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Medical Cannabis in Indonesia: Constitutional Restraint, Maqāṣid Al-Sharīa, And A Rights-Compatible Regulatory Pathway

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Abstract

Indonesia's categorical exclusion of Schedule I narcotics from health services has made medical cannabis a test case for the relationship among scientific uncertainty, constitutional health rights, international drug control, and Islamic legal reasoning. This article asks whether the existing prohibition remains normatively defensible and, if reform is justified, what form it should take. Using doctrinal, comparative, and *maqāṣid*-based analysis, it examines Law No. 35 of 2009, the 1961 Single Convention, Constitutional Court Decisions No. 106/PUU-XVIII/2020 and No. 13/PUU-XXII/2024, selected clinical evidence, and regulatory developments in Germany and Thailand. The article makes three claims. First, legal analysis must distinguish the cannabis plant, intoxicating tetrahydrocannabinol, non-intoxicating cannabidiol, and standardized cannabinoid medicines; therapeutic evidence is indication- and product-specific, not a warrant for unrestricted legalization. Second, the Constitutional Court's restraint is institutionally understandable, but its repeated demand for Indonesian research creates a governance obligation that cannot be satisfied by indefinite executive inaction. Third, Islamic doctrines of necessity, proportionality, harm prevention, and *maqāṣid* do not support recreational use, yet can justify tightly supervised therapeutic access where benefit, dosage, and lack of adequate alternatives are clinically established. The article therefore proposes a staged regulatory pathway: research authorization, product-specific assessment, specialist prescribing,

pharmacovigilance, traceability, and periodic review. This approach protects both life and intellect without collapsing medical access into commercial legalization.
KEYWORDS: medical cannabis; Indonesian constitutional law; Islamic law; *maqāṣid al-sharīʿa.*

Introduction

Global cannabis policy no longer fits a simple binary of prohibition and legalization. The 1961 Single Convention on Narcotic Drugs requires parties to limit controlled drugs to medical and scientific purposes, but it does not prohibit those purposes. Its architecture therefore leaves states regulatory space to authorize medicines while suppressing diversion and non-medical supply.[1] In December 2020, the Commission on Narcotic Drugs removed cannabis and cannabis resin from Schedule IV of the Convention while retaining them in Schedule I. The decision acknowledged therapeutic relevance without declaring cannabis harmless or requiring a recreational market.[2]

Indonesia has chosen a more categorical domestic rule. Cannabis and its derivatives remain within Narcotics Category I under Law No. 35 of 2009, and Category I substances may be used for scientific development but not for health services or therapy.[3] This arrangement produces an internal tension. The same statute seeks both to prevent abuse and to ensure the availability of narcotics needed for health and science. Yet its classification rules treat a heterogeneous plant, its intoxicating constituents, non-intoxicating constituents, and standardized finished medicines as though they presented a single risk-benefit profile.

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[1] United Nations, Single Convention on Narcotic Drugs, 1961, as Amended by the 1972 Protocol, 520 UNTS 151, arts. 2(5)(b) and 4(c).

[2] Commission on Narcotic Drugs, "Decision 63/17: Deletion of Cannabis and Cannabis Resin from Schedule IV of the Single Convention on Narcotic Drugs of 1961 as Amended by the 1972 Protocol," December 2, 2020; United Nations Office on Drugs and Crime, "CND Votes on Recommendations for Cannabis and Cannabis-Related Substances," December 2, 2020, https://www.unodc.org/unodc/en/frontpage/2020/December/cnd-votes-on-recommendations-for-cannabis-and-cannabis-related-substances.html.

[3] Indonesia, Law No. 35 of 2009 on Narcotics, State Gazette No. 143 of 2009, elucidation to art. 6(1)(a), art. 8(1), and sch. I.

The consequences are not abstract. The litigation that culminated in Constitutional Court Decision No. 106/PUU-XVIII/2020 arose from families seeking lawful access to cannabinoid-based treatment for children with serious neurological conditions. The record also recalled the prosecution of Fidelis Arie Sudewarto after he cultivated cannabis in an attempt to treat his gravely ill wife.[4] Such cases expose two simultaneous dangers: desperate families may resort to unstandardized and unlawful products, while a purely punitive response can obstruct medical supervision, reliable dosing, and adverse-event monitoring.

