HUDA MUN'25

UNODC: United Nations Office on Drugs and Crime

Study Guide

Table of Contents

2. Letter from the Under-Secretary-General

First of all, I would like to express my great pleasure to see you here as the USG of the United Nations Office on Drugs and Crime (UNODC) Committee.

This year our conference focuses on a topic of utmost urgency: **The Legalization and Decriminalization of Controlled Substances for Medical Purposes**. This agenda invites us to examine one of the most evolving aspects of global drug policy. As medical science advances nations around the world face increasing pressure to reconsider the legal status of certain controlled substances especially in cases where they demonstrate therapeutic potential.

Our goal as a committee is not only to understand the mechanisms behind such illegal networks but also to develop strong, innovative, and enforceable solutions that the international community can rely on. I encourage you to approach this agenda with a problem-solving mindset and a strong understanding of your country's stance, capabilities, and responsibilities.

In this committee, what I expect from you is realistic and well-researched resolutions, as well as respectful and productive debate. I trust each of you will bring your full potential to the table. Express yourselves with confidence, challenge ideas with diplomacy, and don't hesitate to ask questions or seek support when needed. I am here to help you at every step of the way.

Let this conference be a space where you not only represent your country, but also grow as individuals who care about global justice and cooperation.

Rüya Sarı
Under Secretary General

3. Introduction to the Committee

The UNODC, also known as the United Nations Office on Drugs and Crime, is an international entity that has the responsibility of combating drug and other substances, specially organized crime, terrorism and corruption. UNODC was founded in 1997 with a United Nations mandate to tackle issues that threaten international stability, security and progress. Its mandate aims at supporting Member States to address challenges inside and outside their borders such as drug trafficking, drug abuse, transnational crimes involving human trafficking, money laundering and cyber crimes among others. Through technical cooperation, analytical work and capacity building UNODC assists countries in addressing their challenges and implementing positive reforms with governments, institutions of the United Nations system, civil society organizations. It works closely on the principle of international cooperation in the fight against organized crime; criminal justice reforms and the support for human rights in crime prevention and drug control. Another relevant element of activity of UNODC is the promotion of the implementation of the international drug control treaties and the development of the scientific evidence for effective drug policy. This office also produces valuable statistical information through its world drug reports; the office also spearheads awareness campaigns such as the International Day Against Drug Abuse and Illicit Trafficking. 5 UNODC is present in more than 80 countries; its activities support the implementation of the Sustainable Development Goals 2030: its work is particularly relevant for SDG 16 – Peace, Justice and Strong Institutions. UNODC as an organization is determined to make the world safer, healthier, and fairer through its work, as well as address the problem of crime's causes and offer sustainable development approaches. Introduction to The Agenda Item Combating sedate rings and cartels is

4. Introduction to agenda

4.1. Key terms and definitions:

Controlled Substances: Drugs or chemicals whose manufacture, possession, and use are regulated by law as a potential for abuse and harm exist. Opioids, cannabis, and some stimulants qualify.

Decriminalization: Decriminalization means relieving or reducing the criminal penalties associated with, in this case, the possession or use of controlled substances for medical purposes. Decriminalization does not necessarily make the act legal, but reduces the severity of the punishment.

Legalization: The act of making something legit under the law. In the case of controlled substances, this refers to allowing the cultivation, production, distribution, possession and use of certain substances for medical purposes under controlled, regulated systems that are accountable to health authorities and designed to minimize misuse.

Medical Use: The administration of a substance under medical supervision to prevent, diagnose, treat, or relieve the effects of disease or other medical conditions. The medical use of controlled substances has scientific evidence to support its efficacy and has been prescribed by licensed healthcare practitioners within a legal framework.

Narcotic Drugs: Substances with analgesic (pain-relieving) characteristics and potential for dependence, as outlined under the 1961 Single Convention on Narcotic Drugs. While narcotics are stereotypically viewed with disfavor, many narcotics (e.g., morphine) are important medicinal agents when managing pain.

Psychotropic Substances: Substances that influence cognitive functioning, including mood, perception, and behavior, and which fall under the control of the 1971 Convention on Psychotropic Substances include benzodiazepines, barbiturates, and some stimulants.

