Review of International Studies (2026), page 1 of 20
doi:10.1017/S0260210526101867

RIS

RESEARCH ARTICLE

Political-epistemic disciplining in global governance: Producing ‘global’ Indigenous knowledges

Annabelle Littoz-Monnet

Department International Relations/Political Science, Geneva Graduate Institute, Switzerland
Email: annabelle.littoz-monnet@graduateinstitute.ch

(Received 9 October 2024; revised 27 February 2026; accepted 16 March 2026)

Abstract

International Relations scholarship has shown that persisting epistemic hierarchies rooted in colonial domination continue to exclude, silence, or sideline alternative knowledges in global governance, even as International Organizations increasingly open up to formally marginalized groups and attempt to pluralize their expertise. While building on such accounts, this article argues that epistemic hierarchies are deeply entangled with political-economic logics, which permeate global epistemic politics in multiple ways. These intersecting epistemic and political-economic logics produce complex forms of ‘political-epistemic disciplining’, which do not simply exclude alternative knowledges, but rearticulate them. I identify three intertwined modalities of this process: *de-epistemization*, whereby alternative knowledge claims are recoded as social or identity concerns rather than treated as competing epistemologies. This operation recognizes the subjects of the critique but not the epistemic critique itself. *Conditional recognition* occurs when prevailing criteria of validity regulate the acknowledgement of such claims. Finally, *transposition* constitutes or reformulates alternative knowledge claims through the lenses of dominant epistemic frameworks and categories. These processes rearticulate alternative knowledges and transform them a new into ‘globalized alternative knowledges’. The argument is developed through an in-depth analysis of engagements with Indigenous knowledges in Global Mental Health governance.

Keywords: epistemic disciplining; expertise; global governance; global health; Indigenous knowledge; knowledge

Introduction

At a side event during the 24th Session of the United Nations Permanent Forum on Indigenous Issues, which gathered together representatives of Indigenous peoples, global health experts, and activists, participants emphasized that ongoing discussions on Indigenous health within the World Health Organization (WHO) must reflect ‘Indigenous conceptualizations of health, considering self-determination, culturally grounded healing systems and ancestral knowledge’.[1] The event was organized in the context of the WHO’s recent commitment to prepare a Global Plan of Action for the Health of Indigenous Peoples, a milestone in its recent turn towards pluralizing its knowledge toolkit – or ‘expertise’ – through greater recognition and integration of marginalized knowledges.

Activists, Indigenous people, and representatives of other historically marginalized groups have, indeed, increasingly sought recognition of their own epistemologies and knowledges within global arenas, asking that they are considered on an equal footing with dominant forms of global expertise.

[1]WHO, ‘Indigenous Leadership and Views Must Shape New Global Health Action Plan’ (6 May 2025), available at: {https://www.who.int/news/item/06-05-2025-indigenous-leadership-and-views-must-shape-new-global-health-action-plan}, accessed November 2025.

© The Author(s), 2026. Published by Cambridge University Press on behalf of The British International Studies Association. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (http://creativecommons.org/licenses/by/4.0), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

Indigenous people have repeatedly made the case that their own knowledge systems and practices should be recognized and used as a basis for addressing mental health conditions on a par with other forms of knowledge.[2] Similar claims have been made in domains such as biodiversity, climate governance, human rights, or development finance.[3] Global governors therefore face growing pressure to reconsider their epistemic frameworks; in response, several International Organizations (IOs) have progressively acknowledged the need for greater inclusivity – particularly in domains where global programmes disproportionately affect specific communities, such as Indigenous rights, gender-based violence, and youth participation.[4] Accordingly, they have taken initiatives to engage with such groups, in order to better integrate their knowledges into global 'knowledge toolkits'.

The opening up of IOs to groups which put forward '*alternative knowledge claims*', that is, *claims aimed at the recognition of a knowledge system distinct from the dominant transnational expertise embedded within IOs*, is, of course, laudable. The attention currently granted to the breadth of Indigenous knowledges in the health domain was particularly long overdue. At the same time, ongoing engagements with Indigenous knowledges – as with any other forms of alternative knowledges – do not take place in a space that is horizontal, inherently pluralistic, and free of asymmetries. This article, therefore, sets itself to examine what 'happens' when IOs pluralize their knowledge base and engage with knowledge claims that do not align with their own. How do they apprehend and manage such claims, aimed at the full epistemic recognition of an alternative knowledge system and its practices? This examination enables an analysis of encounters between knowledge systems and the subtle processes of transformation they produce, while remaining attentive to the asymmetries that shape such dealings.

Research in International Relations (IR) and International Political Sociology (IPS) has produced insightful accounts illuminating the hierarchies that continue to structure contemporary global politics. Scholarship informed by decolonial thinking has made explicit that processes of epistemic domination that emerged during the colonial era persist in contemporary global governance,[5] so that Western knowledge still acts as the dominant framework, fashioned as universal and applicable everywhere.[6] Despite the presence of a novel discourse emphasizing pluralism, participation, and cultural nuance, alternative knowledges often receive little consideration.[7] Indeed, while spaces for participation and engagement increasingly mushroom in global governance *fora*,

[2]K. Ranchod and D. S. Guimarães, 'Transcending global health dogma: An Indigenous perspective', *The Lancet Global Health*, 9:10 (2021), pp. e1357–e1358.

[3]A. Standring and R. Lidskog, '(How) does diversity still matter for the IPCC? Instrumental, substantive and co-productive logics of diversity in global environmental assessments', *Climate*, 9:6 (2021); and M. A. R. de Mattos Vieira and L. Viaene, 'Indigenous Peoples' rights at the United Nations Human Rights Council: Colliding (mis)understandings?', *Journal of Human Rights Practice*, 16:2 (2024), pp. 512–32.

[4]S. Elbe, D. Vorlíček, and D. Brenner, 'Rebels, vigilantes and mavericks: Heterodox actors in global health governance', *European Journal of International Relations*, 29:4 (2023), pp. 903–28; K. Edquist, 'EU mental health governance and citizen participation: A global governmentality perspective', *Health Economics, Policy and Law*, 16:1 (2021), pp. 38–50; N. McKeon, '"One does not sell the land upon which the people walk": Land grabbing, transnational rural social movements, and global governance', *Globalizations*, 10:1 (2013), pp. 105–22; and M. Gauthier, 'Operationalizing epistemic justice: Participatory 3D modelling in conservation practice', *Academia Environmental Sciences and Sustainability*, 2:2 (2025).

[5]R. Dunford, 'Peasant activism and the rise of food sovereignty: Decolonising and democratising norm diffusion?', *European Journal of International Relations*, 23:1 (2017), pp. 145–67.

[6]W. D. Mignolo, 'Delinking: The rhetoric of modernity, the logic of coloniality and the grammar of de-coloniality', *Cultural Studies*, 21:2–3 (2007), pp. 449–514; A. Quijano, 'Coloniality of power and Eurocentrism in Latin America', *International Sociological Association*, 15:2 (2000), pp. 215–32; J. K. Gani, 'The erasure of race: Cosmopolitanism and the illusion of Kantian hospitality', *Millennium*, 45:3 (2017), pp. 425–46; K. Tucker, 'Unraveling coloniality in international relations: Knowledge, relationality, and strategies for engagement', *International Political Sociology*, 12:3 (2018), pp. 215–32; and L. Odysseos, 'Prolegomena to any future decolonial ethics: Coloniality, poetics and "being human as praxis"', *Millennium*, 45:3 (2017), pp. 447–72.

[7]L. M. Coleman, 'The making of docile dissent: Neoliberalization and resistance in Colombia and beyond', *International Political Sociology*, 7:2 (2013), pp. 170–87; L. Amoore and P. Langley, 'Ambiguities of global civil society', *Review of International Studies*, 30:1 (2004), pp. 89–110; Felix Anderl et al. (eds), *Rule and Resistance Beyond the Nation State: Contestation, Escalation,*

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

existing research shows that such mechanisms tend, in practice, to reproduce the subjugation of alternative perspectives.[8]

While such accounts have greatly enriched our understanding of persisting hierarchies in global governance, they also exhibit two intertwined blind spots. First, they conceive hierarchies in global governance as primarily 'epistemic', emphasizing the privileging of Western knowledge frameworks over other forms of knowledge. When political-economic dimensions are considered, it is primarily in terms of class relations and the international division of labour.[9] This 'narrow' understanding of political economy obscures how *political-economic logics also permeate epistemic politics* and work to the effect of privileging certain ways of knowing and precluding others. Political-economic logics are not merely an external backdrop; they are deeply intertwined with epistemic hierarchies and work to sustain the privileged position of particular knowledge forms in global governance. Second, and as a result of a primary emphasis on epistemic forms of domination, existing insights argue that alternative knowledges are excluded, or silenced, in global arenas. This conceals that when certain kinds of incentives are at play, the disciplining of alternative knowledges operates not only through overt silencing but also through the *rearticulation of alternative epistemologies* into globalized knowledge forms that conform to dominant templates of validity and credibility.

