Cannabis amnesia – Indian hemp parley at the *Office International d'Hygiène Publique* in 1935

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Abstract

Background: In 2016-2019, the WHO Expert Committee on Drug Dependence scientifically reviewed cannabis products. In that context, multiple references to a previous and similar assessment dating back to 1935 were made; but the content, outcome, and stakeholders involved in the 1935 review were unclear.

Method: Transnational historiography of the international conversation on cannabis control in and around 1935, based on previously-unavailable primary material from international organisations, archives, and literature searches.

Results: Two evaluations were undertaken in 1935 and 1938 by the "Comité des Experts Pharmacologistes" convened under the "Office International d'Hygiène Publique" (OIHP), predecessor of the WHO. Five specific medicines marketed by Parke-Davis were briefly reviewed, based on which the Experts recommended placing under international control all cannabis medicines –prior to that, only pure extracts were under control. The measure was confusing; few State Parties to the 1925 Convention implemented it; the second World War precipitated its oblivion. The international community resumed work on cannabis under the WHO in 1952; that same year, the OIHP was definitely closing its doors. No trace of the 1935 events appeared in any post-war proceeding.

Conclusion: Political biasses and numerous methodological and ethical issues surround the 1935 episode: it cannot legitimately be called a "scientific assessment." The role of stakeholders like Egypt and the OIHP in norm entrepreneurship and advocacy for multilateral controls over cannabis have been largely forgotten; that of the USA somewhat exaggerated. There might be other forgotten pieces of History: predecessor of WHO, the under-documented OIHP had mandates on other important fields, be it drug or epidemics control. Much knowledge on the History of humankind lays in unexplored archival records; errors made and lessons learnt from the past could inform our management of the conflict between public health and politics today.

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Highlights

- Some parts of the history of global cannabis prohibition are not enough researched
- The predecessor of WHO in charge of drug control (and pandemics) is under-documented
- In the 1930s, numerous medical marijuana formulations were used worldwide
- Egypt pushed the League of Nations into attempting to control cannabis
- The first international scientific assessment of cannabis was not in 1935 but in 2016-2019

Introduction

The 2020s decade was opened by a change in the legal status of *Cannabis sativa* L. and some of its products, after half a Century of stand-still: on 2 December 2020, the Commission on Narcotic Drugs (CND; the prime policymaking body of the United Nations (UN) responsible for *Cannabis* -related matters) voted upon

scheduling recommendations of the Expert Committee on Drug Dependence (ECDD) of the World Health Organization (WHO).

The ECDD is the only body with a treaty mandate to carry out scientific assessment of drugs and recommend scheduling changes (WHO, 2018); its recommendations sketched a number of changes in the legal control applying to "medical cannabis" under the international drug control Conventions (Mayor, 2019; Riboulet-Zemouli and Krawitz, 2022). But that change was only the latest development in a complex and convoluted history of multilateral controls applied to medicinal *Cannabis* , plant and products.

Research has seen, in recent decades, a renewed interest in the historiography of the placement of *Cannabis* within the framework of international drug control and its different legal instruments. In particular, scholarship has focused either on (1) the inception (the lead to the International Opium Convention of 1925 (C25) which incorporated some provisions related to "Indian hemp"[1]/haschish alongside coca/cocaine and poppy/opium; Collins, 2021; McAllister, 2000; Mills, 2016) or (2) the immediate period leading to the adoption of the Single Convention on narcotic drugs in 1961, in the aftermaths of the second world war (WWII). Surprisingly, however, the two decades running between 1925 and the end of WWII have received very little scrutiny.

This 20-year gap in the history of *Cannabis* control became apparent in 2014, during the early preparations of the ECDD cannabis assessment process, when a particular episode surfaced and was labelled as an apparently key moment of that history:

> "Cannabis and cannabis resin has not been scientifically reviewed by the Expert Committee since the review by the Health Committee of the League of Nations in 1935 [. . .] which recommended that preparations obtained from cannabis extract or tincture were placed under control of the second Opium Convention" (WHO, 2014, p. 3).

This quote, extracted from the preparatory documentation of the 2014 ECDD meeting, only presents one single reference to back the 1935 event: *The Genesis of International Control of cannabis – 1912 to 1978* , an internal document published by the International Narcotics Control Board (INCB) on 12 May 1978, with reference number E/INCB/W.22. Regrettably, this document is not listed (let alone conserved) in INCB or UN archival records.[2]

That "review by the Health Committee" of the League of Nations (LoN) in 1935 was arguably an important moment since it "recommended that preparations obtained from cannabis extract or tincture were placed under control." But it has disappeared from the records.

Although some direct mentions of the 1935 review are found in late compilations of the works of the LoN (1945a, p. 187), the 1 860 bibliographical references about *Cannabis* compiled by UN Secretary-General in 1965 includes no mention of it (CND, 1965, p. 45). In the *Bulletin on Narcotics* , published by the UN, the article "Principal League of Nations Documents Relating to Narcotic Drugs" (1952) fails to reference any such event in 1935, similarly to important authors like Itsván Bayer and Hamid Ghodse (1999); only "The cannabis problem: A note on the problem and the history of international action" (1962) details that:

> "Preparations made from extract or tincture of cannabis were not mentioned in the 1925 Convention, but in 1935 were brought within the control of the Convention by a decision of the Health Committee of the League of Nations under article 10 of the Convention."

Note the difference between "a review" and "a decision" of the Health Committee. . .

By contrast, documents and meetings of the "Sub-Committee on *Cannabis sativa* " (a subsidiary organ under the "Advisory Committee on the Traffic in Opium and Other Dangerous Drugs" of the LoN) are extensively referenced. Most reviews of the early history of *Cannabis* control focus on this organ (Bewley-Taylor et al, 2014; Kozma, 2011b; The cannabis problem. . . , 1962). Yet, this Sub-Committee was not the organ invested with the mandate to review substances and recommend measures of control as appropriate (as the ECDD is nowadays): under the C25, such a task was mandated to the *Office International d'Hygiène Publique* of

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Paris (OIHP),[3] which informed the decisions of the LoN's Health Committee. Yet, few publications reflect the role of –or indeed even mention– the OIHP.

Beyond the 1935 episode, the important drug control treaty functions discharged by the OIHP have been generally overlooked by observers, analysts, and historians. Key publications celebrating a Century of global drug control fail to mention the Office even once (Pietschmann, 2009; UN Office on Drugs and Crime, 2008).

After 2014, in the context of the assessments of *Cannabis* -related substances by the ECDD between 2016 and 2019 (Riboulet-Zemouli and Krawitz, 2022), additional mentions of the 1935 episode were made by scholars (Bewley-Taylor et al., 2016; Curran et al, 2016, p. 5; Danenberg et al, 2013 p. 177) and civil society stakeholders alike (International Drug Policy Consortium, 2018; Kazatchkine, 2016), without much clarity as to the content or outcome of what happened in 1935, however. In 2018, the authors of the present study found the minutes of the 1935 review meeting; they reproduced excerpts of it in a contribution to the 40th WHO ECDD meeting, commenting:

> "The myth of an assessment of Cannabis under the LoN has justified the WHO shirking its responsibilities in the face of draconian measures of control, relying on a supposed previous ruling to avoid making decisions on a difficult subject" (Krawitz and Riboulet-Zemouli, 2018, p. 7).

This article seeks to document the context, stakeholders involved, content, and outcome of the *1935 review* , and to ascertain the functions, mandates and dynamics of the world's drug control organisation as it related to *Cannabis* and its products, in and around 1935.

To do so, after describing the approach used, the study introduces the legal regime of the time and the OIHP in the first subsection of the findings, before moving to a complete overview of the multifaceted organisational structure; the third and fourth subsections respectively analyse in detail the 1935 and 1938 episodes; a fifth subsection reviews the consequences over international works related to *Cannabis* after WWII, before discussing the findings in conclusion.

Approach

This study intends to present a transnational historiography based essentially on primary research in archived materials gathered in 2016, 2018 and 2019 (LoN archives, UN and WHO libraries in Geneva, UN Archives at Vienna, Dag Hammarskjöld Library remotely). Additional documents and correspondence was yielded in 2017 and 2018 at the Université de Paris (Sainte-Geneviève Library; "Bibliothèque interuniversitaire de santé" rue de l'Observatoire), the Libraries of the Académie des Sciences/Institut de France, Académie Nationale de Médecine, Académie Nationale de Pharmacie, Muséum National d'Histoire Naturelle, and French Diplomatic Archives, at former OIHP headquarters (195 boulevard Saint-Germain) and Belgian Diplomatic Archives. In a second stage (2020–2022), literature searches were undertaken to attempt discussing the findings within the intertextuality of the new transnational historiographies of the international drug control regime complex.

In addition to documenting the 1935 *Cannabis* episode, this article seeks to contribute to the study of the history of international drug control, by expliciting its structure and organisation at that particular moment. To aid the understanding of a complex and under-documented system, parallels are drawn with the drug control apparatus operating in 2022 throughout the article.

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Findings

1925: Cannabis in the International Convention relating to Dangerous Drugs

> "Starting with the International Opium Commission (Shanghai, 1909), Governments over time established an international consensus on the need for the regulation of psychoactive substances. Moreover, a set of normative instruments and multilateral bodies and systems were developed to help States implement and adjudicate such regulation" (Pietschmann, 2009, p. 1).

Cannabis was for the first time placed under international control on 19 February 1925 with the "International Convention relating to Dangerous Drugs" (C25) adopted at the end of the Second Opium Conference, 1924–1925 (Kendall, 2003; Kozma, 2011b; League of Nations, 1925; Mills, 2003; The cannabis problem. . . , 1962) and entered into force in 1928 (LoN, 1928). Contrary to what is sometimes believed, this was more the result of "a triangulation between various State interests and blocs" (Collins, 2020, p. 280) than an initiative of the United States (Scheerer, 1997): "Indian hemp" was indeed added to the C25 "at the behest of Egypt, and previous encouragement from South Africa, Italy, and others" (Collins, 2020 p. 281; UNODC, 2008; Waetjen, 2018) and in particular, similarly conservative governments in African and Latin American countries (Campos, 2012; Collins, 2021; Duvall, 2019; Gootenberg and Campos, 2015; Kozma, 2011a; 2011b).