Harm Reduction: A comprehensive set of policies, programs, and practices designed to reduce the negative health, social, and legal impacts of drug use, but does not necessarily require abstinence. Harm reduction is rooted in human rights and public health and acknowledges the dignity of people who use drugs.

International Drug Control Treaties: There is a framework of international conventions – the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Each of these treaties authorizes, under certain conditions, the medical or scientific use of controlled substances; however, the treaties put forth measures to eliminate the misuse and illicit traffic in these substances.

Access and Availability (WHO definition): The principle that controlled medicines should be available for legitimate medical purposes - while attempts are made to prevent diversion and misuse. This balance is core to an international drug policy.

Essential Medicine: Medicines that are considered to address the populations' priority health care needs, according to the World Health Organization (WHO). This list also includes a number of controlled medicines, including morphine, as they relate to pain management and palliative care.

4.2. Historical Background of Drug Policy and Medical Use:

Historically, controlled substances have been utilized in health-care, therapy, and rituals. In ancient societies including Mesopotamia, Egypt, India, China, and Greece, some natural substances like opium, cannabis and coca leaves were integral to traditional medical practice. For example, opium was respected as a pain reliever, cannabis was applied to sleeping problems and digestive disorders, and crowds chewed coca leaves in the Andes to help them with fatigue and altitude sickness. These examples show how indigenous and simply ascribed uses of the substances were entrenched in the medical practice present at that time, and in many cases across cultures.

During the colonial period, trade in such substances surged, often because of economic interests rather than medical need. For example, the British opium trade in China, which was a critical contributor to the Opium Wars of the 19th century, demonstrated how an unchecked, global trade in such substances created social harms and spurred international disputes. This period also marked the start of greater recognition of the imperative to regulate narcotic and psychotropic substances.

By the beginning of the 20th century, concerns about addiction and the consequences of unregulated drug use of drugs led to the first international attempts to regulate narcotic drugs. The 1912 International Opium Convention was the first treaty to limit the yield of opium and its manufacture, use, and trade strictly for medical or scientific purposes. The 1925 Geneva Convention extended the control initially applicable only to opium to include cannabis and coca products as well. In 1961, the Single Convention on Narcotic Drugs unified earlier conventions into one binding treaty for control of narcotic

drugs, limiting the consumption of these drugs to strictly medical and scientific use. The Convention on Psychotropic Substances (1971) provided additional control for synthetic drugs like amphetamines and barbiturates. In 1988, the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances focussed primarily on combating drug trafficking and related non-drug crimes.

These treaties, while recognizing the integral medical value of some controlled substances sometimes led to overly repressive national legal frameworks. In many of the world's countries, assessing medications like morphine for pain, became extremely limited access, particularly in low- and middle-income countries. People suffering severe pain, cancer, or terminal illness were often locked out of appropriate medications due to worries with misuse and liabilities, or with strict protocols and regulations, and/or they would have practical issues with getting them, or obtain medications in the proper dosage. Compounding the barriers people faced to accessing pain medications was a stigma ascribed to some of these substances,

which further deterred clinical use by both clinicians and patients even in a medically warranted situation.

Organizations, such as the World Health Organization, have not only indicated that all countries must successfully resolve the conflicting dynamics of control and access but also that the right to health includes an obligation to make controlled medicines available for medical purposes. There can be little argument that the historical evolution of drug policy highlights a competing approach to sanctioning the prohibition of controlled medicines based on the concern of misuse first, and determining if they have medical uses after. This contrasting perspective remains evident in global discussions of the decriminalization and legalization of controlled medicines for medical use today.

4.3. The Shift from Criminalization to Medical Legalization:

Historically, international and national drug policies have rested on a foundation of prohibition and criminalization for decades. These criminal laws were designed to stop misuse of controlled substances, such as cannabis, opiates, and certain stimulants. Unfortunately, often these laws do not distinguished between non-medically and harmful use, and any medical need for a controlled substance. Therefore, those who needed the medication along with their health care providers faced significant obstacles. Seeking out medication in many places in the world became impossible, causing unnecessary suffering around the world in many areas including palliative care and pain management. Outside of increasing the number of people behind bars, criminalization fuels the stigma around both using substances and using substances for medicating.

