



## Summary of the CEDD regional report

This document is a summary of the report *Cannabis in Latin America:  
The Green Wave and Challenges for Regulation*

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## Introduction

The Americas are at the forefront of processes and efforts to reform cannabis-related laws and policies. The regulated markets established in Uruguay and Canada will very likely be joined soon by Mexico, where President Andrés Manuel López Obrador has backed a legislative proposal that, at the time of this writing, was being considered in the legislature. In the United States, ten states and the District of Columbia have adopted legal, regulated markets for recreational use. Also at the time this report was being finalized, a bill was being presented before Colombia's Congress to reform Article 49 of the Constitution with regard to the prohibition of narcotic substances, with a view to paving the legal way for future regulation. In 2018, the Regional Commission on Marijuana of the Caribbean Community (CARICOM) concluded that the prohibitionist system "is not fit for purpose" with regard to international drug control treaties, and it called for a paradigm shift.

At the same time, medical marijuana is growing by leaps and bounds. In the United States, 33 of its 50 states along with the District of Columbia permit the medical use of cannabis, while in Canada this use has been legal since 2001. In Latin America, some form of medical marijuana is allowed in Argentina, Brazil, Chile, Colombia, Mexico, Paraguay, Peru and Uruguay. As this publication was being finalized, Ecuador's National Assembly was concluding a debate on a legislative proposal that would create the means of access to medical marijuana in that country. However, it is important

to note that in the majority of these countries, reforms are quite limited and do not ensure access for all people who could benefit from medical marijuana.

In addition, more tolerant attitudes toward cannabis do not necessarily translate into public support for broader drug policy reform. In the majority of Latin American countries, a change in the discourse has not led to significant domestic policy reforms. At the Organization of American States (OAS) and the United Nations (UN), Latin American countries have spearheaded efforts to promote debate about the failure of the prohibitionist paradigm and the need to explore alternative approaches. However, as tends to happen, this rhetoric has not been matched by concrete actions. In other words, drug policy reforms in the region have been minimal despite the tremendous societal costs of current policies, and governments continue to rely on repression and criminalization.

That is why, for people in countries where there are still no legal markets, the consequences of being caught with any amount of cannabis can be severe. Previous studies by the Research Consortium on Drugs and the Law (*Colectivo de Estudios Drogas y Derecho*, CEDD) have shown that throughout the region, people who consume cannabis face stigmatization and harassment by police, and they are often detained for growing plants or for simple possession of the substance. In several of the countries studied, people who use cannabis constitute a significant percentage of those impacted by drug laws. Many of them end up being subjected to the criminal justice system and, on occasion, they are referred to compulsory (or semi-compulsory) treatment, even when they do not show signs of a drug dependency. In several countries, “drug court” models are making headway, which repeat the logic of using the criminal justice system to refer people who use drugs to treatment programs. To sum up, harsh and disproportionate cannabis-related laws in the region cause significant harm to people, their families, their communities, and to society in general.

This disconnect between the trend toward regulating cannabis in the Americas, on the one hand, and the continuation of a punitive approach in nearly all Latin American countries, on the other, led CEDD to undertake its current research, which analyzes the way

in which punitive drug laws disproportionately affect people who use, grow, and sell small amounts of cannabis.

Cannabis is also the most widely used substance declared to be illicit in Latin America. Its medical uses are beneficial, and its problematic use causes less harm than other drugs, licit or illicit. Therefore, it is the only substance for which there is an impetus for reform. The expansion of legal and regulated marijuana markets would have a significant impact on reducing the damage caused by repressive drug policies, and we hope that this research contributes to that aim.

## 1. Methodology

This document is based on the report *Cannabis in Latin America: The Green Wave and Challenges for Regulation*, written by Alejandro Corda, Ernesto Cortés and Diego Piñol Arriagada, with support from Isabel Pereira Arana and Coletta Youngers. The long version of the report is based on studies carried out between 2017 and 2018 by researchers in 11 countries: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, Peru, Uruguay and Venezuela. Each researcher drew from statistical information, official, secondary sources, and interviews with key actors.

It is important to highlight that the lack of disaggregated data by type of offense and substance – meaning the lack of specific data on cannabis – posed a challenge to this research. In addition, there are great gaps in information and knowledge regarding marijuana markets and their dynamics. The majority of official information does not disaggregate by substance, but instead presents everything under the generic term of “drugs” or “narcotics,” which means those official figures say little about cannabis in particular. With regard to research, there are major holes regarding cultivation dynamics and the socioeconomic situation of grower families, as well as a lack of knowledge about the way in which illicit urban markets function and about the demands and operating mechanisms of pro-cannabis social movements (among other gaps that we seek to address to some extent in this report).

As in all its prior research studies, CEDD calls on States to improve and expand data systems on criminal justice matters and the health system, and to ensure that policy makers and members of the pub-

lic can have timely access to this information. That is crucial for being able to design, implement and evaluate public policies.

With regard to terminology, in this text we use the term marijuana to refer to cannabis seeds, fibers, leaves and flowers, as well as to the plant itself. Although some texts distinguish between cannabis (genus) and marijuana (species), in general that distinction is not made. To avoid confusion, in this document we use the terms cannabis and marijuana interchangeably. It is also important to note that the word marijuana has racist roots in the United States, where it was used to stigmatize Mexican immigrants. In no way do we want to reinforce this extremely negative stereotype. However, given that this word is very commonly used in the region, especially with regard to medical marijuana, and that it is also used as a form of identity by the pro-cannabis movement itself, we have opted to use it in this text.

## **2. Cannabis in the international drug control treaties**

The first cannabis prohibitions were developed in the 1920s in conjunction with the creation of the current international drug control system, which did not initially include cannabis. That incorporation came later, in 1925, with the signing of the International Opium Convention of Geneva, giving impetus to prohibition efforts. The controls were limited to restrictions on international trade, and they did not obligate States to pass domestic laws to control access to it or restrict its use. Nonetheless, various governments in the region – for example, Argentina, Brazil and Colombia – followed in the steps of the United States and some European countries by taking stances against cannabis even before it was prohibited on an international level.

