 20, 2021	Response to second and third waves: multiple lockdowns, emergency brakes, stay-at-home orders, mask mandate, gathering restrictions, business restrictions
	June 11 – October 8, 2021	Return to re-opening: vaccine passport for indoor spaces, capacity limits lifted
	December 17, 2021 – January 3, 2022	Provincewide shutdown: Capacity limits, restrictions on business hours
	February 16 – March 1, 2022	Return to re-opening: stay-at-home order and capacity limits lifted, masks and vaccines required
QC	March 16 – April 8, 2020	Initial response: closures, prohibition of gatherings, physical distancing
	June 2020	First re-opening: gradual resumption of non-essential services and sports, limited public and private indoor gatherings
	March – May 2021	Temporary restrictions amid re-opening (implementation of special emergency measures by region and municipality): limited school and business opening, curfew lifted
	December 2021	Renewed restrictions: temporary closure of schools and non-essential services, ban on gatherings, curfew instituted
	January – February 2022	Re-opening: Return to schooling, re-opening of certain businesses and indoor spaces, authorization of private gatherings, curfew lifted

Abbreviations: BC, British Columbia; NS, Nova Scotia; ON, Ontario; QC, Québec.

stakeholders, participated substantively in governance of the response.

The underlying reasons for these distinct approaches were noted to be institutional (eg, authority for public health to take independent decisions in an emergency), political (eg, collaboration in decision-making, support for health officials) and organizational (eg, team culture, previous experience with coordination). These patterns and approaches were far from static – in fact, the level of coordination and access within government and between government and non-government actors evolved considerably across waves of the pandemic, shaped by epidemiological, political, economic, and societal factors.

Institutional Structures and Organizational Culture Fostered Inclusive and Transparent Coordination Within Government

The impetus for collaboration within government originated in both institutional structures for crisis decision-making and the organizational culture around cross-sectoral inputs. Across each of the provinces, the locus of provincial-level decision-making for COVID-19 varied considerably, reflecting province-specific institutional frameworks for addressing public health emergencies, but moving beyond these frameworks as they adapted to changing scenarios and context.

In BC, respondents were overwhelmingly clear that the Provincial Health Officer (PHO) played their *de jure* role as a central authority in emergency decision-making, in close coordination with the Premier and Minister of Health. In the case of public space measures, the centrality of the PHO and the Minister of Health within decision-making structures in BC – supported by the Premier – appeared to anchor a flexible or nimble approach to coordination across the different sectors and ministries within government involved in this domain (BC-1, BC-3, BC-6, BC-11, BC-14). The Office of the PHO (OPHO) and the Ministry of Health