The constitutional question is thus narrower than the political slogan "legalize cannabis." It is whether the state may maintain an undifferentiated therapeutic ban while scientific evidence and regulated models exist, and while the Constitution protects access to health services. International human-rights law does not create an automatic entitlement to any requested medicine. It does, however, require health measures to be evidence-based, non-discriminatory, and directed toward available, accessible, acceptable, and good-quality care.[5] A defensible legal regime must therefore explain why a restriction is necessary and proportionate, not merely repeat a statutory classification.

This article advances a calibrated thesis. Indonesia is not legally or ethically compelled to permit home cultivation, smoked cannabis, or commercial recreational supply. It should, however, create a controlled route for research and product-specific therapeutic authorization. The route should begin with recognized indications and pharmaceutical-grade preparations, rather than treating the cannabis plant as a single medicine. This formulation reconciles constitutional prudence, public-health risk management, and the Islamic legal objectives of preserving life and intellect.

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[4] Constitutional Court of the Republic of Indonesia, Decision No. 106/PUU-XVIII/2020, decided July 20, 2022, 3–15, https://www.mkri.id/public/content/persidangan/putusan/putusan_mkri_8588_1658299840.pdf.

[5] United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, August 11, 2000, paras. 12, 30–37.

Data and Method

The study uses normative legal research combining statutory, case-law, conceptual, and comparative approaches. Primary materials comprise the 1945 Constitution, Law No. 35 of 2009, Law No. 8 of 1976 ratifying the 1961 Single Convention as amended, implementing health regulations, the two Constitutional Court judgments, the Convention and the 2020 scheduling decision, and official regulatory materials from Germany and Thailand. Secondary materials include clinical trials, evidence reviews, and works of Islamic jurisprudence and maqāṣid theory.

The method is evaluative rather than merely descriptive. It first identifies the governing rule and the institutional reasons offered for it. It then tests the coherence of those reasons against four criteria: scientific differentiation, constitutional proportionality, consistency with international drug-control obligations, and compatibility with Islamic principles of necessity and harm prevention. The comparative jurisdictions are selected for functional, not transplantational, reasons. Germany illustrates separation between medical regulation and adult non-medical rules; Thailand illustrates the regulatory risks of rapid liberalization followed by renewed medical restriction. Neither system is treated as a template that can be copied wholesale.

The article is bounded in three respects. It does not make individual clinical recommendations, evaluate recreational legalization, or claim that all cannabis-derived products are effective. "Medical cannabis" is used as an umbrella term only where necessary; otherwise, the discussion distinguishes plant material, THC-containing preparations, purified CBD, and registered medicines. This limitation is methodologically important because legal categories should track relevant differences in evidence, intoxication, dosage, and abuse potential.

The Scientific Premise: Product-Specific Evidence, Not Botanical Exceptionalism

Cannabis sativa contains numerous cannabinoids, of which delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) are the most legally salient. THC can produce intoxication and impairment through activity at cannabinoid receptors, whereas CBD is not intoxicating in the same manner. That distinction does not mean CBD is risk-free. Pharmaceutical CBD can

cause somnolence, gastrointestinal effects, drug interactions, and liver-enzyme elevations; its use requires quality control and clinical monitoring.[6] The correct contrast is therefore not "dangerous THC" versus "harmless CBD," but different compounds and preparations with different risk-benefit profiles.

The strongest evidence cited in the Indonesian debate concerns purified oral CBD used as adjunctive therapy for defined severe epilepsies. In a randomized trial involving Dravet syndrome, CBD reduced the median frequency of convulsive seizures more than placebo, although adverse events were common.[7] Trials involving Lennox-Gastaut syndrome likewise reported significant reductions in drop seizures at tested doses.[8] These findings supported regulatory approval of Epidiolex in the United States for seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, and tuberous sclerosis complex in patients aged one year and older.[9]

Evidence for other uses is more variable. A major evidence review found substantial evidence for cannabinoids in chronic pain in adults, chemotherapy-induced nausea and vomiting, and patient-reported multiple-sclerosis spasticity symptoms, but it also emphasized modest effects, heterogeneous products, and major evidence gaps.[10] The World Health Organization's critical review found that pure CBD showed no effects indicative of abuse or dependence potential and had demonstrated efficacy

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[6] U.S. Food and Drug Administration, Epidiolex (Cannabidiol) Oral Solution: Prescribing Information (2025), 1–8, https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/210365s023lbl.pdf.