As the 20th century drew to a close, many experts began to take a more skeptical view of punitive kinds of policy. Over the years many studies showed the impact of criminalization on the treatment of substance misuse and substance addiction was negligible, and that it can contribute to negative public health outcomes. In addition, increasing scientific evidence began to illustrate the medical uses of many controlled substances. For example, cannabis was shown to be effective in treating, chronic pain, epilepsy, and nausea from chemotherapy; while opioids remain essential for severe pain management and end-of-life care.

This expanding body of research, coupled with evolving public sentiment, led many countries to examine and reform their drug laws. Countries like Canada, Germany, and Uruguay, as well as some U.S. states, implemented frameworks to legalize and regulate medical use of cannabis and other substances. Other countries implemented

policies advancing toward decriminalization, or removal or reduction of criminal penalties for the possession of a small quantity for personal or medical use, while also putting controls in place to monitor production and trafficking.

International organizations, such as the World Health Organization (WHO), and UNODC have supported this reform in emphasizing a balance in law and policy, and upholding access and the right to health. This shift represents a broader international commitment to drug policy change—one that departs from a purely punitive model to one that emphasizes harm reduction interventions, evidence-based medicine, respect for human rights, while still managing diversion and misuse.

5. Medical Use of Addictive Substances: Global Trends

5.1. Scientific and Medical Justifications

Global perceptions on the medical usage of some addictive substances have changed over the last 20 years due to an increasing amount of scientific study. Substances including cannabis, opioids, ketamine, MDMA (ecstasy), psilocybin, and even LSD which were once considered illegal due to their potential for misuse and dependency are now being reexamined for their potential as therapeutics in regulated medical contexts. The change is mostly due to new discoveries in psychiatry, pharmacology that have shed light on how these drugs affect the human brain.

Medical cannabis for instance has demonstrated efficacy in treating chronic pain multiple sclerosis-related muscle spasticity, chemotherapy-induced nausea, and some types of epilepsy. The effectiveness of psilocybin a naturally occurring hallucinogenic substance present in "magic mushrooms" in treating PTSD, terminally ill patients' anxiety, and treatment-resistant depression is presently being researched.

The significance of reconsidering these substances scheduling under the United Nations drug control conventions specifically the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances has been recognized by international organizations like the World Health Organization (WHO) and several national health agencies. There is increasing agreement that when used under medical supervision and in a regulated environment the advantages of some banned substances may exceed the hazards for particular patient populations,

5.2. Case Studies on Medical Legalization

Different methods to the legalization or regulation of addictive substances for medical use have been taken by a number of nations worldwide providing a range of models that other countries can examine and possibly imitate.

Since the statewide legalization of medical cannabis in 2001, Canada's system has developed into a completely controlled, prescription-based framework under Health Canada's supervision. Medical professionals have the authority to prescribe cannabis as part of a larger pain management or symptom-relief approach, and patients may obtain it from authorized manufacturers.

In the US, more than 30 states have authorized cannabis for medical use, in spite of federal prohibitions. Furthermore, the FDA has permitted ketamine-based treatments for treatment-resistant depression under stringent clinical standards, and Epidiolex, a CBD-based medication, has been approved for some types of epilepsy.

Portugal, which is well-known for decriminalizing all narcotics in 2001, has also looked at the medical applications of cannabis and opioids. Under a public health-centered model, individuals with certain conditions may receive controlled substances through the healthcare system, even though recreational use is still prohibited.

In 2017, Germany authorized the use of medical cannabis, enabling doctors to prescribe it for a variety of ailments, especially neurological diseases and chronic pain. To guarantee a legitimate and traceable supply chain, the German government has teamed up with both domestic and foreign businesses.

Australia and New Zealand have just been added to the list of countries that allow the use of some restricted substances for medicinal purposes. For example, starting in 2023, Australia legalized MDMA and psilocybin for usage in psychiatric settings under the supervision of licensed psychiatrists.