The change came in 1961, with the approval of the Single Convention on Narcotic Drugs (and the 1972 Protocol, which strengthened its legal framework). As explained in our first report from 2010, *Systems Overload: Drug Laws and Prisons in Latin America*, this convention “codified all existing multilateral drug control treaties and extended the existing control systems to include the cultivation of plants grown as raw material to produce drugs” (TNI and WOLA, 2010). Thus, it obligates signatory States to limit the pro-

duction, manufacturing, exportation, importation, distribution, trade, use and possession of narcotics to strictly medical and scientific purposes.

Under the Single Convention on Narcotic Drugs, cannabis and heroin were classified in Schedules I and IV – the treaty’s strictest categories, which include substances considered to be the most addictive, susceptible to improper use and/or used as a gateway for other drugs. Schedule IV of the 1961 Convention includes a subgroup of substances from Schedule I that are considered to have little or no value for therapeutic or medical purposes.

According to the Single Convention, “‘Cannabis’ means the flowering or fruiting tops of the cannabis plant (excluding the seeds and leaves when not accompanied by the tops) from which the resin has not been extracted, by whatever name they may be designated.” Also, it is important to note that the control system does not include non-psychoactive cannabis (hemp) used exclusively for horticultural or industrial purposes (fibers and seeds).

The second phase of the prohibitionist regime with regard to cannabis began with the adoption of the 1971 Convention on Psychotropic Substances, which created four levels of controls. THC (tetrahydrocannabinol, its best-known phytocannabinoid at that time) ended up receiving less rigorous treatment than the plant species that contains it (cannabis). Even dronabinol – a synthetic form of THC produced by the pharmaceutical industry or which can be found naturally in the cannabis plant – which was on the same schedule as cannabis at first, was eventually reclassified and put on a schedule with fewer controls due to industry pressure (Bewley-Taylor, Blickman and Jelsma, 2014).

Finally, the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances calls on States to take measures to classify the possession, purchase or cultivation of narcotics or psychotropic substances for personal use as a criminal offense. However, this is subject to compliance with countries’ constitutional and national legal principles. It is therefore important to stress that the Convention does not require the criminalization of use (TNI and WOLA, 2010).

Of particular importance, cannabis's inclusion in the international drug control treaties was not based on scientifically validated evidence – not even by the scientific research standards of the time. On the contrary, cannabis was scheduled without a proper evaluation by the World Health Organization (WHO), which is the entity in charge of recommending the scheduling of substances. It was not until 2018 that the WHO's Expert Committee on Drug Dependence (ECDD) dedicate a special meeting to reviewing scientific evidence related to cannabis.<sup>1</sup>

Thus, the three major UN drug conventions promoted harsher penalties for drug offenses on a global level. They obligated States to adapt national legislation criminalizing all aspects of illicit drug markets, and in Latin America in particular, national laws often went beyond what was required by the treaties. Although the medical and scientific use of cannabis was permitted under the conventions, few countries took advantage of this possibility.

Despite being subjected to a prohibitionist framework, cannabis is considered to be the most widely used “illegal” drug worldwide, although it is used less than alcohol or tobacco. According to the United Nations Office on Drugs and Crime (UNODC) in its *World Drug Report 2018*, 192.2 million people used cannabis at least once in 2016 (which represents a sustained increase in the decade prior to that), as compared to 34 million people who used opioids and 18 million who used cocaine (UNODC, 2018b). The medical use of cannabis, according to the International Narcotics Control Board (INCB), has also increased significantly. In 2018, it reported that “since 2000, more and more countries have started to use cannabis and cannabis extracts for medical purposes, as well as for scientific research. In 2000, total licit production was 1.4 tons; by 2017, it had increased to 406.1 tons” (INCB, 2018, p.44).

### **3. Possibilities for reforming the international treaties**

Today the international conventions are not in tune with the changing attitudes and trends regarding marijuana. A significant bloc of countries continues to be firmly opposed to any reform of the international drug control conventions, so reaching a new global consensus to review or amend them to accommodate cannabis

1. For a detailed analysis of the process and results of the critical review of the WHO's Expert Committee, see *The WHO's First-Ever “Critical Review” of Cannabis: A Mixture of Obvious Recommendations Deserving Support and Dubious Methods and Outcomes Requiring Scrutiny*, available at: <https://www.wola.org/analysis/policy-brief-whos-first-ever-critical-review-cannabis/>

regulation does not seem to be a viable option in the near future. In the meantime, countries that want to adopt legal and regulated markets, while ensuring that such reforms are aligned with their obligations under the international treaties, have limited but real options based on treaty procedures and international law. States could opt to unilaterally withdraw from the drug treaties and try to re-adhere to them with new reservations related to cannabis (this is the path that Bolivia successfully took with regard to coca leaves). Alternately, a group of like-minded States could reach an agreement that diverges from what the conventions establish on cannabis to govern their mutual relations, without halting compliance with their obligations vis-à-vis other signatory countries. This option, known as an *inter se* agreement, is contemplated in Article 41 of the Vienna Convention on the Law of Treaties as one of the ways to modify these instruments. It would allow countries to build a platform for regulating cannabis that more countries could join over time, thereby promoting progressive reform at a country level, but without undermining international law (Jelsma *et al.*, 2018).

## The history of cannabis in Latin America

Despite the fact that cannabis is at the center of the regional debate on drug policy reform, the history of its arrival and development in Latin America is not well known. For example, many of the uses that cannabis had in these countries in the past have been forgotten. This includes the varied uses it had amid the distinct waves of immigration to the Americas starting in the 16th century, its inclusion in medicine and pharmacology between the late 19th and early 20th centuries, and the industrial uses that endured from colonial times to recent years.

The cannabis plant's arrival in Latin America appears to have occurred during the colonial era. The kings of Spain promoted the development of flax and hemp cultivation in the country's colonies. The highly resistant hemp fibers were strategically used primarily in the production of cloth and rope for sailing purposes.

