

OFFICIAL APPEAL

Care Before Discrimination — Patients' Rights and the Proposed Restriction of CBD

*An appeal of the international patient coalition · campaign: **CBD is a Human Right***

This appeal does not assert a free-standing legal right to a product. It concerns how a proposed administrative restriction of CBD would harm patients' established rights — their autonomy, their dignity, and their right to transparent, evidence-based decision-making.

In brief: what the coalition asks

This appeal is addressed to the governments of EU Member States — in particular the Government of the Czech Republic — to the United Nations drug-control bodies, and to the institutions of the European Union. It makes six requests:

1. **Publish the evidence.** Any restriction of CBD must be preceded by a transparent, published assessment of the scientific and legal evidence — including the INCB's own statement that the precursor evidence is “limited”.
2. **No covert or administrative restriction.** Measures affecting patients' access must not be introduced without open public debate, a test of proportionality, and an assessment of the impact on patients.
3. **Respect patient autonomy and dignity.** Honour the patient's right to make informed, autonomous decisions about their own treatment, and reject the stigmatisation of patients as holders of an alleged “drug precursor”.
4. **Regulate proportionately — we do not ask for deregulation.** We support good-manufacturing and quality standards, mandatory contaminant testing, accurate labelling, and age restrictions where relevant, and we accept that States may lawfully regulate CBD for public health, food safety, labelling, age limits, licensing and market surveillance.
5. **Act on the real risk.** Direct enforcement at the genuinely dangerous products — the synthetic and semi-synthetic cannabinoids sold as “collector's items” — not at the tested CBD products patients rely on.
6. **Give patients a voice.** Consult patient organisations formally in decisions that affect access to treatment.

Who is issuing this call, and to whom it is addressed

This call is issued by an international coalition of patient organisations, comprising **Aube** (Canada), **Centrum Para-ple** (Czech Republic), **Dosemociones** (Spain), **Fuck Cancer** (Czech Republic), **KOPAC — Patient Association for Cannabis Treatment** (Czech Republic), **Mothers for Cannabis** (Portugal), **PatientsCann** (United Kingdom), and **Verein Medcan** (Switzerland).

This is an open call. Additional patient organisations and representatives from further countries are joining the coalition, and further organisations and individuals may join as signatories; later joining remains welcome.

We address this call to: the governments of EU Member States, in particular the Government of the Czech Republic; the United Nations Commission on Narcotic Drugs (CND) and the International Narcotics Control Board (INCB); the bodies and institutions of the European Union; journalists and the media; and the patient community and the general public.

Why we are issuing this call now

On 24 February 2026, the International Narcotics Control Board issued an internal notification, *PP Notice No. 1/2026 “Observations concerning cannabidiol (CBD)”*, marked “For Official Use Only”.¹ The document follows China's designation of CBD as a drug precursor in September 2024 and reports that, since October 2024, China has voluntarily pre-notified CBD exports: as of 16 February 2026 there had been 211 pre-notifications to 25 countries (15 of them in Europe), for a total offered volume of nearly 450 tonnes and 33,660 litres of CBD.

Since the beginning of March 2026, increasingly pointed public statements about the “danger of CBD as a precursor of synthetic drugs” have been voiced in some States, including the Czech Republic. On the afternoon of Friday, 29 May 2026, the Czech Government quietly sent a CBD restriction proposal into the internal inter-ministerial comment

¹Although the notice is headed “For Official Use Only”, it is available online and the coalition has verified it as authentic. In the spirit of the transparency this appeal calls for, the coalition publishes the notice alongside this document so that readers can check every statement against the source.

procedure. The coalition views this manner of proceeding with concern — both because of *how* it was done, out of public view, and because the public claims go beyond what the available evidence supports.

This is the heart of the matter. A decision that would reach hundreds of thousands of patients in the Czech Republic — and, if it sets a precedent, millions across the European Union and potentially tens of millions worldwide — is being shaped quietly, on a document the public cannot read, justified by an argument the evidence does not establish. Whatever one's view of CBD, a decision of this kind should be made in the open.

What the record actually shows

This appeal draws on the INCB's own *PP Notice No. 1/2026* — which the coalition has verified and publishes alongside this appeal — read together with the INCB's **public Precursors Report for 2025** (E/INCB/2025/4) and the conventions themselves. We quote the notice rather than characterise it, so that the record speaks for itself.

CBD is not a controlled substance. CBD is not scheduled under the international drug-control conventions. Purified CBD is an authorised medicine for certain seizure disorders, and CBD is non-intoxicating.

