Questions on WHO's recommendations on cannabis and cannabis-related substances

asked during the 4th Intersessional Meeting on 24 June 2019 and submitted in writing by 27 June 2019

5.0 General

Canada	In addition to our written questions which had been submitted in advance, we also asked what complementary or supplementary considerations the WHO's guidance on the WHO review of psychoactive substances under international control had added to the ECDD's consideration of the criteria stipulated in the Conventions, in developing its recommendations regarding cannabis?
Mexico	1) Do the medical and scientific communities have the same tools now that they had when the Single Convention and the other two Conventions were crafted?
	2) Does the knowledge about the different components of Cannabis is the same in 2019 than 50, 60 or more years ago?
	3) Could you confirm if the "single species concept" was still widely accepted by the time of the drafting of the Single Convention?
	4) Could you confirm if the original concept of Cannabis as a "single species" has finally been fully overcome? Should it be not the case, could you elaborate in which circles is this outdated notion still en vogue?
	5) Is there now a better understanding by the scientific and medical communities both of the different components of Cannabis, well beyond the differentiation captured in the Single Convention, as well as the differences of their characteristics and properties?
	6) Is there a different perception regarding the Poppy plant and seeds versus opium and heroin, or the Coca plant and leaves versus cocaine than there is between Cannabis as a plant and as a narcotic drug? Did this difference prevail in the Single Convention? If so, what were the reasons?

5.1 Cannabis and Cannabis Resin

Canada	Under recommendation 5.1, we asked whether ECDD was able to take into consideration comparisons between cannabis and other substances which are not controlled under the Conventions, including alcohol and tobacco. This was particularly relevant in light of ECDD's consideration of the harms associated with use, such as rates of substance use disorders and driving under the influence of cannabis.
Mexico	1) If Δ9-THC is the only psychoactive constituent of Cannabis then, why continue to refer to Cannabis as whole, when addressing the narcotic effects of just one of its constituents?
	2) Could you elaborate on why Δ9-THC was and continue to be paragoned to fentanyl, heroin and other opioids, given that in terms of toxicity and mortality are completely different? Is there any medical or scientific reason, other than the prevailing lack of knowledge and understanding, that would continue to justify the inclusion of THC within the same List as those substances?
	3) If the Committee "did not consider that Cannabis is associated with the same level of risk to health of most of the other drugs that have been placed in Schedule I", then why it still "recommended that Cannabis and Cannabis resin continue to be included in Schedule I of the 1961 Single Convention on Narcotic Drugs"?
	4) If toxicity and mortality are out of the question as Cannabis doesn't relate at all to the other two substances on these fields, what are then the other "public health problems arising from Cannabis use and the global extent of such problems", referred in the report? What is the metric for determining that there are "high rates" of those public health problems? What would be the difference between those "health problems" and problems arising from the consumption of other substances such as sugar, not to mention alcohol or tobacco, or modern practices such as "work burn out"?
Nigeria	1) Nigeria Drug Use Survey indicate that 14million used drug in 2017 and cannabis was the most abused and given the INCB Report on the medical use of cannabis as not the first line of treatment, what is the justification for the resheduling when the abuse is high and the harm and impact not abating?
	2) Secondly, in view of Article 3 of the Single Convention particularly in paragraphs 3 and 5, can we justify the recommendations in view of the fact that information on the therapeutic value is not available or substantial enough to offset the impact of the abuse?
Pakistan	1) What was the criteria for first including the cannabis and cannabis resin in schedule IV of the Single Convention on Narcotic Drugs of 1961.
	2) What are findings/scientific evidence which have compelled WHO to recommend deletion of the cannabis and cannabis resin from schedule IV.
	3) Whether the removal of cannabis from schedule IV would not increase the repercussions caused by its legalization.
Russian Federation	Which criteria did the ECDD apply to recommend the exclusion of cannabis from Schedule IV of the 1961 Single Convention on Narcotic Drugs? Why was the argument about alleged barriers to scientific research and medical use of

	cannabis, which was initially used by the WHO, replaced by the principle of similarity? How does the similarity criterion correlate with the provisions of Article 3 Paragraph 5, where it is clearly stated that a drug could be placed in Schedule IV if it "is particularly liable to abuse and to produce ill effects and that such liability is not offset by substantial therapeutic advantages not possessed by substances other than drugs in Schedule IV". Are cannabis or its derivatives used as the first line or only treatment option for any medical condition?

5.2 Delta-9-tetrahydrocannabinol (dronabinol)

Canada	Under recommendation 5.2, we asked for clarification about what had changed to lead the ECDD to develop a different recommendation regarding dronabinol than it had on previous occasions.
Mexico	1) If Δ9-THC was already identified by 1971 as being the only narcotic agent present in Cannabis, why did the international regime on Cannabis control was never updated?
	2) What would be the rationale for ECDD to compare the "active and naturally occurring stereoisomer of Δ9-THC known as dronabinol" to synthetic versions? Is it even scientifically sound to address together and to paragon any natural product with synthetic ones?
	3) Does Δ9-THC at concentrations as high as 90% of exists naturally or is the result of human manipulation or bioengineering? If it is not naturally produced then, is it scientifically sound to address the natural concentrations of Δ9-THC together with manipulated versions?
	4) Are you familiar with the work on sugar and yeast of companies such as San Francisco based CB Therapeutics?
	5) Could you elaborate on the last paragraph in relation to the requests received by Member States and information by UN agencies? Who, what and why? Could you elaborate on why listing dronabinol and Δ9-THC "would greatly facilitate the implementation of the control measures of the Conventions in Member States"?
	6) Bearing in mind that ECDD undoubtedly affirms that Cannabis cannot be associated to the same level of risk to health than other substances scheduled in Lista 1 of the Single Conventions, at the same time it recommends to place individually dronabinol and TCH on that List. Is it not a contradiction?

5.5 Cannabidiol Preparations

Canada	Finally, under 5.5, we asked for clarification on the origin of the proposed 0.2% threshold and of ECDD's statement that it had considered leaving the matter of defining a threshold for THC content in CBD preparations to the member states themselves.
Mexico	1) How did the ECDD came to the range of 0.2% of THC for making this recommendation?
	2) Could it not be somewhat arbitrarily to set a specific percentage?
Russian Federation	CBD might be easily converted into delta-9 THC (dronabinol) with acid and heat (or light). Has the WHO considered that removal of CBD preparations from the international control might lead to its misuse for the illicit production of dronabinol?

5.6 Pharmaceutical Preparations of Cannabis and delta-9-tetrahydrocannabinol (Dronabinol)

Mexico	1) Could you reconfirm that the statement "There is no difference in the therapeutic effects or adverse effects of synthetic Δ9-THC compared to Δ9-THC from the Cannabis plant", refers exclusively to the current/known versions of synthetic Δ9-THC approved for medical use? Hence, would it be safe to affirm that new versions of synthetic Δ9-THC should be addressed on their own?
	2) Could you elaborate further on what would be covered by the term "pharmaceutical preparations of Cannabis" in relation to this recommendation?
Pakistan	1) What are findings/scientific evidence which have compelled WHO to recommend deletion of the cannabis and cannabis resin from schedule IV.
	2) Whether the removal of cannabis from schedule IV would not increase the repercussions caused by its legalization.

5.7 Questions addressed to UNODC

Jamaica	1) What are plans of the UNODC, in particularly the INCB, as regards assisting Member States in the application/implementation of the recommendations in the event they are successfully adopted.
	2) What is the timeline for which the proposed recommendations will be placed before the CND for a decision.