I therefore put forward the notion of 'political-epistemic disciplining' to account for the intersecting asymmetries that produce the rearticulation of alternative knowledges in global governance. The global epistemic field – the discursive, procedural, and institutional ensemble – that orders what counts as relevant and valid knowledge in global governance,[10] produces three complex and intertwined forms of political-epistemic disciplining: 'de-epistemization', 'conditional recognition', and 'transposition'. 'De-epistemization' occurs when alternative knowledge claims are stripped out of their epistemic content and reinterpreted, for instance, as calls for 'attention'. This operation recognizes the subjects of the critique, but not the epistemic critique itself. The knowledge claims are recoded as social or identity concerns, so that IOs do not need to treat them as competing epistemological claims. 'Conditional recognition' takes place when alternative knowledge claims are accepted, on the condition that they conform to dominant criteria of knowledge validity. This may occur through explicit procedural requirements, such as evaluation mechanisms, methodological 'rites of passage', or through implicit market-oriented expectations of measurability, operational relevance, and scalability. Finally, 'transposition' occurs when alternative knowledge claims are interpreted and assembled through dominant knowledge schemes of understanding and categories, in a fashion that is decontextualized. Focusing on such transformations is an acknowledgement that knowledges transform and blend when put in dialogue, but also that such processes take place in profoundly asymmetrical settings even when they appear inclusive and consensual on the surface.

These political-epistemic processes are explored through an in-depth examination of how Indigenous knowledges have been incorporated into the WHO's Global Mental Health (GMH) agenda. Although 'defining' Indigenous knowledges carries the risk of subsuming a rich and plural body of knowledge under a simplified and uniform label, it is possible to emphasize that such knowledges are characterized by their attention to local contexts, relations, experience, and interactions with the natural world. GMH is a particularly interesting site to explore encounters between

Exit (Bloomsbury, 2019); and L. M. Coleman and K. Tucker, 'Between discipline and dissent: Situated resistance and global order', *Globalizations*, 8:4 (2011), pp. 397–410.

[8]F. Anderl, P. Daphi, and N. Deitelhoff, 'Keeping your enemies close? The variety of social movements' reactions to international organizations' opening up', *International Studies Review*, 23:4 (2021), pp. 1273–99.

[9]Dunford, 'Peasant activism and the rise of food sovereignty'.

[10]A. Littoz-Monnet, 'Exclusivity and circularity in the production of global governance expertise: The making of "Global Mental Health" knowledge', *International Political Sociology*, 16:2 (2022); C. Bueger and J. Stockbruegger, 'Oceans, objects, and infrastructures: Making modern piracy', *Global Studies Quarterly*, 4:3 (2024); and L. Pantzerhielm, A. A. Holzscheiter, and T. Bahr, 'Power in relations of international organizations: The productive effects of "good" governance norms in global health', *Review of International Studies*, 46:3 (2020), pp. 395–414.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

knowledge systems. While the dynamics at play in the field of mental health in many ways echo those of global health at large, zooming in on a specific aspect of health makes it possible to achieve depth in the empirical investigation. Moreover, GMH relies on a body of knowledge that has long been contested – not only by Indigenous peoples but also by critical psychiatrists and groups of activists. GMH thus makes for an ideal terrain to observe the political-epistemic forms of disciplining at work in global governance. Since the emergence of GMH as a new field of global governance in the early 2000s, its agenda and practices have indeed largely relied, like global health at large, on a body of knowledge that favours biological explanations of mental conditions, where such conditions are seen as brain diseases. As this agenda and its underlying assumptions have come under criticism,[11] the WHO has operated a turn in its discourse, making it more attuned to cultural diversity and nuances, emphasizing in particular the need to engage with Indigenous knowledges, as evidenced by the issuing of the *Global Plan of Action for the Health of Indigenous Peoples*, the creation of the Global Traditional Medicine Centre (GTMC) in 2022, and the organization of events where representatives of Indigenous peoples are convened. As this shift has occurred, this article shows that the knowledge claims of Indigenous people have been reshuffled through political-epistemic disciplining processes, which have rearticulated their content.

In terms of methods, this article relies on a discursive analysis of the WHO's policy reports and agenda-setting documents on GMH and civil society participation in global health policy-making. I have included in my analysis all core documents published by the WHO between 2001, when GMH was identified as an area of 'global concern', and 2025. While analysing these documents, I have paid attention to how the WHO evokes Indigenous people and their knowledge. Additionally, I have also examined the 2007, 2011, and 2022 Lancet commissions related to mental health, and the 2020 and 2022 reports by the UN Rapporteur on the Right to Health, which have discussed mental health and the participation of marginalized groups in global governance. The article also relies on immersive strategies, including an in-depth exploration of relevant websites, including those of the WHO, the GTMC, and organizations representing Indigenous groups. I have read and analysed news pieces and documents available on these websites, in order to understand the positions of actors in the field and relationships between dominant epistemic frameworks and Indigenous ones. I have additionally conducted eight semi-structured interviews with officials from the WHO and other health organizations, and individuals working for organizations representing Indigenous peoples. All interviewees were informed, both orally and in writing, of their right to anonymity and the confidentiality of their responses. It is worth noting that the category 'Indigenous' is a Western one, and most individuals who are active within such organizations are English-speaking and often located in the North. The fact that many Indigenous voices are too diverse, dispersed, and often marginalized to be represented at all in many global arenas, including IOs, remains a limitation of this contribution.

Epistemic hierarchies in global governance

Existing scholarship in IR and IPS has largely established that epistemic hierarchies patently persist in contemporary global politics. Scholars have emphasized that knowledge is deeply intertwined with power, so that Western knowledge frameworks are privileged and rendered universal, while others are marginalized.[12]

[11] S. Ecks and S. Basu, 'The unlicensed lives of antidepressants in India: Generic drugs, unqualified practitioners, and floating prescriptions', *Transcultural Psychiatry*, 46:1 (2009), pp. 86–106.

[12] A. Tickner, 'Seeing IR differently: Notes from the Third World', *Millennium*, 32:2 (2003), pp. 295–324; and T. Barkawi, C. Murray, and A. Zarakol, 'The United Nations of IR: Power, knowledge, and empire in global IR debates', *International Theory*, 15:2 (2023), pp. 237–61.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

Research building upon postcolonial or decolonial thinking has made it explicit that processes of epistemic domination that have emerged during the colonial era persist in the 'afterlife' of colonialism, as Western thought was made globally hegemonic.[13] Mignolo, for instance, points to the roles of 'global designs', those hegemonic projects of the West, which have spanned from the Christian mission in the early colonization period, the civilizing mission in the nineteenth century, and development and modernization after World War II.[14] From this perspective, 'modernity' and its close association with 'reason' is the latest of these grand designs, which contemporaneously operates as a hegemonic project across the globe. Knowledges that have emerged in a Western historical-cultural context are therefore fashioned as a 'universalistic, neutral, objective point of view', that is applicable everywhere.[15] Modern reason, and its associated scientific paradigm, is thus opposed to premodern Western knowledge, associated with beliefs and superstitions, as well as knowledge of the non-Western, which is seen as less 'rational' and therefore inferior.[16] The Western scientific paradigm holds a position of epistemic power, understood as the power to produce meaning, but also to validate what counts as valid knowledge and who the relevant knowers are. Epistemic power structures the terms through which knowledge can be recognized as credible, valid, or relevant. Knowledges that do not fit with such contours are, reversely, at risk of being marginalized.[17]

In the field of health and medicine, scholars have shown that biomedicine, with its emphasis on 'modern technologies and scientific explanations', is rooted in the dominance of a Western understanding of rationality, which works to exclude knowledges that do not conform.[18] Adam, for instance, argues that global health governors favour 'knowledge that is based on universals (biology, disease, vaccines, etc.), in which multiplicity is visible only in and through global (that is, universal) forms of data production that get lumped together as "metrics"'.[19] The enduring nature of cultural and epistemic processes of oppression has, thus, largely been recognized.[20]

Acknowledging that epistemic hierarchies need to be examined beyond the realm of academia, more recent accounts have started to explore and problematize how epistemic hierarchies unfold in specific sites of governance, including the World Social Forums, United Nations (UN) agencies, and contemporary aid regimes.[21] This scholarship has evidenced that such hierarchies constrain meaningful participation and the ability to shape the conceptual vocabulary of governance.[22] Sondarjee in her research on the World Bank shows, for instance, that as the Bank has been opening up participation, this has not 'fully challenged the asymmetry of epistemic power relations', so that Western epistemes are privileged in all attempts to define global problems and how to address them.[23]

As scholars have started to examine what happens when IOs open up and formerly marginalized groups are invited to participate, they have shown indeed that IOs increasingly use the

[13] Mignolo, 'Delinking'; and Dunford, 'Peasant activism and the rise of food sovereignty'.

[14] Walter D. Mignolo, *Local Histories/Global Designs: Coloniality, Subaltern Knowledges, and Border Thinking* (Princeton University Press, 2012).

[15] Ramón Grosfoguel, 'A decolonial approach to political-economy', p. 16.

[16] Quijano, 'Coloniality of power and Eurocentrism in Latin America'.

[17] E. Adler and P. Haas, 'Conclusion: Epistemic communities, world order, and the creation of a reflective research program', *International Organization*, 46:1 (1992), pp. 367–90; and J. Eijking, 'Brain worlds: Information order and interwar intellectual cooperation', *European Journal of International Relations*, 31:3 (2024), pp. 537–60.

[18] A. S. Patterson, 'Biomedical and spiritual approaches to mental health in Tanzania: How power and the struggle for public authority shaped care', *Studies in Comparative International Development*, 58:3 (2023), pp. 403–29; and J. Holst, 'Global health – Emergence, hegemonic trends and biomedical reductionism', *Globalization and Health*, 16:1 (2020).

[19] Vincanne Adams (ed), *Metrics: What Counts in Global Health* (Duke University Press, 2016).

