Equal

Cannabis medicines, the right to health and the international drug control system

Written submission to the Expert Panel established pursuant to CND resolution 68/6, November 2026
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Equal International consents to this submission being made public.

Summary

The 1961 Single Convention recognises that the medical use of narcotic drugs is "indispensable" and that adequate provision must be made to ensure their availability.[1] In South Africa, patients with refractory neurological conditions, many of them children, are losing access to prescribed, locally manufactured cannabis medicines as a side effect of enforcement directed at an unregulated retail market.

Who we are

Equal International is a specialist inclusive development consultancy and think tank registered in the United Kingdom and South Africa, with associates working internationally. For ten years our work has concerned people who are marginalised and left behind.

Equal International and co-founders established AKOS BIO Pharmacy, an independent community pharmacy licensed by the South African Pharmacy Council and the Department of Health. It exists to demonstrate a fully compliant route by which cannabis medicines made in South Africa to EU Good Manufacturing Practice (EU-GMP) standard can reach patients.

The problem at international level

Article 4(c) of the 1961 Convention obliges parties to limit controlled substances to medical and scientific purposes, and Article 9(4) directs the International Narcotics Control Board (INCB) to endeavour to ensure their availability for those purposes.[1] The Convention gives both aims equal standing. In practice the first is enforced and the second encouraged.

South Africa is also bound by human rights law. Under Article 12 of the International Covenant on Economic, Social and Cultural Rights, providing essential medicines is a core obligation, and health goods must be available, accessible, including affordable, and of good quality.[2] Article 24 of the Convention on the Rights of the Child, Article 25 of the Convention on the Rights of Persons with Disabilities, Article 16 of the African Charter and sections 27 and 28 of the South African Constitution protect the same interest.[3]

In January 2019 WHO recommended that cannabis be removed from Schedule IV of the 1961 Convention and that preparations containing predominantly cannabidiol (CBD) be declared outside international control. On 2 December 2020 the Commission accepted the first recommendation by 27 votes to 25 and rejected the second.[4] Cannabis remains in Schedule I, and the international status of CBD remains unsettled.

The South African case

AKOS BIO Pharmacy dispenses two medicines made in South Africa to EU GMP standard by a manufacturer licensed by the South African Health Products Regulatory Authority (SAHPRA). C100 NOIA® is a high-dose CBD oral solution. B25 NOIA® is a balanced 1:1 THC:CBD formulation. Neither is yet registered, so each patient's doctor must apply for named-patient authorisation under section 21 of the Medicines and Related Substances Act 101 of 1965.

Randomised controlled trials have shown that high-dose CBD reduces seizure frequency in Dravet and Lennox-Gastaut syndromes, and regulators in the United States and the European Union have

licensed a CBD medicine for those indications.[5] Balanced THC:CBD medicines are licensed in numerous jurisdictions for spasticity in multiple sclerosis and have been studied in neuropathic pain. South African neurologists and paediatricians prescribe C100 NOIA® for drug-resistant epilepsy and B25 NOIA® for severe neuropathic pain. Under specialist supervision, both are prescribed for severe autism spectrum disorder where other treatment has failed.

In late July 2026 section 21 authorisations for these medicines stopped being issued. No written reasons were given. About thirty existing and prospective patients were affected, many of them children. SAHPRA later said publicly that it had decided in July 2026 to act against unregulated commercial "dispensaries" which supply cannabis flower to the adult-use market.

The impact on patients has been immediate and severe. Three current cases illustrate it:

– Patient 1, aged three, has Dravet syndrome and was having about 120 seizures a day despite several antiseizure medicines. After C100 NOIA® was titrated up, seizures fell by 90% and his general health improved. After six months of treatment SAHPRA refused his neurologist's request for re-authorisation, and allowed treatment to continue only after legal representations.
– Patient 2, aged 14, has severe autism with violent episodes, extreme anxiety and occasional seizures, and was non-verbal. On C100 NOIA® and B25 NOIA® he became far less anxious, spoke again, returned to school and went from six medicines to the two NOIA® medicines and one other. His section 21 application was recently rejected. He has deteriorated, and his clinician has had to return to polypharmacy with its side effects.
– Patient 3, aged 28, has had drug-resistant epilepsy for 14 years. Seizures fell by almost 100% only once C100 NOIA® was introduced. After six months SAHPRA rejected his re-authorisation. At the time of writing he has 21 days of medicine left, and his neurologist expects uncontrolled seizures to return.