Table 4. Summary of Findings and Illustrative Quotes

Analytic Categories	Definition	Findings	Illustrative Quotes
Collaboration within government	Collaboration between two or more units within government, including within and across policy domains (eg, health, public safety, commerce)	• Institutional structures and organizational culture facilitated or hampered collaboration across sectors. • In BC and NS, existence of institutionalized structures (eg, tables, working groups) supplemented by regular direct communication. • In ON and QC, perception of opaque, closed-off communication within government. • Provinces varied in authority given to health officials to lead and/or coordinate response within government.	*"Even though the plans were there, my argument is always that's because no emergency is typical. And in fact, if you do enough work and help them into management, you realize that one needs flexibility within that structure. And that is not taught in incident command structure and emergency management"* [BC-1, Public health official]. *"It became a very, very complicated and controversial issue, as well, because within Cabinet, of course, everyone had their responsibility, and nobody wanted anything in their sector to be shut down or limited in any way"* [ON-7, provincial health official]. *"That was a pretty easy decision for the CMOH (National director of public health), Premier and Minister of health to say "we're putting Quebec on pause." But when it came to reopening little by little, what bit do you open? And commercial, financial, socio-political interests make themselves heard. We kept making science-based recommendations supported as much as possible by the literature. But the decisions were taken within government. And god only knows who had the most influence on government. We saw that there were political games going on because some things just didn't make sense*" [QC-10 Provincial public health officer]. *"Size matters absolutely. Like I mean, the fact that all of our Public Health doctors, and all of our ID [Infectious Disease] doctors know each other and they know who we are in the bureaucracy, and in Nova Scotia Health. You wouldn't see that necessarily in another province with a bigger workforce, and that text or phone call away does provide a different access"* [NS, health official].
Collaboration between governments and non-government stakeholders	Collaboration between government and stakeholders outside of government, including for-profit private sector industries and non-profit organizations	• Provinces varied in which venues engagement took place with non-governmental stakeholders (eg, direct conversations, working tables, etc). • Transparency of those processes varied between provinces, with BC and NS having more open engagement with non-governmental stakeholders. • Role of public health involvement in engagement with non-government stakeholders varied (greater in BC and NS). • More limited engagement with public interest or civil society groups when compared with business interests.	*"So, you know, we had a good ally, I believe, in government. And that was not that was not the case everywhere else, by the way. So BC, was unique in that regard"* [BC-5, non-profit representative organization]. *"We recognize the huge impact this was having on the hospitality industry, generally; in hotels, and in concert halls, and theaters... everything, because we had all of those voices around the table with our Cabinet ministers. They all did their job and spoke up for their stakeholders. But it was still— it was a health decision, at the end of the day, that had to rule"* [ON-7 health official]. *"There was a lot of pressure from every quarter - unions, chambers of commerce, culture industries, sports, religious groups. Many accommodations were made for religious groups that were not made for culture, so it's deeply political: a movie theatre isn't more risky than a mosque but we said yes to the mosque and no to the movie theatre"* [QC-12, regional health official]. *"Again, that would be primarily in the Public Health workstream. But our communications team… it's not possible for us to engage everybody, and so we placed the accountability on certain teams. The trick was to identify what teams we would create for a small business or, you know, industrial sector, or certain health professions, academic communities and things, and essentially provide the broad parameters that they had to design to, and then those plans would be approved by Public Health"* [NS, government official].
Perceived impacts on policy	Perceptions around the influence of collaboration on public policy decisions	• Diversity of inputs into public policy decisions yielded considerations beyond virus transmission and impacts on the healthcare system. • Sensitivity of public policy to implementation considerations within sectors (eg, modifying language in public space regulations to optimize feasibility and clarity).	*"So we saw that government obviously doesn't have the expertise to run the industry, they have the expertise in terms of public guidelines, health guidelines. But it was just it was magic. It truly was magic. Had we been sitting, waiting for WorkSafe slash [PHO]'s office to reopen our industry, I think it would have been a failure, because they don't know. They don't know the practical side of what can be done"* [BC-2, industry representative]. "*And so, there was a lot of hand wringing about it. Could you make it rational? I don't know. I don't know. I actually stayed away from that process as much as I could, because it was really painful, right? And if something was outdoors, is the Maid of the Mist a -- or something like that, if it's an outdoor event, is that an essential business that's allowed? So, all of those kind of went through, kind of a policy grinder inside government, trying to meet with the spirit of the lockdown. And this spirit of the word essential. And sometimes things got on the list. And then, obviously, there was some lobbying somewhere, and they got moved"* [ON-02]. *"We learned about public health directives at the same time as everyone else, during the triumvirate - Premier, Health, Public health - press conference. There was nothing communicated in writing, and the website was only updated a few days later. But it was up to us to implement the directive/order. I never got the feeling that they consulted experts in education, in ethics, in psychology to diversify the expertise around the table and consider the various impacts of decisions and reduce collateral impacts"* [QC-08, provincial public health officer]. *"I think that the new government also coincided with just a broader public shift, Pandemic fatigue, elevated risk tolerance… we started to realize omicron for many people is not a serious illness. So we really need to start moving to the principle of least restrictive means, and really be considering what we're doing from public… and if the steps we've taken in the past have been appropriate"* [NS, health official].