During the 1924–1925 Conference, proposals to extend international controls to *Cannabis* were soon tabled by the government of King Fuad I from the recently-independent Egypt, a country that "prides itself on being the first country to ban cannabis cultivation, as early as the late 1870s" (Kozma, 2011a, p. 444). During the Conference, the country's Ambassador, which considered "the illicit use of hashish [being] the principal cause of most of the cases of insanity occurring in Egypt," (UNODC, 2008, p. 54), called on to other delegates:

> "even at the risk of seeming importunate, I insist, and shall continue to insist on the importance of this question [. . .] I am certain that you, gentlemen, who work under the aegis of the League of Nations, will help us in the struggle we have undertaken against this scourge, which reduces man to the level of the brute and deprives him of health and reason, self-control and honour" (UNODC, 2008, p. 55)

Such efforts to place hashish's *Cannabis* under international control, just like with opium's *Papaver* and coca's *Erythroxylum* , went knowingly "against a 2,000 year long history of drug cultivation, production, trading and use" (Buxton, 2008, p. 3). They can be seen as surprising given the fact that, at that time, *Cannabis* -based medicines were well-accepted globally (Buxton, 2008, p. 3; Collins, 2020, p. 280; Duvall, 2019; Frankhauser, 2002; Hamilton, 1912; Krawitz, 2006; Mathre and Krawitz, 2002; Mikuriya, 1969; Pisanti and Bifulco, 2017; Zuardi, 2006). If *Cannabis* -based medicines enjoyed a number of standardised pharmacopeial monographs under the 1925 Brussels Agreement on the Unification of Pharmacopoeial Formulas for Potent Drugs (Riboulet-Zemouli, 2020 pp. 13–14, 16), the plant was mainly present in traditional medicine, but also as a commonly used ingredient in locally-compounded medicines, often containing a variety of actives principles varying importantly between pharmacies and villages.11Until the mid-20th Century, most popular practices of day-to-day healthcare maintenance and treatment of minor ailments fundamentally relied on self-medication, eventually under the advice of pharmacists or other traditional healers –and not necessarily on consultations of a clinical practitioner, better documented in the medical literature.

The Egyptian Ambassador did not pretend to ignore it (UNODC, 2008, p. 55), yet, the confluence of several moral impetus for prohibition, as far as Egyptian authorities and elites were concerned, was also solid:

> "it was a public health concern, it was a religious concern, it was also Egypt's image abroad that was on the line here. All were backed by a strong centralizing state (since the 1870s), a nationalist agenda and a civilizing process" (Kozma, 2011a, p. 455).

After centuries of irrelevance in the public debate, *Cannabis* progressively became a symbol of what certain elites saw as "the nation's weakness" and its moral decline, as well as a filter through which Egyptian elites

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looked down at popular classes, where the use of *Cannabis* products was normalised. As Liat Kozma (2011, p. 454) puts it:

> "The 1924[-1925 Opium] conference was the first in which an Egyptian delegation was represented. Putting cannabis on the table, alongside opium and coca-based manufactured drugs, had both practical and symbolic dimensions. A mere five years after the British had prevented the participation of an Egyptian delegation in the post-First World War Versailles conference to present its demand for independence, a purely Egyptian delegation of diplomats and medical doctors presented an Egyptian agenda in an international forum."

In spite of Egypt wrestling the mention of "Indian hemp" in the C25 from the international community, the "control of cannabis was far less comprehensive than control of opium/morphine/heroin or coca/cocaine" (UNODC, 2008, p. 55), and this was particularly explicit by the fact that

> "the 1925 Geneva Convention only placed under control galenical preparations of Indian hemp, that is the extract and the tincture, but it did not mention pharmaceutical preparations containing the extract or tincture of Indian hemp." (OIHP, 1935, p. 161, *author's translation*).

These "galenical preparations (extract and tincture) of cannabis" were

> "subject to all the provisions of the 1925 Convention relating to such manufactured drugs as morphine, except that parties need not furnish statistics on manufacture and that manufacture need not be confined to establishments licensed for the purpose" (The cannabis problem. . . , 1962)

Only "pure" resin obtained from *Cannabis* was under the international controls established by the C25: theoretically 100-percent pure "extracts" without any added substance. Since the molecular composition of these was not known by the time (Mechoulam and Hanuš, 2000) it was considered that "the resin [. . .] is the active principle of Indian hemp" (LoN, 1939d, p. 29). Consequently, anything other than pure, uncut raw *Cannabis* extract was outside of the treaty's controls and legal realm, and this was the case

> "even [for] those containing 99 parts or more of Indian hemp extract or Indian hemp tincture to one part or less of any indifferent substance, [which] are not considered as possible agents of drug addiction" (Wesserberg, 1935).

A situation evidently unsatisfactory for Egyptian diplomacy at the time.

The structure of drug control under the League of Nations

Under the C25, Article 8 (exempting preparations of drugs from international control) and Article 10 (adding new preparations to international control) vested two international bodies with a joint mandate of selecting the preparations that should start or cease to be internationally controlled: the Health Committee of the LoN and the OIHP. Today, Articles 8 and 10 of the C25 find echo in Article 3 of the 1961 Single Convention on narcotic drugs and Article 2 of the 1971 Convention on psychotropic substances, which both externalise the appraisal of any change in the scope of control over substances to the WHO –which took over the mandates of both LoN's Health Committee and the OIHP (Howard-Jones, 1950; 1979; Renborg, 1957, p. 101).

A multifaceted global health leadership

The OIHP was created in Rome on 9 December 1907 in the wake of the series of International Sanitary Conferences held in the second half of the 19th century (Howard-Jones, 1950; OIHP, 1938). The Office became fully operative in 1909 (incidentally also considered the year of inception of the international drug control system with the Shanghai Commission). OIHP's core objectives were to

> "centralize all information concerning epidemic diseases, in a context of European imperialist expansion and fear of the return on the Old Continent of large cholera epidemics" (Frioux, 2009 p. 168,*translated by the author*).

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It rapidly ended up summing plague, tuberculosis, yellow fever and influenza to cholera, as progresses in medicine and epidemiology boomed. Essentially focused around the "quarantine concept" for its first 10 years, the OIHP started to diversify its activities by the turn of the first world war (Howard-Jones, 1979, p. 13; OIHP, 1933). This came not only in reaction to the health-related consequences of the armed conflict, but also to maintain the leadership of the Office in a nascent international health landscape where glimpses of competition had arisen with competing organisations, including from the private sector like the Red Cross (informal, yet mentioned in humanitarian treaties; Durand, 1978; Howard-Jones, 1979) or the Rockefeller foundation (Lin and Birn, 2021; Paillette, 2012). More threatening even for the OIHP was the adoption in 1919 of the Treaty of Versailles, founding the LoN and giving it a mandate on "the prevention and control of disease" and task to "[place] under the direction of the League all international bureaux already established by general treaties" (LoN, 1935b, pp. 14–15).

The LoN quickly wished to centralise public health concerns under a single international "Health Organisation" to be based in Geneva, and "of which the [OIHP] shall be the foundation" (Howard-Jones, 1979 p. 22). The Office would progressively have been incorporated within the LoN system (Ghebali, 1972; Howard-Jones, 1979; LoN, 1945a, pp. 5–9; LoN, 1945b, pp. 62–64).

But the OIHP resisted, and consistently managed to maintain its independence from the League, basked in its self-proclaimed status of first-ever international public health body,[5] a relative success on the control of pandemics, "firmly rooted in 19th-century conceptions of international health work" (Howard-Jones, 1979 p. 25), and thanks to the fervent support of the governments of Italy and France which jointly handled the Secretariat of the Office (Howard-Jones, 1979; Paillette, 2021). Its independence is evidenced by the fact that, after WWII, it survived six years after the dissolution of the LoN (WHO, 1947b; 1952a).

Consequently, in the 1925–1945 period, various international health organisations coexisted, in a context of tensions and drama (Howard-Jones, 1979 pp. 27, 61; Le Monde, 1946). The situation was maintained thanks to a *status quo* with the LoN that was negotiated by OIHP's founder, French diplomat Camille Barrère, in which:

> "the functions of general consultative council on health [are] entrusted to the [OIHP], which remains autonomous and maintains its headquarters in Paris, without modification of its composition or its attributions" (LoN, 1945a, pp. 6–7; see also OIHP, 1925).

In the 1930 *Yearbook of the LoN* , this "consultative council" is described as follows:

> "*Composition:* composed by permanent representatives of about forty States, it remains autonomous and maintains its headquarters in Paris, without alteration of its composition or attributions. [...]
>
> *Attributions:* It has the power to discuss and propose international conventions. It examines the works of the Health Committee, exposed in its resolutions, and discusses all questions submitted to it by that Committee, so as to provide consultative advise. [...]
>
> *Procedure:* It meets twice a year. Its sessions follow those of the Health Committee by a few days. It receives the text of the Committee's resolutions in the form of a report." (Ottlik, 1930, p. 144, *author's translation*).

Not only "the organizational structure upon which international health work was based during the twenty inter-war years was the result of a deadlock" (WHO, 1958, p. 27), but the OIHP was a

> "club of senior public health administrators, mostly European, whose main preoccupation was to protect their countries from the importation of exotic diseases without imposing too drastic restrictions on international commerce" (Howard-Jones, 1979, p. 17)

Far from secondary, the role of individuals is enlightening, if not critical, in understanding the shaping of early international politics (Rodogno et al, 2013, pp. 96–97). This is particularly true in the field of global

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drug control, where a "more personal, idiosyncratic cast" persisted until the 1950s (Fig. 1; McAllister, 2000, p. 210).

Camille Barrère illustrates this. French Ambassador in Rome (1897–1924) and "great protector" of the OIHP (Howard-Jones, 1979, pp. 31–33; Paillette, 2021), he had chaired the 1907 funding conference of the Office. Barrère, who had an opinion on all issues, assiduously attended OIHP meetings until his death, in 1940. In addition to unconditional support from France, his views of "the nascent fascist movement [in Italy] with almost unalloyed favour and enthusiasm" (Shorrock, 1975, p. 595),33Renzi (1971, pp. 193-194) even presents evidence that Barrère provided personal financial support to Benito Mussolini. and his inclination to balancing public health concerns with trade requirements –and particularly, commerce in and between European countries and their foreign colonies (Howard-Jones, 1979)–, Camille Barrère knew how to play "the hostility of the United States and USSR, membersof the Office, but from which [the LoN] had not obtained adherence" (Le Monde, 1946) in order to sustain the OIHP and its independence. Howard-Jones (1979, p. 32) explains:

> "In fact, that Barrere should have had any influence at all in planning international health work was grossly anomalous. He was neither a health expert nor a health administrator, but a fulltime professional diplomat."