In 1545, King Carlos I of Spain enacted Law 20 – title 18 – of the IV book of the Indies, whereby he ordered that the viceroys and governors of the country's colonial territories cultivate flax and hemp.

Hemp was also included in the Royal Order signed by Carlos III in 1779, via which ports in the Americas were authorized to trade various products with Spain and Portugal. Some years later, in 1796, King Carlos IV issued another such order so that lands would be granted to “any liege” who wanted to cultivate flax and hemp, in order to promote these crops (Soriano, 2017).

According to Schultes and Hofmann (1982), hemp appears to have been introduced in Chile in 1545 and in Peru in 1554. Chile was an important producer in the colonial period. By 1558, a factory producing blankets and riggings had already been established; and in 1645, batches with 27,300 quintals were being exported to Spain. As ports were expanded, Chile appears to have become the main producer of seeds as well as sails for the Spanish Empire’s ships (Rivas, 2013). Also, starting in the mid-16th century, hemp was cultivated in Mexico, though little was known about its uses in other countries at that time (Campos, 2012).

In Argentina, the main hemp cultivations appeared in the 20th century. Yet much earlier, one of the country’s founding fathers and the creator of the national flag, Manuel Belgrano, had written journal entries in which he promoted and explained the way to grow hemp, as a form of generating wealth (Soriano, 2017). Meanwhile, in Costa Rica, a tax on importing it was imposed in 1865, while the first authorization of hemp production was issued in 1907 (Carter, 1980).

The plant also arrived in the Americas, in the colonial era, through the slaves that arrived from west African when the slave markets began functioning in the early 16th century in Brazil, Uruguay and Argentina. “Pango” or “pito de pango” was how the populations arriving from western Africa referred to smoking cannabis in a pipe. Both these and other names (such as “diamba” and “maconha”) come from the *ambundu* and *kimbundu* languages that still live on in regions of Angola and Congo (Bewley-Taylor, Blickman and Jelsma, 2014; Soriano, 2017).

2. “Candombe” is the name of different expressions (including music, dance and cultural and religious components) developed by the various peoples of western Africa who were brought as slaves to Argentina, Brazil and Uruguay in the colonial era.

Various accounts from the 19th century mention that the Afro-descendant population in these countries had the custom of smoking “pango” as medicine and while working or participating in religious or festive activities; in the latter case, the custom was linked to the cultural phenomenon known as “candombe.”<sup>2</sup> In Brazil, during

much of the 19th century, distinct city councils prohibited the sale and use of “pito de pango,” although it is not clear how much this was enforced. The first to do so was Rio de Janeiro in 1830, followed by others such as Caxias in 1846, São Luís in 1866, Santos in 1870 and Campinas in 1876 (Bewley-Taylor *et al.*, 2014; Soriano, 2017). However, in Uruguay and Argentina, that custom was tolerated as part of the culture of those populations, although by the end of the 19th century, it seemed to have vanished (Soriano, 2017).

In Central America and the Caribbean, some Asian migrations brought cannabis among their customs. In the second half of the 19th century, this occurred in the British colonies of Guyana, Trinidad and Jamaica (Allsopp, 2016). A similar phenomenon was seen around that same time, until the beginning of the 20th century, with other waves of migration of Caribbean people, Afro-descendants and Asians to work on the Panama Canal and Central American banana plantations. In Costa Rica, cannabis appears to have arrived with soldiers who participated in World War I and who spent some time in Mexico (Carter, 1980).

Cannabis was used as part of the remedies that pharmacies offered between the late 19th century and the first decades of the 20th century. For example, in Mexico, cannabis was included on the official list of medical substances for pharmacies and drugstores that was in force starting in 1892, and it was mentioned in a manual used in medicine, chemistry and pharmacology until the 1941 edition (Vargas, 2017).

With the arrival of the 20th century and the creation of the current international drug control system, the region’s countries began passing legislation to limit the use of cannabis to “medical and scientific” purposes, or to prohibit it outright. First, controls and administrative sanctions were developed to regulate the importation, distribution and sales (records, prescriptions). Later, criminal legislation began to be developed that established prison terms for those involved in trafficking. With regard to users, the policy was generally to refer people to treatment, although not always through the criminal justice system.

In some Latin American countries, in line with the evolution of the international framework, cannabis prohibitions were established

after bans on the derivatives of opium and cocaine. After the Single Convention on Narcotic Drugs of 1961 treated cannabis the same as other “narcotics,” cannabis-related behavior was sanctioned with increasingly harsh penalties.

In sum, the history of cannabis in Latin America goes far beyond its prohibition since the early decades of the 20th century. Starting in the 16th century, the Spanish promoted the industrial cultivation of cannabis. At this time, it also appears to have arrived along with the slaves coming from Africa, and then again later, with the waves of migration coming from Asia. Between the 19th and early 20th centuries, it was even part of the pharmaceutical industry’s repertoire. Today, the criminalization of cannabis and the behavior associated with it is the norm in the region, with different manifestations that include administrative and criminal sanctions. With the exception of the atypical case of Uruguay, people who use drugs in Latin America run the risk of having the law catch up with them.

## Measuring cannabis use

The data provided by the UNODC (UNODC, 2018b) for 2016<sup>3</sup> points to a total of 192.2 million people worldwide who say they have used cannabis at least once during the last year, a figure that marks a 16% increase from a decade earlier. Taking a broad view, use varies significantly between countries and continents, with each region having at least one country in which consumption levels were around 20% in the last year.

By region, average cannabis use in the last year ranges from 1.9% in Asia to 11% in Oceania, with the highest figure seen in Micronesia at 16.6%, mainly due to high use in Palau (UNODC, 2018b). In this context, the Americas region has an annual prevalence of cannabis use of around 8%, with North American countries showing the highest average use at 12.9%. Although the average in South America is around 3.9% and in Central America 2.8%, the differences between countries are quite significant. Nonetheless, the region of the Americas has neither more cannabis users nor higher rates of annual prevalence<sup>4</sup> than other regions in the world.

