

Cannabis rescheduling: What could it mean for Africa?

By Dania Putri

Executive Summary

Following its first-ever critical review of cannabis, in January 2019 the World Health Organization issued a collection of formal recommendations to reschedule cannabis and cannabis-related substances. 53 member states of the Commission on Narcotic Drugs (CND), 11 of which are African states, are set to vote on these recommendations in December 2020.

Among the WHO's recommendations, two in particular appear to be the most urgent and relevant for African countries: namely recommendations 5.1 (acknowledging cannabis' medicinal usefulness) and 5.4 (concerning the need to remove the term 'extracts and tinctures of cannabis' from the Convention). Supporting these two recommendations presents an opportunity for African governments and civil society to further decolonise drug control approaches on the continent, as well as to strengthen the international legal basis for emerging medicinal cannabis programmes in several African countries.

In this regard, the recommended principle 'asks' for African advocates and policy makers are to:

- Support the most urgent recommendations 5.1 and 5.4.
- Actively engage with CND members, in particular the 11 African members of CND, emphasising the urgent nature of recommendations 5.1 and 5.4.

- Actively engage in relevant meetings and processes at the CND level, as well as emphasising the need for further follow-ups to the critical review.
- Actively engage and encourage support from other African governments and other key stakeholders such as the African Union, as well relevant civil society organisations, experts, and affected communities.

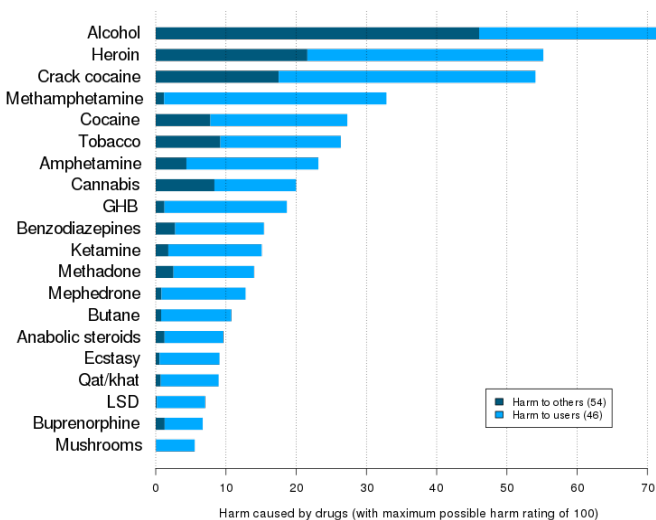
Background: Cannabis and the UN drug scheduling system

Around the world, most national legislations relating to the consumption, production, and distribution of cannabis and cannabis-related substances are rooted in the current global drug control system as institutionalised by the three main UN drug conventions.¹ Over 300 substances listed under these conventions are subject to varying degrees of control depending on the categories in which they have been scheduled, 'defined according to the dependence potential, abuse liability and therapeutic usefulness of the drugs included in them'.² It is thus crucial to note that these UN drug conventions exist to ensure the global (legal) trade in, production, and use of controlled substances for medical and scientific purposes, while aiming to prevent diversion to the illegal market which typically caters to non-medical and non-scientific needs.

From the moment that the 1961 Convention was first negotiated, cannabis has been included in the most restrictive sections – Schedule I and IV – along with drugs such as heroin and fentanyl. Schedule IV in particular is designated – incorrectly, in the case of cannabis – for substances with limited ‘therapeutic advantages’.³ However, one of the essential chemical components of cannabis, dronabinol/ Δ 9-tetrahydrocannabinol (THC), is listed separately in the less restrictive Schedule II of the 1971 Convention.⁴

As reiterated by experts of various backgrounds, the manner in which substances are categorised and controlled at the UN level is largely based on cultural and political ideologies, rather than on impartial scientific assessment⁵ of each substance’s potential harm for its users and their surroundings. In fact, the level of health and social harms of cannabis (as well as other strictly controlled drugs such as LSD and MDMA) is proven to be lower than others currently placed in the same category (cocaine, heroin), and also lower than legally regulated substances like tobacco and alcohol (Figure 1).⁶

Figure 1: Relative harms of selected psychoactive substances (source: Wikimedia Commons)⁷



Furthermore, as articulated by the WHO, ‘preparations of cannabis have shown therapeutic potential for treatment of pain and other medical conditions such as epilepsy and spasticity associated with multiple sclerosis’⁸ – to name only a few. By early 2020, over 30 countries have developed some kind of legal framework for the legal use of medicinal cannabis.

As reflected in global trends,⁹ cannabis remains the most widely used illegal substance on the African continent, where cannabis is also illegally grown by rural communities with few other viable alternative livelihoods.¹⁰ In most African countries, the (restricted) status of cannabis corresponds to that prescribed by the UN drug conventions, and hence the continued punitive approach to cannabis consumption, trade, and production.