Abbreviations: BC, British Columbia; NS, Nova Scotia; ON, Ontario; QC, Québec; CMOH, Chief Medical Officer of Health.

were closely engaged in decision-making and stakeholder management, with the OPHO taking on a key role in developing guidance on public space measures (BC-1, BC-3, BC-12, BC-14). This flexible approach enabled OPHO and Ministry team members to engage directly with actors inside and outside government, without substantially expanding intra-governmental veto points, while tailoring public spaces guidance to sector-specific requirements and acting nimbly, or with speed. Temporary forums that served as virtual sites of engagement, termed as "tables" or working groups, involving ministries and non-governmental/representative organizations or institutionalized structures such as Emergency Management BC (EMBC) were also key venues in coordination and implementation (BC-3, BC-4, BC-7, BC-8, BC-14, BC-17, BC-20, BC-21, BC-22, BC-26). This type of structure, in addition to regular public and behind the scenes communication from key leaders in BC, was seen as crucial to help facilitate connections with the wide range of stakeholders impacted by regulations to public spaces.

"The EMBC table became the space where we were actually going to coordinate across government, to then take the PHO decisions, and use that particular table, to then exactly as you say, each ministry would have their own key stakeholders, and that they would be then responsible for helping with across government, implementation and management of the stakeholders..." [BC-14, provincial health official].

However, not all policy pertaining to public spaces emerged from the health sector. In some cases, industry stakeholders initiated discussions on measures with their related ministries, without prompting from health authorities (BC-1, BC-6). Closures and mask mandates were in some cases ordered by ministries other than health, such as the Ministry of Public Safety (BC-26, BC-6, BC-14, Ministry of Public Safety Order 2021). The key role of sectors outside of health in managing the response to the pandemic – in domains such as public spaces - departed from health and public emergencies that the BC government had experience in or had developed preparedness plans to address (eg, the more common outbreak control model).

Some participants noted disagreements within public health (eg, between OPHO and regional health authorities) and with other sectors of government (BC-4, BC-11, BC-20, Human Rights Commission Letter 2022) about how to balance health with other sectors' priorities as the pandemic wore on. Engagement with First Nations, Métis and Inuit communities (Indigenous peoples in Canada) was also initially seen as tokenistic, but evolved over the course of the pandemic to be more meaningful and collaborative. The presence of the First Nations Health Authority in BC was seen as an institutional lever in driving participation.

"I think initially … there was a lot of eye rolling when we showed up, right? It was like, Oh, God, here they are. But over time, I think a couple of things happened. They just got tired of not listening, because we were going to be there and say it anyway. But I think there was also a, hey, you know, they're somethings, things that make sense and we can really work together on this, it doesn't have to be an us v. them, it can be a collective view. And we saw things adapt over time" [BC-27, provincial health official].

In NS, while public health's role in decision-making was elevated, similar to BC, political leadership played a pivotal role in decision-making around public spaces and processes were also perceived as open within government. Political leaders drew primarily on recommendations from public health and other government officials tasked with COVID-19 response functions; however, these leaders also engaged with other senior government decision-makers (NS-5, NS-26). Temporary committees were instituted to facilitate this type of engagement across sectors (NS-5). Respondents described how one of the Premiers who served during the pandemic played a particularly important role as a "challenge function" in trying to determine the rationale behind restrictions.

"So Premier McNeil would be a great challenge function to say, okay, I'm listening to what you're recommending but I don't get why the kids playing basketball have to wear the masks but the other things don't have to, and so it would actually be like a good policy conversation about how does this make sense? So I think largely, that government, I don't want to say deferred to Public Health. But I would say really leaned on and supported Public Health recommendations. We had three premiers, remember, so Premier one really did that" [NS-7, political leader].