The levels of prevalence of cannabis use in the general population in the last 12 months in the participating countries show great di-

3. Not all countries have statistics for that year; this is a global estimate based on the latest data available as of 2016.

4. Annual prevalence refers to the number of people who say they have used a drug at least once in the 12 months prior to when the survey was taken.

versity. Some countries have a prevalence of around 15% (Uruguay and Chile) while others are closer to 1% (Ecuador and Bolivia), meaning that the South American average has values at either extreme or, said another way, there are very different patterns of cannabis use between countries.

It is interesting to note that the Southern Cone (Argentina, Chile and Uruguay) has the highest rates of cannabis use in South America, while the Andean region (Colombia, Peru, Ecuador and Bolivia) has the lowest. Meanwhile, Mexico has a very different prevalence (2.1%) from that of the other North American countries, with an average for all three countries of 12.9%, as noted before. This contrasts with the case of Costa Rica, where the prevalence of annual use is 4.8 %, coming in above Central America's average (2.8%).

Beyond the magnitudes involved, similar patterns can be discerned in the trends shown by official figures on cannabis use in the participating countries. In terms of patterns of use, it is clear that there has been an increase in cannabis users in the last decade, and those between the ages of 18 and 35 are the biggest cohort. However, the types of use can be quite varied, depending on the kind of marijuana that is consumed.

The data from some countries indicates that there is much less problematic use of cannabis than other drugs, including alcohol, and problematic use has declined in some countries. Argentina's Secretariat for Comprehensive Drug Policies (*Secretaría de Políticas Integrales sobre Drogas*) estimated that in 2017, 18.8% of people who use cannabis (as a percentage of the general population) show signs of dependence, a figure relatively similar to those reported in previous years in that country, but which is quite different from the 50% of people who use cocaine and show signs of drug dependence. In Colombia, a 2013 study indicates that 1.9% of people who use cannabis show signs of problematic use. In Chile, even as overall use has increased, there has been a decline in problematic use, which dropped from 28% in 2006 to 14.8% in 2016. In the case of Chile, this change (the decline in the percentage of problematic use, both in the general and university-age populations) occurs in a context in which the pattern of use has been altered by the increased consumption of locally grown types of marijuana. For this reason, it would be pertinent to have information regarding the

varieties used in these countries to be able to reach any relevant conclusions.

Even in Uruguay, where cannabis markets have been regulated, the information available thus far (which does not allow for making definitive conclusions) seems to indicate that consumption patterns correlate to those in neighboring countries, which refutes some catastrophic predictions about the change to the legal framework.

Another relevant trend, which may be related to the previous figures, lies in the change in the cannabis varieties that are being used; this is revealed in the studies in Chile as well as from qualitative inquiries in several other participating countries. The data from Chile indicates that Paraguayan pressed marijuana (of lower quality) is being used less, with people progressively shifting to locally grown types of marijuana or buds. This could have relevant implications as purchase and supply patterns are modified, and it could also be an indicator of the substance's improved quality. All of this should be analyzed in other countries in order to observe broader regional trends and their possible consequences. In several countries of the region, home growing has increased, which is another possible indicator of an improvement in the quality of the cannabis used.

At the same time, another issue sharply emerging in the region relates to the advance of “creepy” (marijuana with high levels of THC). Although it is not possible yet to assess its impact among people who use cannabis, it has started to appear in markets and in public opinion in different countries, stoking prejudices, stigma and misinformation.

In fact, despite the increase in cannabis use and its acceptance in certain social groups, people who use the substance continue to face strong stigmatization. This results in people isolating themselves and hiding their use, which creates very few possibilities for discussing and analyzing the issue within families, at work or at school. This in turn means that informed and responsible use is confined to certain specific groups, rather than extending to all people who use cannabis. Furthermore, this stigma means that people with a dependency have fewer opportunities to access the health care they need.

To summarize, it is clear that the number of people who use marijuana has grown significantly in the last ten years. This necessitates a change in the way that drug policies are designed and implemented in the region. States must shift toward regulation and providing information for people who use drugs, as a preventive strategy based on reducing risk and harm, as well as an approach that is centered on public health rather than criminalization. In addition, it is important to continue monitoring changes in the patterns of use and the appearance of new, more potent cannabis varieties, with the aim of addressing the possible consequences for people who use this substance.

Finally, the studies carried out in all 11 countries highlight the need to have updated and complete information regarding substance use. Several of the countries analyzed have significant gaps in data that is essential for reaching conclusions regarding use. This leads to fewer possibilities for producing evidence-based public policies on this issue and, in turn, government strategies that are underpinned by reliable and verifiable information.

### **The difficult task of assessing the market**

The UNODC's *World Drug Report 2018* (UNODC, 2018a) characterizes the cannabis market as an intraregional one in which trafficking occurs in the same region where production takes place, which stands in contrast to other kinds of drugs, where production and sales occur in very different areas. In the case of the Americas, it is possible to distinguish between three major sub-regions: North America, where Mexico appears as the major supplier; Central America and the Caribbean, where Jamaica plays that role; and South America, where Paraguay meets a significant amount of demand and Colombia has begun to regain relevance (after the “marijuana bonanza” of the 1980s and 90s) due to the emergence of “creepy” varieties that have higher THC content.

This classification of markets identifies supplier countries; however, market dynamics and organization is very distinctive in each country, and even in each sector within countries, which means that it is difficult to identify commonalities even though it is the same substance being sold, or even when the same producer is in-

volved. Said in another way, the cannabis market tends to be highly diverse and varied depending on the geographic, economic, socio-cultural and political characteristics of each territory, which leads to local factors determining the form of supply, distribution, sales and purchase.

In addition, very little is known about the configuration of cannabis markets in our region. The indicators that are used only shed light on efforts to attempt to disrupt the cannabis trade, not on market dynamics. Data on the number of hectares of eradicated crops, seizures and the number of people detained only reveals actions carried out by police and the judiciary. Despite the complexities involved in studying phenomena that are criminalized, the qualitative information produced by this study has sought to shine some light on an issue that should be analyzed in depth.