Figure 1: Picture from the meeting of OIHP's *Comité Permanent*, Paris, May 1933 (Camille Barrère is visible at the centre on the front row, with a white hat in hand. Photo from the public domain).

Beyond the role of individuals, the democratic, representativity, and health-focused characteristics of the Office were dubious. The OIHP was not composed of members acting in their personal capacity as independent experts, but by Government representatives. Worse, the weight of each member's vote was indexed on the financial contribution of his country to the Office (OIHP, 1938). Within the Office, the broadly-shared vision of an international sanitary action limited to the "minimum hindrances to commerce compatible with the protection of public health" (Howard-Jones, 1979, p. 32) probably contributed to gather sympathy, among governments, for maintaining the politically-docile OIHP independent from a Health Committee of the LoN which may have been inclined to put health first.

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Heir of an international trade order recently established on the basis of colonial trade wars, and direct continuation of the eurocentric, coercitive, trade-oriented, and morally-tainted "civilising" mission that characterised international public health in the second half of the nineteenth and early twentieth centuries (Howard-Jones, 1979; Huber, 2006; Lin and Birn, 2021; Paillette, 2012; Sinha, 2001; Tworek, 2019) the OIHP represented a continuation, in the early twentieth century, of an

> "international health diplomacy [which] proved how vulnerable global health governance was to the machinations of states and the volatile dynamics of international politics" (Fidler, 2001 p. 847).

This was far from unfamiliar to the development of drug control treaties. Politics, trade, and (opium) trade wars are also the genesis which led to legal drug control instruments that, although claiming to protect health, ended up regulating commercial activities.

Organisational structure of international drug control in 1935

This rugged landscape of international health organisations resulted in the administration of drug control by a large number of organs interacting in a complex fashion, not uncommonly at the time (Fig. 2; Grandjean, 2017; Howard-Jones, 1979, pp. 30–31; Paillette, 2012). Dozens of interlinked, overlapping, sometimes "do-nothing" sub-, joint-, or interim- committees, commissions, boards, and bureaux, shared a piece of the cake of drug-related treaty mandates, rarely reaching efficiency (Ghebali, 1972).

Nonetheless, the basic structure Secretariat-Executive Council-Assembly was generally retained (as is still often the case today with international organisations). Within the LoN, the "Health Committee" represented an organ that could nowadays be assimilated to something in-between the WHO's Executive Board and World Health Assembly (Fig. 3). Under the C25, the Health Committee was mandated by Articles 8 and 10 to decide on the addition of new preparations to, or withdrawal from international control (Lande, 1945).

The Secretariat of the LoN (equivalent to today's UN Secretary-General's office) had a dedicated Health Section (the main roles of which are nowadays assumed by WHO Director-General, and for some drug control functions, by the UN Office on Drugs and Crime).

Together, Health Committee and Health Section of the Secretariat formed the upper part of the hierarchy of a very-theoretical "Health Organisation" of the LoN (Fig. 2).

Below the Health Committee, within the LoN (1945b, p. 61) was the Advisory Committee on Traffic in Opium and other Dangerous Drugs: the central policy making body where State Parties to the drug control treaties convened –an ancestor of today's CND (Bayer and Ghodse, 1999; Boister, 1997, p. 16). Within the Advisory Committee was eventually created a Sub-Committee on *Cannabis* (officially "Sub-Committee to study Questions in regard to Indian Hemp and Indian Hemp Drugs" where tumultuous political discussions recurred; Kozma, 2011b) and a Sub-Committee on the List of Drugs to keep track of inclusions and exemptions of preparations from control ("Sub-Committee of Experts to draw up the List of Drugs and Preparations coming under the Hague (1912) and Geneva (1925) Opium Conventions and the Limitation Convention (Geneva, 1931)" (LoN, 1945c, p. 61), a task nowadays assumed by the INCB with its regularly-updated "Yellow List" and "Green List;" INCB, 2021a; 2021b), among others.

Within the Health Organisation (but outside of the LoN!) and in Paris, was the OIHP –or, as they preferred to call it in Geneva, the "general advisory health council" (LoN, 1945c, p. 64). Under Articles 8 and 10, C25, the Office was tasked with providing scientific advice ahead of the decisions of the Health Committee. Differing from the classical Secretariat-Board-Assembly structure of the LoN, the OIHP had a single plenipotentiary decision-making body called "Comité Permanent," whose president was *ex officio* vice-president of the Health Committee (LoN, 1945c, p. 63). Within the Comité Permanent was a "Commission de l'Opium" which eventually discussed drug control matters.[7] Because Governments tabled every week new demands for the exemption of preparations under Article 8, the OIHP had developed an internal process and "constituted, to enlighten its decisions, a Committee of Expert Pharmacologists, currently composed of six members" (OIHP,

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1933, p. 61, *author's translation*). This "Comité des Experts Pharmacologistes" (CEP) is the ancestor of today's ECDD. To assist the OIHP's advising role to the Health Committee, the same six individuals met within the CEP from its start to 1935:

- Pr. Emil Bürgi (Switzerland),
- Pr. James Andrew Gunn (UK),
- Pr. Erich von Knaffl-Lenz (Austria),
- Lieutenant-colonel Dr. Jerzy "George" Leopold Modrakowski (Poland),
- Dr. Émile Perrot (France), and
- Pr. Walther Straub (Germany).

The CEP was not always the body tasked with drug assessment: that role was sometimes held by the Commission de l'Opium (OIHP, 1933b, p. 26).

Finally, separately from the Health Organisation, two organs were monitoring and controlling the application of the drug treaties:

- the Permanent Central Opium Board, established under the C25, partially operated within the LoN system as of 1935;
- the Drug Supervisory Body (*Organe de Contrôle*), established under the "Limitation Convention" of 1931, remained independent from the LoN system (McAllister, 2000, pp. 73, 96).

With the adoption of the Single Convention of 1961, both Permanent Central Opium Board and Drug Supervisory Body were merged into a single body: the INCB (Fig. 3). Notably, one of the four members of the Drug Supervisory Body was appointed by the OIHP (Lande, 1945, p. 410; LoN, 1945c, p. 22) which is reflected nowadays by the fact that WHO appoints 3 of the 13 Members of the INCB.

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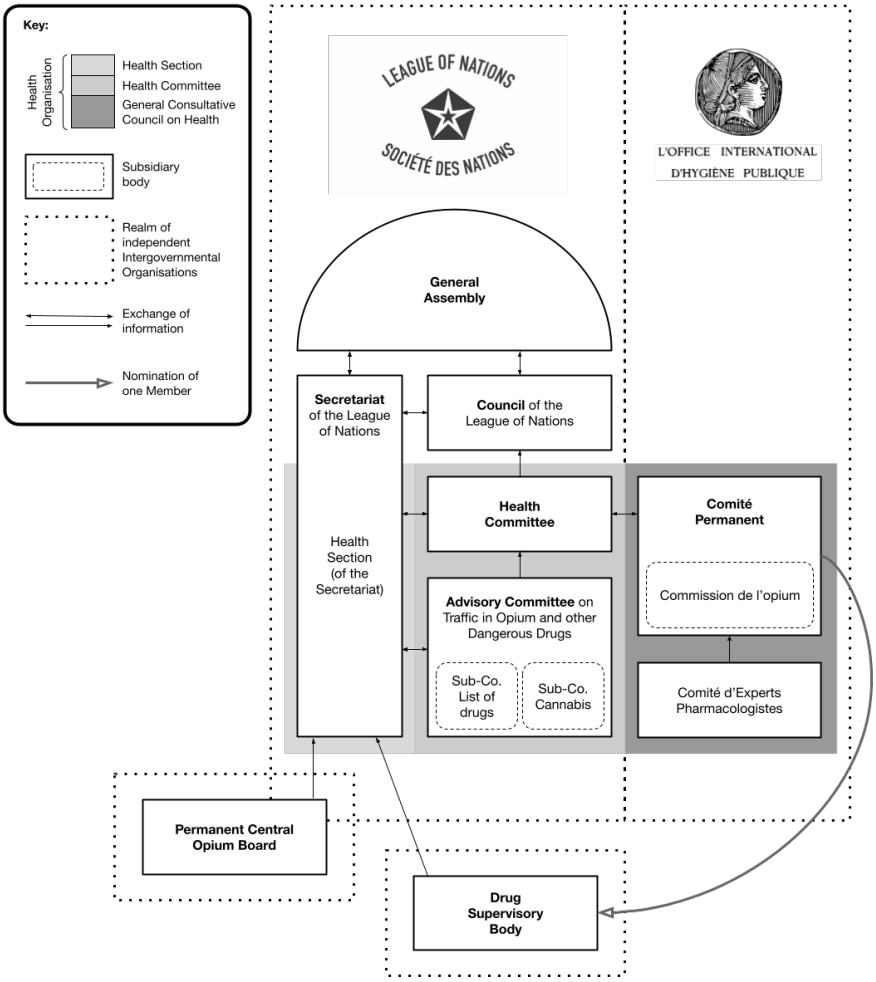

Figure 2: Organisational chart of intergovernmental organisations with a mandate related to Cannabis control in 1935 (LoN emblem: CC BY-SA 4.0 Martin Grandjean 2018/League of Nations 1939. OIHP emblem: public domain).