In ON and QC, decision-making processes within government were viewed by many participants as insular and opaque when compared with respondent perspectives from BC and NS. In ON, respondents noted that decision-making was largely in the domain of the Premier and Cabinet, with limited transparency into processes or consultations (ON-7, ON-9). A Command Table, and later, a Central Coordinating Table that brought together leadership of Ontario Health and the Chief Medical Officer of Health in the province, was tasked with providing recommendations to Cabinet (ON-2, ON-7). The dynamics of decision-making and authority within Cabinet varied over time (ON-2, ON-4, ON-9). Within Cabinet, health officials and other non-health officials that were seen as more 'effective' appeared to take dominant positions at various points in time, which impacted the regulation of public spaces (ON-4, ON-7, ON-9). The prominence of the role of health officials also appeared to shift throughout the pandemic.

"Government decision-making happens behind the curtain; I will provide input; I typically might not even find out about what the decision is until it's publicly announced. It's quite different. We don't know about the conversations that are happening; we don't know, necessarily, about who else the government has spoken to, unless we hear about it" [ON-9, public health official].

One of the challenges identified by respondents were restricted and uneven information flows to and from key decision-making units, such as the Ministry of Health. For example, some respondents perceived the Ministry of Health in ON to be closed-off to communication and engagement with other sectors.

"Ministry of Health almost became like MI6 [British intelligence agency], during this period. It was very difficult to get an answer out of anybody … it was very difficult to get

questions answered" [(ON-17, government official)].

The approach in QC was similar to that of ON, in that decisions were taken through closed-door meetings led by the Premier and Cabinet officials, assessing inputs given by multiple constituencies, including the equivalent of the Chief Medical Officer of Health in QC, the Directeur National de Santé Publique, and also private consultants (QC-9, QC-19). Respondents noted that in reopening decisions around public spaces, industry and other interests began to lobby for particular measures, resulting in what one respondent termed "political games" (QC-10). QC was also unique in its enforcement of a curfew at different periods in 2021 and 2022, criticized by some as a unilateral measure that exacerbated inequalities for particular communities and restricting individuals' access to public spaces.[46] Daily or periodic announcements from elected officials also began to influence decision-making. This became more evident as the province moved closer to elections in 2022 (QC-18).

"*The decision-making process was iterative through interactions between public health, the health network, the national director of public health as intermediary between these experts on the scientific side, and on the other side, the political actors. Ultimately, decisions were taken by political authorities; when a decision was less popular, it was sometimes attributed to public health. There were some tensions*" [QC-19, provincial public health official].

Provinces Were Divided in the Extent and Quality of Engagement With Non-government Stakeholders

Engagement with non-governmental organizations, specifically associations representing various groupings of industry, was crucial to developing and implementing public space regulations in all provinces. However, there were two distinguishing factors: the locus of engagement with non-governmental stakeholders and transparency of those processes (ie, direct relationships or conversations, working groups), and the engagement of public health officials in these discussions with non-governmental stakeholders.

In BC, there was widespread agreement amongst respondents that non-governmental stakeholders, particularly certain segments of industry and non-profits, were given significant voice in shaping policy pertaining to public spaces. Non-government respondents noted that their perspectives were respected within discussions, repeatedly mentioned how this was distinct from their counterparts in other provinces.

"*BC had the strongest relationship with government and decision-makers of any of the provinces....except maybe some of the Maritime Provinces, they sort of came to that. But early on, we formed a real trust relationship between us and the various decision-makers in government*" [BC-8, industry representative].

In BC, the process of engaging with these stakeholders took multiple pathways. Non-governmental stakeholders noted that they drew upon pre-existing relationships within government to help build an entry point to public health officials (BC-2, BC-4, BC-5, BC-7, BC-21). Over the first few months of the pandemic, a system of coalitions and "industry tables" was established, supplemented by smaller tables that focused on particular constituencies, such as hospitality and small business (BC-3, BC-4, BC-7, BC-8, BC-17, BC-20, BC-21, BC-22, BC-26). Access points to government by non-governmental stakeholders were multiple, with several respondents noting bilateral relationships with OPHO (BC-2, BC-5, BC-8, BC-16, BC-21, BC-24, BC-27), but with additional pathways through other government units within and outside the health sector (BC-3, BC-5, BC-6, BC-8, BC-14, BC-17, BC-21). For the faith community, engagement was handled in a highly structured manner through a series of facilitated dialogues (BC-10).[47]

"*So we saw that government obviously doesn't have the expertise to run the industry, they have the expertise in terms of public guidelines, health guidelines. But it was just it was magic. It truly was magic. Had we been sitting, waiting for WorkSafe slash [OPHO] to reopen our industry, I think it would have been a failure, because they don't know. They don't know the practical side of what can be done*" [BC-2, industry representative].