Today we do not know for certain what kind of cannabis is being sold, which is an essential piece of data for a substance that has many varieties and can therefore have very different effects. Nor do we have much knowledge about the violence associated with the operation of markets, dominated in various regions by groups that seek to monopolize sales by force, and which can produce victims among those who use drugs. This ignorance should raise red flags for authorities, since the people who use cannabis (a broad and growing segment of the population) are completely unprotected and at risk. Likewise, growers and dealers who often rely on this activity for their family's economic livelihood are not only being excluded, but also persecuted and abused, mainly due to the actions of the police and the judiciary.

What we have found in this research is that few countries have a big enough crop to supply their internal market. According to the data gathered, Colombia, Paraguay, Mexico and Jamaica appear to be in this situation, which also allows them to export cannabis to other countries. In the case of Mexico, some studies indicate that between 50% and 80% of the marijuana sold in the United States is Mexican; Jamaica and Colombia (in a distant second place) supply many of the Central American and Caribbean countries; and Paraguay emerges as the main producer for South America. Overall, while the majority of the region's countries have some amount of cultivation, they still depend on imports from a nearby produc-

er country, which reinforces the intraregional nature of the cannabis market.

According to the information collected in the CEDD's country studies, two other countries, Peru and Bolivia, appear to supply their own markets with their own crops. In the rest of the countries (Costa Rica, Brazil, Chile, Argentina, Ecuador and Venezuela), marijuana is cultivated, but they still depend on imports to meet demand.

The way in which cannabis is transported from production centers to sales markets is extremely varied. In the case of Paraguay, the merchandise is usually transported by land toward Brazil, accounting for an estimated 80% of Paraguayan production (Corda, 2018). Paraguayan cannabis also supplies Argentina, Uruguay and Chile, and in the latter case it passes through other countries, such as Bolivia. Colombia's "creepy" variety appears to be arriving in Ecuador, Peru and Chile both by land and water (Piñol, 2018). Although air routes are used in some cases, the data gathered points mainly to land and water transportation.

Also of significance, home growing, or growing for individual or collective use, is becoming a significant supply source for people who use cannabis, which reduces the size and power of criminal organizations. Only a part of this production ends up being sold, generally in order to fund additional home growing rather than as a means of personal or familial livelihood.

It is not clear if increased cannabis use in the region can be attributed to the expansion and larger size of open or fixed-location markets run by trafficking or micro-trafficking networks, or if it responds more to the spread of home growing and to sales aimed at financing personal cultivation or use. The closed and mobile markets associated with the latter case tend to be safer for people who use cannabis, and they generally offer a higher quality substance. However, the advantages of this type of market seem to be concentrated in socioeconomic groups from the upper-middle and upper classes, which means that more impoverished and excluded classes still face the same situation of risk, violence and lack of protection.

The main difference between these distinct markets, in the long run, is the level of risk faced by the consumer, since markets that are open or fixed-location tend to be dominated by violence and

territorial control. This allows for the possibility of being cheated or of accessing low quality products, and even of running into trouble with criminal organizations or the police. In addition, there is no clear distinction made between the sale of cannabis and other substances. Because these markets are concentrated in more impoverished sectors, these higher risks intersect with the process of exclusion experienced by people who use drugs, giving rise to a new form of inequality and social inequity.

Nevertheless, what is clear in light of this research is that the increase in cannabis use has not necessarily led to the strengthening of trafficking or micro-trafficking networks. And what is absolutely clear is that the prohibitionist approach to cannabis, and to those drugs declared to be illicit more generally, has not achieved the stated objective of reducing the size of the market. As indicated previously, cannabis use has increased throughout the region, a fact indicating that its cultivation and the market for it have grown. This means that law enforcement efforts and repression by the criminal justice system have not managed to impact local markets, which continue functioning and adapting.

In contrast, the cannabis market regulation implemented by Uruguay appears to have incorporated half of all marijuana users, and is estimated to have taken \$22 million dollars away from the illicit market over the course of four years.<sup>5</sup>

## Consequences of the criminal justice response

As indicated before, the current model of prohibiting certain substances – one of which is cannabis – has produced illicit markets around which different kinds of violence emerge, perpetrated by illicit organizations as well as law enforcement agencies. The brunt of this violence is borne by lower-level actors in the drug trade and those who use drugs; these groups are easy for law enforcement officials to pursue, and easy for criminal organizations to replace.

CEDD's investigations have documented, across the region, the very high and disproportionate penalties for substances subjected to the prohibitionist model, which include cannabis. In some legislation, distinct behaviors related to drug trafficking (without ag-

5. See “Uruguay: el experimento legal con marihuana que asombra a todo el mundo”, available at: [https://www.eldiario.es/internacional/Uruguay-experimento-legal-asombra-mundo\\_o\\_917259074.html](https://www.eldiario.es/internacional/Uruguay-experimento-legal-asombra-mundo_o_917259074.html)

gravating circumstances) are punished with prison terms ranging from between 4 or 5 years to between 12 or 15 years.

This is true in Argentina and Brazil, where the prison terms for these offenses run from 4 to 15 years and 5 to 15 years, respectively. In the case of Costa Rica, the minimum is even higher, with sentences ranging from 8 to 15 years in prison. In Bolivia, drug trafficking sentences range from 10 to 25 years, although there is a lower scale (from 8 to 12 years) for behavior related to transporting or supplying drugs. The same occurs in Uruguay, although with lower sentences, ranging from 20 months to 8 or 10 years, depending on the criminal definition utilized. Chile can also be included in this group, with its legislation establishing a penalty of 5 to 15 years in prison for trafficking offenses; however, there is an attenuated scale (of 541 days to 5 years in prison) for cases of “small quantities of narcotic or psychotropic substances or drugs,” better known as micro-trafficking.