In recent years, however, a number of African countries have adopted different forms of legislative changes to regulate cannabis cultivation, with South Africa leading the way as the first African country to decriminalise small-scale cultivation for personal use. Other countries have taken (or are taking) steps to allow cannabis production for medical, industrial, and/or research purposes, including Lesotho, Zimbabwe, Malawi, Zambia, and Ghana.¹¹

The WHO’s first ever critical review of cannabis

As mandated by the UN drug conventions, the World Health Organization (WHO) Expert Committee on Drug Dependence (ECDD)¹² serves as a body whose task is to assess a substance’s potential harm and medicinal usefulness, primarily from a public health perspective, and to provide scheduling-related recommendations for member states at the UN Commission on Narcotic Drugs (CND).

Being one of the first substances (together with coca and opium) scheduled under international control, cannabis was not subject to a WHO critical review until 2018. The results of this first-ever critical review of cannabis were published in January 2019, along with a list of recommendations for the rescheduling of cannabis and cannabis-related substances (Figures 2 and 3).

Figure 2: WHO recommendations on cannabis and cannabis-related substances (source: UNODC)⁴⁸

WHO recommendations on cannabis and cannabis-related substances

5.1	Delete cannabis and cannabis resin from Schedule IV of the 1961 Convention	5.4	Delete extracts and tinctures of cannabis from Schedule I of the 1961 Convention
5.2.1	Add dronabinol and its stereoisomers (<i>delta</i> -9-THC) to Schedule I of the 1961 Convention	5.5	Add a footnote on cannabidiol preparations to Schedule I of the 1961 Convention to read: "Preparations containing predominantly cannabidiol and not more than 0.2 per cent of <i>delta</i> -9-tetrahydrocannabidiol are not under international control"
5.2.2	If 5.2.1 is adopted: Delete dronabinol and its stereoisomers (<i>delta</i> -9-THC) from Schedule II of the 1971 Convention	5.6	Add preparations containing dronabinol , produced either by chemical synthesis or as preparations of cannabis that are compounded as pharmaceutical preparations with one or more other ingredients and in such a way that dronabinol cannot be recovered by readily available means or in a yield which would constitute a risk to public health, to Schedule III of the 1961 Convention
5.3.1	If 5.2.1 is adopted: Add tetrahydrocannabinol to Schedule I of the 1961 Convention		
5.3.2	If 5.3.1 is adopted: Delete tetrahydrocannabinol from Schedule I of the 1971 Convention		

Figure 3: Implications of WHO recommendations on cannabis and cannabis-related substances (source: TNI)

1961 Single Convention on Narcotic Drugs

Schedule I	Schedule II	Schedule III	Schedule IV
<p>Substances that are highly addictive and liable to abuse or easily convertible into those (e.g. opium, heroin, cocaine, coca leaf, oxycodone)</p> <p>Cannabis and resin Extracts and tinctures + Tetrahydrocannabinol + Dronabinol (Δ9-THC)</p> <p>* CBD preparations with <0.2% THC not under control</p>	<p>Substances that are less addictive and liable to abuse than those in Schedule I (e.g. codeine, dextropropoxyphene)</p>	<p>Preparations with low amounts of narcotic drugs that are exempted from most control measures placed upon the drugs they contain (e.g. <2.5% codeine, <0.1% cocaine)</p> <p>Certain 'pharmaceutical preparations' containing dronabinol from which the Δ9-THC cannot be easily recovered</p>	<p>Drugs also listed in Schedule I with "particularly dangerous properties" and little or no therapeutic value (e.g. heroin, carfentanil)</p> <p>Cannabis and resin</p>

1971 Convention on Psychotropic Substances

Schedule I	Schedule II	Schedule III	Schedule IV
<p>Drugs with a high risk of abuse posing a particularly serious threat to public health, with little or no therapeutic value (e.g. LSD, MDMA, cathinone)</p> <p>Tetrahydrocannabinol (Moved to Schedule 1 1961)</p>	<p>Drugs with a risk of abuse posing a serious threat to public health, with low or moderate therapeutic value (e.g. amphetamines)</p> <p>Dronabinol (Δ9-THC) (Moved to Schedule 1 1961)</p>	<p>Drugs with a risk of abuse posing a serious threat to public health, with moderate or high therapeutic value (e.g. barbiturates, buprenorphine)</p>	<p>Drugs with a risk of abuse posing a minor threat to public health, with a high therapeutic value (e.g. tranquilizers, diazepam)</p>

Main implications of the WHO's recommendations

Recognition of cannabis' medicinal usefulness (Recommendation 5.1)

The current status of cannabis in Schedule I of the 1961 Convention means that cannabis is considered as 'highly addictive and liable to abuse'.¹³ The additional mention of cannabis in Schedule IV of the 1961 Convention implies that cannabis contains 'particularly dangerous properties'¹⁴ with little or no therapeutic value. The WHO recommends (5.1) the removal of cannabis from Schedule IV, which, if adopted, would mean that the medicinal usefulness of cannabis would be implicitly acknowledged under the UN drug control system. However, even if this recommendation is not followed by the CND, African countries could still move ahead with allowing medical cannabis, as the imposition of full prohibition for medical purposes has always been optional.¹⁵ In this regard, it is important to note that the WHO recommends keeping cannabis in Schedule I of the 1961 Convention, even though the WHO's assessment shows that cannabis does not pose 'the same level of risk to health of most of the other drugs that have been placed in Schedule I'.¹⁶