[20] R. Icaza and R. Vázquez, 'Social struggles as epistemic struggles', *Development and Change*, 44:3 (2013), pp. 683–704.

[21] Tucker, 'Unraveling coloniality in international relations'.

[22] J. Conway, 'Cosmopolitan or colonial? The World Social Forum as "contact zone"', *Third World Quarterly*, 32:2 (2011), pp. 217–36; Dunford, 'Peasant activism and the rise of food sovereignty'; and Meera Sabaratnam, *Decolonising Intervention: International Statebuilding in Mozambique* (Rowman & Littlefield International, 2017).

[23] M. Sondarjee, 'Coloniality of epistemic power in international practices: NGO inclusion in World Bank policymaking', *Global Society*, 38:3 (2024), pp. 328–50.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

language of inclusion to legitimize their authority, but that such practices also exclude, marginalize, or induce compliance.[24] Dunford, for instance, has shown that grassroots peasant voices have been marginalized in favour of 'the liberal and individualistic language' that prevails in UN discussions.[25] This might not be very surprising if we consider, following Sending and Neumann, that 'the self-association and political will-formation characteristic of civil society and nonstate actors (…) is a most central feature of how power, understood as government, operates in late modern society'.[26] Existing insights have indeed shown that IOs' emphasis on the 'civility' of associational life, as opposed to 'illegitimate' modes of expressing dissent, fashioned as irrational or irresponsible, tend to exclude certain voices.[27] Such accounts illuminate that while IOs put in place mechanisms designed to promote broader inclusion and participation, thus displaying a pluralistic ethos, this also enables epistemic hierarchies to persist and bureaucratic modes of governing to go unchallenged.[28]

While those accounts have evidenced that epistemic hierarchies inherited from the time of colonialism are being reproduced in global governance, I argue that we need to reconsider how we conceive the asymmetries at play. First, existing scholarship mainly conceives existing hierarchies as 'epistemic'. When economic inequalities are considered, it is essentially in terms of class hierarchies, with 'colonized' people occupying lower ends of the labour market and an international division of labour that splits a core area producing high-value-added goods from a periphery from which resources are extracted.[29] This 'narrow' understanding of political economy obscures how *political-economic logics also operate in relation to knowledge*, *and work to the effect of privileging certain ways of knowing and precluding others*. Political-economic logics, which include questions of access to resources, the spreading out of market logics, and the power of the corporate sector, indeed *permeate epistemic politics* in multifold ways and operate in an entangled fashion with cultural forms of domination to favour certain forms of 'global knowledge'.

Second, considering the intersecting hierarchies that permeate epistemic politics makes it possible to move beyond the prevailing binaries in the literature – between knowledges that are 'included' and those that are 'excluded', 'marginalized', or 'erased' – and instead consider the more subtle processes and incentives that rearticulate alternative knowledges in seemingly normalized forms as they enter into dialogue with dominant frameworks.[30] This approach thus 'takes knowledge seriously' by paying attention to the complex processes that recast alternative knowledges, rather than straightforwardly erase them.

Political-epistemic forms of disciplining

I conceptualize the nuanced disciplining processes that unfold in global arenas as 'political-epistemic' to account for the intersecting forms of asymmetries, which permeate global epistemic politics and produce 'globalized knowledges': knowledge forms that, while appearing plural and inclusive, are rendered governable and compatible with dominant global frameworks.

These disciplining processes might be sustained by IOs but cannot be conceived solely as intentional tactics on their part. IOs are part and parcel of a global epistemic field – a discursive,

[24] Amoore and Langley, 'Ambiguities of global civil society', p. 109. See also: J. Uribe, 'Excluding through inclusion: Managerial practices in the era of multistakeholder governance', *Review of International Political Economy*, 31:6 (2024), pp. 1–24.

[25] Dunford, 'Peasant activism and the rise of food sovereignty'.

[26] O. J. Sending and I. B. Neumann, 'Governance to governmentality: Analyzing NGOs, states, and power', *International Studies Quarterly*, 50:3 (2006), p. 652; Edquist, 'EU mental health governance and citizen participation'; and Anderl, Daphi, and Deitelhoff, 'Keeping your enemies close?'.

[27] Amoore and Langley, 'Ambiguities of global civil society'.

[28] Coleman, 'The making of docile dissent'.

[29] Dunford, 'Peasant activism and the rise of food sovereignty'.

[30] C. Rojas, 'Contesting the colonial logics of the international: Toward a relational politics for the pluriverse', *International Political Sociology*, 10:4 (2016), pp. 369–82; and Marilyn Strathern, *Partial Connections* (Rowman Altamira, 2004).

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

procedural, and institutional ensemble that orders what counts as relevant, valid, or usable knowledge in global governance *fora*.[31] This epistemic field is traversed by epistemic hierarchies, but also by neoliberal rationalities, power relations, and political-economic dynamics that shape access to financial resources and knowledge infrastructures.[32] On the one hand, the global epistemic field has genealogies in colonial epistemic orders that universalized Western scientific rationality as the benchmark of truth. As outlined above, such frameworks continue to function as a standard of intelligibility, ensuring that non-Western epistemologies can only be incorporated once they are normalized and made commensurable within this dominant framework.[33]

On the other hand, the global epistemic field is also embedded in neoliberal regimes of efficiency and accountability, which valorize specific epistemic forms that align with market logics and cost-effectiveness imperatives, and also fit in line with corporate interests and donor-driven priorities.[34] The spreading out of market logics in all spheres and domains, together with the power of corporate actors and investors in global governance, privileges forms of knowing that align with the favoured frameworks of the private sector. The ubiquity of philanthrocapitalists, consultants, and private companies in global health governance, but also beyond, which act as policy partners, experts, or data providers, is deeply shaping the global epistemic field.[35]

What counts as relevant knowledge is, therefore, that which can be operationalized, measured, and rendered compatible with such imperatives – knowledge forms that fit dominant standards of scientificity but also logics of cost-effectiveness, scalability, and measurability.[36] Such logics do not necessarily exclude alternative knowledges; as long as such knowledges *can be rearticulated along those lines, and even perhaps create new value for corporate actors, there is no particular reason to ignore or exclude them*.

In global health, existing research has shown that the dominance of biomedicine reflects the epistemic power of a Western conception of how to cure,[37] but also the spreading out of market logics and the growing presence of corporate actors in the governance of the field.[38] Such dynamics shift global health priorities towards individualized solutions, where citizens, rather than health authorities, are seen as capable of addressing their pathologies, and quick biomedical and technological fixes, an approach which clearly 'aligns with the neoliberal health perspectives'.[39] This perspective creates the need for evidence of the cost-effectiveness of such solutions in terms of alleviating the global health 'burden'.

---

[31]Karin Knorr Cetina, *Epistemic Cultures: How the Sciences Make Knowledge* (Harvard University Press, 1999), pp. 12–13; Bueger and Stockbruegger, 'Oceans, objects, and infrastructures'; and A. Littoz-Monnet, 'Knowledge machineries and their objects of expertise. Knowing bodies, moves, and moods through "Mobile Health" data', *Global Studies Quarterly*, 4:3 (2024).

[32]S. Moon, 'Power in global governance: An expanded typology from global health', *Globalization and Health*, 17:1 (2022), article 74.

[33]Mignolo, 'Delinking'.

[34]A. Littoz-Monnet, L. Montes Ruiz, and J. Uribe, 'Bringing the economic back! Thinking about the politics of expertise within and beyond the social', *International Political Sociology*, forthcoming; N. Bernards, 'The World Bank, agricultural credit, and the rise of neoliberalism in global development', *New Political Economy*, 27:1 (2022), pp. 116–31; and A. Kentikelenis and C. Rochford, 'Power asymmetries in global governance for health: A conceptual framework for analyzing the political-economic determinants of health inequities', *Globalization and Health*, 15:(Suppl 1) (2019), article 70.

[35]A. Littoz-Monnet and X. Osorio Garate, 'Knowledge politics in global governance: Philanthropists' knowledge-making in global health', *Review of International Political Economy*, 31:2 (2024), pp. 755–80; J. Uribe 'Governing on par with states: Private power and practices of political normalisation', *Review of International Studies*, 52:1 (2026), pp. 42–61; and A. de Bengy Puyvallée, K. T. Storeng, and S. Rushton, 'The Gates Foundation's network diplomacy in European donor countries', *Global Health*, 21:22 (2025).

[36]Littoz-Monnet, 'Knowledge machineries and their objects of expertise'.

[37]Patterson, 'Biomedical and spiritual approaches to mental health in Tanzania'; and K. T. Storeng and D. P. Béhague, '"Playing the numbers game": Evidence-based advocacy and the technocratic narrowing of the safe motherhood initiative', *Medical Anthropology Quarterly*, 28:2 (2014), pp. 260–79.

[38]Lane Kenworthy, *Social Democratic America* (Oxford University Press, 2014).

[39]Emma Rich and Andy Miah, 'Mobile, wearable and ingestible health technologies: Towards a critical research agenda', in Deborah Lupton (ed.), *Self-Tracking, Health and Medicine* (Routledge, 2016), pp. 84–97.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

These intersecting asymmetries permeate the global epistemic field: the institutional, procedural, and discursive ensemble that processes knowledge, validates evidence, and regulates how knowledge is circulated, negotiated, and legitimized in IOs.[40] IOs' incentives to preserve their authority in global governance also sustain the enactment of technocratic modes of governing, in which procedural filters and managerial toolkits sustain certain forms of global knowledge. I argue that this epistemic field *favours certain forms of knowledge expression in global governance and, as such, produces 'formatted' globalized knowledges*, through three forms of disciplining: de-epistemization, conditional recognition, and transposition, which actively rearticulate alternative knowledges so that they can fit with dominant global frameworks.