These outcomes are as reported by the treating clinicians. Withdrawing an effective treatment without reasons is difficult to reconcile with the provisions cited above.

From the treaties to the patient

SAHPRA faces a real enforcement problem, particularly if it is left to regulate both cannabis medicines and the personal-use market.

First, Schedule I status is mirrored in domestic law. The Drugs and Drug Trafficking Act 140 of 1992 still classifies cannabis as a dangerous dependence-producing substance. A cannabis medicine is therefore approached as a control risk before it is approached as a medicine, and it reaches patients only through an exceptional, discretionary pathway.

Second, South Africa has no lawful market for adult use. The Constitutional Court decriminalised private use by adults in 2018, and the Cannabis for Private Purposes Act 7 of 2024 has not commenced.[6] Trade remains prohibited, so an unregulated retail market has grown.

Third, with no trade or licensing framework for adult use, enforcement runs through the medical pathway, and compliant pharmacies are caught up with non-compliant outlets. Regulating adult-use cannabis under a separate trade and industry framework with quality and safety standards, as alcohol is regulated, would leave the medicines regulator to deal with cannabis medicines.

Fourth, the absence of clear guidance from Vienna encourages the most cautious reading of the treaties. For patients in a middle-income country the practical alternative is a costly imported product, while a locally manufactured GMP medicine goes undispensed.

Recommendations

The Panel should recommend that Member States reforming cannabis policy:

- Place the reform under the leadership of the head of government, with one cross-ministry plan naming a lead department and a deadline for each action.
- Keep named-patient access to prescribed medicines open during enforcement against unregulated markets, with published criteria, written reasons and affordability treated as relevant.
- Prioritise a registration category for quality-assured, locally manufactured cannabis medicines.
- Remove cannabis from drug trafficking legislation, bring pending private-use laws into force, and regulate adult use under a trade and industry framework, as alcohol is regulated, with entry routes for small and traditional growers.

To make that possible, the Commission should:

- Invite WHO to undertake a fresh critical review of cannabis under Article 3 of the 1961 Convention, with a view to removal from the schedules or the lowest level the evidence supports, and reconsider the WHO recommendation that CBD preparations are not under international control.
- Affirm that ensuring availability is an aim of the conventions equal to preventing diversion, and set out which domestic reforms the conventions permit, so that treaty caution is not a reason for delay.

UN bodies should give governments direct technical support:

- UNODC and the INCB should help governments draft laws and regulations that separate medical supply from adult-use markets.
- WHO should consider quality-assured cannabis medicines for the Model List of Essential Medicines, beginning with drug-resistant epilepsy, issue guidance on access building on its 2025 guideline,[7] and help regulators register locally produced medicines.
- OHCHR and UNAIDS should include access to controlled medicines in rights-based monitoring of drug policy.[8]

Conclusion

Reform is urgent at every level, and none of it can wait for the 2029 review. The Commission can invite the WHO review at its next session. UN bodies can start supporting governments now. With political will, South Africa's President and ministers can see section 21 access restored and bring the law into force within months. Patient 1 kept his medicine only through lawyers. Patient 2 has already deteriorated. Patient 3 has 21 days of medicine left. The system will be judged by whether they can access their treatment.

References

1. Single Convention on Narcotic Drugs 1961, preamble, arts 3, 4(c), 9(4).
2. ICESCR art 12; CESCR General Comment 14 (E/C.12/2000/4), paras 12, 43(d).
3. CRC art 24; CRPD art 25; African Charter art 16; Constitution of South Africa ss 27, 28(1)(c).
4. WHO ECDD, 41st report (2019); CND decision 63/17.
5. Devinsky et al, N Engl J Med 2017;376:2011; Thiele et al, Lancet 2018;391:1085.
6. Minister of Justice v Prince [2018] ZACC 30.
7. WHO guideline on balanced national controlled medicines policies (2025).
8. International Guidelines on Human Rights and Drug Policy (2019); CEB/2018/2; A/HRC/54/53; A/65/255; A/HRC/56/52.