The damage caused by harsh drug laws is accentuated in the case of cannabis, where the impact on “public health” (a legal interest to be safeguarded in criminal legislation) is not only less serious than other substances, regardless of their legal status, but which in some cases can improve people’s health. Research shows that the greatest amount of drug law enforcement activity is focused on cannabis-related behavior. And within that, the majority corresponds to low-level actors (growers, users or small-scale traffickers), who are the most visible and the easiest for the criminal justice system to catch, and who have little impact on markets. This situation is often motivated by the need to bulk up police and judicial statistics, as a way of demonstrating effectiveness in “the fight against drug trafficking.”

The opposite reality is seen in Uruguay, which regulated the market for cannabis used for medical, industrial and “other” purposes in 2013. Among its objectives and principles, Law 19.172 mentions the promotion of public health “through a policy aimed at minimizing risks and reducing the harm of cannabis use.” Therefore, by separating markets for different drugs, it seeks to “protect the country’s inhabitants from the risks entailed by ties to illegal trade and drug trafficking,” in order to ensure the highest possible level of health. The regulations allow people 18 years and older to access cannabis

via three means: individual home growing (up to 6 female plants), Membership Clubs (up to 45 members and up to 99 female plants), and pharmacy sales. In all cases, a maximum of 40 grams per person per month is allowed, and there is a registry in which people must choose one means of access. However, despite this change in the model, eradicating the practices that took root among law enforcement agencies during so many years of prohibition has been difficult.

Although some legislation seeks to avoid criminalizing the behavior of people who use drugs (and sometimes growers), or seeks to treat them less harshly, criminal laws continue to affect them, including by categorizing them as traffickers in some cases. In charging people with the offense of possession, often vaguely defined in the law, those who possess drugs for personal use can be charged with intent to sell, thereby inverting the burden of proof. And in those laws that opt for systems involving quantities (or thresholds), the tiny amounts established allow for trafficking-related offenses to be applied as soon as those limits are exceeded.

Growing cannabis for personal use is rarely codified in these laws. In Argentina, Brazil and Chile, it is treated in the same way as possession for personal use. However, if a determination is made that the amount is more than what is needed for personal use, then they face the penalties for trafficking offenses: in Argentina, 4 to 15 years in prison; in Brazil, 5 to 15 years; and in Chile, 3 to 10 years (with the possibility of a sentence reduction due to “the perpetrator’s personal circumstances”). In other countries’ laws, cannabis cultivation is punished with prison time but on a lower scale than trafficking offenses, and occasionally thresholds are used to determine quantities allowed for personal use.

The statistical information available on the application of such laws in these countries continues to be limited (although it is better than some years ago), and information disaggregated by the type of offense or substance remains hard to find. However, the research carried out for this investigation reveals surprising facts about the law’s application to cannabis users, growers and dealers. The data laid out in the following paragraphs was gathered in the CEDD’s country studies.

For example, in Bolivia, not only were the majority of people detained for drug possession between 2008 and 2012 charged with

possession of cannabis, but those detentions increased over time. While in 2008 and 2009, they amounted to 50%, they rose in the following years (to 56% in 2010 and 60% in 2011) and reached 65% of all detentions for drug possession nationwide in 2012.

A study carried out in Chile (De Rementería, 2016) found that in nearly 58% of drug-related cases the substance seized was cannabis; 53% in relation to possession and 4.9% for growing plants. Moreover, the quantities possessed were small: 49.2% involved up to 1 gram of cannabis, 69.9% up to 2 grams, and 93.8% up to 10 grams.

In Colombia, according to data from the National Police, 46.3% of drug-related operations were focused on cannabis seizures and were concentrated on confiscating doses from people who carry small quantities with them on the street; 77% involved up to 100 grams and 44.8% were quantities below 20 grams.

Finally, in Argentina between 2015 and 2016, plant seizures shot up by 500%, which coincides with the accounts of growers who point to increased persecution.

Furthermore, drug legislation continues to be used by police as a tool for controlling certain populations or public spaces, a practice that is sometimes backed by judicial entities. Even in Costa Rica, where possession for personal use is not sanctioned, police practices continue affecting people who use drugs in an arbitrary way: They are searched on the street, their substances are seized, and other abuses of authority are committed. In Peru, a small sample of 32 cannabis users indicated that 72% of them were subjected to some kind of police intervention. Thus, there is a recurrence of different kinds of abuse and extortion of people who use drugs, even in places where the legislation expressly does not criminalize their behavior.

Finally, it is important to highlight – once again – that governments' repressive responses affect small-scale participants in the drug trade, who often experience multiple situations of vulnerability. Among those who stand out are female heads of household with dependents, and indigenous peoples living in rural areas, due to the high impact of such responses on these people and their environments.

Likewise, drug laws continue to be used by police as a tool to control certain populations or public spaces, which enables abuse and extortion, even when the legislation expressly does not criminalize related behavior. This state violence is even graver when military forces take action based on the logic of national security.

Given these results, and the human costs described above, repressive responses should be halted or moderated and alternative approaches explored, such as the various models for regulation that have been developed in recent years in Uruguay, Canada and some of the states in the United States.

### **Crop eradication: Exacerbating poverty**

The crop eradication activities that are carried out among the rural populations of many countries represented in the CEDD merit special attention. The areas where cannabis crops are located tend to coincide with conditions of poverty or extreme poverty, minimal state presence, and conditions of marginalization. On occasion, these lands belong to indigenous peoples, who find they can earn more with this crop than with licit crops, in contexts of deep rural poverty. The lack of access to land, to basic services such as health and education, and to job opportunities serve as incentives for rural inhabitants to engage in cannabis cultivation. Crop eradication in these areas has harmful effects on the health, development and environment of communities and people in situations of vulnerability. The destruction of what often constitutes one of their main sources of income endangers the subsistence of communities of growers.

In Mexico, the situation is particularly troubling. According to the *World Drug Report 2013* (based on information produced by the U.S. Department of State), Mexico had 12,000 hectares of cannabis cultivation in 2011 (UNODC, 2013). National data shows that between 2000 and 2017, 324,426 hectares of this plant were eradicated. Despite the limited information available, two forms of cannabis eradication have been identified: manual methods and spraying (on the ground or by air), depending on the place and the size of the crop. Spraying involves the use of paraquat and glyphosate, two chemicals that have harmful consequences. Conducting aerial spraying of pesticides is particularly harmful for the health of local

inhabitants and for the environment. This damage even extends to the people who use cannabis.