De-epistemization

De-epistemization occurs when claims aimed at the full recognition of an alternative knowledge system and its associated practices are *stripped of their epistemic content*. In this process, the epistemic demands for the recognition of the alternative knowledge system are, instead of being acknowledged, fully reinterpreted as calls for 'attention', inclusion, and diversity. The marginalized group becomes the object of special consideration, often through a kind of 'minoritizing' language. This operation recognizes the *subjects of the critique*, but not the *epistemic critique itself*. In this process, dissenting knowledges are not acknowledged as valid epistemic contributions, but are recoded as social or identity concerns, so that global institutions do not need to treat them as competing truth claims that might require reconsidering dominant rationalities. This form of disciplining typically occurs when the knowledge claims of the marginalized groups are not intelligible in the dominant paradigm – either because they cannot be translated into its vocabularies, quantified, or turned into project-based interventions – and thus become 'non-knowledge'. For instance, feminist scholarship has well captured that as global governors have been approaching the feminist agenda from a neoliberal lens, where women must simply be included in projects, this has left aside more fundamental knowledge claims that challenge patriarchal approaches to problems and ask for an epistemological shift.[41] Such attention to the subjects of the critique does not necessitate an adjustment of the dominant knowledge framework, which is still seen as fully applicable to the group deemed worthy of special consideration. De-epistemization thus exemplifies a form of political-epistemic disciplining in which participation is opened up, and new subjects are recognized as participants, but the dominant knowledge framework is not challenged. Instead, the proponents of alternative knowledge claims are made legible and governable within it.

Conditional recognition

Conditional recognition occurs when alternative knowledge claims are accepted, on the condition that they conform to dominant criteria of knowledge validity. When this occurs, such claims become integrated into the dominant narrative in an adjusted or corrected form that streamlines them of their 'heretic' elements. Such adjustments can be prompted by IOs and their networks, but they can also be self-imposed by dissenting groups themselves, who are cognizant of the conditions for recognition and seek legitimacy through alignment with recognized forms of 'evidence'. Existing insights have pointed out that when civil society groups and activists want their claims to be considered on an equal footing with those of technocratic experts, they need to adopt a language and toolbox that fit with dominant understandings of evidence validity.[42] This may occur through explicit procedural requirements, such as evaluation mechanisms, methodological 'rites of passage', or through implicit market-oriented expectations of measurability, operational relevance,

[40] Bernards, 'The World Bank, agricultural credit, and the rise of neoliberalism'.

[41] K. Lanz, E. Prügl, and J.-D. Gerber, 'The poverty of neoliberalized feminism: Gender equality in a "best practice" large-scale land investment in Ghana', *Journal of Peasant Studies*, 47:3 (2020), pp. 525–43.

[42] S. Epstein, 'The construction of lay expertise: AIDS activism and the forging of credibility in the reform of clinical trials', *Science, Technology, & Human Values*, 20:4 (1995), pp. 408–37.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

and scalability. In the field of global health, evidence-based medicine (EBM), which acts as the dominant paradigm through which the quality of medical evidence is evaluated, strongly emphasizes methods as the main criterion for the recognition of evidence – and considers randomized controlled trials (RCTs) as the condition that guarantees the 'validity' of scientific evidence. All forms of knowledge that have not been tested through an RCT are, thus, considered suspicious or anecdotal. In other domains than global health, knowledge must meet other conditions to be recognized, such as being presented in a specific material or visual form, or being framed in relation to a dominant narrative. Knowledge claims targeted towards global policy-makers must, for instance, be embedded within the discursive universe of the 'accelerating progress toward the Sustainable Development Goals (SDGs)' in order to be heard.[43] Alternative knowledge forms are therefore recognized if they are reformulated in the dominant terminology, comply with recognized procedural criteria, and dominant markers of scientificity. Conditional recognition thus disciplines knowledge by inducing epistemic conformity, blending alternative knowledges into a standardized epistemic repertoire compatible with dominant understandings of scientificity and the neoliberal knowledge economy. By contrast, knowledge claims that cannot be produced or framed according to such criteria tend to be discredited.

Transposition

When the process of transposition is at play, the identities, preferences, and needs of the groups that formulate alternative knowledge claims are constituted through dominant epistemic frameworks. Crucially, transposition does not straightforwardly ignore or silence other ways of knowing; it *recreates them in the image of dominant epistemic and economic rationalities.* Rather than engaging alternative knowledges on their own terms, dominant interpretive schemata are projected onto them, translating difference into governable and even commodifiable categories. IOs then become the 'spokespersons' of the groups that voice alternative knowledge claims.[44] In the health domain, so-called 'traditional knowledges' from the South, including Indigenous ones, are often seen through the dominant concepts of biomedicine, which are embedded in a Western conception of scientificity, but also in private actors' frames of reference.[45] As a result, Indigenous knowledges are often seen through their potential for extractability, or contribution to innovation pipelines, rather than in their own terms. Thus, even when IOs' discourse appears as culturally sensitive, it often defines 'local specificities' through pre-existing global frameworks and assesses them for their comparability with dominant categories. Situating alternative epistemes within pre-defined frameworks can simultaneously endow global policies with an aura of pluralism, while allowing the dominant schemes of interpretation to thrive.

The GMH paradigm and its critics

The WHO considers mental health as the 'foundation for the well-being and effective functioning of individuals'.[46] Under the impetus of the WHO, 'GMH' has emerged as a visible domain in global health governance, with its expert networks, action plans, special *Lancet* Series, and partner professional organizations. Although the WHO had already created a division on mental health at the end of the 1970s, it was with the publication of the report *Mental Health: New Understanding, New Hope* and its emphasis on the 'burden' of mental disorders worldwide that GMH gained greater

[43]M. Tichenor et al., 'Global public policy in a quantified world: Sustainable Development Goals as epistemic infrastructures', *Policy and Society*, 41:4 (2022), pp. 431–44.

[44]M. Callon, 'Some elements of a sociology of translation: Domestication of the scallops and the fishermen of St Brieuc Bay', in John Law (ed), *Power, Action and Belief: A New Sociology of Knowledge?* (Routledge & Kegan Paul, 1986), p. 223.

[45]L. Seabrooke and O. J. Sending, 'Contracting development: Managerialism and consultants in intergovernmental organizations', *Review of International Political Economy*, 27:4 (2020), pp. 802–27.

[46]WHO, 'Mental Health' (2024), available at: {https://www.who.int/westernpacific/health-topics/mental-health}, accessed November 2025.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

momentum.[47] In its 2008 Mental Health Gap Action Programme (mhGAP), the WHO made a plea for putting mental health issues centre stage, arguing that 14% of the global burden of disease can be attributed to mental, neurological, and substance use disorders.[48] In its Mental Health Action Plan 2013–2020, it states that between 76% and 85% of people with severe mental disorders in low- and middle-income countries (LMICs) receive no treatment.[49]

Since the early 2000s, the WHO's agenda has indeed been focusing on the so-called 'treatment gap' in LMICs, defined as the difference between the number of people estimated to need treatment for mental illness and the number of people actually receiving treatment in such countries. The 'treatment gap' has acted as a rallying call, 'crafting an identity for global mental health actors'.[50] In its mhGAP, targeted at LMICs, the WHO claims that tens of millions could be prevented from suicide and live 'normal lives', were they to receive proper treatment.[51] In direct connection with this diagnosis, it emphasizes the need to scale up interventions in LMICs, professing the necessity of deploying 'evidence-based interventions' to address conditions such as depression, schizophrenia, suicide, epilepsy, and dementia.[52] The epistemic standards of EBM have indeed become dominant in the medical and global health spheres.[53] As this has happened, policy-makers have sought to support all their decisions with reference to 'evidence' defined through the lens of the standards of EBM, which largely privileges scientific research produced through RCTs.

The 'evidence-based interventions' put forward in GMH have long relied on a body of knowledge that favours biomedical explanations of mental disorders, which posit that mental disorders are brain diseases. Such an understanding of mental health naturally results in a focus on the use of, and access to, medicines. In the 2001 WHO Report *Mental Health: New Understanding, New Hope*, psychotropic drugs are defined as 'first line treatment', as 'these drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse'.[54] The mhGAP Intervention Guide proposes standardized descriptions of different types of disorders and of diagnostical methods and prescribes, along with psychological treatment, psychotropic medication for depression and all other mental health disorders.[55] Mental health disorders, from this perspective, are stable entities that can be diagnosed according to fixed and universally valid categories. Thus, the WHO's mhGAP Intervention Guide proposes both standardized categories of disorder and diagnostical methods designed to be applicable everywhere.[56] Such descriptions are based on the International Classification of Diseases (ICD) diagnostic classifications, which, despite being created by the Western medical profession, establish stable psychiatric categories and their presumed universality.[57] Following this logic, standard treatments are to be applied throughout the globe, regardless of the context. This has resulted in an emphasis on the use and access to medicines such

[47] WHO, 'The World Health Report 2001: Mental Health – New Understanding, New Hope' (2001), available at: {https://iris.who.int/handle/10665/42390}, accessed November 2025.

[48] WHO, 'mhGAP Mental Health Gap Action Programme', p. 4, available at: {https://www.who.int/publications/i/item/9789241596206}, accessed November 2025.