[7] Orrin Devinsky et al., "Trial of Cannabidiol for Drug-Resistant Seizures in the Dravet Syndrome," New England Journal of Medicine 376, no. 21 (2017): 2011–2020, https://doi.org/10.1056/NEJMoa1611618.

[8] Orrin Devinsky et al., "Effect of Cannabidiol on Drop Seizures in the Lennox–Gastaut Syndrome," New England Journal of Medicine 378, no. 20 (2018): 1888–1897, https://doi.org/10.1056/NEJMoa1714631.

[9] U.S. Food and Drug Administration, "FDA Regulation of Cannabis and Cannabis-Derived Products, Including Cannabidiol (CBD)," updated July 16, 2024, https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd.

[10] National Academies of Sciences, Engineering, and Medicine, The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research (Washington, DC: National Academies Press, 2017), 85–140, https://doi.org/10.17226/24625.

in some epilepsies, while cautioning that cannabis, cannabis extracts, and THC raise distinct control issues.[11]

These findings support a limited legal proposition. The premise in Indonesian law that every Category I cannabis-related substance lacks therapeutic utility is too coarse. They do not establish that raw cannabis is an essential medicine for every claimed condition, nor that home extraction provides equivalent safety and efficacy. The appropriate legal unit of assessment is the product-indication-dose combination. Regulation should be capable of authorizing one standardized preparation for a specific indication while continuing to prohibit unlicensed cultivation, smoking, advertising, and diversion.

Table 1. Legally Relevant Distinctions in Cannabis-Derived Products

Category	Principal concern	Evidence posture	Regulatory implication
Raw plant/flower	Variable potency, combustion risks, diversion	Not interchangeable with a standardized medicine	Prohibit or confine to separately licensed channels
THC-dominant product	Intoxication, impairment, dependence and dose variability	Possible indication-specific benefit; higher control burden	Specialist prescription, dose limits, warnings and monitoring
Purified CBD	Drug interactions, hepatic effects, quality and labeling	Strongest support for specified severe epilepsies	Product registration and indication-specific access
Finished cannabinoid medicine	Adverse effects and pharmacovigilance	Assessed as a defined formulation and dose	Ordinary medicines regulation plus narcotics safeguards where appropriate

Source: Authors' synthesis of the clinical and regulatory materials cited in this section.

[11] World Health Organization, Cannabidiol (CBD): Critical Review Report (Geneva: World Health Organization, 2018), 5–6, 24–25, https://cdn.who.int/media/docs/default-source/controlled-substances/whocbdreportmay2018-2.pdf.

Indonesian Positive Law and the International Drug-Control Framework

Article 28H (1) of the 1945 Constitution recognizes the right to health services, while Article 28H(2) protects special measures needed to obtain equal opportunities and benefits. These provisions operate with the state's duty to protect the public from dangerous substances; neither interest is absolute.[12] The doctrinal task is therefore to determine whether a categorical ban is a proportionate means of protection when narrower controls could address diversion and unsafe use.[13]

Law No. 35 of 2009 classifies narcotics into three categories. The elucidation to article 6(1)(a) defines Category I substances as usable only for scientific development, not therapy, and as having a very high potential to cause dependence. Article 8(1) then bars Category I narcotics from health services.14 Cannabis appears in the Category I schedule without a product-level distinction between THC-rich material and purified CBD. Research is legally possible, but therapeutic delivery cannot follow directly from positive research results without legislative or regulatory reclassification.

The statute's purpose clause complicates a literal reading. Article 4 seeks both to guarantee the availability of narcotics for health services and scientific development and to prevent abuse and illicit trafficking. A teleological interpretation does not erase article 8, but it reveals that controlled medical availability and abuse prevention are coexisting statutory objectives. The legislature's classification choice should consequently remain reviewable when scientific knowledge changes.