Respondents noted that this type of collaborative approach was anchored in trust and mutual learning, but that it also shifted over time. Public health officials learned quickly that engaging non-government stakeholders early in the development and communication of measures, and supporting them through implementation, was going to be crucial to sustaining an effective response strategy. Trust was gained in some relationships, leading to some stakeholders having a consistent and constructive relationship with public health officials (BC-3, BC-4, BC-10), including improvements to public health orders[48-50] (BC-20, BC-21). In some instances, trust eroded due to factors such as leakage of information, legal action, or what were perceived as sudden policy decisions (eg, decision to halt hospitality activities during New Years' Eve of 2021) (BC-6, BC-7, BC-21, BC-23). Broader questions were raised about unequal access to government, particularly in limited access for public interest or civil society groups (BC-12).

Interviews with government respondents in NS also report a collaborative approach to engaging non-governmental actors in policy processes, with one participant reflecting that both the "small" nature of the province and more limited resources meant that relationships between government and non-government stakeholders were important to achieving a successful response (NS-4, NS-26).

"*The expectation was that those actors would help us ensure compliance with those measures, and advise us on when they needed to be changed. So the approach was just that, you know, based on the reality that we had limited resources, and we were a small province, and we needed to work with our civil society in that way*" [NS-26, provincial government official].

However, respondents did note that opposition to public health measures became more visible from various non-governmental sectors as the pandemic wore on (NS-11).

"*So Rankin had the biggest wave yet to that point. That's really the third wave, the delta wave, the third wave in a spring of 21. And so the previous summer we had the beautiful Atlantic bubble, and it was great, people were getting over it,*

the tourism sector, all the various sectors, were really railing against things at that point. Restaurants, tourism, definitely arts and culture, all of them" [NS-7, political leader].

In ON, the process of developing relationships between government and non-governmental representatives appeared comparatively slower, with one respondent from an industry association noting that "*the first 15 months of the pandemic was about access and flow of information*" (ON-17). The depth of these relationships, specifically in terms of listening to and engaging with feedback from non-governmental stakeholders, also appeared to be less robust in ON when compared with BC and NS. Public health officials at the provincial level also do not appear to have been engaged in discussions or negotiations with non-government stakeholders. These dynamics had a direct impact on the quality of public policy that emerged from these processes. Respondents from the health sector for example noted that these were "painful" processes (ON-2) of determining the application of measures to different sectors. Stakeholders outside of government struggled to gain a clear reading of what was occurring within government (ON-6). One respondent from the business sector noted that they were both not consulted on policy measures and they also wanted to stay away from policy negotiations around public spaces *because* of its public health impact (ON-16).

"*We weren't consulted, I know that there were various organizations were doing lobbying efforts towards it. We stayed out of that, because it was, we saw it as a, public health response. But I do know other organizations, were in, there lobbying for different things*" [ON-16, industry representative].

As the pandemic progressed, other ministries in the ON government began to serve as conduits for concerns from various industries (ON-16). Another pattern that emerged in ON was the role of the media in shaping policy decisions, particularly in spotlighting issues that were not receiving policy attention from the point of view of particular constituencies (ON-16).

"*When wave three was emerging, that was the first wave that I saw really big pushback from other ministries. Certainly, a lot of lobbying from industry, really pushing back on keeping the measures in place*" [ON-4, provincial health officer].

QC was similarly viewed as being more closed to engagement to certain types of non-governmental stakeholders, with relative degrees of openness depending on the category of stakeholder. Civil society organizations had very limited engagement provincially, while industry groups attempting to "intervene" (QC-24) and had more communication, but little room for negotiation. Consulting firms on the other hand were actively involved in multiple aspects of pandemic policy-making, including around the lifting of public health measures (Canadian Broadcasting Corporation 2022).