[49] WHO, 'Mental Health Action Plan 2013–2020' (2013), available at: {https://www.who.int/publications/i/item/9789241506021}, accessed November 2025.

[50] A. M. Lovell, U. M. Read, and C. Lang, 'Genealogies and anthropologies of global mental health', *Culture, Medicine, and Psychiatry*, 43:4 (2019), pp. 519–47 (p. 526); and Littoz-Monnet, 'Exclusivity and circularity'.

[51] WHO, 'mhGAP Mental Health Gap Action Programme'.

[52] P. Y. Collins et al., 'Grand challenges in global mental health', *Nature*, 475 (2011), pp. 27–30.

[53] Stefan Timmermans and Marc Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine* (Temple University Press, 2010).

[54] WHO, 'The World Health Report 2001: Mental Health', p. 9.

[55] WHO, 'mhGAP Intervention Guide', version 2.0, available at: {https://iris.who.int/bitstream/handle/10665/250239/9789241549790-eng.pdf}, accessed November 2025.

[56] WHO, 'mhGAP Mental Health Gap Action Programme'.

[57] K. Edquist, 'Globalizing pathologies: Mental health assemblage and spreading diagnoses of eating disorders', *International Political Sociology*, 2:4 (2008), pp. 375–91; and J. Moncrieff, 'Psychiatric diagnosis as a political device', *Social Theory & Health*, 8 (2010), pp. 370–82.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

as psychotropic medication for depression and other mental health disorders.[58] In the GMH's narrative, granting access to psychotropic medicines to people with mental illness 'offers the chance of transformative improvement in health and the opportunity for re-engagement in society'.[59]

This paradigm has been articulated and sustained not only by the WHO but also by the ecosystem of actors and sites with which it interacts in a circular fashion. While the WHO, and in particular its Department of Mental Health and Substance Abuse, occupies a central place in the fabric of GMH knowledge, it works in close collaboration with the *Lancet* expert groups; the *Lancet* Series on GMH indeed played a foundational role in the establishment and consolidation of the GMH knowledge base.[60] Beyond this closed circle, the WHO limits its partnerships to a few carefully selected professional organizations and patient organizations.[61] It has established collaborations with the World Psychiatry Association (WPA), the World Federation for Mental Health (WFMH), and the International Association for Suicide Prevention (IASP) (which presents itself as an 'NGO concerned with suicide prevention').[62] Despite presenting themselves as NGOs, these organizations mainly represent professionals from the field of psychiatry. Moreover, these organizations entertain close ties with the pharmaceutical industry: for instance, WFMH donors include India Lundbeck, a pharmaceutical company focused on brain diseases and acknowledged for having supported its campaign.[63] In addition to those financial connections, professional organizations also directly collaborate with private actors to produce knowledge on mental health: a booklet published by the IASP mentions its collaboration with the international pharmaceutical industry 'in providing educational material on depression, the condition associated with suicidal behaviour'.[64] Such entanglements substantiate the criticism of those who have been vocal about the role of the private industry in shaping how mental health problems are understood, prompting the proliferation of psychotropic medication use.[65] As a global health official puts it, the WHO struggles to open up dialogue and consultation beyond its 'traditional eco-chambers'.[66] The biomedical paradigm is, thus, not just sustained by the epistemic authority of 'Western' conceptualizations of health; rather, political-economic logics intersect with cultural forms of domination to promote its assumptions, categories, and favoured epistemic forms.

GMH knowledge has, however, been subject to mounting criticism. The evidence behind universal and biomedical explanations of mental disorders has been contested within the discipline of psychiatry itself for decades, where professionals increasingly agree that biological constructions of mental disorders might be wrong, or should, at minimum, be examined in light of alternative or complementary approaches focused on environmental and contextual factors.[67] Critical voices

[58] WHO and Fundação Calouste Gulbenkian, 'Improving Access to and Appropriate Use of Medicines for Mental Disorder' (2017), available at: {https://iris.who.int/handle/10665/254794}, accessed November 2025.

[59] Ibid., p. 13.

[60] The Lancet, 'Global Mental Health Series 2007' (2007), available at: {https://www.thelancet.com/series-do/global-mental-health-series-2007}, accessed November 2025; and The Lancet, 'Global Mental Health Series 2011' (2011), available at: {https://www.thelancet.com/series-do/global-mental-health-2011}, accessed November 2025.

[61] Interviews with Global Mental Health professionals, October–December 2019.

[62] IASP – International Association for Suicide Prevention, website, available at: {https://www.iasp.info/about.php}, accessed November 2025.

[63] WFMF, 'Annual Report 2016' (2016), available at: {https://wfmh.global/img/what-we-do/publications/2016-wfmh-annual-report.pdf}, accessed November 2025.

[64] R. D. Goldney, A. T. Davis, and V. Scott, 'The international association for suicide prevention: The first 50 years', *Crisis*, 34:3 (2013), pp. 137–41; and International Association for Suicide Prevention, website, available at: {https://www.iasp.info/about.php}, accessed November 2025.

[65] P. Lehmann, 'Transparency first: Disclosure of conflicts of interest in the psychiatric field', *Journal of Critical Psychology, Counselling and Psychotherapy*, 19 (2019), pp. 131–51.

[66] Interview with a WHO official, 28 June 2023.

[67] Moncrieff, 'Psychiatric diagnosis as a political device'; L. McGoey, 'Profitable failure: Antidepressant drugs and the triumph of flawed experiments', *History of the Human Sciences*, 23 (2010), pp. 58–78; L. J. Kirmayer, 'Rethinking cultural competence', *Transcultural Psychiatry*, 49 (2012), pp. 149–64; and Lovell, Read, and Lang, 'Genealogies and anthropologies of global mental health'.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

have also emerged outside the scientific community, with a diverse set of dissenting groups calling for the pluralization of the GMH's knowledge toolkit.

In 2018, the coalition Transforming Communities for Inclusion-Asia Pacific, representing people with psychosocial disabilities and cross-disability supporters from the Asia-Pacific region, adopted a statement, known as the Bali Declaration, which called for a paradigm shift in the WHO's mental health approach and for the inclusion of diverse knowledges and understandings of mental health.[68] In this context, Indigenous knowledge claims have found a more favourable terrain for being voiced.

Indigenous knowledge claims

Indigenous peoples have been putting forward a particularly forceful critique of GMH, calling for a stronger inclusion in discussions and the acknowledgement of their own understandings of health, including those that diverge from or challenge biomedical paradigms.[69] They have, thus, been questioning the assumption that mental health syndromes have a universal nature – a core assumption of the GMH agenda, which assesses the global 'burden' of mental conditions based on Western psychiatric categories and makes it its core objective that of 'scaling up' GMH treatments throughout the globe.[70]

Despite the wide variety of knowledges subsumed by the term 'Indigenous knowledge', the latter can be seen as 'a cumulative body of knowledge and beliefs, handed down through generations by cultural transmission, about the relationship of living beings (including humans) with one another and with their environment'.[71] As a consequence, such knowledge systems tend to lay the emphasis on local context, relations, experience, and interactions with the natural world.[72] As put by a member of the UN Expert Mechanism on the Rights of Indigenous Peoples:

> Indigenous peoples have a different concept of health. It is not only just about the body itself, there is a spiritual connection, ritual activities, and a generational aspect of connectivity. These all are connected. We also don't see health management from the scientific perspective; we also see how the nature itself, the way we are involved with the land, forest, territory, waters. All things are connected from our perspective.[73]

From an Indigenous perspective, community-based and ritualized practices are therefore more desirable than psychiatry.[74] Indigenous health care tends to focus on 'rituals of encounter' to establish ways of conversing, listening, witnessing, and creating spaces 'that form the foundation of an ongoing dialectics of engagement'.[75] For instance, Mãori psychology in Aotearoa New Zealand is embedded in a worldview that strongly values interconnection.[76]

[68] Transforming Communities for Inclusion-Asia Pacific, 'Bali Declaration' (2018), available at: {https://tci-global.org/bali-declaration/}, accessed November 2025.

[69] V. Adams, N. J. Burke, and I. Whitmarsh, 'Slow research: Thoughts for a movement in global health', *Medical Anthropology*, 33:3 (2014), pp. 179–97.

[70] Laurence J. Kirmayer and Leslie Swartz, 'Culture and global mental health', in Vikram Patel et al. (eds), *Global Mental Health: Principles and Practice* (Oxford University Press, 2013), pp. 41–62 (p. 46).

[71] Fikret Berkes, *Sacred Ecology*, 4th ed. (Routledge, 2017), p. 8.

[72] R. Hill et al., 'Working with Indigenous, local and scientific knowledge in assessments of nature and nature's linkages with people', *Current Opinion in Environmental Sustainability*, 43 (2020), pp. 8–20; and J. Mistry and A. Berardi, 'Bridging indigenous and scientific knowledge', *Science*, 352 (2016), pp. 1274–5.

[73] Interview with Indigenous rights activist and member of the UN Expert Mechanism on the Rights of Indigenous Peoples, 23 June 2025.

[74] Interview with WHO official, 26 June 2023.

[75] Shilo Groot et al., 'Rituals of encounter, recognition and engagement', in D. S. Guimarães (ed.), *Dialogical Multiplication: Principles for an Indigenous Psychology* (Springer International Publishing, 2019), p. 152.

