

Cannabis rescheduling: A global introduction

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) are set to vote on these recommendations in December 2020.

Among the WHO's recommendations, two in particular appear to be the most urgent: namely recommendation 5.1 (concerning the acknowledgment of cannabis' medicinal usefulness) and recommendation 5.4 (concerning the need to remove the term 'extracts and tinctures of cannabis' from the 1961 Convention). Supporting these two recommendations presents an opportunity for governments and civil society to further reform and decolonise drug control approaches across the globe, as well as to strengthen the international legal basis for existing and emerging medicinal cannabis programmes in different parts of the world.

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

- Support the most urgent recommendations 5.1 and 5.4.
- Actively engage with CND members, 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 governments and key regional stakeholders, 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 or recreational 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

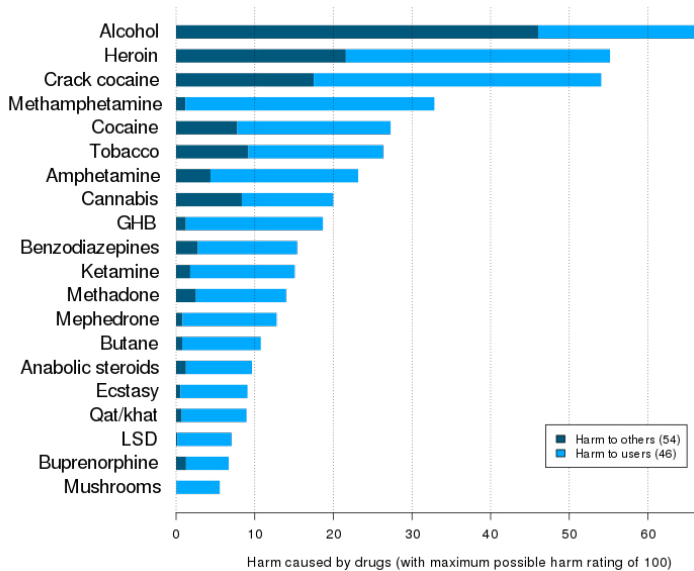


Figure 1: Relative harms of selected psychoactive substances (source: Wikimedia Commons)⁷⁸

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 sclerosis⁹ – 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,¹⁰ cannabis remains the most widely used illegal substance on the planet, while cannabis is also illegally grown by millions of people in rural areas with few other viable alternative livelihoods.¹¹ In most 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 growing number of countries, from Uruguay and Canada to South Africa and Thailand, have adopted different forms of legislative changes to regulate cannabis cultivation and use, for either medical or adult non-medical purposes.¹²

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)¹³ 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 among the first substances (together with coca and opium) scheduled under international control, cannabis has never been subjected 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).

Main implications of the WHO’s recommendations

Cannabis remains in Schedule I of the 1961 Convention

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’.¹⁴ However, the WHO recommends keeping cannabis in Schedule I of the 1961 Convention, on the basis of ‘the high rates of public health problems arising from cannabis use and the global extent of such problems’.¹⁵ This is not a robust argument for keeping cannabis in Schedule I, as the basic test for recommending the inclusion of a substance in either Schedule I or Schedule II of the Convention is the ‘similarity principle’, that is, whether the substance is ‘liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or Schedule II’ or is ‘convertible’ into one of those drugs.¹⁶



Credit: Jasper Hamann

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

CND

UNITED NATIONS COMMISSION ON NARCOTIC DRUGS

POLICYMAKING BODY OF THE UNITED NATIONS WITH PRIME RESPONSIBILITY IN DRUG-RELATED MATTERS

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 (delta-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 (delta-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>

Having recognised explicitly that this is not the case, it is hard to understand why the WHO would still recommend the inclusion in Schedule I. The ‘high rate’ and ‘global extent’ of cannabis use is not sufficient grounds, as the WHO itself has recognised that ‘prevalence of use per se is not a good indicator of public health harm’.¹⁷ If cannabis does not satisfy the similarity test with the drugs included in Schedule I, the logical conclusion would be to consider moving it to Schedule II, as the Commentary says: ‘Substances which are comparatively less dangerous and widely used in medical practice may therefore often be proposed for inclusion in Schedule II’. Subsequently, if cannabis would also not satisfy the criteria of similarity with substances in Schedule II, the conclusion would have to be not to subject it to international control at all. However, since the decision to keep cannabis in Schedule I does not involve a change in the existing scheduling system, this decision is not among the list of WHO recommendations and is not up for a vote at the CND.