"*Other association, notably gyms and campgrounds tried to intervene. But government was strict, very strict. Our organisations didn't have much influence*" [QC-24, industry association].

As noted by one participant, "*public participation in decision-making is difficult in normal times. These channels have to be pre-established if they're going to work during crises. I didn't see much of it*" [QC-13, regional public health official].

Discussion

Health policy challenges are increasingly complex, with few issues remaining the sole remit of health or other specific unit within government. It is now well-established that obstacles to effective collaboration between and with sectors outside of health, levels of governments, and non-governmental actors contribute to persistent health inequalities.[24] These challenges are heightened during periods of crisis. In federal countries such as Canada, the complexity of governance in a federal and decentralized context have presented additional challenges to governance,[51] particularly during health emergencies.[5] Research that examines collaborative governance during crisis from a holistic and relational standpoint, and importantly, situates these patterns in institutional, organizational and political contexts, is an emerging area of scholarship. Using the regulation of public spaces during COVID-19 in four Canadian provinces, we deepen theoretical and empirical understandings of intersectoral collaboration and governance in health emergencies. By focusing on a policy domain that traverses governmental and non-governmental actors, we generate comparative insights into how these approaches were perceived to shape policy choices and by extension, health and societal outcomes.

Our research confirms that Canadian provinces differed vastly in their approach to intersectoral collaboration in governance[25] in the regulation of public spaces. We found that differing approaches to collaboration across the provinces could be assessed through the access of non-decision-makers to decision-making forums and processes, the transparency of those processes, and the responsiveness of decision-makers to non-decision-makers. In BC, the OPHO and select cabinet officials (eg, Premier, Minister of Health) shared decision-making responsibility, while in NS, ON, and QC, cabinet official retained central control over decision-making. In BC and NS, decision-makers engaged substantively with non-decision-makers in government (eg, public health officials in the NS case, non-health ministries in the BC case) and non-government organizations through bilateral communciations and committees. This engagement generated transparency and responsiveness on the part of decision-makers; that is, non-decision-makers were generally informed about the processes of decision-making and their input was, at minimum, seriously considered, if not directly integrated into decisions. The opposite was perceived to be true by respondents in ON and QC, where non-decision-making government and non-government stakeholders appear to have inconsistent engagement with decision-makers, even if formal committees existed, and limited access to information about decision-making processes and justifications, including the extent to which stakeholder input was addressed.

We posit that a combination of institutional frameworks, organizational culture and capacity and political support fostered higher levels of collaboration within and outside government in BC and NS (the latter as reported by government respondents), while these same factors constrained collaboration in ON and QC. Such factors have been identified

previously in analysis on COVID-19 governance[6,7,52] and in theory on intersectoral collaboration.[28] However, few empirically driven studies have taken a comparative approach using robust empirical data, particularly in federal contexts, which allowed us to deepen and nuance these insights. Canadian federalism presents a particularly interesting case for exploration[5] given the highly decentralized nature of public health and healthcare.[53] Prior research has highlighted extremely heterogenous approaches to state-non-goverment relationships in provincial politics and policy-making.[54] In this study, we show how institutional, organizational and political factors distinctly shaped approaches to collaboration, such as independence of public health authorities, existence of First Nations' health authorities, experience of coordination in previous emergencies, existing and new organizational mechanisms to coordinate stakeholders, leadership style, and individuals' willingness to work collaboratively. What is important is that they amounted to a *qualitative* difference in levels of access to decision-makers and more importantly, a bi-directional flow of information between parties. The result was a perceived willingness to adopt policy approaches that, from the perspective of respondents, considered a broader range of inputs beyond transmission and hospitalization and resulted in policy more attuned to implementation realities.

