Reviewer’s report

Title: Blending Integrated Knowledge Translation with Global Health Governance: A blended approach for advancing action on a wicked problem

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Reviewer: Elysee Nouvet

Reviewer’s report:

This is a novel and thought provoking article. I really appreciated the highlighting of limits to IKT (page 10-11) and I think this article will be very useful to a broad range of scholars. I do not agree entirely with the authors: I think there is an idealism in the expectation that co-learning/dialogue between IKT and GHG will make a difference. I would recommend the authors acknowledge that while both IKT and GHG could operate with a greater positive impact on health inequities if they borrow/learn from each other, evidence-based recommendations and plans go nowhere if there is no political will for change.

While I am not completely convinced by the authors’ arguments, I think it is a great piece to teach and discuss GH equity and processes of change with learners and colleagues. I think this is publishable. I would recommend minor revisions: (1) to nuance a bit further existing limitations in GHG and IKT. I’ve indicated a few passages below that I think can be reworded/nuanced to strengthen the article in this vein.

There are minor spelling mistakes that copy editing process should catch.

(1) GHG and the politics of change

There is not sufficient acknowledgement in my view of the politics of GHG. Indeed, while I am onboard with the authors’ proposal of having GHG and IKT ideals being brought into dialogic co-learning relationship, I take issue with a statement the conclusion that “Governance...strives to tackle issues of conflicting norms and values head on, with explicit examination of the role these play in shaping health problems.” I actually totally disagree with this statement and if it remains, I think it can seriously undermine the credibility of the authors because it is quite naive. There is a LOT of obscuring and persistence of (as the authors’ acknowledge anyways earlier) colonial-inspired lines of vision and processes of decision-making in global health governance. Maybe the authors want to consider acknowledging that just like IKT and GHG are limited in what they achieve within structures of inequality that intentionally and unintentionally reproduce normative inequalities, the co-learning they propose will not advance anything without some desire for change that is sincere (political will+collective action). In other words, maybe acknowledge in the conclusion that any strategy for change, however perfect in theory, can be co-opted and/or serve to further legitimate the powers that be.
The statement "Indeed, calls for social policy reform to improve health dating back more than 160 years reveal the depth and tenacity of root causes" (p6) might be rephrased slightly to better acknowledge that the tenacity of root causes are power inequities. Calls for change do not equal attempts at change. Therefore, calls for change not resulting in change does not have to do with something as vague as the complexity of the root causes, but rather with a lack of political will and who decides on whether or not a recommendation becomes change. I highly recommend that, to avoid reproducing the whitewashing 'mystery' of wicked health problems in some GH narratives, the authors be more explicit about the difference between evidence-informed recommendations and evidence-informed moves to actually translate recommendations into concrete changes in policy, processes, distributions of resources.

I am not convinced that "much health equity work unfolds in a broader context of linear, reductionist, hierarchical assumptions stemming from 17th century mechanistic assumptions about reality." (p. 7) A lot of health equity work stems from lived messy experience of people on the margins of society. I recommend this first paragraph on page 7 be reworded to be further nuanced (I know the authors say "much" and not all, but statement still sounds very unconvincing and generalizing to me.)

"Furthermore, the role of power...recognized as a pivotal driver of health inequities is only occasionally acknowledge and infrequently used to guide study goals and objectives." (p. 7): I recommend authors acknowledge that lack of explicit naming of power in study goals, objectives, recommendations may be strategic (when I and my colleagues leave it out, this is definitely strategic rather than based on lack of understanding/acknowledgement)

I would recommend the authors include a diagram to illustrate the dialogic relationship they are proposing between GHG and IKT, for those of us who like such visuals. But, this should not be a tie-breaker. I respect that not everyone loves diagrams or benefits from them, and I think it is important to support swift publication of this important article.

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