The precursor evidence is limited — but the concern is not nothing, and we say so. The INCB's reporting records that some States raised concerns that CBD may be used in the manufacture of delta-9-THC, delta-8-THC, HHC and HHC-O, and that forensic analysis of certain HHC products indicated a manufacturing pathway that may have begun from CBD. At the same time, the INCB describes the evidence of CBD's *actual* use as a starting material as “limited”, and States raising concerns have not pointed to evidence of use in clandestine laboratories at scale. The honest position is therefore not that the precursor argument is baseless, but that it is **not adequately evidenced** to justify reclassifying a non-intoxicating substance — the active ingredient of an approved medicine — as a controlled precursor.

Two different things are called “synthetic cannabinoids” — and only one is linked to CBD. This distinction is the whole argument, so we state it plainly. The genuinely dangerous products sold as “collector's items” are *fully synthetic* cannabinoids — the “spice” family. They are made from industrial chemicals that have nothing to do with CBD, so restricting CBD would do nothing to stop them. The only real link between CBD and an intoxicating product is *semi-synthetic* **HHC**, which can be made from CBD extracted from low-THC hemp. But HHC has itself now been placed under international control — Schedule II of the 1971 Convention on Psychotropic Substances, in force 6 December 2025 — so even that single concern has already been dealt with, directly, at the level of the dangerous product. To restrict CBD today, in the name of an HHC synthesis that is now controlled at source, would be disproportionate: you do not reclassify a non-intoxicating feedstock — the active ingredient of a children's medicine — when the dangerous product that can be made from it is already controlled.

Why “the medicine is not being banned” misses the point

We anticipate the natural reply: *no one is banning medicine — the authorised product (Epidiolex) remains available, and CBD in food is simply a Novel Food question.* This answer does not meet the appeal, for three reasons.

First, the measure under consideration is **not** a marketing-authorisation or food-safety measure; it is a **drug-control reclassification** of CBD as a precursor. Its reach is far wider than one purified product: it would cast a shadow over full-spectrum CBD preparations and the CBD content of prescribed medical cannabis, and over the legal supply on which patients actually depend — most of it produced by local EU manufacturers.

Second, the Novel Food point **cuts the other way**. If the genuine concern were consumer safety, the proportionate instruments already exist: Novel Food authorisation, good-manufacturing and quality standards, contaminant testing, accurate labelling, and age limits. Reaching past those settled tools for a *drug-precursor* classification — the heaviest instrument available — to address what is framed as a consumer-market question is the definition of a disproportionate measure. Under EU law a restriction must be the least restrictive measure adequate to the aim; a precursor reclassification is not.

Third, and most fundamentally, the objection answers a question we are not asking. We are not asserting a stand-alone legal right to buy any given product. We are asserting the right of patients to **decide their own treatment**, to be **treated with dignity rather than as suspects**, and to have decisions that affect them made **transparently and on real evidence**. A measure can leave one authorised medicine on the shelf and still violate all three.

What is at stake for patients

CBD and complex cannabis-derived preparations are used to maintain a tolerable quality of life by patients — often of advanced age — living with chronic pain, sleep disorders, anxiety, depression, and post-traumatic stress disorder. A

covert restriction, introduced administratively without open debate and without a firm evidentiary basis, would remove from these patients a treatment they have chosen and that helps them, and would brand them, in effect, as people who “possess a precursor”. That is an affront to their dignity as much as a restriction on their care.

We are unambiguous on one point: we do not ask for CBD to be left unregulated, and we recognise that States retain the competence to regulate it. We ask only that any restriction be introduced **transparently** — on the basis of a published assessment of the evidence, a test of proportionality, and an assessment of the impact on patients — rather than covertly or by administrative measure.

We also distinguish clearly between **pharmaceutical CBD** and **consumer CBD**. Purified CBD (Epidyolex) received EU marketing authorisation in September 2019, on the basis of phase-3 randomised controlled trials, for seizures in Dravet syndrome, Lennox–Gastaut syndrome and tuberous sclerosis complex. Much of the CBD used by patients in Europe is not a prescribed medicine but a consumer product used for pain, anxiety or sleep. Both matter here, but they are not the same legal object — and, as set out above, the existence of an authorised medicine answers none of the autonomy, dignity, or transparency concerns this appeal raises. The difference is also one of **dose**, and it is large: prescribed Epidyolex is given by body weight at roughly 10–25 mg/kg/day — about 700–1,750 mg/day for a 70 kg adult — whereas most people using consumer CBD oils take on the order of 25–100 mg/day, perhaps ten to fifty times less. Proposed acceptable-intake and supplement-limit values sit in that same low range — tens of milligrams per day, including an acceptable daily intake on the order of 10 mg per adult per day adopted in the United Kingdom. A measure framed around a consumer product taken in tens of milligrams should not be built on the dosing and risk profile of a high-dose prescription medicine.