In addition, evidence regarding the eradication of other crops bound for illicit markets casts doubt on its effectiveness for reducing supply. Aerial spraying is costly and difficult and does not diminish the total number of crops; yet it does impoverish growers by destroying what is often their only source of income. It also establishes a relationship of violence between the State and communities of growers (Perez and Ruiz, 2018).

To undo or remedy these negative effects, regulation could provide a means of economic development for small farmers and their communities. For example, in Colombia, Law 1787 (approved in 2016) regulates all activities related to the medical marijuana market, stipulating that the State has the duty to protect small and medium-scale growers of the plant. In fact, those who obtain a license to produce medical marijuana have to buy at least 10% of their raw material from small growers. As this report underscores, the participation of “patients” as well as small growers and producers is key to ensuring that regulation benefits those who have been harmed the most by repressive policies.

## **Pro-cannabis social movements in Latin America**

In response to these punitive trends, pro-cannabis movements have emerged in several Latin American countries to demand respect for their fundamental rights and to question the existing legal framework that prohibits marijuana-related behaviors. These pro-cannabis movements share two characteristics: They are mainly urban, and they openly assert the fact that they use illicit substances. The vast majority of people who participate actively in these organizations consume cannabis themselves, and they are tired of being bullied, detained and abused by the police and other state authorities. In recent years, these movements have also been incorporating patients and their family members, who are demanding access to medical marijuana and who have become involved in politics on their own account.

The social movements advocating for drug policy reform have developed at very different speeds in each of the countries of Latin

America due to many factors, such as the level of stigmatization and repression of drug use, the culture of social protest, and the impact of drug trafficking on society and national politics. But throughout the region, as these movements have emerged, participation has increased in the Global Marijuana Marches that are held annually in various Latin American cities. Other forms of action include educational activities; the production of magazines, newspapers and other means of communication; as well as strategic litigation.

These movements vary in terms of their formalization and impact. Although some are very prominent in the public debate, many others are part of the counterculture. In this sense, there is one group of social movements that engages with and has an influence in public policy spaces, while there are many others that express themselves through grassroots actions such as marches, public demonstrations and protests.

Even so, the emergence of social organizations that seek cannabis regulation is relatively recent in the region. While in some countries there is greater representation of formal organizations that carry out public activities for political advocacy, in many others there is still no sign of this, or those organizations that do exist simply share related information on their social media pages.

The winds of change in the hemisphere – with the regulation of marijuana use in several states of the United States, Canada and Uruguay, and with regulatory frameworks for medical marijuana – have necessarily entailed a transformation in the role of these movements. While they are in favor of these changes, pro-cannabis activists are dealing with new concerns, such as the role of the pharmaceutical industry, commercial interests, and the failure to incorporate measures for reparation and social justice. In addition, market regulation calls for engaging with bureaucratic processes, an issue that had not previously been of much relevance to the movement.

With regard to this, an activist in Colombia noted that, in the process of regulating medical marijuana, “there are corporate and business interests, which we aren’t opposed to, but there needs to be a social purpose. We are opposed to the fact that meaningful inclusion of the real actors is not taking place. There are only techno-

crats, rendering others invisible and excluding them” (Pereira and Cruz, N. D.).

But at the same time, this has been an opportunity for the movement to draw participation from more diverse sectors, in particular the mothers of children who use cannabis for medical purposes. In most cases, these people had not been part of the counterculture that characterizes pro-cannabis movements, which means that these movements have become more diverse.

In short, the social movements to reform policies regulating cannabis in the Latin American context are diverse and relatively new. The variety of actors involved and the actions they carry out demonstrate the heterogeneity of the people interested in change, as well as their resources and capacity for advocacy. There is a confluence of people who use cannabis for medical or “recreational” purposes, farmers, academics, health care professionals, lawyers, communicators, artists, musicians and businesspeople who – through collective organization and the development of educational, commercial, litigation-related activities or social protests – are changing the way our societies conceive of cannabis and how States think it could be best regulated.

## Medical marijuana in Latin America

Change is coming to the region with regard to medical marijuana, driven by movements of family members and patients and other pro-cannabis social movements; by litigation before judicial bodies; or by executive branch initiatives, that may be influenced by industry interests. This is taking place in a global context in which investors are viewing the region with great interest and amid a process of review and possible rescheduling of cannabis in the international drug control system. There is also an element of imitation, since countries in the so-called Global North are taking this path.

Latin America is the region of the world with the greatest number of countries that regulate the medical or therapeutic use of cannabis in some way.<sup>6</sup> The different modalities that governments have chosen to control access to cannabis for medical purposes range from allowing only imports of pharmaceutical medication or me-

6. In a comparative table at the end of this text, the regulations of each country are summarized according to the specific legislation, access-related characteristics, types of products, requirements and the entities in charge. Paraguay is excluded, because at that time the country was not part of the CEDD, and Ecuador was also left out, since the model had yet to be approved.

dicinal preparations, to complex systems that regulate each of the links in the chain of production, distribution and prescription. All approaches, however, must align with what is permitted in the international drug control system, which sets forth States' obligations to guarantee access to controlled substances for their medical and scientific uses.

These changes are occurring in a global context in which cannabis is emerging as a rapidly growing and very lucrative industry. Many Latin American countries have geographic and climatic conditions that are favorable to this industry, which is why companies with significant capital show great interest in investing in the places where regulation is taking place. As Jelsma, Kay and Bewley-Taylor (2019, p. 5) note, the Global South offers an optimal scenario, with low production costs, marijuana varieties suited to pharmaceutical needs, and local and export markets.

However, the current classification limits progress on systems for accessing medical marijuana, since it hampers the possibility of producing evidence about the plant's therapeutic benefits. Other difficulties include the stigma around cannabis use since it is classified as an illicit drug, and the medical profession's limited education regarding its use and prescription. That said, these notions seem to be slowly disappearing as ever more people speak publicly about its use and benefits, and as ever more countries regulate access to it (Aguilar *et al.*, 2018).