Moving THC into the 1961 Convention (Recommendations 5.2.1, 5.2.2, 5.3.1 and 5.3.2)

At present, dronabinol/ Δ 9-THC – either naturally obtained from plant materials or synthetically produced – is placed under Schedule II of the 1971 Convention. Following their critical review, the WHO now recommends (5.2.1) that dronabinol/ Δ 9-THC (and six other isomers of THC) to be added to the stricter Schedule I of the 1961 Convention. This is one of the main consequences of the decision to recommend keeping cannabis in Schedule I: because of the 'similarity principle', THC should be included in the same schedule as cannabis, despite the fact that the ECDD in previous critical reviews of dronabinol/ Δ 9-THC recommended it to be scheduled in Schedule II and even III of the 1971 Convention that require substantially less strict controls.¹⁷ Only if these recommendations (5.2.1

and 5.3.1) are adopted would CND members then vote on whether dronabinol/ Δ 9-THC and the isomers should be deleted from the 1971 Convention (recommendations 5.2.2 and 5.3.2).¹⁸

Exempting preparations containing cannabidiol (CBD)¹⁹ with <0.2% THC from international control (Recommendations 5.4 and 5.5)

Following recommendations to keep cannabis in and add dronabinol/ Δ 9-THC into Schedule I of the 1961 Convention, the WHO also recommends (5.4) deleting the term 'extracts and tinctures of cannabis' from Schedule I of the 1961 Convention. In this regard, the WHO recommends (5.5) including a footnote stating that non-psychoactive CBD-containing preparations (which technically cover 'extracts and tinctures') with not more than 0.2% THC²⁰ are not under international control.²¹ Such CBD-containing preparations²² could range from medicinal oil to food and wellness products. However, psychoactive 'extracts and tinctures' which typically contain higher levels of THC, such as butane hash oil and edibles, would still be subject to the same control as other substances listed in Schedule I of the 1961 Convention.

Less control and restrictions for 'pharmaceutical preparations containing THC' (Recommendations 5.4 and 5.6)

The WHO's last recommendation is based on the growing legitimacy of approved pharmaceutical products such as Sativex and Marinol, which 'are not associated with problems of abuse and dependence and they are not diverted for the purpose of non-medical use.'²³ According to the WHO, these pharmaceutical preparations – which may contain naturally obtained or chemically synthesised THC – should be moved into Schedule III of the 1961 Convention, though it remains unclear what the implications of this recommendation (5.6) would be for other 'natural cannabis extracts with medicinal properties'²⁴ – many of which may not necessarily qualify as 'pharmaceutical preparations'²⁵ as mentioned by the WHO.

The relevance of these recommendations for African countries

Of the 193 UN member states, 53 are selected at any one time to be 'members' of the CND, 11 of which are from the Africa region. At the moment, these countries are: Algeria, Angola, Burkina Faso, Côte d'Ivoire, Egypt, Kenya, Libya, Morocco, Nigeria, South Africa and Togo.²⁶ Although all governments are able to participate in CND meetings and discussions, only these 53 member states are able to vote on the WHO recommendations on scheduling. In December 2020, the CND is set to vote on the aforementioned recommendations on cannabis and cannabis-related substances – having already delayed a vote in both March 2019 and March 2020 to allow for further consideration. The vote outcomes would be legally binding for all signatories of the 1961 and the 1971 Convention (including 52 African states²⁷), requiring states to amend relevant national drug laws and scheduling accordingly. However, it should be made clear that adopting these recommendations would not necessarily *obligate* national governments to initiate legal medical cannabis programmes in their respective countries.

Nevertheless, as we move forward, several questions arise. How relevant are the WHO's recommendations for African countries? What would rescheduling cannabis at the UN level mean for African countries, especially considering the origins and transformation of cannabis-related policies in Africa? And could they in the future offer benefits and legal alternatives for the millions of traditional small farmers in countries like Morocco, South Africa, Lesotho or Ghana who are currently dependent on cultivating cannabis for the illegal market?

Decolonisation of drug control

The WHO recommendation to remove cannabis from Schedule IV of the 1961 Convention (5.1) may serve as an opportunity for African civil society and governments to further decolonise drug control approaches on the continent, particularly by challenging the discourse that has long undermined the medicinal potential of cannabis

and reclaim centuries-old cultural and traditional use of the plant predating colonialism.²⁸

Historical accounts show that cannabis first arrived in Africa in the tenth century, prompted by exchanges with South Asian traders or travellers, through which cannabis spread from the south-eastern part of Africa, and a few centuries later from the Mediterranean coast.²⁹ Over the following five to seven centuries, cannabis – known by its different names (such as *qannab* or *kif* in northern Africa, *urumogi* in central Africa, *dagga* in southern Africa) spread to other parts of Africa, where it became increasingly valued and traded primarily for its smokable and psychoactive qualities, as well as for its manufacturing and medicinal uses.