The legal and human-rights framework

The campaign’s banner — *CBD is a Human Right* — is shorthand for a set of **established** rights, not a claim that any person holds a free-standing legal right to a particular product. Read as the coalition intends it, the three letters stand for **Care Before Discrimination**: the right of patients to receive care and to be treated as patients rather than as suspects. The strongest of these grounds are autonomy, dignity and transparent process.

Autonomy and informed consent. The Oviedo Convention affirms free and informed consent and autonomous decision-making about one’s own treatment, alongside equitable access to healthcare of appropriate quality. A covert restriction overrides the patient’s settled, informed choice without consultation.

Transparency, participation and accountability. These are not only good-governance norms; in the human-rights framing of health they are integral to it. The United Nations treats access to medicines of good quality as “one of the fundamental elements” of the right to the highest attainable standard of health (OHCHR; ICESCR Art. 12), and ties it expressly to *transparency, participation and accountability*. A decision taken on a non-public notice, without patient consultation, is the antithesis of that standard. (*We rely on this as supporting context: the right to health does not guarantee any particular product, but it does demand that decisions affecting access be transparent, participatory and evidence-based.*)

Dignity and non-discrimination. Measures that reduce access to CBD and medical cannabis, and that stigmatise patients as holders of a precursor, may engage States’ obligations under the Convention on the Rights of Persons with Disabilities, in particular Article 5 (equality and non-discrimination) and Article 25 (the right to health).

The drug-control treaties do not support treating CBD as a controlled narcotic. Article 4(c) of the 1961 Single Convention limits controlled substances to medical and scientific purposes, while Articles 23 and 28 establish a specific regime for the cultivation of cannabis. These provisions do not provide a basis for treating CBD — which is not scheduled — as a controlled narcotic.

INCB communications are opinions, not binding law. Under Articles 31 and 32 of the Vienna Convention on the Law of Treaties, treaties are interpreted in good faith according to the ordinary meaning of their terms in context. INCB communications are the views of a treaty-based oversight body and must be read alongside the treaty text, not as law in themselves. The INCB’s own position has shifted — an earlier communication treated CBD as not covered by the conventions, while the 2026 advisory raises CBD as a potential starting material while conceding the evidence is limited. That tension reinforces a rights-based and proportionality-based reading.

EU law: proportionality, not immunity. In *Kanavape* (CJEU, C-663/18, 19 November 2020) the Court held that CBD is not a narcotic, that a Member State may not prohibit CBD lawfully produced in another Member State, and that public-health restrictions on free movement “cannot be based on purely hypothetical considerations”. The CBD at issue was lawfully produced in the Czech Republic. *Kanavape* does **not** mean CBD cannot be regulated — States may act for public health, food safety, labelling, age limits, licensing and market surveillance — but a restriction must be justified by real, published evidence and a genuine proportionality test, and must be the least restrictive measure adequate to the aim. A covert, precursor-based restriction founded on an evidentially limited hypothesis would sit uneasily with this

case-law.

What a covert restriction would actually cause

A restriction of CBD pushed through non-transparently, supported by claims that are not adequately evidenced, would drive patients — for whom CBD products made mostly by local EU suppliers help to manage their illnesses — to the black market. The collapse of legal availability would be filled quickly by unregulated supply, exposing patients to contamination with heavy metals, polycyclic aromatic hydrocarbons, pesticides and herbicides. A restriction resting on an unsubstantiated argument would thus not protect patients but expose them to a substantially higher health risk than a rationally regulated legal market. It would also fail to protect children from synthetic cannabinoids, because it would change nothing about the availability and continual production of new synthetic-cannabinoid molecules in the grey market — which are made from molecules other than CBD.

This is the coalition’s central warning: a measure presented as protective would hand patients to exactly the market it claims to protect them from.

What we propose instead: proportionate regulation

This coalition does not call for CBD to be left unregulated. We call for proportionate, transparent regulation that protects patients and the public: clear quality and good-manufacturing standards; mandatory testing for contaminants — heavy metals, pesticides, residual solvents and microbial contamination; clear and accurate labelling of content and concentration; age restrictions where relevant; and, above all, effective enforcement directed at the genuine risk — the synthetic and semi-synthetic cannabinoids sold as “collector’s items”. Regulation of this kind protects patients; a covert prohibition of CBD does not, because it removes tested products from a regulated market while leaving the genuinely dangerous products untouched.