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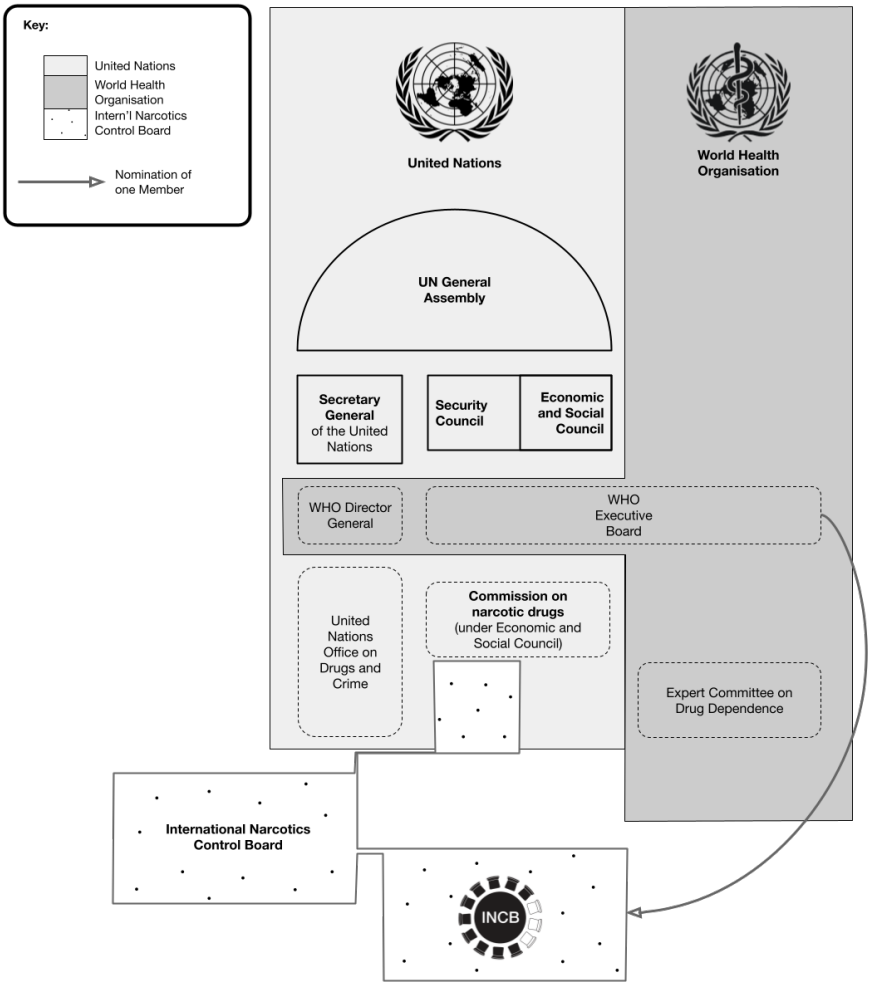

Figure 3: Layer of the organs in charge of international drug control in 2022, superposed over the organisational chart presented in Fig. 2.

1935: The non-review of *Cannabis* by the Office International d'Hygiène Publique

In 1933, although seizures of raw *Cannabis* , mostly imported from Syria, had been cut by half in the 3 previous years (LoN, 1933, p. 12), the Egyptian government sent a notification to LoN's Health Section (OIHP, 1935, p. 161; Supplemental materials Table S1) alerting of the alleged widespread harms caused by five particular medicines sold by the firm Parke, Davis & Co. (nowadays part of Pfizer, the Detroit-based "Parke-Davis" was then already a global pharmaceutical company; Hoefle, 2000, p. 33; Pfizer, s.d.). Alongside Merck in Germany, Holtmann-La Roche & Co. in Switzerland, Eli Lilly in the USA, and many other important or smaller pharmaceutical manufacturers (Frankhauser, 2002; Hamilton, 1912; Krawitz, 2006; OIHP, 1934b, pp. 104–110), Parke-Davis was proactively marketing two classes of *Cannabis*medicines (Museum of Healthcare…, 2022b; Parke, Davis & Co., 1911, p. 12):

- A wide array of specific (often proprietary) preparations, some containing *Cannabis* herb or extract as main ingredient (pills, tablet triturates), others compounded preparations containing it as an additional, residual ingredient (elixirs, tablets, and "a number of combinations");

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- Raw extracts (fluid and solid extracts of North American-grown *Cannabis*), herbal parts (powdered *Cannabis*, dried tops), and United States Pharmacopœia standardised products (fluid extract, solid extract, and tincture of Indian-grown *Cannabis*), used for compounding by local pharmacist –a mainstream practice at the time.

In a specific booklet dedicated to these medicines, Parke, Davis & Co. (1908, p. 2) claimed that *Cannabis*

> "has been used as an intoxicant in Asiatic countries from time immemorial, and under the name of 'hashish,' 'bhang,' 'ganja' or 'charas,' is habitually consumed by upwards of two hundred millions of human beings."

The five preparations that Egypt notified did contain extracts of *Cannabis* , but, compared to so many other popular medicines at the time, contained relatively minor amounts of *Cannabis* extract but instead copious amounts of other particularly notable sedatives or harmful substances[8] (Table 1; Fig. 4). As noted by the OIHP (1934b, pp. 106–110), if someone wanted to *get high* with these preparations, the lethal dose of strychnine would most likely be reached much before any narcotic effect could be felt.

Because they were not "pure" extracts of *Cannabis* , however, these preparations did not fall under the terms of C25. Pursuing its agenda started in 1925, Egypt saw this as something convenient to object to. The reasons for the particular attention given to Parke-Davis medicines, however, remain unclear, particularly since "the only among these [preparations] that [was] being exported in appreciable quantities to Egypt [was] the one called Compounded Damiana Tablets," which was only supplied on medical prescription (OIHP, 1934b, p. 106).

As a matter of fact, the intention of Egypt was to extend international controls "not only to the five preparations mentioned earlier, but all preparations containing an extract or tincture of indian hemp" (OIHP, 1935, p. 162, *author's translation*) or at least to preparations containing above a certain percent of *Cannabis* extract (OIHP, 1934, p. 23). On 12 June 1934 (OIHP, 1934, pp. 23–24) the Health Committee of the LoN triggered the mechanism of Article 10, C25, allowing the OIHP to convene its CEP, towards eventually "recommend[ing] that the provisions of [C25] be applied to such drug" in case it "is liable to similar abuse and productive of similar ill-effects as the substances to which this Chapter of the Convention applies" (LoN, 1925).

Table 1. **Translation of the "List of preparations made of Indian hemp indicated by the Egyptian Government as being used by drug addicts" reviewed by the Office International d'Hygiène Publique in 1935.**

Source: "Liste des préparations à base de chanvre indien indiquées par le Gouvernement égyptien comme employées par des toxicomanes," in: OIHP (1935, pp. 163–164). Author's translation. A full list and the reproduction or the original can be consulted in the Supplemental Materials.

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Elixir composed of bromide and chloral compound, formerly known as compound bromide *(Parke, Davis & Co.),*	*Each ounce of fluid represents:*	
	Potassium bromide	120 grains
	Chloral hydrate	120 grains
	Indian hemp extract	1 grain
	Hyoscyamus extract	1 grain
Sedative pills *(Parke, Davis & Co.)*	*Muskroot extract*	1/2 grain
	Hyoscyamus extract	1/2 grain
	Valerian extract	1/2 grain
	Indian hemp extract	1/10 grain
Compounded Damiana tablets. *No. 154* *(Parke, Davis & Co.)*	*Damiana extract*	1 1/2 grain
	Zinc phosphide	1/10 grain
	Indian hemp extract	1/4 grain
	Strychnine sulphate	1/40 grain
Neuralgic tablets *(Parke, Davis & Co.)* *C.C.T 107*	*Zinc phosphide*	1/16 grain
	Strychnine	1/60 grain
	Indian hemp extract	1/8 grain
	Sodium arsenate	1/20 grain
	Aconitine	1/400 grain
Improved neuralgic tablets *(Parke, Davis & Co.)* *C.T 169*	*Quinine sulphate*	2 grains
	Acetanilide	2 grains
	Hyoscyamus extract	1/2 grain
	Indian hemp extract	1/8 grain
	Arsenious acid	1/100 grain
	Strychnine sulphate	1/60 grain

Figure 4: This is a caption

Elixir composed of bromide and chloral compound, formerly known as compound bromide *(Parke, Davis & Co.),*	Each ou
Sedative pills *(Parke, Davis & Co.)*	*Muskroo*
Compounded Damiana tablets. *No. 154 (Parke, Davis & Co.)*	*Damian*
Neuralgic tablets *(Parke, Davis & Co.) C.C.T 107*	*Zinc ph*
Improved neuralgic tablets *(Parke, Davis & Co.) C.T 169*	*Quinine*

Fig. 4. **Photographs of some of the *Cannabis*-containing formulations mentioned in this article.**

A: *Bottle of "Improved neuralgic tablets, C.T. 169" marketed by Parke-Davis, similar to one of the formulations included in Egypt's list – origin: USA;* ***B:*** *Generic version of Parke-Davis' formulation "Neuralgic tablets C.C.T. 107" marketed by Jamieson & Co., similar to one of the formulations included in Egypt's list – origin: USA;* ***C:*** *Bottle of "Powdered extract No. 16, Cannabis (East Indian)" with handwriting reading "Do not dispense, New law, Oct. 1st 1937" – origin: USA;* ***D:*** *"Indian Cigarettes" marketed by Grimault Laboratories – origin: India;* ***E:*** *Brochure on Cannabis published by Parke-Davis in 1908 – origin: USA. (Photos: Ciara Kelley-Cannabis Museum/Michael A. Krawitz collection, CC BY-NC-SA 4.0).*

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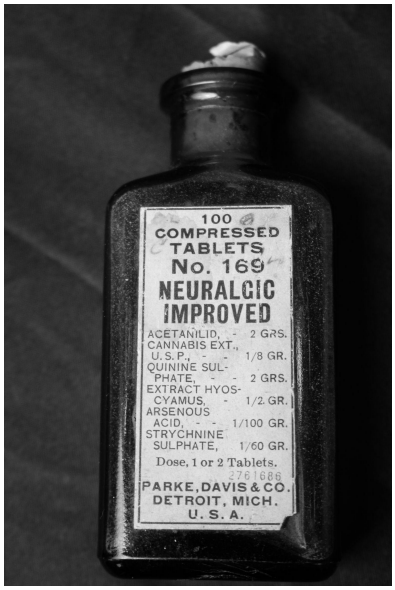