International law does not require Indonesia to establish a commercial cannabis market. Article 4(c) of the Single Convention requires production, manufacture, possession, distribution, and use to be limited exclusively to medical and scientific purposes, subject to the Convention. Schedule I control therefore coexists with medical availability. The 2020 deletion from Schedule IV reduced the Convention's expression of exceptional

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[12] Constitution of the Republic of Indonesia of 1945, arts. 28H(1)–(2) and 28J.

[13] Chairul Fahmi, Audia Humairah, and Ayrin Sazwa, 'MODEL OF LEGAL DISPUTE RESOLUTION FOR BUSINESS CONTRACT DEFAULT', *JURISTA: Jurnal Hukum Dan Keadilan* 7, no. 2 (December 2023): 242–63, https://doi.org/10.22373/JURISTA.V7I2.228.

[14] Indonesia, Law No. 35 of 2009, elucidation to art. 6(1)(a) and art. 8(1).

dangerousness but retained Schedule I controls.[15] The domestic question is not whether the international decision self-executes as a national medicine authorization; it is whether Indonesia can continue to cite the Convention as though the treaty forbade medical use.

Implementing regulations demonstrate both possibility and fragmentation. Minister of Health Regulation No. 16 of 2022 provides a procedure for production or use of narcotics for scientific and technological development, while Minister of Health Regulation No. 5 of 2023 addresses narcotics, psychotropics, and pharmaceutical precursors.[16] The 2024 litigation record nevertheless showed institutional disagreement over mandates, research priorities, and whether existing rules adequately implemented the Court's call for cannabis-specific study. Formal permission to research is not the same as a funded, coordinated, ethically approved, and clinically actionable research pathway.

Constitutional Adjudication: Restraint and the Problem of an Unfulfilled Research Mandate

Decision No. 106/PUU-XVIII/2020

The petitioners challenged the elucidation of article 6(1)(a) and article 8(1) of Law No. 35 of 2009. They sought a reading that would permit Category I narcotics to be used for health services or therapy, particularly where children with serious neurological conditions had exhausted conventional options. The Court rejected the petition in July 2022.[17]

The Court's central reasoning was evidentiary and institutional. It accepted that some countries lawfully use narcotics in health services but declined to generalize those choices to Indonesia, given differences in legal culture, infrastructure, supervision, and abuse risk. It considered domestic, comprehensive scientific study necessary before changing the use of Category I substances. The Court also emphasized that classification and the

[15] United Nations, Single Convention, arts. 2 and 4(c); Commission on Narcotic Drugs, "Decision 63/17."

[16] Indonesia, Ministry of Health Regulation No. 16 of 2022 on Procedures for the Production and/or Use of Narcotics for the Development of Science and Technology; Indonesia, Ministry of Health Regulation No. 5 of 2023 on Narcotics, Psychotropics, and Pharmaceutical Precursors.

[17] Constitutional Court, Decision No. 106/PUU-XVIII/2020, 173–181.

design of safeguards were matters requiring legislative and executive capacity.[18]

This is best characterized as judicial restraint rather than a judicial finding that cannabinoids have no medical value. The Court did not construct a medical-access exception itself. Instead, it urged the Government to undertake comprehensive scientific assessment and stated that the results could guide lawmakers in changing policy.[19] The distinction matters: rejection preserved the statute, while the reasoning made continued policy inertia increasingly difficult to justify.

Decision No. 13/PUU-XXII/2024

The later petition challenged article 1(2) of Law No. 8 of 1976, which ratified the 1961 Convention as amended. In March 2024, the Court again rejected the application and applied its earlier reasoning mutatis mutandis. It noted Indonesia's opposition to the WHO scheduling recommendation and stated that the 2020 international development did not oblige Indonesia to legalize medical cannabis.[20]

The result is defensible insofar as a scheduling decision does not itself approve a finished medicine or dictate a domestic delivery system. Some of the Court's treaty language, however, should be read carefully. The Commission's scheduling decision was not a separate treaty for Indonesia to "ratify," and removal from Schedule IV did not remove cannabis from international control. The legally relevant point is that the Convention reserves controlled substances for medical and scientific purposes; it leaves parties discretion over the means of domestic control. National sovereignty supports strict regulation, but it does not convert an internationally permitted medical purpose into an internationally prohibited one.