After the arrival of European colonial powers in Africa in the 1800s, legal cannabis cultivation and trade became subject to taxation by colonial governments, mainly as a way to extract wealth and partly to supply the European pharmaceutical market. In North Africa, this led to the formation of cannabis monopoly regimes controlled by French and Spanish colonial powers until the 1950s. In other parts of Africa, however, this period was short-lived and quickly followed by prohibitive measures and attempts to demonise cannabis use among locals, especially as colonial governments foresaw higher revenue from exporting new drug commodities such as coffee and tobacco. In this context, one can observe the duality of colonial legacy of cannabis control in Africa: from the taxation of legal production and trade in the 19th century, to prohibition from early 20th century onwards. The latter was initiated by colonial governments even before the issue of cannabis was raised at the 1925 International Opium Convention³⁰, one of the foundational treaties preceding the UN drug control regime.

Cannabis prohibition also led to the stigmatisation and marginalisation of people who used the substance, including 'unemployed workers in South Africa, peasant farmers in Egypt, prostitutes and mendicants in Morocco, and hard laborers in Angola'.³¹ Suffice to say, the highly restrictive categorisation of cannabis in Africa and elsewhere today is colonially rooted, but more importantly, it is outdated and scientifically baseless.

Medicinal cannabis programmes

Indeed, the colonially rooted discourse that disregards cannabis' medicinal usefulness has slowly faded in Africa, as more and more African countries are eyeing the socioeconomic prospect of legally regulating cannabis for medicinal, industrial and scientific purposes. Even though the current institutional framework of the UN drug control regime does not serve as a barrier for such efforts,³² transforming the status of cannabis within the UN drug scheduling system would strengthen the international legal basis for these emerging medicinal cannabis programmes. In accordance with this development, the African Union highlights, in its Plan of Action on Drug Control and Crime Prevention (2019-2023) the need to consider 'local provisions for the local production of controlled substances and plants for scientific and medical use, in line with the international drug conventions'.³³

The WHO's recommendation (5.1) to delete cannabis from Schedule IV of the 1961 Convention appears relevant as its adoption would further legitimatise the international status of cannabis as (a source of) medicine. Meanwhile, the WHO's recommendation to loosen control measures for certain medicinal preparations (5.4, 5.5, and 5.6) could in principle constitute another opportunity for African countries interested in developing a domestic (and potentially export-oriented) legal cannabis industry. However, governments and civil society need to remain cautious and ensure that the door for the more natural herbal preparations is not closed via these developments. Ghana, for instance, recently passed a bill regulating the legal production of hemp containing less than 0.3% THC, a percentage already higher than that prescribed in Recommendation 5.5.

Further, the explicit reference to 'pharmaceutical preparations' and underlining of products like Sativex and Marinol in Recommendation 5.6 may pose challenges for countries with a long history of therapeutic use of cannabis preparations which are more herbal and traditional in nature,³⁴ such as South Africa³⁵, Zimbabwe,³⁶ Mozambique,³⁷ and many others.³⁸ This seems to contradict the renewed importance the WHO is giving to promoting traditional medicines.³⁹

Inevitably, the establishment of legal medicinal cannabis programmes in Africa would yield considerable impact on millions of rural working people currently dependent on illegal cannabis cultivation.⁴⁰ Such communities have so far been largely excluded from the emerging legal market, and would likely continue to be so should the UN drug control regime evolve into an institution that increasingly favours large corporations, many of which have enjoyed preferential treatment in licensing systems of medical cannabis production around the world,⁴¹ including in Lesotho⁴² and South Africa.⁴³

Given that, some recommendations of the WHO, particularly the transfer of THC from the 1971 to the 1961 Convention and 5.5 and 5.6, should be approached with caution. Approving them in their current form with the extremely low threshold of 0.2% and the phrasing 'pharmaceutical preparations' appears to give preferential treatment to big companies over more traditional cultivation techniques and herbal medicines. On the other hand, support for Recommendation 5.1 and 5.4 appears more urgent and potentially more fruitful, particularly in the context of scientific and policy development on medicinal cannabis that is based on public health and human rights principles. In support of this, Article 28 of the 1961 Convention requires countries to establish specialised government agencies responsible for maintaining control over production of and trade in medicinal cannabis.