A warning against a “domino effect”

The effort to classify CBD among precursors has long been promoted at the CND chiefly by some States, while the European Union has so far resisted it. The coalition is concerned that if the Czech Republic — which has long advocated a rational, evidence-based drugs policy — creates a precedent of restriction based on a precursor argument that is not adequately evidenced, it may trigger a chain reaction across the EU and beyond. We submit this assessment for public and expert discussion.

On the weight of evidence

It is often objected that there are “too few randomised controlled trials” confirming the efficacy and safety of CBD. This objection should not be overstated in either direction. Over roughly three decades of wide availability, patients and their clinicians have already generated a large body of **real-world evidence — our own patient data — from everyday clinical practice**. This is not an absence of evidence; it is evidence that exists in abundance and is too readily set aside. Real-world evidence is valuable — particularly for safety, tolerability, quality of life and effectiveness in the complex, multimorbid patients that randomised trials exclude — and forms an essential part of the **totality of evidence**; it should not be dismissed merely because it is not derived from randomised trials, nor presented as equivalent to them.² The two are complementary, and a sound assessment weighs the whole evidence base. We note, too, the documented phenomenon of “reverse spin bias” — the tendency of some systematic reviews to understate genuine benefit even where their own data show a statistically significant effect.³

Our demands: transparency in decision-making

As a patient community, we assert a legitimate claim to information about decisions that directly affect us. We call on the relevant governments to answer, transparently and publicly:

Who received the notice, and how was it handled? Which national focal points received *PP Notice 1/2026*, when, and what did they do with it?

²Schlag AK, Nutt DJ, et al. The value of real world evidence: the case of medical cannabis. *Front Psychiatry*. 2022;13:1027159. doi:10.3389/fpsy.2022.1027159.

³O’Leary R, La Rosa GRM, Polosa R. Reverse spin bias: preliminary observations of reporting bias in medical systematic reviews. *Res Integr Peer Rev*. 2026;11(1):1. doi:10.1186/s41073-025-00185-9.

What measures, and in what conformity with patients’ rights? What measures have governments arrived at, and how would they withstand a test of patient autonomy, the Oviedo Convention, and proportionality under EU law?

What evidence of a precursor role exists? What specific evidence do governments relying on the precursor argument actually hold, given that the INCB itself describes the evidence as limited?

Where is the line between proven risk and hypothesis? What documented information about the real production chain of synthetic and semi-synthetic cannabinoids do governments hold, and what have they done about products sold as “collector’s items”?

On what data do the public statements rest? We request an explanation of the public statements about CBD as a precursor, and the specific data relied upon.

We hold ourselves to the same standard. The coalition is committed to the transparency it asks of others: we are finalising and will publish our funding and independence policy, and we are registering in the EU Transparency Register.

A call to the European Union

We call on the institutions of the European Union to examine whether the public claims about CBD as a “precursor” made in Member States are supported by verified evidence, and to protect both the internal market and patients against administrative restrictions that lack such a basis. We request an assessment of whether the measures under consideration correspond to the actual content of the INCB materials or to a distortion of them, and we recall the constraints established in *Kanavape*.

Questions for the media

We call on journalists to put specific questions to those responsible: What exactly is meant by the claim about CBD as a precursor of synthetics, and on what data does it rely? How is it reconciled with the INCB’s own statement that the evidence is limited? Why is the heaviest instrument — drug-precursor control — being considered when proportionate consumer tools already exist? What impact would the measures have on seniors and chronic patients? And is there a risk that one Member State becomes the trigger of a chain of restrictions across the EU?

Conclusion and a call to join

We call for a rational, transparent and evidence-based policy that respects patients’ autonomy, dignity, and right to decide about their own health. We do not ask for CBD to be left unregulated; we ask that it be regulated proportionately and transparently, and that enforcement be directed at the genuine risk. We oppose a covert restriction of CBD founded on a precursor argument that is not supported by the currently available evidence — and we oppose, just as firmly, the making of such a decision behind closed doors. We call on governments, the CND, the INCB and the EU institutions to be open, and we call on patient organisations and individuals to join this appeal.

Add your name — sign the appeal: <https://www.openpetition.eu/petition/online/care-before-discrimination-is-a-human-right>

CBD is a Human Right.

International coalition of patient organisations: Aube (Canada), Centrum Paraple (Czech Republic), Dosemociones (Spain), Fuck Cancer (Czech Republic), KOPAC (Czech Republic), Mothers for Cannabis (Portugal), PatientsCann (United Kingdom), and Verein Medcan (Switzerland); further organisations joining.

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