[76] Linda W. Nikora et al., 'Indigenized internationalization: Developments and lessons from two Aotearoa/New Zealand universities', in Grant J. Rich et al. (eds), *Internationalizing the Teaching of Psychology* (Information Age Publishing, 2017), pp. 129–42.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

Rather than the local context being the endpoint – and implementation stage – of a 'global project', Indigenous people demand that *their knowledges be incorporated in the GMH knowledge base itself*. Indigenous people have however encountered many layers of barriers when trying to access the WHO and put forward their perspectives. Resources of course prevent travel to global epicentres like Geneva, but language is also a major issue, in particular for Indigenous people from the Global South. Considering that some Indigenous people speak their own dialect, and not the official language of the country they live in, gives a sense of the actual potency of the language barriers they encounter. Because of such obstacles, the WHO often relies on its own network when it consults Indigenous people, thus favouring those representatives already working in the UN circle. Despite such bottlenecks, the necessity of better integrating Indigenous perspectives has found receptive interlocutors within the UN system itself: at the UN Human Rights Office of the High Commissioner, the UN Special Rapporteur Tlaleng Mofokeng on the Right to Health, in its 2022 Report, directly addresses the potential medical benefits of Indigenous knowledges, stating that 'acceptable health requires an urgent focus on ensuring an end to the demonization and belittling of Indigenous and traditional health, and instead promotes an inclusive approach that is respectful and seeks to understand and support integration into primary health care'.[77] In response to such concerns, the WHO has operated a turn in its discourse, making it more attuned to cultural nuances and acknowledging the need to pluralize its knowledge toolkit, with a particular focus on the integration of Indigenous knowledges.

Pluralizing the GMH's knowledge toolkit: 'seeing' Indigenous knowledges at the WHO

With the pluralistic turn, the necessity of better including Indigenous people and their knowledges in GMH knowledge has been put centre stage. In 2023, the WHO Secretariat launched its 'Framework for Meaningful Engagement of People Living with Non-Communicable Diseases and Mental Health and Neurological Conditions' (hereafter 'the Framework for Meaningful Engagement'). The Framework for Meaningful Engagement clearly specifies that the WHO and its member states should foster programmes that aim at 'bridging the gap from global to local meaningful engagement should account for local contexts, languages, cultures and practices in order to be effective and sustainable'.[78] To that effect, it emphasizes the necessity of creating opportunities for participation and ensuring the use of 'correct language, a culture of acceptance, active listening and engagement, and no tokenism, stigmatization or discrimination of any kind'.[79] Although the Framework for Meaningful Engagement lays the emphasis on the inclusion of local knowledges 'at large' in the official GMH knowledge toolkit, it pays specific attention to those emanating from diverse contexts and cultures. The WHO has indeed initiated discussions on traditional medicine, which is central to Indigenous peoples' approach to health. In August 2023, the first WHO Traditional Medicine Global Summit took place in Gandhinagar, Gujarat, India, 'to mobilize political commitment and evidence-based action on traditional medicine'.[80] A diverse group

[77]Human Rights Council, A/77/197: 'Report of the Special Rapporteur … Racism and the Right to Health' (2022), p. 23, available at: {https://www.ohchr.org/en/documents/thematic-reports/a77197-report-special-rapporteur-right-everyone-enjoyment-highest, accessed November 2025. See also: Human Rights Council, A/79/177: 'Report of the Special Rapporteur. Harm Reduction for Sustainable Peace and Development' (2024), available at: {https://www.ohchr.org/en/documents/thematic-reports/a79177-report-special-rapporteur-right-everyone-enjoyment-highest}, accessed November 2025.

[78]WHO, 'WHO Framework for Meaningful Engagement of People Living with Noncommunicable Diseases, and Mental Health and Neurological Conditions' (2023), p. 35.

[79]Ibid., p. 40.

[80]WHO, 'The First WHO Traditional Medicine Global Summit' (2023), available at: {https://www.who.int/news-room/events/detail/2023/08/17/default-calendar/the-first-who-traditional-medicine-global-summit}, accessed November 2025.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

of Indigenous peoples attended the event and made the case that traditional medicines 'play a fundamental role in not just health care, but also culture and livehoods'.[81]

As part and parcel of this move towards making GMH knowledge more plural, the WHO has recently committed itself to developing a Global Action Plan for the Health of Indigenous Peoples (hereafter 'the Global Action Plan'). In doing so, the WHO signalled its commitment to integrating the perspectives of Indigenous peoples in the GMH knowledge toolkit. In the context of the development of the Global Action Plan, in July 2024, the WHO hosted an event dedicated to 'Advancing the development of situation analysis on the health of Indigenous Peoples'.[82] The event was targeted towards presenting 'preliminary findings of a global literature review on the health of Indigenous Peoples', but also providing 'an opportunity for Indigenous Peoples to input into ongoing research'. Indigenous researchers were present and asked that Indigenous people 'lead and participate' in the process leading to the Global Action Plan. They also suggested that Indigenous methodologies be used when research is conducted about Indigenous peoples' health, criticizing existing biases in conventional academic research.[83] In response to such calls, the WHO has thus committed itself to ensuring the 'meaningful participation' of Indigenous peoples in the process leading to the preparation of the Global Action Plan – and GMH knowledge more at large. This ongoing turn towards pluralizing GMH knowledge is laudable. At the same time, the WHO has not created any particular mechanism within the WHO for Indigenous peoples to come and share their views. Their participation thus remains *ad hoc* and strongly reliant on the WHO's existing networks through the UN system. This incipient encounter between knowledge systems that formerly only had 'partial connections' is not a horizontal and open-ended one. It is shaped by complex and intersecting asymmetries, which subject Indigenous knowledges to political-epistemic forms of disciplining.

Political-epistemic disciplining in GMH

As the WHO is opening up to Indigenous knowledges, 'de-epistemization', 'conditional recognition', and 'transposition', all operate to rearticulate Indigenous knowledges as they enter global governance fora.

De-epistemization

As the WHO makes it a new priority to open up its GMH toolkit to Indigenous peoples, it often tends to transform their plea for the recognition of their knowledges into one for special attention, as a vulnerable population requiring additional care *within existing frameworks*. When this happens, Indigenous peoples' knowledge claims are subject to a process of de-epistemization, through which their initial content is stripped of its epistemic components. Indigenous peoples' pleas for a stronger acknowledgement and recognition of their own understandings of mental health conditions are, when this occurs, refashioned as identity or social concerns, positioning Indigenous people as populations in need of special protection or care rather than as producers of authoritative knowledge.

Indigenous groups and their representatives have put forward substantive knowledge claims, asking that their more holistic and person-centred approaches to mental health be integrated into the GMH agenda.[84] Such integration would involve the WHO to 'embrace people who are often

[81] WHO, 'Global Partners Commit to Advance Evidence-Based Traditional, Complementary and Integrative Medicine' (19 August 2023), available at: {https://www.who.int/news/item/19-08-2023-global-partners-commit-to-advance-evidence-based-traditional–complementary-and-integrative-medicine}, accessed November 2025.

[82] WHO, 'First Steps Taken Towards a Global Plan of Action for the Health of Indigenous Peoples', available at: {https://www.who.int/news/item/12-07-2024-first-steps-taken-towards-a-global-plan-of-action-for-the-health-of-indigenous-peoples}, accessed November 2025.

[83] Ibid., accessed November 2025.

[84] Interview with an official from the Native Women's Association of Canada (NWAC), 3 July 2023.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

ignored, their words, and their thought systems, in theory, method, and intervention', thus recognizing ontologies and life-worlds, where health conditions and health care are understood in ways that radically differ from the Western biomedical model, which compartmentalizes syndromes and associated solutions.[85]

The ongoing development of the 'Global Action Plan' does not, however, provide a mechanism for the inclusion of Indigenous knowledges, beyond *ad hoc* invitations to side events or roundtables. Instead, the preparation of the Action Plan is led by the Gender Rights and Equity Department of the WHO, which is responsible for the treatment of minorities.[86] While the objective of affording greater consideration to the specific circumstances of Indigenous peoples is commendable, it remains insufficient insofar as it fails to address the more fundamental demand that Indigenous knowledges be meaningfully integrated into and inform the epistemological foundations of the GMH framework.

Thus, the 2022 WHO Report describes Indigenous peoples as 'vulnerable',[87] and the 2022 'Lancet World Psychiatric Association Commission on Time for United Action on Depression' (hereafter 'Lancet-WPA Commission on Action for Depression'), composed of WHO officials, mainstream experts, and psychiatrists, emphasizes that the mental health conditions of Indigenous populations require 'special attention'.[88] These formulations echo earlier WHO recommendations about the 'special needs' of Indigenous people and the necessity of incorporating them in the 'delivery of the intervention package'.[89] The demands of Indigenous people are reinterpreted into a benevolent minoritizing language, calling for the better application of existing interventions onto them, rather than the pluralizing of the WHO's existing toolkit.

The WHO indeed proposes that existing 'evidence-based' care be applied to Indigenous people through a 'task-sharing approach' involving general health workers and community providers.[90] Additionally, it recommends relying on digital technologies in order to provide guidance and deliver remote care more 'effectively'. This *de facto* results in expanding the delivery of *the GMH's mainstream solutions and interventions*, through the involvement of Indigenous communities and the use of technological devices. In effect, this promotes and further enables the application of the biomedical paradigm, which is favoured by the GMH community, but also the private pharmaceutical sector, which anticipates new markets for its products as new groups are targeted as in need of treatments.