Next steps: timelines and the 'advocacy asks' for African governments

Given the early inclusion of cannabis in the international drug control regime, the WHO's critical review of cannabis had long been overdue. While fully respecting the independent and critically important role that the WHO ECDD plays, many feel that the recommendations could have been more far-reaching in nature. Critics have questioned the WHO's decision not to recommend deleting cannabis from Schedule I of the 1961 Convention, especially since the WHO's own risk assessment shows that cannabis does not belong there.⁴⁴ Considering the rapidly

advancing scientific research in cannabis, a more regular review of the plant would be advisable to update scheduling considerations with new scientific insights about the plant in order to preserve the integrity of the international scheduling system. Notwithstanding this, the political significance of the WHO's critical review of cannabis is not to be underestimated, nor are its resulting recommendations, which represent an opportunity towards the modernisation of the UN drug control system (and, by extension, of national drug control policies in Africa and worldwide). In this regard, active engagement from civil society and governments is needed to encourage a positive outcome at the CND.

Timeline for advocacy

At the CND in early March 2020, member states agreed by consensus to delay a vote and 'continue... the consideration of the recommendations of the World Health Organization on cannabis and cannabis-related substances, bearing in mind their complexity, in order to clarify the implications and consequences of, as well as the reasoning for, these recommendations, and decides to vote at its reconvened sixty-third session in December 2020, in order to preserve the integrity of the international scheduling system'.⁴⁵

Member states have continued discussions since March via informal (closed and unrecorded) consultations being held online (due to the global COVID-19 pandemic that has taken hold since the CND was held in March). A series of three so-called 'Topical Meetings' have now also been scheduled to take place on 24-25 June (online again - with a focus on 'extracts and tinctures' and CBD), 24-25 August (on THC and preparations) and 16-17 September 2020 (on deletion from Schedule IV). These 'Topical Meetings' are a new structure, but disappointingly appear to remain informal in nature with no translation, no web-casting or recording, and no invitation for civil society observers (as would have been the case for a formal meeting, according to UN rules). However, member states have been encouraged to include 'experts' on their delegations for the 'Topical Meetings', which can include experts from civil society. Member states have also been invited to make written submissions.

This series of 'Topical Meetings' will then be followed by a formal CND intersessional meeting on 18 September 2020, which should be possible for civil society to attend and request to intervene. On 12-16 October the WHO Expert Committee will hold its next meeting, opening the possibility that they could reconsider some of the recommendations if the CND discussions have given them convincing arguments of a social, legal or administrative nature to do so (the CND does not have a mandate to challenge the WHO's medical/scientific assessment).

The 63rd Reconvened CND is then scheduled for the 3rd and 4th December 2020 in Vienna,⁴⁶ where the 53 CND members should finally vote on the WHO's recommendations. It is possible for CND members to vote only on certain recommendations, and not on others. In this regard, priority should be given to the more obvious and urgent recommendations 5.1 (to remove cannabis from Schedule IV) and 5.4 (to remove the term 'extracts and tinctures of cannabis' from the 1961 Convention).

Now it is therefore a key time for civil society advocacy across the continent to raise awareness of this 'live' process and its importance for African countries. It is important that as many African governments as possible are engaged in these discussions, and not just the 11 CND members from the region who are able to actually vote. Below are the proposed 'advocacy asks' which NGOs can bring to their government representatives:⁴⁷

Substantive ask:

- Support the more obvious and urgent recommendations: 5.1 (to remove cannabis from Schedule IV, thereby acknowledging its medical usefulness) and 5.4 (to remove the term 'extracts and tinctures of cannabis' from the 1961 Convention).
- Question the potential implications of the other recommendations for the recognition and regulation of traditional and herbal cannabis-based medicines, and request the WHO to amend some details accordingly in the upcoming ECDD meeting or to reconsider them at a later stage.

Process asks:

- Emphasise the need for follow ups to the critical review as scientific research continues to shed new light on the risks and benefits of cannabis, especially in response to the WHO recommendation to keep cannabis in Schedule I of the 1961 Convention.
- Participate and engage at the CND meetings related to the WHO's recommendations on cannabis and cannabis-related substances, especially in order to support recommendations 5.1 and 5.4, to ensure clear voting mechanisms, and to improve clarity about the WHO's recommendations and their implications.
- Engage with governments to discuss these issues, particularly with the African CND members: Algeria, Angola, Burkina Faso, Côte d'Ivoire, Egypt, Kenya, Libya, Morocco, Nigeria, South Africa and Togo.
- Engage with the African Union on this issue to encourage their engagement and coordination, in line with the Plan of Action on Drug Control and Crime Prevention (2019-2023).
- Actively consult and engage with relevant civil society organisations, experts, and representatives of affected communities in African countries.