These case studies show that addictive substances can be safely included into contemporary healthcare systems with the right regulatory control, data collecting, and professional training. But they also highlight how crucial customization is.policies to the unique legal, cultural, and medical contexts of each country.

5.3. Risks and Benefits of Medical Decriminalization

A complicated but more pertinent topic in modern drug policy is the decriminalization of addictive substances for medical use. Decriminalization can on the one hand be extremely helpful in increasing access to care for individuals with serious medical or mental health issues that have not improved with traditional treatments. Patients who have been treated with medical cannabis, ketamine, or psilocybin have reported notable improvements in their quality of life in conditions like multiple sclerosis, chronic pain, epilepsy, or post traumatic stress disorder (PTSD). Decriminalizing these drugs' medicinal use lessens the stigma associated with them, promotes scientific study, and establishes a more humane framework for patient treatment.

The decrease in jail rates and fines for those who use these drugs under medical supervision is another significant advantage. Patients who possess or use pharmaceuticals that are legally limited but medically required have been criminalized in numerous nations. In addition to reducing this legal burden decriminalization changes the focus from punishment to public health, emphasizing treatment over prosecution. This strategy aids disadvantaged groups that severe drug laws may otherwise isolate and is better in line with human rights standards.

Decriminalization can also spur innovation in the medical industry. Scientific organizations and pharmaceutical corporations are more inclined to fund clinical trials and therapeutic development involving formerly illegal substances when legal hurdles are reduced. Future treatments for mental disease persistent pain and even neurological

illnesses may be revolutionized by these new, very effective remedies. By reducing reliance on long-term medication regimes.

Medical decriminalization carries significant hazards in spite of these benefits. Potential abuse and diversion into non-medical or recreational contexts is the most urgent worry, particularly in systems with lax regulatory supervision. Substances used for therapeutic purposes may be accessed by people without a medical need if they are not properly controlled, which could raise the prevalence of addiction or cause public health issues. Countries without professional training for healthcare workers or established prescription processes are at even greater danger.

Additionally there is a chance that business interests will take advantage of decriminalization for financial gain, putting market expansion ahead of patient care. In such cases, the original intent may be overshadowed by aggressive marketing strategies, poorly controlled distribution channels,Ethical concerns about how and to whom these substances are prescribed must therefore be considered with utmost seriousness.

Lastly medical decriminalization may create tensions with international drug control treaties particularly for countries bound by the 1961, 1971, and 1988 United Nations conventions. Navigating the legal gray areas between national reforms and international obligations will require diplomatic finesse and cooperative policy making among states.

In conclusion, the medical decriminalization of addictive substances offers both hope and hazards. The challenge for the international community is to find a balanced and evidence-based path forward one that acknowledges the therapeutic value of certain substances while ensuring public safety and ethical medical practice.

6. International Legal frameworks and UN Policies:

6.1. UNODC's Role and Mandate on Controlled Substances:

The United Nations Office on Drugs and Crime (UNODC) is the UN's main body supporting the implementation of international drug control policy. Their mandate is to assist countries with a balanced and comprehensive approach to drug issues based on the international drug treaties and conventions, while simultaneously ensuring an adequate balance between the public health dimension, access to controlled substances for medical and scientific purposes and combating drug use, trafficking, and other forms of illegal drug-supply chain. The UNODC also provides technical assistance, legal support, capacity-building, and research to Member States so they can strengthen their national legislative and enforcement practices, drug prevention and treatment capabilities, user-centred approach.

Significantly, the UNODC has made it clear that while drug control is an important priority, it should not come at the cost of either public health or human rights. A core part of the UNODC's role is the promotion of access to controlled medicines and substances for medical and scientific purposes, such as ensuring that patients have access to opioid pain relief medications, and to assist national governments in eliminating obstacles to availability that may be legal, regulatory or stigma related. This is particularly so for low- and middle-income countries who often lack access to these essential medicines.