When methods of engagement that account for the languages, cultural nuances, socio-economic backgrounds, and religious beliefs of individuals are put forward, it is in the hope that the 'target population' will be more likely to accept external health interventions. In other words, when de-epistemization occurs, the goal of GMH remains that of 'improving' diagnosis and medication amongst Indigenous populations – rather than including their knowledge in the global knowledge toolkit on mental health conditions and ways of addressing them.

A professor in medicine with a specialization on mental health from the Global South argues that the WHO and its global health experts engage in a box-checking exercise: they 'value our names, but our ideas are never sought after'.[91] As a result, even when representatives of Indigenous populations are invited, they perceive their involvement as tokenistic. The health representative of an Indigenous women's group notes that when invited at a WHO event, Indigenous groups were not treated on an equal footing with other participants, 'partnering would have meant planning the

[85] Ranchod and Guimarães, 'Transcending global health dogma'.

[86] WHO, 'Global Plan of Action for Health of Indigenous Peoples' (2024), available at: {https://www.who.int/initiatives/global-plan-of-action-for-health-of-indigenous-peoples}, accessed November 2025.

[87] WHO, 'World Mental Health Report: Transforming Mental Health for All' (2022), available at: {https://www.who.int/publications/i/item/9789240049338}, accessed November 2025.

[88] H. Herrman et al., 'Time for united action on depression: a Lancet–World Psychiatric Association Commission', *The Lancet*, 399 (2022), pp. 957–1022.

[89] WHO, 'mhGAP Mental Health Gap Action Programme', p. 23.

[90] WHO, 'World Mental Health Report'.

[91] Interview with a health expert, 22 June 2023.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

whole thing with us, and this was not the case.'[92] Indigenous peoples have complained about the de-epistemization of their claims, emphasizing that the planned Global Action Plan 'must be developed *with* Indigenous Peoples, not *for* them, and must reflect Indigenous conceptualizations of health, considering self-determination, culturally grounded healing systems and ancestral knowledge.'[93] As Ranchod and Guimarães argue, 'accepting plurality means inviting diverse, discordant voices and understanding that agreement might not always be possible.'[94] Thus, even the qualification of Indigenous knowledges as 'traditional' (and thus 'non-scientific') can serve to justify their continued marginalization.[95]

Conditional recognition

In its attempt to address critiques and be more inclusive, the WHO has been more open to the potential inclusion of some Indigenous forms of care for mental health conditions – such as plant-based medicines – in its own knowledge toolkit. Yet, for Indigenous understandings of mental health conditions (and their associated forms of care) to be recognized and prescribed by the WHO, they need to be formulated and validated in the terms that prevail in the GMH ecosystem. This results in the rearticulation of Indigenous knowledges, which need to adjust to the dominant language and criteria of validity in order to be recognized.

Thus, the WHO now lays the emphasis on the need to include 'traditional' knowledges in the GMH's toolkit. The above-mentioned WHO Framework for Meaningful Engagement acknowledges that members of local communities, such as 'families, formal and informal caregivers, support groups and organizations, religious leaders, and community health workers', provide essential support to individuals.[96] The 2022 WHO Report also recognizes that there are opportunities for collaboration between health services and local healers, who play an important role in Indigenous communities.[97] At the same time, to become part of the WHO's toolkit, Indigenous forms of care must pass the validity tests recognized by Western medicine. In particular, the emphasis is on the necessity for such interventions to be 'evidence-based'. 'Evidence', however, is narrowly defined as the demonstrated outcome of an intervention that has been tested through recognized methods. In practice, the kind of evidence seen as valid in the GMH ecosystem is the one that has passed the test of an RCT. This approach in effect limits the kinds of interventions that can be seen as 'evidence-based' to those evaluated through this technique.[98] Psychosocial interventions such as behavioural cognitive therapies have for instance been included in the GMH's 'toolkit' only after their effectiveness was proven by RCTs in the 2000s.[99]

Evidence-based practice acts, therefore, as a technology to impose biomedical categories and treatment toolkits.[100] In its 2022 Report, the WHO specifies that 'fruitful collaboration between health services and local healers is possible' in Ghana and Nigeria, given that a large RCT 'showed the effectiveness and cost-effectiveness of a shared care model for psychosis delivered by local healers and primary health care providers.'[101]

[92] Interview with an official from the NWAC, 3 July 2023.

[93] Author's emphasis, WHO, 'Indigenous Leadership and Views'.

[94] Ranchod and Guimarães, 'Transcending global health dogma', p. e1357.

[95] Glen S. Coulthard, *Red Skin, White Masks: Rejecting the Colonial Politics of Recognition* (University of Minnesota Press, 2014).

[96] WHO, 'WHO Framework for Meaningful Engagement', p. 33.

[97] WHO, 'World Mental Health Report'.

[98] A. Littoz-Monnet and J. Uribe, 'Methods regimes in global governance: The politics of evidence-making in global health', *International Political Sociology*, 17:2 (2023).

[99] V. Patel et al., 'The movement for global mental health', *British Journal of Psychiatry*, 198 (2011), pp. 88–90.

[100] N. Cox and L. Webb, 'Poles apart: Does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice?', *Sociology of Health & Illness*, 37 (2015), pp. 683–97.

[101] WHO, 'World Mental Health Report', p. 196.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

Similarly, the GTMC was set up by the WHO 'to harness the potential of traditional medicine (…) *when founded on evidence, innovation* and sustainability'.[102] Not only does the language resonate with market logics where knowledge is seen as a commodity valued in relation to 'innovation' and potential profits, but additionally, even in the context of the GTMC's work, 'evidence' on the effectiveness of traditional medicines needs to be confirmed by an RCT to be considered valid within the GMH community.

With a constant emphasis on the need for 'strong evidence', the GTMC also commissioned a project aimed at 'mapping existing evidence' on traditional forms of medicine, which includes all systematic reviews on traditional medicine conducted between 2018 and 2022.[103] The existence of a systematic review, conducted according to a well-defined methodology, also acts as a methodological condition for Indigenous knowledge to be incorporated.[104] In August 2023, as the WHO organized its first-ever Summit on Traditional Medicine, WHO officials further emphasized 'the important role that artificial intelligence can play to mine complex data available on traditional medicine and identify practices *that show promise for further scientific evaluation*'. Eventually, this evidence can translate into policies 'that accelerate the safe and effective use of traditional medicine into health systems'.[105] This shows that traditional medicines are not *a priori* recognized, but must go through evaluative procedures that format them and render them more compatible with the dominant categories, and also make them more promising in terms of 'effectiveness' and 'innovation potential' – ideas that resonate perfectly well with the market logics that permeate global governance. Given that the WHO's GTMC was identified as 'an important mechanism to support the delivery of the Global Plan of Action', this indicates that the integration of Indigenous knowledges in the GMH's toolkit is primarily understood as one that is conditional upon their compliance with the GMH's notion of what is 'scientific'.[106]

This disciplining process, of course, raises the issue of methodological, epistemological, and political pluralism. Indigenous communities have pointed out that an outcome should be measured not only in terms of symptom reduction, behavioural change, or instrumental functioning, but also by the individuals' ability to pursue culturally relevant goals in relation to their family and community. The favouring of RCTs in GMH has therefore been criticized as costly, insensitive to cultural and environmental contexts, and not necessarily more effective.[107] It also largely favours those actors that possess the financial resources to carry out resource-intensive RCTs, such as private pharmaceutical companies. Indeed, often Indigenous plant-based remedies are considered for their profit-making potential; they 'are targeted by the pharmaceutical companies, and they don't give intellectual property acknowledgement to them'.[108] Thus, although the WHO and the GMH ecosystem at large have acknowledged the necessity of including interventions of a non-biomedical nature, in particular traditional plant-based medicines, they are mainstreaming such interventions into a GMH-oriented paradigm where the validity of 'evidence' remains tied to its own notions of scientific validity.[109]

[102] WHO, 'WHO Global Traditional Medicine Centre' (2024), available at: {https://www.who.int/initiatives/who-global-traditional-medicine-centre}, accessed November 2025.

[103] WHO, 'EPPI-Mapper', available at: {https://terrance.who.int/internet/tmc/gap_map_traditional_medicine.html}, accessed November 2025.

[104] D. Bemme and N. A. D'Souza, 'Global mental health and its discontents: An inquiry into the making of global and local scale', *Transcultural Psychiatry*, 51 (2014), pp. 850–74.

[105] WHO, 'WHO Traditional Medicine Centre', available at: {https://www.who.int/initiatives/who-global-traditional-medicine-centre/traditional-medicine-global-summit}, accessed November 2025.

[106] WHO, 'Indigenous Leadership and Views'. See also L. Aue and T. Hanrieder, 'The quest for diffusible community health worker projects and the pitfalls of scaling culture', *Critical Public Health*, 33:4 (2023), pp. 485–94.

[107] Vincanne Adams, 'Evidence-based global public health: Subjects, profits, erasures', in Joâo Biehl and Adriana Petryna (eds), *When People Come First: Critical Studies in Global Health* (Princeton University Press, 2013), pp. 54–90.

[108] Interview with Indigenous rights activist and member of the UN Expert Mechanism on the Rights of Indigenous Peoples, 23 June 2025.