Acknowledgements

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Endnotes

1. The three main UN drug conventions guiding today's global drug control system include the UN Single Convention on Narcotic Drugs (1961) as amended by the 1972 Protocol, the UN Convention on Psychotropic Substances (1971), and the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988). The different categories of controlled drugs are defined under the 1961 and the 1971 Convention.
2. United Nations Office on Drugs and Crime (2016), *Terminology and Information on Drugs: Third Edition*, https://www.unodc.org/documents/scientific/Terminology_and_Information_on_Drugs-E_3rd_edition.pdf
3. United Nations (1961), *Single Convention on Narcotic Drugs, as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961*, https://www.unodc.org/pdf/convention_1961_en.pdf
4. Six isomers of Δ^9 -THC are currently placed under Schedule I of the 1971 Convention, which is more restrictive than Schedule IV of the 1961 Convention. However, in the 41st meeting, the WHO's Expert Committee on Drug Dependence stated: 'While these six isomers are chemically similar to Δ^9 -THC, there is very limited to no evidence concerning the abuse potential and acute intoxicating effects of these isomers. There are no reports that the THC isomers listed in Schedule I of the 1971 Convention induce physical dependence or that they are being abused or are likely to be abused so as to constitute a public health or social problem. There are no reported medical or veterinary uses of these isomers'. Source of citation: World Health Organization (2019), *Annex 1: Extract from the Report of the 41st Expert Committee on Drug Dependence: Cannabis and cannabis-related substances*, p. 4, https://www.who.int/medicines/access/controlled-substances/Annex_1_41_ECDD_recommendations_cannabis_22Jan19.pdf
5. Government of India (1895), *Report of the Indian Hemp Drugs Commission. Finance and Commerce Department*, <https://digital.nls.uk/indiapapers/browse/archive/74908458>. See also: Bewley-Taylor, D., Blickman, T. & Jelsma, M. (2014), *The Rise and Decline of Cannabis Prohibition: The History of Cannabis in the UN Drug Control System and Options for Reform* (Amsterdam: Transnational Institute). https://www.tni.org/files/download/rise_and_decline_web.pdf
6. Global Commission on Drug Policy (2019), *Classification of Psychoactive Substances: When Science Was Left Behind*, <https://www.globalcommissionondrugs.org/reports/classification-psychoactive-substances>
7. Wikimedia website, File:HarmCausedByDrugsTable.svg, <https://commons.wikimedia.org/wiki/File:HarmCausedByDrugsTable.svg> (Accessed: 22nd June 2020). Data sourced from: Nutt, D., King & L., Phillips, L., 'Drug harms in the UK: a multi-criteria decision analysis', *The Lancet*, 376:9752, DOI: [https://doi.org/10.1016/S0140-6736\(10\)61462-6](https://doi.org/10.1016/S0140-6736(10)61462-6)
8. World Health Organization (2019), *Annex 1: Extract from the Report of the 41st Expert Committee on Drug Dependence: Cannabis and cannabis-related substances*, https://www.who.int/medicines/access/controlled-substances/Annex_1_41_ECDD_recommendations_cannabis_22Jan19.pdf
9. United Nations Office on Drugs and Crime (2019), *World Drug Report 2019*, <https://wdr.unodc.org/wdr2019/>
10. Carrier, N. & Klantschnig, G. (2016), 'Illicit livelihoods: drug crops and development in Africa', *Review of African Political Economy*, 43:148, 174-189, DOI:10.1080/03056244.2016.1170676
11. See: Weinberg, B. (2020), *What will the cannabis economy mean for Africa?* (California: Project CBD), <https://www.projectcbd.org/cannabis-in-africa>; Ane, M, G. (2020), *Parliament of Ghana passes historic new drug law, paving the way for a West African approach* (London: International Drug Policy Consortium), <https://idpc.net/blog/2020/04/parliament-of-ghana-passes-historic-new-drug-law-paving-the-way-for-a-west-african-approach>
12. The ECDD is 'an independent group of experts in the field of drugs and medicines. The ECDD assesses the health risks and benefits of the use of psychoactive substances according to a set of fixed criteria. These criteria are: evidence of dependence potential of the substance, actual abuse and/or evidence of likelihood of abuse, therapeutic applications of the substance'. Each year in December, '[t]he ECDD recommendations are presented by the Director General of the WHO to the UN Secretary General and the United Nations Control Narcotic Board (CND)' for consideration by the CND every March. See: World Health Organization website, *WHO Expert Committee on Drug Dependence*, <https://www.who.int/medicines/access/controlled-substances/ecdd/en/> (Accessed: 22nd June 2020).
13. Bewley-Taylor, D., Blickman, T. & Jelsma, M. (2014), *The Rise and Decline of Cannabis Prohibition: The History of Cannabis in the UN Drug Control System and Options for Reform* (Amsterdam: Transnational Institute), p. 23, <https://www.tni.org/files/download/>

rise_and_decline_web.pdf.