UNODC also plays a coordinating role within the broader UN system, working closely with bodies such as the World Health Organization (WHO), which provides scientific and medical expertise, and the International Narcotics Control Board (INCB), which monitors the implementation of the conventions. Together, they aim to ensure that

drug policies strike the right balance: preventing diversion and misuse while upholding the right to health and ensuring the availability of necessary medications. Through its work, UNODC encourages Member States to pursue drug policies that are evidence-based, respectful of human rights, and aligned with broader sustainable development goals.

6.2. Relevant UN Conventions (1961, 1971, 1988) and WHO Recommendations:

There are three main legal instruments that form the basis of international drug control. The first, the 1961 Single Convention on Narcotic Drugs, established an international regime aimed at the worldwide limitation of the production, trade, and use of narcotic drugs for strictly medical and scientific purposes. It also included a schedule for narcotic drugs, regulating narcotic drugs primarily through two factors: potential abuse and medical use. The 1971 Convention on Psychotropic Substances extended this system of international drug control by covering synthetic drugs, including stimulants, hallucinogens, and benzodiazepines, to ensure they are only used for legitimate purposes. The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances included provisions to combat illegal production, trafficking, and possession of drugs from a law enforcement and criminal justice perspective as well as an international cooperation framework.

These conventions comprise the legal basis of international drug policy and aim to strike a balance between the circumstances of misuse and access for medical purposes. That said, the implementation has not always been balanced. Many states have interpreted the conventions with, at times, narrow legalistic restrictions that can lead to overregulation, limiting access to life-saving medicines and impeding

medical care, especially in the area of pain control and management and palliative care. The singular focus on criminalization under the 1988 convention has also been a contributory factor in the cause of disproportionately severe penalties for minor drug offences in many parts of the world.

The World Health Organization (WHO) provides scientific evaluations of substances to help develop these conventions. When it provides an evaluation through the WHO Expert Committee on Drug Dependence (ECDD), the WHO gives the Commission on Narcotic Drugs (CND) its recommended classification. More recently, the WHO has called two times to reclassify substances, including cannabis, based on new evidence of medical value, and it has also helped minimize the perceived risks of certain substances when compared to the risks of controlled substances. These decisions further underscored the importance of having international frameworks that can adapt to modern science and evolving public health priorities.

6.3. Limitation in Gaps in Current Legal Instruments:

Despite the important contribution of the international drug control conventions towards the prevention of the diversion and abuse of narcotic drugs and psychotropic substances, they also have important drawbacks. One of the most problematic aspects is that rigid national interpretations of those conventions have created barriers for patients and health care professionals to access controlled medicines for legitimate medical or scientific reasons. In many instances around the world, particularly in low- and middle-income countries, patients with serious health conditions do not get essential pain relief or palliative care because of regulatory processes and fear of legal consequences,

and/or restrictive prescribing practices of doctors. This ultimately undermines the underlying principle that these substances are available for medical and scientific purposes.

Another significant limitation is a tendency to over-emphasize criminalization (as encouraged by the 1988 convention). The criminalization approach is meant to address drug trafficking on a large scale and the criminal organizations involved unjustly allows for disproportionate punishment of individuals for minor drug offenses such as personal possession, whether for a medical or non-medical purpose. The approach has led to other issues such as prison overcrowding, concerns about human rights, and stigma associated with patients and providers who work with controlled substances. This criminal justice perspective tends to negate even the recognition of public health approaches (e.g., prevention, treatment, harm reduction).

Ultimately, the conventions have not kept pace with changing knowledge about science and public health priorities. The classification of substances like cannabis no longer accurately represents the current evidence concerning their risks and medical uses. The conventions now lack mechanisms that would allow for flexibility to adapt quickly to new developments, new health issues, or new modes of treatment. What is also lacking is guidance on how states can balance drug control measures and obligations to protect human rights, including effective universal healthcare and access to critical medications. These shortcomings reveal the necessity for up-to-date legal responses that more intentionally link public health, science, and human rights.