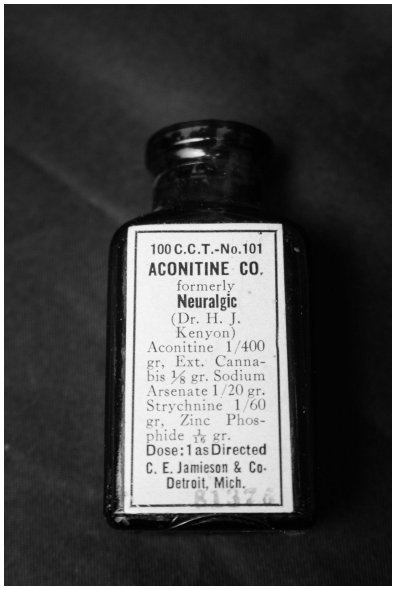

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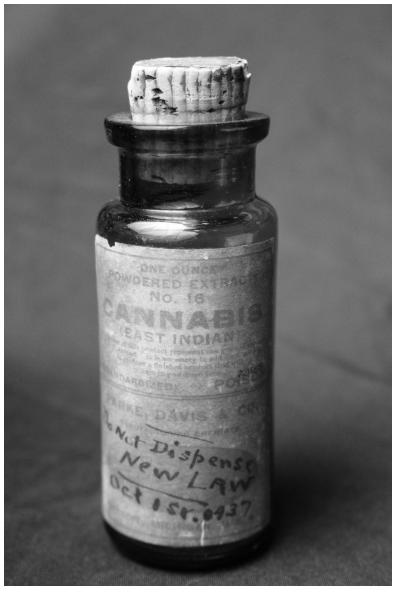

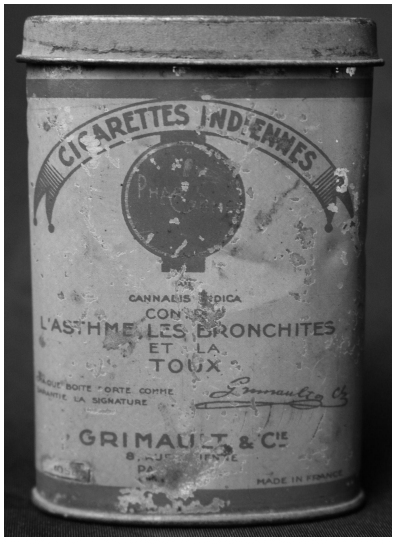

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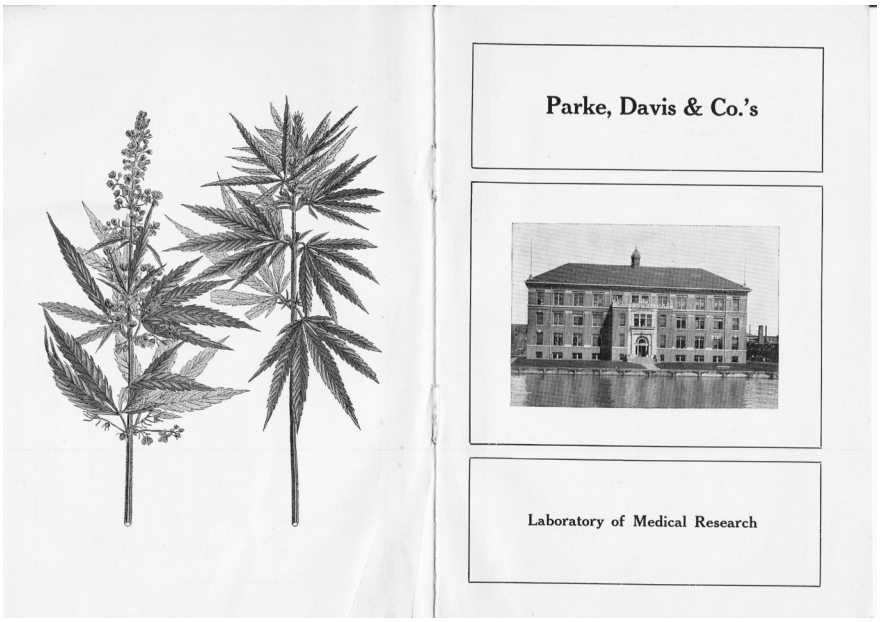

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The Expert Committee meets in Bern

On 4 and 5 March 1935, in Bern, Switzerland, the same six European men that had been attending every previous CEP meeting reconvened to address the issue raised by Egypt (OIHP, 1935, pp. 161–165, 207–209). Three observers joined:

- Dr. Henri Carrière (Switzerland), director of the Federal Office of Public Health, who attended in his capacity of Chair of the*Commission de l'Opium* at the OIHP (1935, p. 207; Steffen Gerber, 2003). Surprisingly, he also chaired the CEP meeting,
- Dr. Ignatius Wasserberg (Poland) from the Health Section (LoN Secretariat; LONSEA, s.d.), in representation of the Health Committee, and
- Dr. Georges Abt (France), OIHP director.

Three questions were asked to CEP Experts:

> "a. Are all preparations based on an extract or tincture of Indian hemp liable to lead to similar abuse and produce similar ill-effects as [a pure extract or tincture]; or b. At the least, those of which the content in the above-mentioned substance exceeds a particular upper threshold, and c. What is, in this case, such an upper threshold?" (OIHP, 1935, p. 208, own translation)

It is notable that the CEP remarked the manoeuvres of the Egyptian government: their concerns about increased, massive imports of these preparations, and widespread use in Egypt, was not reflected in the statistics (OIHP, 1935, p. 162) and, pharmacologically, the potential for harm was clearly not primarily related to *Cannabis* extracts "because of the little quantities of hashish they contain, and the associated presence of toxic substances" (OIHP, 1935, p. 163). Henri Carrière reported that the five preparations were "so to speak, unknown" by the delegates from Australia, Belgium, British India, Canada, Germany, Italy, the Netherlands, Turkey, Tunisia and the United States.[9] Germany and the Netherlands had opposed straightforward Egypt's proposal, but Canada had expressed support (OIHP, 1934b, p. 105) out of concern for the "mariuana cigarettes" sold on its territory (LoN, 1933, pp. 11–13; 1935a, p. 20; OIHP, 1934b, p. 106).

Among the Experts, only the rapporteur, Knafll-Lenz, clearly favoured placing all *Cannabis* -containing

preparations under control. He found it illogical that "hashish preparations be treated differently than opium or cocaine preparations" (OIHP, 1935, p. 208, *author's translation*). LoN's representative Wasserberg eventually joined him, asking however for the establishment of a maximum threshold of extract above which the preparations would fall under control. The proposal was quickly dismissed by the Experts, which recognized that

> "no method currently exists allowing to ascertain the content in extract or in tincture of a preparation, and also that it is not possible to measure the activity of an Indian hemp extract which, besides, is rather uneven" (OIHP, 1935, pp. 208–209, *author's translation*).

The minutes of, and correspondence surrounding the meeting suggest that no additional documentation or bibliographical support was relied upon –unlike the LoN's Sub-Committee on *Cannabis* , created three months later, which would consult many knowledgeable experts, compile much information, and even commission research on various aspects of the plant (CND, 1965; Kozma, 2011b; LoN, 1935a). The Sub-Committee did not provide input to the CEP meetings since it first met in May 1935 (LoN, 1935a, p. 32).

Uncomfortable with the whole process, but willing to move forwards, the Experts agreed on a consensual option proposed by Wasserberg of the LoN Health Section, as middleground: the CEP would recommend placing*Cannabis* preparations under control generally, while keeping "the benefit of Article 8" allowing to later exempt specific ones from international control on a case-by-case basis. It was argued, among others, that control over *Cannabis* -containing preparations would reduce the likelihood of them being used as carriers for more harmful compounds.

After the review: confusion and reservations

The CEP's recommendation still had to go through OIHP's Comité Permanent in May 1935 –first, Commission de l'Opium, then plenary– before being considered at the LoN's Health Committee in October 1936 (LoN, 1935c, pp. 5–6). Because "it is a matter of course that the opinions of the [OIHP] are confirmed by the Health Committee" (OIHP, 1933, p. 62,*author's translation*), the recommendation was agreed on (LoN, 1937), and then again at the Council of the LoN (90th meeting, 5th seance, 23 January 1936).

Surprisingly, the LoN's Sub-Committee on Cannabis, which started its works on 29 May 1935, seemed to be totally unaware of the entire process going on under the C25 (LoN, 1935a, p. 34).

After the multi-approval procedure of the CEP recommendations, the C25 mandated the Secretariat of the LoN to "communicate the said recommendation to the Contracting Parties" but, contrary to today's drug control treaties –where the scheduling changes agreed on take effect upon notification, worldwide– the C25 leaved the option for each country to accept or not the placement of a new drug or preparation under control. The recommendations of the CEP, consequently, had legal effect only "between the Contracting Parties who have accepted [them]" (LoN, 1925).

On 10 September 1936 (LoN, 1936) a Circular Letter was sent to the 52 countries party to the C25 at the time (LoN, 1935a, pp. 7–8, 38–39), among which Argentina, Canada, Mexico, the USSR, Peru, and others. Nonetheless, notable countries had not, and never ratified the C25, like the USA (Leinwand, 1971, p. 415; LoN, 1935a, p. 38; McAllister, 2000) or China (LoN, 1935a, p. 39; UNODC, 2008, p. 53).

But even among the 52 Parties, the "formal acceptance" of the CEP's recommendation"necessary in order to establish as between the High Contracting Parties the international obligations to which allusion is made" (LoN, 1936) remained scarce. One year after the notification, 25 countries had accepted the placement under control,[10] 20 were silent, and seven governments had expressed direct reservations: Austria, Denmark, Netherlands, and Norway wished to exempt a number of specific proprietary formulations manufactured in their country, and Germany, Portugal, and Sweden wished for all topicals to be exempted (LoN, 1937, p. 2). This was leaving the change without effect in two dozens of ratifying countries, such as Brazil, Colombia, Cuba, Finland, Luxemburg, Spain, Switzerland, Uruguay, Yugoslavia, and colonial empires like France and the UK. In addition to all the non-Parties, this was *de facto* making the change null even for the Parties

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that had accepted it. Dr Carrère had anticipated that as soon as he had heard of Egypt's request, in 1934 (OIHP, 1934, p. 23)

At its 26th Session, in November 1937, the Health Committee noted that these feedback "must be taken into consideration, with a view to the possibility of so modifying the Health Committee's decision of October 1935," with the goal of securing "unanimous and unconditional acceptance" (LoN, 1937, p. 2). Noting that "it would be impossible to exempt from the Convention a group of preparations described in such a vague manner" (LoN, 1937, p. 3), the Health Committee seconded the question to the OIHP, again, for further consideration.