More significantly, the Court expressly repeated that the government should immediately conduct a specific, deep, and comprehensive study of medical cannabis and use it as a reference for legislative reform.[21] By 2024,

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[18] Ibid., 172–176.

[19] Ibid., 175–176.

[20] Constitutional Court of the Republic of Indonesia, Decision No. 13/PUU-XXII/2024, decided March 5, 2024, pronounced March 20, 2024, 97–103, https://mkri.id/public/content/persidangan/putusan/putusan_mkri_9695_1710906677.pdf.

[21] Ibid., 100–101.

the absence of the research requested in 2022 had become part of the reason for refusing relief again. This creates a circularity problem: access is denied for want of domestic evidence, yet the state does not build the institutional pathway capable of producing that evidence.

From Judicial Restraint to a Duty of Reasoned Follow-Through

Courts are legitimately cautious about designing drug formularies. Product registration, clinical protocols, prescriber qualifications, supply security, and pharmacovigilance require administrative expertise. But deference is not a license for indefinite non-decision. Once the Court has twice identified research as the rational bridge between prohibition and possible access, executive agencies should specify the responsible institution, timetable, priority indications, ethical review process, funding source, and publication obligation.

A rights-compatible response should also avoid a false choice between immediate legalization and permanent prohibition. The state can authorize imports of reference products for trials, license a small number of public or accredited research sites, and permit compassionate or expanded access only after predefined safety thresholds are met. Judicial restraint is strongest when paired with administrative action; without that action, restraint risks becoming a mechanism by which evidentiary uncertainty perpetuates itself.[22]

Islamic Legal Reasoning: Intoxication, Necessity, and Maqāṣid

The Prohibition of Intoxication and the Scope of Analogy

The Qur'an does not name cannabis. Classical and contemporary jurists reason from the prohibition of khamr and from the effective cause of intoxication. Qur'an 5:90–91 condemns intoxicants because of their social and spiritual harms, while the Prophetic maxim states that every intoxicant is khamr and every khamr is forbidden.[23] The prohibition therefore extends

[22] Muhammad Siddiq Armia et al., 'Legal Transformations in Governance, Security and Technology', *PETITA* 10 (2025): i.

[23] Qur'an 5:90–91; Ṣaḥīḥ Muslim, kitāb al-ashriba, hadith no. 2003.

through analogy to the recreational use of psychoactive cannabis that impairs intellect.

The analogy must nonetheless track its effective cause. A standardized preparation that does not intoxicate cannot be analyzed solely by attaching the moral history of recreational cannabis to its botanical source. Nor does the absence of intoxication automatically establish permissibility: toxicity, unlawful acquisition, deception, and avoidable harm remain relevant. Islamic analysis, like sound medicines regulation, is product-, dose-, purpose-, and context-sensitive.

Necessity, Medical Need, and Proportionality

Islamic law recognizes that necessity can alter the application of a prohibition. Qur'an 2:173 permits otherwise forbidden consumption where a person is compelled, does not desire the prohibited thing for its own sake, and does not exceed the limit.[24] Jurists developed this into the maxim *al-ḍarūrāt tubīḥ al-maḥẓūrāt* (necessities permit prohibitions), paired with *al-ḍarūra tuqaddar bi-qadrihā* (necessity is measured according to its extent).[25]

The paired maxims prevent "necessity" from becoming an unrestricted exception. Therapeutic use should require a serious condition, a credible expectation of benefit, the absence or failure of reasonably available lawful alternatives, prescription by a qualified clinician, pharmaceutical quality, and a dose no greater than needed. Classical discussions of treatment with impure or forbidden substances differ across schools, but they commonly give legal significance to necessity, expert judgment, and the absence of an adequate alternative.[26]

This framework supports neither self-medication nor the claim that every chronic illness creates *ḍarūra*. It supports a tiered concept. Life-threatening or severely disabling conditions with strong evidence may satisfy necessity; other conditions may be assessed through *ḥāja* (pressing need) and

[24] Qur'an 2:173; see also Qur'an 5:3, 6:119, and 16:115.