7. Major Parties Involved

7.1. Key Member States and Their Policies

INDONESIA: Indonesia's drug laws are notoriously rigid, among the strictest in the world. There is a death penalty for drug trafficking, while even possession of small amounts can lead to lengthy prison sentences. Cannabis, opioids, and other controlled substances are banned for both medical and recreational use. There is no established program of medical cannabis or anything like it in Indonesia. Opioids are regulated for medical use, but ongoing regulations and cultural stigma against prescribing these medications have led to poor pain management and continued undertreatment of pain, particularly in cancer patients and in palliative care. Indonesia's laws and policies are based on Indonesia's obligations under the international drug conventions, reinforced through a punitive lens. The Indonesian government perceives any form of legalization or decriminalization as incompatible with Indonesia's priority of public health and moral standing, and remains a vocal opponent at international forums.

RUSSIA: Russia has a strict approach to drug control, continuing to emphasize a zero-tolerance on drug use. All controlled substances, including cannabis, are illegal and there is no legal avenue for medical cannabis or decriminalization of personal use. Russian law punishes minor drug offenses harshly; possession of a small quantity may lead to imprisonment or court-ordered treatment. Opioids for medical purposes are extremely difficult to access because of bureaucratic complexity, paperwork, and risks that shouldered by the healthcare provider, and there is a serious void in both palliative care and chronic pain treatment. Although international health organizations have voiced the need for access to essential medicines, including opioids available for palliative care, the Russian government is resistant to

making policy decisions that would alter drug controls. In fact, Russia continues to oppose international measures to liberalize drug policy. Using the enforcement of laws, prevention campaigns and moral messaging, the government also characterizes drug use as a major danger to society. Russia remains focused on law enforcement, in terms of prevention and harm reduction strategies or public health.

CHINA: China has one of the more restrictive drug control regimes anywhere in the world. This framework is influenced by different historical factors, primarily the devastation of the 19th century related to the national scourge of opium addiction, which helped to precipitate the social and economic collapse. Today China has an intense commitment to prohibition and the harshest potential sanction for drug offenses, generally lengthy prison sentences. The government has extensive control over the manufacture, distribution, and sale of controlled drugs for medical use (e.g., opioids). Doctors must navigate complex reporting and bureaucratic procedures to have that evidence used and dispensed on the frontline, in spite of the sanctioned provocation of threats of sanction or even the prospect of criminal prosecution resulting from their bureaucratic distortions and restrictive prescribing protocols. Pain management in China is inadequate, especially outside urban centers, and patients who do require help are left confronting bureaucratic facades and fear-based institutions and powers of the state. China produces enough opioids that are made and designated for both the domestic and export markets, and yet diversion and abuse has created a circumstance that far too many patients (especially those dying and needing palliative care) have no access to an adequate source of pain relief. The government continues to adamantly oppose global drug policy approaches, suggesting both legalization and decriminalization of controlled substances pose risks to its public health and could help corrode societal stability.

CANADA: Canada has become a recognized global leader in the medical legalization and regulation of a controlled substance, particularly cannabis. Since 2001, patients suffering from certain types of health conditions, including chronic pain, epilepsy, multiple sclerosis, and symptoms associated with cancer, are able to obtain medical cannabis with medical authorization. This complex system has evolved over many years through multiple regulatory frameworks to the current model as identified in the Cannabis Act, which regulates access through a complete supply-chain. Licensed producers are authorized by Health Canada to grow, manufacture, and distribute cannabis for medical purposes while ensuring the quality, safety, and security of their product through oversight. Patients can access medical cannabis through mail order, licensed dispensaries, or in making the limited amount provided by permit for their own personal medical use. By providing legalized access to cannabis, Canada is operating under a dual-track system which provides patients with access to medical cannabis along with multitude of options corresponding to their health needs and specific taxes and product exemptions for medical cannabis users, which are built to track the quantity, quality and safety, and federal government revenue. Within this dual access model, Canada completely and intentionally focused patient access using careful controls to minimize the risk of diversion into the illicit marketplace.