14. United Nations (1961), *Single Convention on Narcotic Drugs, 1961: As amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs 1961*, p. 3.
15. A Party to the Convention is only required to follow the recommendation 'if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare'. (United Nations (1961), *Single Convention on Narcotic Drugs, 1961: As amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs 1961*, p. 3.) In other words, if a Party was of the opinion that this was not the most appropriate way, it could still decide to permit the cultivation and use of cannabis for medical purposes, as many countries indeed have done in spite of its Schedule-IV status.
16. Walsh, J., Jelsma, M., Blickman, T. & Bewley-Taylor, D. (2019), *The WHO's First-Ever Critical Review of Cannabis: A Mixture of Obvious Recommendations Deserving Support and Dubious Methods and Outcomes Requiring Scrutiny* (Amsterdam: Transnational Institute), pp. 7-9, <https://www.tni.org/en/publication/the-whos-first-ever-critical-review-of-cannabis>
17. Ibid, pp. 9-10.
18. Meanwhile, questions have been raised with regard to the possible repercussions of having dronabinol/ Δ^9 -THC and its six isomers in both the 1961 and the 1971 Convention. See: United Nations Office on Drugs and Crime website, *Decision tree depicting the conditionalities of the WHO recommendation on cannabis and cannabis-related substances*, https://www.unodc.org/documents/commissions/CND/Scheduling_Resource_Material/Cannabis/Decision_tree_depicting_the_conditionalities_of_the_WHO_recommendation_on_cannabis_and_cannabis.pdf (Accessed: 22nd June 2020).
19. CBD or cannabidiol is one of the principal chemical compounds found in the cannabis plant. CBD can also be chemically synthesised. In its 41st meeting, the WHO ECDD stated that 'Cannabidiol is found in cannabis and cannabis resin but does not have psychoactive properties and has no potential for abuse and no potential to produce dependence'. Source of citation: World Health Organization (2019), *Annex 1: Extract from the Report of the 41st Expert Committee on Drug Dependence: Cannabis and cannabis-related substances*, p. 4, https://www.who.int/medicines/access/controlled-substances/Annex_1_41_ECDD_recommendations_cannabis_22Jan19.pdf
20. Critics have questioned the WHO's decision to limit the THC quantity threshold to only 0.2%, which may pose issues for countries who have set higher THC quantity thresholds for CBD and/or hemp products, including Ghana (0.3%) and many European countries such as Switzerland (1%).
21. World Health Organization (2019), *Annex 1: Extract from the Report of the 41st Expert Committee on Drug Dependence: Cannabis and cannabis-related substances*, https://www.who.int/medicines/access/controlled-substances/Annex_1_41_ECDD_recommendations_cannabis_22Jan19.pdf
22. At its 40th meeting, the ECDD stressed that, '[t]here are no case reports of abuse or dependence relating to the use of pure CBD. No public health problems have been associated with CBD use' and that 'CBD has demonstrated effectiveness for treating at least some forms of epilepsy, with one pure CBD product (Epidiolex®) found effective in clinical studies of Lennox-Gastaut syndrome (a severe form of epileptic encephalopathy that produces various types of seizures) and Dravet syndrome (a complex childhood epilepsy disorder that has a high mortality rate), which are often resistant to other forms of medication'. See: World Health Organization (2018), 'WHO Expert Committee on Drug Dependence: Fortieth report', *WHO Technical Report Series 1013*, pp. 15-17, <https://apps.who.int/iris/bitstream/handle/10665/279948/9789241210225-eng.pdf?ua=1>
23. World Health Organization (2019), *Annex 1: Extract from the Report of the 41st Expert Committee on Drug Dependence: Cannabis and cannabis-related substances*, p. 7, https://www.who.int/medicines/access/controlled-substances/Annex_1_41_ECDD_recommendations_cannabis_22Jan19.pdf
24. Walsh, J., Jelsma, M., Blickman, T. & Bewley-Taylor, D. (2019), *The WHO's First-Ever Critical Review of Cannabis: A Mixture of Obvious Recommendations Deserving Support and Dubious Methods and Outcomes Requiring Scrutiny* (Amsterdam: Transnational Institute), p. 11, <https://www.tni.org/en/publication/the-whos-first-ever-critical-review-of-cannabis>
25. The term 'pharmaceutical preparations' (with regard to cannabis) is not mentioned or explained in the UN drug conventions, which mainly use the term 'preparations'.
26. This year, these 11 African states include Kenya, Algeria, Egypt, Libya, Morocco, Angola, South Africa, Burkina Faso, Côte d'Ivoire, Nigeria, and Togo. 'In accordance with Council resolution 845 (XXXII), and 1147 (XLI), members are elected (a) from among the States Members of the United Nations and members of the specialized agencies and the Parties to the Single Convention on Narcotic Drugs, 1961, (b) with due regard to the adequate representation of countries that are important producers of opium or coca leaves, of countries that are important in the field of the manufacture of narcotic drugs, and of countries in which drug addiction or the illicit traffic in narcotic drugs constitutes an important problem and (c) taking into account the principle of equitable geographical distribution'. See: United Nations Office on Drugs and Crime website, *CND: Membership and Bureau*, <https://www.unodc.org/unodc/en/commissions/CND/Membership/Membership.html> (Accessed: 22nd June 2020).
27. International Narcotics Control Board, (2020), *Report of the International Narcotics Control Board for 2019*, https://www.incb.org/documents/Publications/AnnualReports/AR2019/Annual_Report_Chapters/English_ebook_AR2019.pdf
28. Since the 15th century, cannabis was used in medicinal settings in Africa to treat snake bite, malaria, fever, blood poisoning, anthrax, asthma, and dysentery, as written by Du Toit, B. M. (1980), *Cannabis in Africa* (Rotterdam: Balkema), as cited by Zuardi, A. W. (2006), 'History of cannabis as medicine: a review', *Brazilian Journal of Psychiatry*, <https://doi.org/10.1590/S1516-44462006000200015>
29. Duvall, C. D. (2019), 'A brief agricultural history of cannabis in Africa, from prehistory to canna-colony', *EchoGéo*, 48:2019, p. 4, <http://journals.openedition.org/echogeo/17599>
30. Ibid, pp. 6-8.
31. Ibid, p. 8.
32. The overarching goal of the UN drug conventions is to help regulate the licit trade in, production, and use of controlled substances (including cannabis) for medical and scientific uses only. Governments must create and implement regulatory policies in compliance with specific articles of each of the three drug conventions, as mapped in this table: United Nations Commission on Narcotic Drugs (2019), *Questions and answers relating to WHO's recommendations on cannabis and cannabis-related substances*, pp. 96-100, https://www.unodc.org/documents/commissions/CND/Scheduling_Resource_Material/Cannabis/Consultations_with_WHO_Questions_and_Answers_26_November_2019.pdf
33. African Union (2019), *African Union Plan of Action on Drug Control and Crime Prevention 2019-2023*. Copy available upon request.
34. Cannabis as an herbal medicine poses serious challenges to modern medicine, which operates according to the "single compound, single target" paradigm of pharmacology'. See: Hazekamp, A. & Fischeidick, J. T. (2012), 'Cannabis - from cultivar to chemovar', *Drug Test. Analysis*, (New Jersey: John Wiley & Sons), https://bedrocan.com/wp-content/uploads/2012-cannabis-from-cultivar-to-chemovar_hazekamp.pdf
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37. Duvall, C. D. (2019), 'A brief agricultural history of cannabis in Africa, from prehistory to canna-colony', *EchoGéo*, 48:2019, p. 5, <http://journals.openedition.org/echogeo/17599>
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39. World Health Organization (2013), *WHO Traditional Medicine Strategy 2014-2023*, https://apps.who.int/iris/bitstream/handle/10665/92455/9789241506090_eng.pdf
40. Jelsma, M. (2018), *Connecting the dots... Human rights, illicit cultivation and alternative development* (Amsterdam: Transnational Institute). <https://www.tni.org/en/publication/connecting-the-dots>
41. Jelsma, M., Kay, S. & Bewley-Taylor, D. (2019), *Fair(er) Trade Options for the Cannabis Market. Cannabis Innovate* (Amsterdam: Transnational Institute) <https://www.tni.org/en/publication/fairer-trade-cannabis>
42. Bloomer, J. (2019), 'Turning Cannabis Into Cash: Agrarian Change and Lesotho's Evolving Experience', *EchoGéo*, 48: 2019, pp. 10-13, <http://journals.openedition.org/echogeo/17612>.
43. Clark, C. (14 October 2019), "'People feel betrayed": small-scale dagga growers fear exclusion from legal trade, *GroundUp*, <https://www.groundup.org.za/article/people-feel-betrayed-small-scale-dagga-growers-fear-exclusion-legal-trade/>
44. In its 41st report, the WHO Expert Committee on Drug Dependence states that '[w]hile the Committee did not consider that cannabis is associated with the same level of risk to health as that posed by most of the other drugs placed in Schedule I, it noted the high rates of public health problems arising from cannabis use and the global extent of such problems. For these reasons, it