The question that follows is why? What might explain vastly different approaches to intersectoral collaboration taken by these provinces? Zooming out, it is evident that no one causal factor can explain these differences. Each province's unique institutional structure for public health is certainly a factor, as demonstrated by the varied roles of public health offices displayed in Table 1. Organizational culture evidently varied considerably across the provinces, with more collaborative leadership styles and team cultures playing a crucial role in participation across policy communities. Each province also navigated unique political contexts, although it is evident that in provinces such as BC where public health officials had considerable independence, political support was a key facilitator of their efforts. Connecting these factors is a value-laden choice of acknowledging the political nature of COVID-19 policy. In BC and NS, there appears to have been more willingness to openly approach COVID-19 policy as a *political* set of decisions (ie, a willingness to engage with the trade-offs on various public health measures and other public policy decisions). In ON and QC, while policy-making was no less political, there was an opacity to decision-making that was, in the view of some respondents, under the guise of being a health-forward decision-making process. It is also important to recognize the myriad other factors that shape decision-making, such as population size, economic context, and governance capacity.

One of the key findings from this study is complicating understandings of access. Existing studies on the role of non-governmental stakeholders in shaping pandemic response have largely drawn on large-N survey data.[20,21] Through direct accounts from respondents, our study provides institutional, organizational and political context for how access takes place in practice during health emergencies. We illustrate that intersectoral collaboration during health crisis *traverses* multiple sectors and levels within and beyond government, calling for a broader analytical lens to more effectively understand the dynamics at play. We find that approaches to communication, transparency and relationships were not specific to internal dynamics within government or between siloes of government and non-government stakeholders. The locus of decision-making, involvement of public health leadership, the well worn ways in which power circulated prior to the pandemic, and the open or closed nature of access, diffused across the system, with important implications on access, and therefore, the types of policy that is put forward.[55] Emerson and colleagues[35] have advanced similar notions of systems approaches to collaborative governance that center specific "collaboration dynamics," such as principled engagement, shared motivation and capacity for joint action, and we encourage more research that adopts this framing to studying how collaboration dynamics evolve and shift during periods of crisis in a range of settings. While not the scope of this research, there are also important questions about how these relationships evolve after crisis; are there "residual" benefits to non-emergency periods?

Examining the institutional and organizational aspects more closely, our findings have particular relevance for the study of the balance between institutional structures and actor agency in intersectoral collaboration for health. Health governance scholarship that has unpacked the relationship between "hard" and "soft" mechanisms of governance,[56] and between the agency of individual policy actors and institutional structures[57] is informative for interpreting this finding. "Hard" mechanisms for coordination, including formal organizational relationships and increased and/or redistributed resources and "soft" mechanisms including individual or organizational-level commitments to leadership, network building and communication were both seen as crucial to effective pandemic response strategy[56] and in other health domains.[57] Our findings build on these studies by bringing the role of interest groups in; "hard" mechanisms for coordination within and outside government (eg, new or existing tables or working groups including with interest groups) created the conditions under which "soft" mechanisms of coordination, such as trust-building, shared purpose and collaborative leadership approaches, could flourish under challenging conditions, with actors that do not typically engage closely together in policy.

Even in situations where respondents perceived higher levels of collaboration (eg, access, transparency, sustained cooperation, coalition building), there remained disparities in access to decision-makers. The available literature on the politics of interest groups at the national and subnational levels during COVID-19 suggests that interest groups representing economic sectors secured access to decision-makers more effectively than those representing societal interests.[21,58] Our findings build on this literature by confirming that some interest groups, largely representing economic interests, did develop productive working relationships with government, but that access varied with societal groups (eg, more access for faith communities over other constituencies). Such disparities in access were not limited to non-governmental stakeholders.