UNITED STATES OF AMERICA: The policies on controlled substances, drugs, and drugs that are considered illicit in the United States are highly complicated and confusing due to the laws that exist at both the federal and state levels. At the federal level, marijuana is still classified as a Schedule I substance under the Controlled Substances Act, meaning that it has been classified as having no accepted medical use and a high potential for abuse. However, the overwhelming majority of U.S. states now have established their own medical cannabis programs, which has created a mish-mash of laws in each of the 50 states. States with established medical cannabis systems include California,

Colorado, New York, and Florida. Medical cannabis systems allow patients with eligible conditions, including chronic pain, epilepsy, post-traumatic stress disorder, or cancer, to access cannabis via licensed dispensaries or authorized caregiving cultivators. Licensed physicians in the several states with established medical systems may recommend cannabis as part of a treatment plan for the eligible patient, though cannabis cannot be “prescribed” due to federal legislation. The discordant position of federal law, state law, the medical cannabis system, and all the stakeholders using this system creates a strain between the state cannabis programs and federal cannabis regulations, and uncertainty regarding legality for patients, health care providers, and all businesses operating in the medical cannabis industry.

URUGUAY: Uruguay was the first country to fully legalize the cannabis plant; through legislation, the country allowed for both medical as well as recreational use in 2013. The Uruguayan model is unique because of its pure state-controlled by the government; the state created these regulations to eliminate illegal trafficking of narcotic drugs, prevent reduction of harm to people who may access illicit products, and to promote and protect the public health of its citizens. The entire cannabis process; from production to distribution and sale, is maintained and enforced by the government. Patients can obtain medical cannabis by participating in the two sanctioned forms of obtaining cannabis, through pharmacies licensed and registered with the government, membership-based cannabis clubs registered with the government, and home grow registration and licensing; all three forms of obtaining cannabis require registration with and licensing from the government. The regulatory and legal model used by the Uruguayan state allows for state reports, tracking and limited diversion of cannabis products to ensure that state-controlled supply is attained. Uruguay's cannabis policy is based on a harm reduction approach; it is aimed at providing a safe and legal alternative to those who wish to access cannabis for therapeutic purposes while at the same time undermining illegal drug markets.

GERMANY: In 2017, Germany enacted legislation pertaining to medical cannabis, which greatly increased a patient's access to cannabis-based medicines available under a closely-controlled framework. Patients suffering serious illnesses—some examples being cancer, multiple sclerosis, a chronic pain syndrome, or severe appetite loss—can receive a prescription for medical cannabis in situations where other treatment avenues have failed or where the available treatments were unsuitable. Medical cannabis products available to patients include extracts and dried flowers from licensed pharmacies. In some instances patients may not have to incur any out-of-pocket costs as the cost of medical cannabis is sometimes covered by statutory ("sickness") health insurance (provided the insurer gets prior authorization). Germany's regulatory approach involves tightly regulated licensing at each step related to a limited number of cultivators, importers and distributors/dispensing pharmacies. The Federal Institute for Drugs and Medical Devices (BfArM) is the overall regulator, but there are many additional laws, regulations and codes that BfArM expects organizations to comply with as well. The German example is often cited by authors who describe Germany's model as a model or a balanced approach because they achieved the patient access while also having many protections in place to prevent misuse and diversion.

OTHER REGIONS: Other countries- especially in Asia, Africa, and the Middle East- typically impose very strict prohibitions against controlled substances, including cannabis and many opioids. Countries in these parts of the world often have a more restrictive version of the international drug conventions based on their own legal, cultural, and religious context. Many of these countries also have a zero-tolerance policy for possession/usage of controlled substances, without any exception for medical use and harsh punishments. But there is increasing recognition that having access to controlled medicines for diseases such as cancer and the palliative care context requires a bit more flexibility and so, there are some limited reconciling of change

occurring in some states. The World Health Organisation (WHO) and the United Nations Office on Drugs and Crime (UNODC) are supporting pilot projects and regulatory reforms in a number of countries such as Nigeria, Egypt, and Thailand- (Thailand is further along than the others, in terms of cannabis policy)- by permitting limited access to essential medicines whereby there are strict restrictions against use and diversion.