1938: A second review at the verge of War

Less archives of the second CEP meeting are available. It was convened on 22 September 1938 in Bern, again, under the chairmanship of the "observer" Dr Carrière. For once, the cast had changed: Carrière's fellow countryman Emil Bürgi was absent for health reasons (Ledermann, 2005; OIHP, 1939, p. 2), and Marc Tiffeneau, another Frenchman, replaced Pr. Perrot (LoN, 1938b, p. 2; Table 2). Carrière relates about this second review of preparations containing extract or tincture of *Cannabis* :

> "... the Experts maintained their previous decision, that is, these preparations should be placed under control, except corn-removers, even if these preparations are obtained directly from Indian hemp in natural form or its resin, without having gone through an extract or tincture.
>
> The Experts motivated this decision, as the previous, by the fact that, to date, no certain method exists to determine the content in extract or tincture of Indian hemp –or, to say it better, in the active principle of Indian hemp, which is cannabinol– of a preparation." (LoN, 1938b, pp. 2–3)

This time, the works of the LoN's Sub-Committee on *Cannabis* had been shared and received by the OIHP, and in particular, the studies of Dr. Bouquet (Tunis) Dr. de Myttenaere (Brussels) related to "the value of Beam's reaction for the detection of cannabinol and [...] a method for the assay of this substance" (LoN, 1935a, p. 7) which were a focus of the CEP's interest. But because the method had only been published in LoN document, not in the literature, the Experts refused to refer to it: instead, they expressed the conviction that the assay would certainly be considered in a future CEP meeting (OIHP, 1939).

The CEP never reconvened. Anyways, while cannabinol is indeed an active compound present in *Cannabis* , it is not the one that Egypt and most parties involved probably had in mind: cannabinol does not cause the effects that characterise the use of *Cannabis* products, but dronabinol ([?]^9-tetrahydrocannabinol), a substance that was only identified three decades after later (Mechoulam and Hanuš, 2000).

Table 2. ***Dramatis personæ* of the 1935 and 1938 CEP meetings.**

Name	Role(s) at the time	Nationality	Role in 1935	Role in 1938
Abt, Georges *(1874–1961)*	Director, OIHP. Medical doctor. Scientist, Pasteur Institute, Paris.	France	Observer	Observer
Bürgi, Emil *(1872–1947)*	Professor of pharmacology and medicinal chemistry, University of Bern.	Swiss	CEP member	CEP member (absent)

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Name	Role(s) at the time	Nationality	Role in 1935	Role in 1938
Carrière, Henri *(1865–1941)*	Director, Federal Office of Public Health (1916–1937). Member, OIHP's *Comité Permanent*. President, OIHP's *Commission de l'Opium*. Member, LoN Advisory Committee on Traffic in Opium and other dangerous drugs (1934–?*). Member, Drug Supervisory Body (1933–1941).	Swiss	Observer; *Chairman*	Observer; *Chairman*
Gunn, James Andrew *(1882–1958)*	Professor of pharmacology (until 1937) and therapeutics (1937–1946), Oxford. Specialist in psychedelic alkaloids. Member, British Pharmacopœia Commission. Founder, British Pharmacological Society.	British	CEP member	CEP member
Knaffl-Lenz, Erich von *(1880–1962)*	Professor of pharmacology and toxicology, Medical University, Vienna. Member, LoN Health Committee.	Austrian	CEP member; *Rapporteur*	CEP Member
Modrakowski, Jerzy Leopold (George) *(1875–1945)*	Professor, Faculty of Medicine, University of Warsaw. Delegate of Poland at several LoN meetings on opium. Died at the Wrocław concentration camp.	Polish	CEP member	CEP member

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Name	Role(s) at the time	Nationality	Role in 1935	Role in 1938
Perrot, Émile Constant *(1867–1951)*	Professeur of medicine, Faculty of Pharmacy, Paris. Member of various governmental committees related to plants and natural resources in numerous French colonies.	French	CEP member	*n/a*
Straub, Walther *(1874–1944)*	Professor of pharmacology, Ludwig Maximilian University of Munich. Known for the Straub Spasticity Test ("Straub tail")	German	CEP member	CEP member
Tiffeneau, Marc *(1873–1945)*	Chemist, known for the "Tiffeneau–Demjanov rearrangement." Member, Drug Supervisory Body (1933–1945). Member, LoN International Pharmacopœia Commission. Member, LoN Advisory Committee on Traffic in Opium and other dangerous drugs (1935–?*)	French	*n/a*	CEP member
Wasserberg, Ignatius (Ignacy Izak) *(1879–1942)*	Technical officer, LoN Health Section (1923–1937). Medical doctor; philosopher. Died at the Auschwitz concentration camp.	Polish	Observer	Observer

** At least until the end of 1935.*

Corn-removers and Pact of Steel

In May 1939, at its 30th session, the Health Committee agreed on maintaining the conclusions from the first CEP review, this time clearly "declaring however that these conclusions do not target those of these

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preparations that can only be used externally" (LoN, 1939a, p. 5; Preparations exempted. . . , 1951). The Council of the LoN ratified the move at its 105th session, on 23 May 1939 –one day after Hitler and Mussolini signed the Pact of Steel– and communicated to State Parties on 12 July a Circular Letter titled "Application of Article 10 of the Geneva Convention of 1925 to preparations based on Indian hemp Extract or Tincture under reserve of certain exemptions" (LoN, 1939a) –the one from 1936 did not made that precision (LoN, 1936). Shortly after,

> "with the outbreak of the Second World War and the occupation of Paris, the OIHP was not able to function as intended and could not fulfil its international health functions" (UN, s.d.).

Although its headquarters were occupied in 1940 (Tworek, 2019), part of the OIHP staff had managed to escape to Southern France, with documents and archives.

In Geneva, the LoN had already started reducing activities in 1938 (Magliveras, 1999, p. 31; LoN, 1938a), and drastically after the expulsion of the USSR in December 1939 (LoN, 1939c). "By June 1940, the staff of the Health Section had been so depleted by resignations and departures for national service that it included only two medically qualified members" (Howard-Jones, 1950) and almost all activities of the LoN had been phased out (Le Monde, 1946) except a few programmes that passed on to be carried on by the Secretariat, among which was the "protection of public health and control of the manufacture of and illicit traffic in narcotic drugs" (Magliveras, 1999, p. 31), carried on throughout WWII and the immediate post-war period (LoN, 1945c; Tworek, 2019); the Permanent Central Opium Board and Drug Supervisory Body also reduced, but maintained activities (Dangerous drugs. . . , 1946, p. 175; May, 1948, pp. 342–345; McAllister, 2000, pp. 134–141).

The last action of the LoN related to *Cannabis* and its 1935/1938 CEP assessments had taken place on 31 December 1939 (Table 3) when, in an attempt of normality, the Secretariat issued a revised list of drugs, preparations, and medicines under international control (drawn-up by the Sub-Committee to the List), which confusingly acknowledged the placement of "preparations made of extract and tincture of Indian hemp" under international control, with a footnote reading:

> "This clause applies to countries which have adopted the recommendation of the Health Committee of the League of Nations to place these products under control [. . .]. The Health Committee [. . .] stated that their conclusions, however, do not apply to those of the said preparations which are capable only of external use" (LoN, 1939d, p. 28)

After the War

The LoN was dissolved in 1946, its mandates transferred to the UN (Myers, 1948; WHO, 1947b). That same year, the penultimate meeting of OIHP's Comité Permanent meeting was held: it discharged its mandates to an interim commission tasked with establishing the WHO (1950a), and suspended the publication of its landmark *Monthly Bulletin* (WHO, 1958, p. 430). By February 1948, the WHO "had absorbed all the OIHP's obligations towards the States parties" (WHO, 1958, p. 56; Fig. 3) including drug assessment under the C25.

Governments had agreed, in 1946, on a plan for the denunciation of the 1907 Rome Agreement (OIHP's constitution) and termination of the Office by 15 November 1949 (UN Relief and Rehabilitation Administration, 1943; WHO, 1948a, add.1; 1950a, p. 2). The decision was unpleasant to France, which feared losing its influence on international health matters (Paillette, 2021); others also continued defending the active role of the Office amidst its liquidation: in September 1947 Dr Morgan, chairman of the Comité Permanent, argued that as long as the Office was not effectively terminated,

> "the consultative opinion of the latter, in pursuance of Articles 8 and 10 of the 1925 Geneva Convention, would be required to give legal authority to the recommendations of the [WHO] experts" (WHO, 1947b).

The LoN was liquidated in effect in July 1947, 15 months after the decision to terminate it (Myers, 1948).

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But the OIHP was a different story. It continued functioning even after its programmed death: an obscure-motivated refusal of Spain to denounce OIHP's funding Agreement, added to legal uncertainties surrounding its termination by the non-self-governed occupied territories of Germany, Japan, and Libya, and by newly-independent countries (WHO, 1949, pp. 2–3) had made "apparent that the Office must continue" (WHO, 1949, p. 4). On 15 November 1950, the last few remaining activities of epidemiological monitoring carried out by the OIHP ceased –one year after the deadline set, and mostly because of a cruel lack of resources (WHO, 1950a; 1950b). Nevertheless, an empty OIHP continued existing *de jure* until 1952 when, finally, the denunciation of the Federal Republic of Germany, Japan, and Spain ended its long agony (WHO, 1950a; 1952a, p. 30).

Early work of the WHO on Cannabis

The inception of WHO did not look particularly promising for *Cannabis* medicines: as early as 1947, the three monographs of *Cannabis* were withdrawn from the International Pharmacopoeia, the management of which WHO had just taken over –although countless other medicines were deleted, particularly herbal ones (WHO, 1947a).

The WHO however really engaged with the drug control aspect of *Cannabis* products in 1952, at the third ECDD meeting –initially named the Expert Committee on Narcotic Drugs (WHO, 1948b), this body created to carry on the scientific tasks previously assumed by OIHP's CEP changed titles several times, until being named ECDD in 1968 (Danenberg et al, 2013). At its 1952 meeting, "the question of justification of the use of cannabis preparations for medical purposes" was discussed, and the committee declared that

> "cannabis preparations are practically obsolete. So far as [the Committee] can see, there is no justification for the medical use of cannabis preparations." (WHO, 1952b)

An opinion reiterated at subsequent meetings (Krawitz and Riboulet-Zemouli, 2018; Riboulet-Zemouli, 2018).

