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Cannabis: legal certainty, coherence and access under the international drug control conventions

Contribution to the Expert Panel under CND resolution 68/6

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1. Who we are

The Cannabis Embassy is a non-profit association registered in Prague, uniting patients, researchers, cultivators, consumers and traditional and faith communities. Constituted in Vienna at the 67th CND session (2024), it had a statement submitted on its behalf to the 68th (E/CN.7/2025/NGO/13). We address cannabis only, within the existing conventions.

2. No shared criteria for cannabis material

The 1961 Convention defines "cannabis" as the flowering or fruiting tops, excluding seeds and leaves not accompanied by the tops (art. 1(1)(b)), and does not apply to cultivation "exclusively for industrial purposes (fibre and seed) or horticultural purposes" (art. 28(2)) [1]. Hemp and drug cultivars share one ancestral gene pool [2]; the practical legal criterion is chemotype, chiefly THC. No agreed criteria cover low-THC flowers, leaves, extracts or cannabidiol (CBD).

The same hemp product is lawful in one State and a narcotic in another, often regardless of THC: Italy banned trade in hemp flowers in 2025, a French ban was annulled in 2022, and England's Court of Appeal held THC levels irrelevant to the statutory definition [3]. In 2020 the Commission did not adopt WHO's recommendation to exclude predominantly-CBD preparations with no more than 0.2% THC from control (decision 63/20) [4].

In *Kanavape* (C-663/18, 19 November 2020), the EU Court of Justice held that CBD extracted from the whole plant, though literally a cannabis extract, is not a "drug" under the Single Convention, as, on current scientific knowledge, that would contradict the treaty's purpose [5]. The ruling applies only within the EU. Disclosure: our President was a *Kanavape* defendant.

3. Article 2(9) and non-medical use

Under article 2(9), Parties need not apply the Convention to drugs "commonly used in industry for other than medical or scientific purposes", provided they ensure the drugs are not liable to be abused or have ill effects, that harmful substances cannot in practice be recovered, and that quantities are reported in their statistics [1]. Whether this may apply to non-medical cannabis products has been argued [6]; the INCB rejects such readings, and no Commission decision addresses it.

4. Traditional use, article 49 and genetic resources

Under article 49(2)(f), reserved non-medical cannabis use had to be discontinued within twenty-five years of entry into force, i.e. by December 1989 [1]. Its effect must be assessed against the "other relevant international instruments" in the Panel's mandate: the 1988 Convention's "traditional licit uses" (art. 14(2)) and, by systemic integration (VCLT, art. 31(3)(c)), ICESCR article 15(1)(a) and ICCPR articles 18 and 27, informed by UNDRIP (arts. 11, 12, 24, 31) and UNDROP [7]. Some traditional preparations may also fall within "medical purposes", which per the Commentary may include "legitimate

systems of indigenous medicine" (art. 4, comment 12) [8]. Jamaica's 2015 reform, permitting Rastafari sacramental use, shows such use can be accommodated [21].

Farmers who preserved cannabis landraces often face sanctions, while benefit-sharing under the Nagoya Protocol and FAO Plant Treaty is rarely applied. The 2024 WIPO Treaty, once in force, will require patents to disclose the origin of genetic resources [12].

5. Medical access: children's lives at risk

Following WHO's 2018 critical review [9], the Commission deleted cannabis and cannabis resin from Schedule IV, keeping them in Schedule I (decision 63/17) [4]. Access to medical flower remains uneven and costly. The Ph. Eur. quality monograph 3028 has applied since July 2024, yet a 2025 EMA draft found an EU herbal monograph not yet possible [11].

For some children, access is a matter of life and death. In a randomised trial, cannabidiol reduced convulsive seizures in Dravet syndrome, a childhood epilepsy with drug-resistant seizures and high mortality [10]. For a child stabilised on a specific cannabis medicine, interrupted supply, forced substitution, unaffordable prices or medicine seized at a border can mean loss of seizure control and danger to life. Continuity of care is a clinical necessity and a State obligation (CRC, arts. 6, 24; CRPD, art. 25) [18].

6. Promising practices

- Regulated pharmacy supply of standardised flower (Netherlands since 2003, with high self-reported patient satisfaction [19]; Czech Republic since 2013).
- Non-criminal responses to personal use and home growing (Czech Republic, Germany, Malta, Luxembourg); outcomes under evaluation [13].
- Privacy-based protection (South Africa, *Prince*, 2018).
- Regulated non-profit cannabis social clubs (Uruguay) [20].
- SDG-based assessment, consistent with the UN System Common Position [14]; cannabis policy bears on 64 of 169 targets [15].

We note the INCB's concerns about some measures; their public-health outcomes (youth use, cannabis use disorder, impaired driving) merit independent assessment.

7. Recommendations

The Panel may wish to recommend to the Commission's seventieth session (2027) that:

1. **Legal certainty.** The Commission, by resolution, request UNODC and invite WHO and the INCB to prepare non-binding technical guidance on the control status of cannabis plant parts and derived products, including THC-based criteria for industrial hemp under articles 1(1)(b) and 28(2), taking into account case law such as *Kanavape*.
2. **Article 2(9).** The same guidance examine whether and under what conditions article 2(9) applies to non-medical cannabis products such as CBD extracts (cf. *Kanavape*), including the meaning of "cannot in practice be recovered".
3. **Medical access.** UNODC be requested, and WHO and the INCB invited, to include indicators on the availability and affordability of cannabis medicines, including flower and traditional preparations (UNGASS 2016 outcome, ch. 2) [16]; and WHO be invited to consider developing an International Pharmacopoeia monograph for *Cannabis* flos building on Ph. Eur. 3028, with pharmacovigilance and prescriber guidance.
4. **Children and continuity of care.** Member States be encouraged to guarantee uninterrupted access for children with drug-resistant epilepsy, including tax and reimbursement parity with other medicines and lawful cross-border carriage of prescribed cannabis medicines [10, 18].

5. **Proportionate justice.** UNODC be requested, with OHCHR, to guide law enforcement, laboratories and courts on quantification by total THC (validated methods, stated uncertainty) rather than gross weight, no extension of control by analogy, consistent with the principle of legality (ICCPR, art. 15), and alternatives to conviction or punishment (1988 Convention, art. 3(4)(c)–(d)) [7, 17].
6. **Article 49.** The Commission request UNODC to analyse how the expired article 49(2)(f) period interacts with the other relevant international instruments, and the options open to Parties (articles 47 and 50(3)), and invite States to accommodate established traditional, religious and sacramental use, drawing on Jamaica's 2015 experience, after consulting the communities concerned (ILO Convention 169, art. 6; UNDRIP, art. 19).
7. **Personal use.** Member States be encouraged, subject to their constitutional principles (1988 Convention, art. 3(2)), to consider decriminalising possession (UN System Common Position) and cultivation (A/HRC/56/52, para. 85(f)) for personal use, with youth protection, and reviewing past convictions [14].
8. **Genetic resources.** UNODC be requested, when advising on licensing cannabis cultivation, to take account of Parties' obligations under the Nagoya Protocol and the FAO Plant Treaty [12].
9. **Participation.** The Panel's consultations under paragraph 2 of resolution 68/6 include patients, cultivators, consumers and Indigenous and faith communities. We offer to assist.

References

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