recommended that cannabis and cannabis resin continue to be included in Schedule I of the 1961 Single Convention on Narcotic Drugs'. See: World Health Organization (2018), 'WHO Expert Committee on Drug Dependence: Fortieth report', *WHO Technical Report Series 1013*, p. 41, <https://apps.who.int/iris/bitstream/handle/10665/279948/9789241210225-eng.pdf?ua=1>

45. United Nations Commission on Narcotic Drugs (2020), *Draft decision submitted by the Chair: Changes in the scope of control of substances: proposed scheduling recommendations by the World Health Organisation on cannabis and cannabis-related substances*, UN Doc. E/CN.7/2020/L.8, <https://undocs.org/E/CN.7/2020/L.8>
46. United Nations on Drugs and Crime website, *Events*, https://www.unodc.org/unodc/en/commissions/CND/CND_Meetings-Current-Year.html (Accessed: 22nd June 2020).
47. If you want to learn which government officials and agencies are already engaged in CND discussions from your country, you can view the official list of participants from the March 2020 meeting here: United Nations Commission on Narcotic Drugs (2020), *List of Participants: Members of the Commission on Narcotic Drugs*, UN Doc. E/CN.7/2020/INF/2, https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_63/LoP_63_CND_Final_V2001716.pdf
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About this Briefing Paper

This Briefing Paper provides an analysis of the recommendations on the rescheduling of cannabis issued by the World Health Organisation in January 2019, highlighting their historical context and their implications for African countries. The recommendations will be put up for a vote at the UN Commission on Narcotic Drugs in December 2020.

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About IDPC

The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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