Oblivion

There is no trace of any inputs from any pre-WWII meetings, decisions, or documentation in 1950s ECDD meetings, let alone of the 1935/1938 episode. The never-ending termination of the OIHP, in conflict with WHO, might not have facilitated knowledge-sharing.

In 1962, an article reported that all *Cannabis* preparations were under control, with the exception of topical preparations and "a medicinal cigarette called 'Indian Cigarettes of Grimault' [...] exempted from control" (The cannabis problem..., 1962),[11] but Parke-Davis medicines of the 1935 list were still produced in the late 1940s (Museum of Healthcare at Kingston, 2022a) and in the 1950s "some Governments had reported that there still existed an appreciable use of cannabis drugs in medical practice" (CND, 1955). In an analysis of "The position of preparations of narcotic drugs under the narcotics treaties..." (1959), the scope of the 1935/1938 decisions was considered "to be a matter of doubt."

Secretary-General's note on "The Question of Cannabis" (CND, 1960) ignores the issue, and its compilation of 1,860 references on *Cannabis* incidentally mentions OIHP, only once, and unrelated to the 1935 assessment (CND, 1965, p. 45). The list of drugs under international control edited by the CND (1961) during the negotiation of the Single Convention only mentions: "Relevant articles of the 1925 Convention which are applicable to Cannabis and its resin, and to galenical preparations of Cannabis" –without mentioning anything about preparations, ignoring the last list of drugs under control of the LoN in December 1939, omitting the entire 1935/1938 episode.

Table 3. **Timeline of discussions on *Cannabis* control, 1933-1939.**

** indicates an action taken by the League of Nations; + indicates an action taken by the Office International d'Hygiene Publique; other rows are actions taken by Governments. C25: International Opium Convention of 1925; CEP: Comite des Experts Pharmacologistes; OIHP: Office International d'Hygiene Publique; LoN: League of Nations.*

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When	Who	What	Source
May 1933	**Egypt**	Notifies the Health Section about 5 preparations containing trace-amounts of *Cannabis* extracts marketed by Parke, Davis & Co. should be subjected to Article 10, C25.	OIHP (1935, p. 161)
October 1933	*** Health Committee**	First meeting where the issue raised by Egypt is addressed. More precisions are asked to Egypt.	OIHP (1935, p. 208)
28 May 1934	**Egypt**	Answers to the LoN's Health Committee, providing details. Clarifies that the proposal is to extend controls to all preparations, not only the 5 notified in 1933.	OIHP (1935, p. 162)
12 June 1934	*** Health Committee**	Asks Egypt further information. Refers the case to OIHP's Comité Permanent, attaching a detailed descriptive note –triggers mechanism for review under Article 10, C25.	OIHP (1934a, p. 23)
Summer 1934	+ **Comité Permanent**	Refers back to the LoN, to undertake preliminary consultations among Governments asking whether the 5 preparations notified by Egypt were reported as liable to produce addiction in their countries.	OIHP (1934a, p. 23)
	Germany, the Netherlands	Express refusal of Egypt's proposal.	OIHP (1934b, p. 105)

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When	Who	What	Source
	*** Secretariat's Legal adviser**	Clarifies that the inclusion of preparations of Indian hemp under the controls of C25 is "perfectly legitimate" and depends only on the responsibility of the Health Committee's decision, upon OIHP's advice.	OIHP (1935, pp. 162, 208)
8 Oct. 1934	*** Health Section**	Dr. Ludwik W. Rajchman (director, Health Section) mentions at OIHP's Comité Permanent that the proposal of Egypt entails a number of general problems, some "issues of principle."	OIHP (1934a, p. 30)

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When	Who	What	Source
12 Oct. 1934	+ **Comité Permanent**	Considers a research made by British representative Dr. Morgan about Parke, Davis & Co.'s preparations, finding that "the only among these that is being exported in appreciable quantities to Egypt is the one called Composed Damiana Tablets" while the other preparations were not exported to Egypt by Parke-Davis, except the elixir, of which less than half a kilogram per year was exported. Regarding Demiana Tablets, the exports were of 3,358 bottles in 1932, 4,576 bottles in 1933, and 2,080 bottles from January to Septembre 1934 (100 tablets per bottle). It was noted that the interest in the tablets may instead have been due to their use as an aphrodisiac (unrelated to cannabis intoxication). The Comité decides that no further action is needed, except a possible future examination, should it be recognised as necessary.	OIHP (1934b, pp. 105–110)
	Canada	Express support for Egypt's proposal; mentions "Mariuana cigarettes" as desirable to be placed under control.	OIHP (1934b, pp. 105–110)

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When	Who	What	Source
	A dozen of Governments	The preparations are unknown, and the elements put forward by Egypt seem doubtful due to the composition of the preparations and the presence of other harmful substances.	OIHP (1934b, pp. 105–110)
27 Nov. 1934	*** Health Committee**	Requests more data to Governments. Decides the creation of a Sub-Committee on Cannabis.	OIHP (1934b, pp. 105–110)
14 Jan. 1935	*** Council**	Acknowledges the need for more research, takes note of the creation of the Sub-Committee.	84th session
4–5 March 1935	+ **CEP**	Meets in Bern, issues the following recommendation: "The Committee of Experts is of the opinion that all preparations based on extracts and tinctures of Indian hemp are liable to give rise to similar abuse and to produce similar ill effects as the extract and tincture themselves; it recommends that they be subject to the provisions of the 1925 Convention, granting them, where appropriate, the benefit of Article 8 of the said Convention" (*translation is of the author*).	OIHP (1935, pp. 207–211, 163–164)
6 May 1935	+ **Commission de l'Opium**	Approves the recommendation, as adopted by the CEP on 5 March.	OIHP (1935, pp. 157–165)
8 May 1935	+ **Comité Permanent**	Approves the recommendation, as adopted by the Commission de l'Opium on 6 May.	OIHP (1935, pp. 157–165)

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When	Who	What	Source
29 May 1935	*** Sub-Committee on Cannabis**	First meeting. Visibly unaware of the CEP recommendation, the Sub-Committee wonders about "the possible expediency of recommending a modification of, or an addition to, the existing conventions" because "The Sub-Committee did not go into the question of galenical preparations of *Cannabis sativa* but its attention was drawn to the fact that the present international conventions, in so far as internal control is concerned, establish a control for preparations of the resin of this drug, which is less strict than that prescribed for other drugs."	LoN (1935a, p. 34)
7–14 Oct. 1935	*** Health Committee**	At its 22nd session, approves the recommendation adopted by the OIHP on 8 May, rephrasing it as follows: "preparations made from tincture or extract of Indian hemp may lead to the similar abuses and may produce similar ill-effects to those resulting from use of the tincture or extract of Indian hemp themselves, and consequently decides that these preparations shall be brought within the control of the 1925 Convention" (note that the rephrasing happened both in French and English languages).	LoN (1935c, pp. 5–6; 1936)

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When	Who	What	Source
23 Jan. 1936	*** Council**	At its 90th session (5th meeting), approves the recommendation, and decides to communicate it to States Parties to the C25, and for information to States Parties to the 1931 Convention.	LoN, *Journal Officiel*, Feb. 1936
10 Sept. 1936	*** Secretary General**	Shares Circular Letter C.L.161.1936.XI titled "Application of Article 10 of the Geneva Convention of 1925 to preparations based on Indian hemp Extract or Tincture" which included the wording from the Health Committee's 22nd session, asking each Government "whether it would agree, so far it is concerned, to the inclusion of preparations made from Indian hempextract or tincture within the scope of the Convention. [. . .] a formal acceptance is necessary in order to establish as between the High Contracting Parties the international obligations to which allusion is made in [Article 10, C25]."	LoN (1936)

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When	Who	What	Source
Fall 1937	**32 Governments**	Answer the Circular Letter agreeing on, or objecting to, the change. 25 countries accepted without reservation (some that accepted were not even Parties to the C25), 7 countries accepted only under specific conditions. All other non-respondent countries *de facto* did not accept the change.	LoN (1937)
16 Oct. 1937	*** Health Section**	Refers the objections and reservations received by countries to OIHP's Comité Permanent for a new examination.	LoN (1937, p. 3)
27 Oct. 1937	*** Health Committee**	At its 26th session, notes the diverging opinions among Governments, and various reservations sent.	LoN (1937)
22 Sept. 1938	+ **CEP**	Blames the Health Committee for altering the content of the recommendation, and reiterates the same recommendation as in 1935.	OIHP (1939)
Sept. 1938	*** General Assembly**	The LoN reduces its activities due to the tense geopolitical situation.	LoN (1938a)
17 Oct. 1938	+ **Commission de l'Opium**	Approves the recommendation, as adopted by the CEP on 22 Septembre.	OIHP (1939)
22 Oct. 1938	+ **Comité Permanent**	Approves the recommendation, as adopted by the Commission de l'Opium on 17 Octobre.	OIHP (1939)
10 Nov. 1938	+ **Comité Permanent**	Shares the recommendation with the Health Committee.	LoN (1939a, p. 5)

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When	Who	What	Source
9 May 1939	*** Health Committee**	At its 30th session, notes the recommendation transmitted by the OIHP in Novembre 1938, expresses the will to reach "unanimous assent" for any decision related to Indian hemp, and decides: "WHile maintaining the conclusions of the 22nd session [...] declares however that such conclusions do not concern those preparations which can only be used externally"	LoN (1939a, p. 5)
23 May 1939	*** Council**	At its 105th session, approves the recommendation, and decides to communicate it to States Parties.	LoN (1939a)
12 July 1939	*** Secretary General**	Shares Circular Letter C.L.99.1939.XI titled "Application of Article 10 of the Geneva Convention of 1925 to preparations based on Indian hemp Extract or Tincture under reserve of certain exemptions"	LoN (1939a)
31 August 1939	Invasion of Poland and outbreak of the second world war.	Invasion of Poland and outbreak of the second world war.	