Acknowledgement 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’.¹⁸ The additional mention of cannabis in Schedule IV of the 1961 Convention implies that cannabis contains ‘particularly dangerous properties’¹⁹ 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, countries could still move ahead with allowing medical cannabis, as the imposition of full prohibition for medical purposes has always been optional.^{20 21}

Moving THC into the 1961 Convention: Recommendations 5.2 and 5.3

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. Countries should be aware that supporting these recommendations in fact is an endorsement of the decision to keep cannabis in Schedule I.

However, this recommendation goes contrary to the WHO’s previous critical reviews of dronabinol/ Δ 9-THC, which led to the recommendation to schedule it in Schedule II (the recommendation was made and accepted in 1991) and even to Schedule IV of the 1971 Convention in 2001 and sustained in 2002,²² before settling on Schedule III (the recommendation was made in 2006 and sustained in 2012,²³ but it was rejected in 2014), which require substantially less strict controls.²⁴ Only if 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).²⁵

Exempting from international control preparations containing CBD²⁶ with not more than 0.2% THC: 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% THC²⁷ are not under international control.²⁸ Such CBD-containing preparations²⁹ 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 cannabis itself because that remains listed in Schedule I of the 1961 Convention.

Less control and restrictions for pharmaceutical preparations with 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’.³⁰ 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’³¹ – many of which may not necessarily qualify as ‘pharmaceutical preparations’³² as mentioned by the WHO.

Why are these recommendations important?

Of the 193 UN member states, 53 are selected at any one time to be ‘members’ of the CND.³³ 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 Convention³⁴, 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. Why are these recommendations important? What would rescheduling cannabis at the UN level mean at the country level, especially considering the varying origins and transformation of cannabis-related policies in different parts of the world? And could they in the future offer benefits and legal alternatives for the millions of traditional small farmers in Global South countries such as Morocco, India, Lebanon, and some countries in the Caribbean, 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 civil society and governments to further reform and decolonise drug control approaches in many parts of the world, particularly by challenging the discourse that has long undermined the medicinal potential of cannabis, and to reclaim millennia old cultural and traditional use of the plant whose origins predate colonially rooted prohibition.³⁵

Cannabis has been grown and used by humans for millennia. Archaeological findings illustrate that the plant was cultivated in China as early as 4,000 BC,³⁶ while recent excavation of ancient burials in western China show that cannabis was smoked as part of rituals around 2,500 years ago.³⁷ Cannabis use also has a long history in India, where it was employed for medicinal and spiritual purposes since around 1,000 BC, as well as in the Himalayas. From Western Asia, cannabis entered and spread across the Arabian Peninsula and then Africa,³⁸ where it became part of medicinal practices around the 10th century.³⁹

Cannabis was reportedly brought to the Americas in the 16th century by enslaved labourers from current-day Angola, who were kidnapped and transported to the sugar plantations in Northeast Brazil.⁴⁰ As a result, rural communities in Brazil have used for centuries cannabis to treat ailments like toothache, or menstrual cramps.⁴¹ Colonialism also played a determinant role in bringing cannabis to the Caribbean, where it was introduced during the 19th century by indentured labourers from the Indian subcontinent.⁴² Subsequently, cannabis was adopted by communities of African descent as part of healing, cultural, and spiritual practices. In Jamaica, for example, the emergence of cannabis-based rituals was heavily linked with communities of African heritage, and the use of cannabis in these communities was therefore strongly tied with anti-colonial resistance.⁴³ Various communities in the Caribbean continue to use cannabis to this