[25] Jalāl al-Dīn al-Suyūṭī, Al-Ashbāh wa-l-Naẓāʾir fī Qawāʿid wa-Furūʿ Fiqh al-Shāfiʿiyya (Beirut: Dār al-Kutub al-ʿIlmiyya, 1990), 84–85.

[26] Muwaffaq al-Dīn Ibn Qudāma, Al-Mughnī (Cairo: Maktabat al-Qāhira, 1968), 9:338–42. Juristic conclusions depend on the substance, necessity, available alternatives, and reliable medical advice.

ordinary benefit-risk analysis. The legal consequence should correspond to the level of need and evidence.

Maqāṣid, Sadd al-Dharāʾiʿ, and Fath al-Dharāʾiʿ

Maqāṣid al-sharīʿa frames law through the protection of religion, life, intellect, lineage, and property. Classical theory treats these necessities as an integrated order, while contemporary accounts emphasize systems, multidimensional welfare, and the avoidance of reductionist conflict.[27] Medical cannabis is often presented as a clash between preservation of life (ḥifẓ al-nafs) and preservation of intellect (ḥifẓ al-ʿaql). That description is incomplete. Intoxicating, uncontrolled use can threaten intellect, but effective treatment of severe seizures may protect both life and neurological function.

The doctrines of blocking and opening the means provide a governance vocabulary. Sadd al-dharāʾiʿ supports closing pathways likely to facilitate diversion, youth access, impaired driving, and commercial normalization. Fath al-dharāʾiʿ supports opening a controlled pathway that is necessary to achieve a recognized benefit.[28] A proportionate synthesis is not blanket permission. It is a licensed chain with secure cultivation or import, validated manufacture, named prescribers, patient registration, dispensing records, adverse-event reporting, and criminal sanctions for leakage.

Indonesia's religious institutions can contribute to this design, but their positions should not be overstated. MPU Aceh's 2012 guidance strongly condemns narcotics abuse and calls for tighter control; it is not, by itself, a detailed medical-cannabis authorization.[29] The more defensible Islamic case therefore rests on general jurisprudential principles applied through verified medical evidence, not on attributing a specific permissive fatwa where the

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[27] Abū Isḥāq al-Shāṭibī, Al-Muwāfaqāt fī Uṣūl al-Sharīʿa, ed. Abū ʿUbayda Mashhūr ibn Ḥasan Āl Salmān (Al-Khubar: Dār Ibn ʿAffān, 1997), 2:17–25; Muḥammad al-Ṭāhir Ibn ʿĀshūr, Treatise on Maqasid al-Shariah, trans. Mohamed El-Tahir El-Mesawi (London: International Institute of Islamic Thought, 2006), 91–125; Jasser Auda, Maqasid al-Shariah as Philosophy of Islamic Law: A Systems Approach (London: International Institute of Islamic Thought, 2008), 1–25.

[28] Shihāb al-Dīn al-Qarāfī, Al-Furūq (Beirut: ʿĀlam al-Kutub, n.d.), 2:32–33.

[29] Majelis Permusyawaratan Ulama Aceh, "Taushiyah No. 11 of 2012 on Narcotics," July 13, 2022, https://mpu.acehprov.go.id/berita/kategori/taushiyah-taushiyah-mpu-aceh/taushiyah-mpu-aceh-nomor-11-tahun-2012-tentang-narkoba.

authoritative text does not clearly contain one. A future fatwa could usefully define evidentiary thresholds, physician responsibility, dose limits, and the distinction between treatment and intoxication.

Comparative Regulatory Lessons

Germany: Separate Medical and Non-Medical Channels

Germany permitted medical cannabis by prescription before its 2024 Cannabis Act. The 2024 reform created distinct statutes for consumer cannabis and medical cannabis. Private possession, home cultivation, and non-commercial cultivation associations belong to the consumer framework; they should not be presented as the medical distribution model.[30] Medical supply remains governed by prescribing, pharmacy, quality, and reimbursement rules.