In BC, respondents noted that First Nations experienced hesitancy and inaction earlier on in decision-making communities (although this evolved to be more collaborative). Pursuing collaborative governance meant decision-makers had to manage relationships and interests and balance health and societal policy objectives. In the context of a protracted emergency response, this necessitated difficult choices that would aggravate particular constituencies, particularly those groups that are not well-organized or resourced. From an equity standpoint, this raises important questions about building more inclusive structures for participation that encourage engagement with constituencies with fewer organizational resources but are no less affected.[20] The scope for regulatory capture is also important to recognize in conditions of unequal access, as evidenced in numerous domains of health policy.[59]

It is important to note some limitations to this study. First, participants were discussing their perspectives on episodes that had occurred during a period of high pressure and therefore, there is the potential for some retrospective recall bias. Further challenges with recall are possible due to the fact that respondents were describing events months or years in the past. Second, as with many qualitative studies, the data were shaped by sampling constraints such as respondent unavailability, and certain perspectives may therefore be absent from the analysis. In particular, perspectives from non-government stakeholders were underrepresented, especially in the NS case, which relied entirely on government accounts, and from those organizations representing community and marginalized group interests. We recognize that these perspectives would strengthen the credibility of the analysis, particularly with respect to grouping BC and NS as provinces that collaboratively engaged non-government stakeholders. That is, interviews with NS non-government stakeholders may differ in their accounts of inclusion as compared to government interviewees. To the extent possible, we mitigated these concerns through a rigorous process of triangulation across respondents and with data sources such as documents. Third, as is typical in qualitative research, the analysts' co-constructive role in development of themes requires readers to interpret our findings with appropriate caution. Fourth, the translation of study materials may have introduced some interpretive bias; however, the analysts' strong bilingual capabilities and familiarity with the Canadian healthcare and public health systems helped minimize this risk. Finally, this study focuses on four Canadian provinces and therefore, readers should contextualize these findings when considering their application to other settings.

Although this study did not seek to assess policy effectiveness, our analysis shows a difference in perception regarding transparency, communication, and engagement across these contexts. Exploring these learnings are important for several reasons. First, there is growing concern about declining trust in government officials and public health leaders,[60] including regarding the rationale behind policy decisions that extend beyond traditional health domains,[61] such as the regulations discussed here affecting public space and mobility. Second, the quality of intersectoral collaboration and governance has implications that extend well beyond crisis response. Finally, as health policy becomes increasingly complex and interdependent,[9] there is a need for more nuanced approaches to understanding both the perceived benefits and potential risks associated with different models of collaboration. Attending to and learning from these models of collaboration is therefore critical for informing improved governance strategies in crises and beyond, particularly in federal contexts such as Canada where province-specific strategies cannot impede from cross-provincial diffusion of disease or other emergencies.

Our research has several policy and practice implications. First, practical guidance on intersectoral health governance is increasing,[62] and would benefit from integrating these and other findings on the realities of how government and non-government networks traverse sectors and levels of government to collaborate. Literature on trust, network building, and collaboration dynamics, are important areas to consider.[35] Second, further understanding of how to balance collaborative governance and conflict management is urgently required, given the possibility for regulatory capture in health governance. Third, understanding how to build up collaborative governance through public interest groups (eg, civil society organizations), Indigenous governance units, and the legislature, will enrich knowledge on participatory governance. Finally, additional research on 'best practices' in collaboration within government is urgently needed globally given the growing complexity of public health challenges.

Conclusion

This paper advances scholarship on the dynamics of intersectoral collaboration in governing health emergencies, by contrasting the experiences of four Canadian provinces in the regulation of public spaces during the COVID-19 pandemic. Provincial approaches to collaboration within and outside government varied from proactive and inclusive to reactive and guarded. Drivers behind these differences included institutional frameworks, political factors and organizational culture and capacity. Robust stakeholder consultation and management within and outside government is crucial to managing complex policy challenges, including during crises.

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Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. The research project as a whole received ethics approval from the Science and Health Research Ethics Board at the University of British Columbia (Research Ethics Board: H21- 03474). Approvals were also received from the university ethics boards of co-principal investigators in each province: the Research Ethics Board at Dalhousie University, NS (decision 2022–6103); the Institutional Review Ethics Board, University of Toronto (Protocol number: 00042662); and the Comité d'éthique de la recherche

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Conflicts of interest

Authors declare that they have no conflicts of interest.

Data availability statement

To protect participants' identities, data from this study is confidential and not available for review.

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