Traditional growers drying cannabis plants in Rif, Morocco. Credit: Dania Putri

day for social, cultural, spiritual, and medicinal purposes.⁴⁴

During the 19th century, the cultivation and trade of cannabis became subject to taxation by colonial governments, mainly as a way to extract wealth and partly to supply the European pharmaceutical market. The British Parliament enacted a tax and licensing regime on cannabis trade in India as early as the 1790s. In Trinidad and Tobago, a license to cultivate, sell and possess *ganja* could be obtained by paying an annual fee to the colonial authority until 1928.⁴⁵ A similar extractive approach can be observed in Africa, with the formation of cannabis monopoly regimes controlled by French and Spanish colonial powers until the 1950s.⁴⁶

However, colonial regimes frequently veered into prohibition, disregarding the traditional uses of cannabis and the communities that were involved in them. The British Parliament discussed outlawing the use and trade of cannabis in India in 1838, 1871, 1877, and 1892. Amongst many other examples, the possession and use of cannabis was outlawed by the Portuguese colonial government in Angola at least since 1857, by the Dutch colonial government in Indonesia in 1927, by the British colonial government in South Africa since 1870, as well as in Egypt since 1868 and by some municipalities in the newly independent Brazil since the 1830s.⁴⁷

In all cases, prohibition was used to oppress the communities under colonial rule. It 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, communities of African descent in Brazil,⁴⁸ and hard laborers in Angola’.⁴⁹ Suffice to say, the highly restrictive categorisation of cannabis across the world today is colonially rooted, while its implementation remains strongly tied with systemic racism.⁵⁰

Medicinal cannabis programmes

The colonially rooted discourse that disregards cannabis’ medicinal usefulness has slowly faded, as more and more 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,⁵¹ transforming the status of cannabis within the UN drug scheduling system would strengthen the international legal basis for these emerging medicinal cannabis programmes.⁵²

The WHO’s recommendation (5.1) to delete cannabis from Schedule IV of the 1961 Convention appears relevant as its adoption would further legitimise 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 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. Some countries have also set their respective regulations around the legal regulation of hemp containing less than 0.3% (Ghana) or even 1% (Switzerland) THC, a percentage already higher than that prescribed in Recommendation 5.5. Furthermore, 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.^{53 54 55 56 57} This seems to contradict the renewed importance the WHO is giving to promoting traditional medicines in general.⁵⁸

Inevitably, the establishment of legal medicinal cannabis programmes would yield considerable impact on millions of rural working people currently dependent on illegal cannabis cultivation.⁵⁹ 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.^{60 61 62} 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 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.⁶³ 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 worldwide). In this regard, ac-

tive 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’.⁶⁴

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 two so-called ‘Topical Meetings’ took place on 24-25 June (online again - with a focus on ‘extracts and tinctures’ and CBD), 24-25

Substantive asks to governments:

- 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).
- Challenge and question the potential implications of the other recommendations (especially to keep cannabis in Schedule I and to move THC to the 1961 Convention) 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 to governments:

- 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.
- Facilitate the participation of civil society, and in particular of ECOSOC-accredited NGOs, in the deliberations leading to the vote on the recommendations.
- Engage with other governments to discuss these issues, particularly with the 53 CND members.
- Engage with the key regional organisations on this issue to encourage their engagement and coordination.
- Actively consult and engage with relevant civil society organisations, experts, and representatives of affected communities in various countries.

August (on THC and preparations). The third ‘Topical Meeting’ will take place on 6-7 October 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 participants (as would have been the case for a formal meeting, according to UN rules).⁶⁵ 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 8 October 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 from the 2nd to the 4th December 2020 in Vienna,⁶⁶ 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 world to raise awareness of this ‘live’ process and its importance. It is important that as many governments as possible are engaged in these discussions, and not just the 53 CND members who are able to actually vote. In the prior page we propose some of the ‘advocacy asks’ which NGOs can bring to their government representatives.⁶⁷

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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 Δ9-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 Δ9-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. See for instance: 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)
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9. 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
10. United Nations Office on Drugs and Crime (2019), *World Drug Report 2019*, <https://wdr.unodc.org/wdr2019/>
11. 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
12. 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>
13. 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).

14. 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>.
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25. 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).
26. 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
27. 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%).
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29. 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>
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32. The term 'pharmaceutical preparations' (with regard to cannabis) is not mentioned or explained in the UN drug conventions, which mainly use the term 'preparations'.
33. 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).
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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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The International Drug Policy Consortium (IDPC) 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.

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