The German lesson for Indonesia is institutional separation. Rules intended to reduce criminalization of adult possession need not determine rules for medicines. Indonesia can consider therapeutic access without adopting home cultivation or associations. It can also preserve tighter controls for THC-containing flower than for a registered, purified CBD medicine. Germany further shows that liberalization can generate new concerns—such as remote prescribing and rising demand—that prompt later tightening. Regulation must remain reviewable.[31]

Thailand: Innovation, Market Expansion, and Regulatory Retrenchment

Thailand authorized medical cannabis in 2019 and removed many cannabises plant parts from narcotics control in 2022, producing rapid market expansion and persistent uncertainty about the boundary between medical and non-medical use. More recent controls have re-emphasized medical justification; the official controlled-herb prescription form limits an

[30] Federal Ministry of Health (Germany), "Cannabisgesetz (CanG)," accessed July 27, 2026, https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/cannabisgesetz.

[31] Federal Ministry of Health (Germany), "Gesetz zur Änderung des Medizinal-Cannabisgesetzes," accessed July 27, 2026, https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/aenderung-medizinal-cannabisgesetzes.

issuance to thirty days and requires the diagnosis to match approved treatment guidelines.[32]

Thailand's experience cautions against deregulating the plant first and attempting to reconstruct a medical system afterward. The relevant lesson is not that reform failed, but that sequencing matters. Clinical indications, licensed professions, product standards, advertising restrictions, inspection capacity, and data systems should precede broad supply. A tightly bounded Indonesian research and medicines pathway would avoid importing the instability of a fast-moving retail market.

Table 2. Comparative Lessons for Indonesian Reform

Jurisdiction	Regulatory feature	Principal risk	Transferable lesson
Germany	Separate medical-cannabis and consumer-cannabis statutes	Conflating adult-use associations with pharmacy access	Create an independent medical channel with prescription and quality controls
Thailand	Medical authorization followed by broad decontrol and later medical re-tightening	Retail expansion outpacing clinical and enforcement capacity	Fix indications, licensing, data, and inspection before scaling supply
Indonesia	Category I research allowed; therapeutic use barred	Circular lack of domestic evidence and informal patient access	Build a staged research-to-registration pathway under existing health institutions

[32] Thailand, Department of Thai Traditional and Alternative Medicine, Prescription for Controlled Herb (Cannabis) (2025), notes 1–3, https://herbctrl.dtam.moph.go.th/uploadAtt/cms/1752737186/ใบสั่งจ่ายสมุนไพรควบคุม%20ภาษาอังกฤษ%20OIC.pdf.

Staged Regulatory Model for Indonesia

The proposed model is deliberately narrower than a medical cannabis special economic zone. A geographically isolated cultivation area may appear secure, but geography cannot substitute for product regulation, ethical review, clinical protocols, and electronic traceability. Nor should economic development become the primary justification before therapeutic need and institutional capacity are established. The first objective is a lawful evidence-and-access pathway.[33]

Stage one should create a national research protocol by joint ministerial decision or a presidentially mandated task force. The protocol should name the Ministry of Health as clinical lead; BPOM as the authority for product quality, trial authorization, and pharmacovigilance; BRIN and accredited universities as research partners; and BNN and the police as security and diversion-control partners. Publicly stated priorities should begin with conditions for which standardized products have the strongest evidence, including specified treatment-resistant epilepsies.

Stage two should authorize pharmaceutical reference products and validated investigational products. Domestic cultivation is not a necessary precondition; lawful import for trials may reduce the time and quality uncertainty involved in developing a botanical supply chain. If cultivation is later authorized, licenses should specify genetics, cannabinoid profiles, pesticide limits, good agricultural practice, secure transport, destruction of waste, and inventory reconciliation.

Stage three should establish a conditional medical-access route after predefined evidence thresholds are met. Access should be restricted to named indications, registered specialists, informed consent, patient registries, pharmacy dispensing, maximum prescription periods, and mandatory reporting of outcomes and adverse events. Product labels should state THC and CBD content, dose, contraindications, interaction risks, and driving restrictions. Advertising to the public should be prohibited.

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[33] Chairul Fahmi, 'The Impact of Regulation on Islamic Financial Institutions Toward the Monopolistic Practices in the Banking Industrial in Aceh, Indonesia', *Jurnal Ilmiah Peuradeun* 11, no. 2 (May 2023): 2, https://doi.org/10.26811/peuradeun.v11i2.923.