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When	Who	What	Source
31 Dec. 1939	*** Advisory Committee on traffic in opium and other dangerous drugs**	Circulates a "Revised list of drugs, preparations, and medicines coming under the international drug conventions" which lists: "*Preparations made of extract or tincture of Indian hemp*[1] [1] This clause applies to countries which have adopted the recommendation of the Health Committee of the LoN to place these products under control as well as extracts and tinctures [. . .]. The Health Committee, in further recommendation [. . .] stated that their conclusions, however, do not apply to those of the said preparations which are capable only of external use" and a list of 29 proprietary medicines of "extracts or tincture of Indian hemp base" (where, from the 5 preparations notified by Egypt, only the "Elixir Bromide and Chloral Compound" from Parke, Davis & Co. is listed) stating again in a footnote that "this clause applies to countries which have adopted the recommendation of the Health Committee of the League of Nations" and mentioning that "other preparations, however, are to be found in the market which fall under the Conventions but which are not included in the list," and precisind that "all drugs, preparations or proprietary medicines mentioned in the list are not subject to an identical form of control [. . .]; for instance, Indian hemp, its resin and its preparations are not covered by Chapter III, Article 4, [C25], but fall	LoN (1939d, pp. 9, 28–29, 102–106)

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When	Who	What	Source

Discussion

For reasons yet to be determined, the process of evaluation and scheduling initiated by Egypt in 1933, which occupied the international community until the last day of December 1939, was forgotten. Already hardly-accepted by, and poorly-implemented among the Parties to the C25 at the time, it was lost to history during WWII. In 2014, the date "1935" resurfaced in a document of the WHO (2014); stakeholders, content, outcome, or consequences of the event did not. A partially-mistaken idea then followed: *Cannabis* had been scientifically assessed in 1935. The present study suggests that no such thing happened.

While in 1935, a review meeting of the *Comité des Experts Pharmacologistes* of the *Office International d'Hygiène Publique*did take place under the auspices of the LoN, it did not assess*Cannabis* or even *Cannabis* extracts. Instead, it briefly considered five specific proprietary medicines containing a variety of highly potent compounds alongside residual amounts of *Cannabis*extracts, and drew conclusions for a myriad of products based on the rapid overview of that random sample of five.

No methodology or supplemental documentation appear to have guided the work of the Experts and, even after (1) acknowledging the political motivations of Egypt's request and (2) noting the likelihood that any harm derived from the use of these preparations was most likely due to any other active principle than *Cannabis* extracts, the Experts still decided to maintained the focus on *Cannabis* as the ingredient deserving their scrutiny, and an increase of controls. A recommendation already weakly-justified for five precise preparations was arbitrarily extrapolated to dozens, if not hundreds of others. But it should be recognized that the way in which were termed the three questions that the Experts were asked already conducted them into such an outcome.

Although it was common at the time, the cruel lack of gender balance (not a single woman was involved in the entire process), the fully-European composition of the bodies involved in the process, and the weight of the personal moralist and conservative beliefs of norm entrepreneurs and drug control advocates arguably participated in hampering any objective and inclusive consideration of the variety of*Cannabis* medicines –at a time where the plant was still broadly used both in popular Western medicine and within traditional healing contexts, worldwide. The influence of two observers in the meetings' decisions should be highlighted (Henri Carrière chaired both meetings; Ignatius Wasserberg came up with the idea of the final recommendation in 1935), and balanced with the absence of any person knowledgeable about*Cannabis* . In addition, the endogamy of stakeholders is extreme: a figure like Dr Carrière was simultaneously holding positions at every stage of the decision-making process: review (CEP observer), decision-making (OIHP Comité Permanent), monitoring (Drug Supervisory Board), as well as diplomatic representative of a particular country.

For these reasons, while many considered the WHO ECDD scientific assessment of *Cannabis* of 2016–2019 as the first of its kind since 1935, it is fair to consider that it was actually the first-ever and only.

Finally, the oft-perceived leadership of the USA (Party to no international treaty controlling *Cannabis* until 1968) in the inception of multilateral *Cannabis* control is questioned, and the role of Egypt as prime advocate of ever-stricter multilateral*Cannabis* controls, already highlighted by Kozma (2011) and Jelsma et al. (2014), calls for a reconsideration. At the same time the international community was discussing Egypt's request to increase controls over cannabis, USA Surgeon-General Hugh Cumming had written to the OIHP (1934b, p. 107): "It does not seem that the abuse of galenical preparations of indian hemp raise any considerable difficulty in the United States."

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Conclusion

This study, presenting previously-undocumented historical records, can be of interest both to an improved understanding of the legal history of *Cannabis* globally, and to analyses of possible future developments. Indeed, many aspects of pre-WWII institutions and organisations are echoed in today's multilateral drug control complex (if not directly inherited from them), making their study to the least enlightening. Furthermore, while the CND approved the withdrawal of "cannabis and cannabis resin" from Schedule IV of the Single Convention on narcotic drugs on 2 December 2020, other ECDD recommendations were rejected (CND, 2020; Riboulet-Zemouli and Krawitz, 2022). Prospects for future works of the ECDD or other treaty-related considerations would benefit from a fresh look at the past –not only the lost history of international cooperation on *Cannabis*control, but also the forgotten tale of the galaxy of formulas with *Cannabis* ingredients, the reported hundreds of millions of people who prepared, prescribed, and used them, or the fact that large pharmaceutical firms had, at the time, such a vivid interest in the plant and an apparently substantial global distribution of its derivatives. As *Cannabis* reemerges in medicine, and as laws and policies surrounding it continue to evolve in every corner of the globe, these findings seem timely.

Beyond *Cannabis* , this study sheds light on an underexplored area of the history of the international drug control system, untapping the fundamental, surprisingly forgotten role of the OIHP in early drug scheduling. Generally, the OIHP is a figure of international public health which has surprisingly been forgotten, at a time where a look at the history of global health can, for instance, enlighten contemporary concerns on the links between trade and health policies, or inform the debates of our days on the course of international actions to take, be it on infectious diseases or on access to controlled medicines.

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Supplemental materials

Supplemental materials have been posted on Researchgate at this link: https://www.researchgate.net/publication/360541027

Footnotes

[1] The term "Indian hemp" is used throughout the text in reference to Cannabis sativa L.. It should not be mistaken with Apocynum cannabinum L., an unrelated plant native to North America and also sometimes called "Indian hemp" or "black Indian hemp." The word "hashish" is used indistinctively to refer to the Cannabis plant, its tops, or its resin. Generally, the terminology related to plants "is somewhat awkward" in these old treaties (Unification of Conventions. . . , 1950; see also LoN, 1935a, p. 33).

[2] Communications with INCB, UN libraries in Geneva and Vienna, and Dag Hammarskjöld library. This is not particularly surprising, given INCB's track-record of great secrecy (Csete, 2012; Fields of Green for All NPC, 2021) in a context where access to the documentation of intergovernmental organisations is often a complicated endeavour (Church and McCaffrey, 2013).

[3] This is sometimes translated as "International Office of Public Hygiene" or "International Public Health Bureau." However, French was the only official language for all names and documents of the OIHP, since that language was at the times the hegemonic diplomatic language. The fact that only French-language versions of the work of OIHP are available may have contributed to their scare presence in the literature. In addition, the archives of the OIHP have had a convoluted history: evacuated from Paris and disseminated during WWI, partially lost, partly transferred at the WHO library in 1950 by decision of the third World Health Assembly (Resolution WHA3.98; WHO, 1950b, p. 59), subsequently de-catalogued by parts, split between various collections of archives, parts of which have been decatalogued: the few archives that survived is nowadays kept at the WHO library and LoN Archives, in Geneva.

[4] Until the mid-20th Century, most popular practices of day-to-day healthcare maintenance and treatment of minor ailments fundamentally relied on self-medication, eventually under the advice of pharmacists or other traditional healers –and not necessarily on consultations of a clinical practitioner, better documented in the medical literature.

[5] This claim reflects the Eurocentric views of the OIHP, and could be disputed: indeed, the International Sanitary Bureau (nowadays the Pan-American Health Organisation, regional office of WHO for the American continent) was established in 1902 under the International Bureau of the American Republics (nowadays Organisation of American States) –that is five years prior to the OIHP (Pan-American Health Organisation, s.d.)

[6] Renzi (1971, pp. 193-194) even presents evidence that Barrère provided personal financial support to Benito Mussolini.

[7] At the time, the *Commission de l'Opium* was chaired by Swiss representative Henri Carrière and integrated by the ambassadors of Egypt (Dr. Shahin Pacha), British India, and United States.

[8] Strychnine (also known as "rat poison"), arsenous acid (closely-related to arsenic), and products like sodium arsenate, potassium bromide, chloral hydrate, or zinc phosphide, are highly toxic substances, today only used as insecticides, pesticides, or products such as semiconductors.

[9] Parke-Davis had three well-established manufacturing laboratories in the USA, Canada, and the UK. This could suggest that the five preparations found in Egypt were marketed from (or via; and possibly also manufactured at) the facilities and laboratory of the company in Hounslow, UK (Hoefle, 2000 p. 31; Parke, Davis & Co., 1908, 4th cover page; Wellcome Collection, 1927). That all correspondence between the OIHP and Parke-Davis in preparation of the CEP meeting of March 1935 was undertaken either by Pr. James Gunn from London ("Obituary," 1958) or by the representative of the UK at the OIHP (1934b; 1935, p. 162) seem to support that suggestion.

[10] Belgium, Bolivia, British India, Bulgaria, Canada, Chile, Czechoslovakia, Egypt, Ecuador, Greece, Haiti, Hungary, Irish Free State, Italy, Japan, Lettonia, Monaco, Peru, Poland, Rumania, Siam, Sudan, Turkey, Union of South Africa, Venezuela (LoN, 1937, p. 1)

[11] These cigarettes contained Belladonna leaves (0.962 g), nitrate of potash (0.033 g) and very small amounts of Cannabis extract (0.0005 g); they were produced in Paris, France (Fig. 4.D; Agence Bibliographique de l'Enseignement Supérieur, 2021; Preparations exempted…, 1951) and commercialised not only in Europe (France, Germany, Italy, Spain, UK) but as far as Siam (Preparations exempted…, 1951), New Zealand (Phillips, 2013), India (Franco-Indian Pharmaceuticals Pvt. Ltd., 2017), and the United States (Davenport, 1880); they were reportedly marketed from the 1860s (shortly after the landmark publications of O'Shaughnessy and Moreau de Tours, see Frankhauser, 2002) until the mid-20th Century.

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