7.2. International Organizations and NGOs

The United Nations Office on Drugs and Crime (UNODC) is the principal UN agency making efforts through the Member States to implement international drug control conventions. The UNODC's approach balances the protection of public health and welfare against the need for access to controlled substances for medical and scientific purposes. To advance balanced and evidence based drug policies, the UNODC provides Member States with technical assistance and policy support and works to build capacity that strengthens legal frameworks, disrupts illicit trafficking, and ensures that enough can always be done to facilitate care for the patient requiring essential medicines. UNODC collaborates with Member States and international partners to support drug policies which prioritize health, human rights, and crime prevention.

The World Health Organization (WHO) is an important scientific body and medical assessor of controlled substances. Through its Expert Committee on Drug Dependence (ECDD), the WHO evaluates the potential risks to health and potential therapeutic purposes of controlled substances and recommends scheduling actions for substances listed in international conventions. WHO advocates for drug policy that allows for drug access, health workers' access to essential medicines, pain relief, and palliative care while also stressing the need for drug control measures to align with the right to health. The

recommendations made by WHO, such as its 2019 recommendation to re-schedule cannabis and certain cannabis-related substances aid other regions and countries in their evidence-based reforms both nationally and internationally.

The International Narcotics Control Board (INCB) is an independent, treaty-based organization that monitors the implementation of the international drug control treaties. The INCB works with governments to ensure that controlled substances are available to doctors and scientists for medical and scientific purposes, while preventing diversion and misuse. The INCB publishes an annual report on its activities which includes information on the successes and failures of drug control efforts and the gaps in drug control, such as the inequality of access to controlled medicine on a global scale, as well as a mention of the understanding of that inequality, specifically for regulated medicines for pain management. The INCB also provides technical advice to the state about how to develop their national regulatory system to ensure compliance with international commitments.

The International Drug Policy Consortium (IDPC) is a worldwide network of NGOs that advocates for drug policies informed by human right, public health, and social justice. IDPC advocates for drug policy reforms to reduce the harms of punitive drug laws; enhance access to controlled medicines; and to support harm reduction approaches. IDPC provides research, analysis and advocacy tools to enable civil society to engage with drug policy debates and to influence national, regional, and international drug strategies.

Médecins Sans Frontières (MSF) or Doctors Without Borders, is an international humanitarian organization that brings visibility to the implications of restrictive drug policies on patient care, especially in low-resource options. MSF advocates around the need for better

access to essential controlled medicines - for example, morphine for palliative care. They call on governments to eliminate unnecessary legal and regulatory barriers to patients receiving palliative pain relief, while MSF's advocacy draws attention to the human cost of too restrictive drug control measure and the need for compassionate, health-centred approaches.

Human Rights Watch (HRW) advocates for drug policies that respect and protect human rights. HRW has pointed out the ways in which strict drug laws may be violations of the right to health, the right to due process, and the right to freedom from cruel, inhuman or degrading treatment. HRW advocates for reforms that limit the use of criminal penalties and custodial sentences for lower-level drug offenses, increase access to controlled medicines for medical purposes, and ensure that drug policy in its entirety is consistent with international human rights policies. HRW holds dismantle drug laws and policies that favor in-jail detainment over rehabilitation and reduce or terminate drug policies that may be harmful to populations that are vulnerable or marginalized.

8. Questions to be Answered

1. What is your country's current legal approach to the medical use of controlled substances such as cannabis, MDMA, or psilocybin?

2. What safeguards can be put in place to ensure that medical decriminalization does not lead to increased recreational misuse or trafficking?

3. Should there be a unified international policy on medical use of controlled substances or should each state decide independently?

4. How can developing or low-resource countries implement safe and effective medical access to these substances?

5. What role should the UNODC and the World Health Organization play in setting global medical standards for controlled substances?

6. What are the potential long-term health and social impacts of allowing medical use of addictive substances?

7. How should governments measure and monitor the success or failure of medical decriminalization policies?

9. Bibliography

https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2023.html

https://www.who.int/publications/i/item/9789241510240

https://doi.org/10.1016/S0140-6736(10)61462-6

https://maps.org/research/mdma/

https://www.emcdda.europa.eu/publications/policy-insights/medical-use-of-cannabis-and-cannabinoids_en

https://doi.org/10.2105/AJPH.2017.303818

https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/medical-use-cannabis.html