Stage four should provide legislative review. Parliament should amend the law only to the extent necessary to permit product-specific medical scheduling or an exception for registered cannabinoid medicines. A formulation-based approach is preferable to removing the entire cannabis plant from Category I. It permits differentiated control: purified CBD medicines may be regulated differently from high-THC flower, while unauthorized cultivation and diversion remain criminal offenses.[34]

Finally, reform should include sunset and evaluation clauses. Independent review after three to five years should assess patient outcomes, diversion, prescribing patterns, adverse events, enforcement costs, and equity of access. The government should publish aggregate data. This turns uncertainty into a reason for structured learning rather than a justification for permanent paralysis.

The integrated analysis reveals substantial convergence among constitutional law, public health, international drug control, and Islamic jurisprudence. None requires unregulated availability. Each permits or favors proportionate differentiation. Constitutional rights require reasoned access and equality but allow risk controls. The Single Convention permits medical and scientific use while requiring control. Clinical evidence supports selected products and indications rather than a botanical cure-all. Islamic law prohibits intoxication yet recognizes necessity, proportionality, expertise, and removal of harm.[35]

The principal weakness of Indonesia's present regime is therefore not simply severity. It is over-inclusiveness combined with administrative underdevelopment. The law places unlike products in one category, while the research system has not converted formal permission into a clear program. This produces three avoidable harms: patients may turn to black-market or homemade products; clinicians cannot supervise use openly; and policymakers remain dependent on the very absence of domestic evidence that government inaction helps sustain.

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[34] Rozatul Fadilla Azza, Chairul Fahmi, and Riza Afrian Mustaqim, 'LEGAL PROTECTION FOR LOCAL PRODUCTS IN ASEAN MARKET LIBERALISM: A Legal Analysis and Fiqh Muamalah Perspective', *Al-Mudharabah: Jurnal Ekonomi Dan Keuangan Syariah* 7, no. 1 (January 2026): 128–51, https://doi.org/10.22373/al-mudharabah.v7i1.9675.

[35] Chairul Fahmi and Syarifah Riyani, 'ISLAMIC ECONOMIC ANALYSIS OF THE ACEH SPECIAL AUTONOMY FUND MANAGEMENT', *Wahana Akademika: Jurnal Studi Islam Dan Sosial* 11, no. 1 (July 2024): 1, https://doi.org/10.21580/wa.v11i1.20007.

The proposed solution is neither judicially imposed legalization nor laissez-faire commercialization. It is institution-building. The Constitutional Court's insistence on research can be respected while being made operational. The maqāṣid framework can inform safeguards rather than functioning as a rhetorical endorsement. Comparative experience can supply design lessons without obscuring Indonesia's legal culture and enforcement constraints.

Conclusion

Indonesia's medical-cannabis debate should be reframed from a binary struggle over legalization into a question of differentiated, evidence-based medicines governance. The available evidence does not justify unrestricted access to cannabis, but it does undermine the proposition that every cannabis-derived preparation lacks therapeutic value. Law No. 35 of 2009 can no longer be evaluated adequately without distinguishing raw plant material, THC-containing preparations, purified CBD, and registered finished medicines.

The Constitutional Court properly recognized that it lacks the institutional capacity to design a complete regulatory system. Its 2022 and 2024 judgments nevertheless imposed a clear normative expectation: government should produce the specific, deep, and comprehensive research needed for a reasoned legislative choice. Repeated reliance on the absence of domestic research, without a credible plan to conduct it, weakens the proportionality of the status quo.

Islamic legal reasoning reinforces a controlled pathway. The prohibition of intoxication protects intellect; the doctrines of necessity and measured exception protect life; and the opening and blocking of means require institutions capable of permitting benefit while preventing diversion. These principles converge in a staged model based on research authorization, product-specific approval, specialist prescribing, traceability, pharmacovigilance, and periodic review.

The immediate reform priority is therefore not a cannabis industry. It is a legally accountable research-to-access pathway for standardized medicines. Such a pathway would preserve Indonesia's legitimate commitment to drug control while ensuring that uncertainty is investigated, patients are not driven

outside medical supervision, and the constitutional promise of health protection is implemented through evidence rather than indefinitely postponed by its absence.

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