[109] Bemme and D'souza, 'Global mental health and its discontents'; and Littoz-Monnet and Osorio Garate, 'Knowledge politics in global governance'.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

Transposition

In a fashion that is strongly entangled with the political-epistemic forms of disciplining described above, the process of 'transposition' further rearticulates the claims of Indigenous people by *constituting* their preferences and needs. Transposition occurs when the knowledge claims of Indigenous people are *made sense of through the lens of the dominant concepts and categories*. In such circumstances, the WHO and its partners engage with Indigenous knowledges. Yet, they do so by overlaying external constructs upon them, thereby constructing them anew.

This becomes particularly apparent when analysing GMH's treatment of depression. The 2022 Lancet-WPA Commission on Action for Depression, a well-resourced initiative which benefited from generous funding by leading academic institutions, but also professional associations and large philanthropies, acknowledges that many somatic or emotional complaints might be context specific.[110] The Commission's Report notes that 'irritability and anger', although not included among the adult symptoms in the Diagnostic and Statistical Manual of Mental Disorders (DSM), are 'frequently noted across diverse cultural groups', but also acknowledges that loneliness might be experienced particularly strongly within specific cultural groups: 'among Aboriginal men in Australia, loss of social connection was a central feature of the depression experience with less salience of hopelessness and somatic complaints'.[111] However, while acknowledging the cultural specificities in the way individuals experience mental health conditions, all these symptoms are *assessed for similarities* with mainstream classifications of depression and other mental health disorders, such as ICD or the DSM, published by the American Psychiatric Association. The Lancet-WPA Commission on Action for Depression has, for instance, conducted a meta-analysis examining the chance that individuals experiencing these symptoms could meet the ICD or DSM depression criteria. After concluding that they do, and that only vocabularies used to describe them differ across cultural contexts, the Lancet-WPA Commission reiterates its concern to make dominant Western frames and their associated health interventions 'culturally acceptable' and therefore deployable in all contexts. The Report, in short, reaffirms Western categories and measurements, rather than questions them. Such framings ignore the complex history of the construction of universal disease categories in mental health. Even within the profession of psychiatry, critical voices have long resisted the endeavour, making the case that a diagnosis can only be applicable to a single patient and that the categories are culturally meaningless in some countries.[112] However, while the WHO sets itself to pluralize its 'knowledge toolkit', the GMH community at large – which includes the WHO, but also the Lancet Commissions, the WHO's expert networks, and the private actors they partner with – still epistemically favours – and also sees economic benefits to – an approach to mental health that privileges their own frames of reference.

Indigenous representatives strongly criticize this bias, emphasizing that 'mental health means so many different things, there's so many different people and trying to lump it under the same word is like, ludicrous'.[113] Putting forward the principle of 'self-determination', they argue that Indigenous people should be in charge of their own health care, and promote holistic healing methods that focus on the mental, emotional, spiritual, and cultural aspects of health.[114]

The process of transposition is part and parcel of the intersecting asymmetries that shape those encounters between knowledge systems and format Indigenous knowledges according to the principles and criteria of another knowledge system. As a plural body of Indigenous knowledge of

[110] H. Herrman, 'Report on the WPA Action Plan at the end of the triennium 2017–2020', *World Psychiatry*, 19:3 (2020), pp. 404–6; and Herrman et al., 'Time for united action on depression'.

[111] Ibid., p. 965.

[112] A. M. Lovell, 'The WHO and the contested beginnings of psychiatric epidemiology as an international discipline: One rope, many strands', *International Journal of Epidemiology*, 43 (2014), pp. i6–i18.

[113] Interview with an official from the NWAC, 3 July 2023.

[114] Interview with Indigenous rights activist and member of the UN Expert Mechanism on the Rights of Indigenous Peoples, 23 June 2025.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

mental health is seen through Western biomedical categories, Indigenous healing services are often perceived by the WHO and the GMH ecosystem as in need of monitoring. Thus, the WHO dismisses as 'old' two of its own studies, conducted in 1979 and 1992, which showed that recovery rates for mental health disorders were higher in developing countries where medication was not available.[115] These forms of dismissal can, at times, also be sustained by Indigenous groups themselves; given the enduring hierarchies between Western and non-Western health systems, Indigenous people may also 'want to belong to the dominant class' of treatment, which is often associated with Western biomedicine or NGOs.[116]

Exploring political-epistemic forms of disciplining opens up the black box of the processes at play when alternative knowledge claims are incorporated into global governance fora.[117] With the 'pluralistic' turn, such claims are no longer straightforwardly dismissed: IOs and their partners give them a platform and even attempt to incorporate them into their knowledge toolkit. Yet, the notion of 'political-epistemic' disciplining enables us to account for the intersecting forms of asymmetries – both cultural and political economic – that are at play when such encounters between knowledge systems occur.

We have seen that Indigenous knowledge claims are subjected to several operations of disciplining. First, they can be de-epistemized when their epistemic content is sidelined and refashioned as a call for special care directed at a venerable group. Second, Indigenous knowledge claims can be conditionally recognized: in such circumstances, alternative knowledge claims are acknowledged and potentially integrated in the global health 'knowledge toolkit', but their acceptability is regulated by certain conditions. Typically, this form of disciplining occurs when knowledge claims are not entirely incompatible with the dominant knowledge system, or even look promising with regard to their potential for novel 'innovations' markets. For instance, Indigenous people's focus on plant-based remedies is less at odds with the Western biomedical paradigm and thus more promising than, for instance, a spiritual approach to mental health. Third, alternative claims can be interpreted through the lenses of dominant schema of interpretation and concepts, which are transposed onto them. These three political-epistemic acts, which are strongly intertwined, result in the rearticulation of alternative knowledge claims. Not only do they delineate the conditions for such knowledges to gain recognition in global ecosystems, but they also constrain the *possible forms of existence* of alternative knowledges in global arenas. As alternative knowledge claims are subject to processes that rearticulate them, they become, in fact, created anew, as 'globalized knowledges'. While this should not discredit existing attempts to include alternative knowledge claims into global governance, the political effects of such processes cannot be ignored.

Conclusion

As IOs have started 'opening up' to formerly marginalized groups, who seek recognition of their knowledges and associated life-worlds in global fora of governance, this article has set out to explore the politics of this pluralistic turn. We gained insight into the less visible processes at work in global governance that delineate the modes of existence of Indigenous knowledges – as a kind of alternative knowledge – in global governmental spheres.

As diversity and pluralist rhetoric become characteristic features of global arts of governing, we need to pay attention to the kind of epistemic politics that is emerging in those spaces, in order to ensure that the knowledge toolkit of global institutions genuinely becomes more plural. Existing insights on the politics of epistemic authority have largely concentrated on epistemic

[115]Interview with the President of an advocacy organization representing survivors of mental health conditions and psychiatry, 5 May 2020.

[116]Bemme and D'souza, 'Global mental health and its discontents'.

[117]Coleman and Tucker, 'Between discipline and dissent', p. 401.

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press

struggles between elite professionals, who seek control over specific issues.[118] But as IOs pluralize their knowledge toolkit, new kinds of epistemic struggles are unfolding, where transnational professionals are no longer competing in an elitist *entre-soi*, but are also facing groups that challenge their foundational epistemological assumptions. In these encounters, it becomes evident that the authority of transnational professionals stems not only from their expertise or institutional capital but also from their embeddedness within broader epistemic and political-economic structures of knowledge production and legitimation.

The 'pluralistic turn' can be conceived as a moment of reconfiguration in which global governance attempts to incorporate plurality while safeguarding the stability of dominant frameworks. Epistemic pluralism must therefore be examined as a site of contestation, where recognition operates through logics that may simultaneously incorporate and domesticate alternative epistemologies. This intervention invites scholars and practitioners to reflect on what it would entail to move towards forms of engagement that allow alternative knowledges to transform how problems are known and governed globally. Such forms of engagement would require *balanced* collaborations that respect the epistemologies, ideas, and practices of all knowledge systems. This would involve recognizing 'correspondences, dissonances and complementarities' between knowledge systems, rather than evaluating and making sense of one system through the categories of the other.[119] This would also involve looking into the political-economic incentives which prevent such engagements, at a time when global health governance is becoming increasingly privatized and marketized, and Indigenous knowledges – at least those that can be commodified – are no longer ignored but sought after for commercial purposes.

Acknowledgements. I would like to thank the colleagues who have provided constructive and insightful feedback on earlier versions of this paper presented at workshops and conferences, as well as all the interlocutors from the field of global health who have kindly shared their time. The anonymous reviewers have also offered important and insightful reflections. I also extend my thanks to the Swiss National Science Fund (SNSF), which has funded the research project underlying this paper.

Annabelle Littoz-Monnet is Professor of International Relations at the Geneva Graduate Institute. She works on the politics of expertise in global governance and the role of private sites in the production of knowledge.

[118] L. Seabrooke and E. Tsingou, 'Bodies of knowledge in reproduction: Epistemic boundaries in the political economy of fertility', *New Political Economy*, 21:1 (2016), pp. 69–89; and A. Hoffmann, 'The plural professional: How UN human rights experts construct their independence', *Review of International Studies*, 52:1 (2026); pp 167–87.

[119] Marie Roué, Douglas Nakashima, and Igor Krupnik, *Resilience through Knowledge Co-Production: Indigenous Knowledge, Science, and Global Environmental Change* (Cambridge University Press, 2022), p. 14.

Cite this article: Annabelle Littoz-Monnet, 'Political-epistemic disciplining in global governance: Producing 'global' Indigenous knowledges', *Review of International Studies* (2026), pp. 1–20. https://doi.org/10.1017/S0260210526101867

https://doi.org/10.1017/S0260210526101867 Published online by Cambridge University Press