In this context, the Americas are at the forefront of the medical marijuana boom. Currently, in Argentina, Brazil, Canada, Chile, Colombia, Jamaica, Mexico, Paraguay, Peru, Uruguay and numerous states of the United States, there are laws or regulations that allow some sort of access to cannabis for medical purposes. In addition, as this publication was being finalized, legislative changes were afoot in Ecuador.

In all the regulations reviewed for this study (whether a new law was promulgated or guidelines developed for an already existing legal provision), regulations or specific ordinances had to be created to resolve legal difficulties or correct errors in the process of regulating cannabis for medical and scientific purposes. The diverse methods used by governments to control cultivation, importation,

exportation, processing and distribution demonstrate that we are still in an initial stage of regulation.

Even though some regulations came about in response to pressure by organizations of patients and their families, only a few take into account small and medium-scale producers, or the possibility of growing for personal use (home growing) or artisanal production of oils and tinctures. In cases like Colombia, or Mexico with herbal remedies, that possibility could exist, but the criteria for economic, health or security-related controls continue to hinder the inclusion of small and medium-scale producers.

In fact, Colombia is the only country that contemplates the inclusion of small and medium-scale cannabis growers in the market, both on an individual level and as associations, and it obligates manufacturing companies to buy a minimum of 10% of raw materials from them. Nonetheless, the control standards and the cost of licenses to cultivate make it much more difficult for these growers to enter the market, and manufacturing companies can indicate, via a simple sworn statement, that there is no provider available to supply this percentage.<sup>7</sup>

Although progress is slow, reforms on access to medical marijuana were nearly unthinkable just a few years ago. Moreover, regulating medical marijuana in a region like Latin America involves different challenges to those seen in other regions. Since marijuana is grown, trafficked and consumed in the region, its regulation entails particular challenges, and should be guided by principles of social justice, reparation and fair trade (Jelsma *et al.*, 2019). It is not just about facilitating the industries that sell cannabis-based medication; it is also about promoting regulations that can serve as a path to integration for diverse communities of farmers, small manufacturers, and patients and family members who have suffered under prohibition. Regulatory processes must incorporate measures for social justice and equity to foster participation by the populations that have been the most affected.

7. Ministry of Health and Social Protection, Decree 579 of 2017, article 2.8.11.10.6. “Protection of small and medium-scale national growers, producers and vendors of medical marijuana.”

## Recommendations

This research shows, from different angles, that the prohibitionist model has failed with regard to cannabis. Not only has it failed to

achieve the objective of “eliminating drugs” enshrined in the conventions; it has also produced collateral effects and costs in terms of human rights. Given the urgent need for change, the following recommendations are intended to improve the living conditions of affected populations across the region.

## Main recommendations

- States should recognize the negative consequences of the prohibitionist model with regard to cannabis (and other substances with a similar legal status) and promote a shift toward legal, regulated markets for the plant’s distinct uses. To this end, it is necessary to put into practice policies and regulations based on scientific evidence and on human rights, public health and sustainable development principles.
- The development, implementation and evaluation of regulated cannabis markets must include the participation of all the actors involved and of those who have been the most affected by punitive policies, such as people who use cannabis and its derivatives, as well as small growers.
- Each country should adopt a regulatory model that is suited to its reality. The options should include accessible ways for purchasing, cannabis clubs and home growing. Although each country must develop a model fitted to its reality, Uruguay’s example appears to provide a design worth considering for other countries in the region. It regulates distinct uses (medical, industrial and “others”), recognizes the preexisting reality (individual home growing or collectives), and establishes distinct means of access.
- States should explore different options for reforming the international drug control treaties with regard to cannabis. These options include withdrawing from the conventions and re-adhering with reservations related to cannabis (as Bolivia successfully did in the case of coca leaves), or a group of like-minded States could create a new treaty framework among themselves, an *inter se* option, while upholding their obligations to other States that continue to be associated with the existing treaties.
- While regulated markets are being established, States should stop law enforcement efforts targeting the cultivation and pos-

session of cannabis for personal use. They should also reeducate police agencies so they leave behind current practices that equate persecuting people who use drugs with “efficiency” – practices that often end up being linked to abuse and extortion.

- With regard to thresholds, they should be used to set minimum quantities below which a person can never be considered a dealer. However, if people have amounts above that minimum, they should not be automatically sanctioned for distribution or trafficking, as the burden should be on the State to prove that they had the intention of selling or distributing the substance.
- The history of the distinct uses of cannabis must be reclaimed in order to be able to better evaluate its benefits and risks, as well as to promote responsible use.

### **Recommendations related to consumption**

- Public policies should be based on reliable scientific information. In this sense, States must produce reliable and periodic estimates on recreational and problematic use, and undertake greater efforts to identify, gather, systematize and disseminate relevant information on the types of use, the services available, and modes of distribution.
- In order to have reliable data on the use of illegal substances, massive studies or those that use population samples may not be the most appropriate tools. The fact that people are being consulted about a behavior that is considered taboo or is punished by law can lead to them either declining to participate or providing false responses. For that reason, studies should ensure that participants’ anonymity and confidentiality is effectively preserved. Furthermore, it is necessary to carry out targeted studies among the user population with different methods, to be able to properly portray the information provided.
- States should rigorously inform the population about the effects of consumption. Educational and information programs should be based on risk and harm reduction approaches, focusing on how to use responsibly and how to mitigate possible negative consequences. To achieve that, the experience of people who use drugs must be taken into account. Similarly, demand-reduction policies should be questioned and reformed to achieve

better results and to ensure that people have access to clear and reliable information based on scientific evidence and on respect for human dignity.

- States should strengthen comprehensive care networks, developing and implementing treatment and rehabilitation programs based on scientific evidence and using harm reduction approaches for those who need and want them, given that the State cannot force treatment on people. Governments should provide access to expeditious, affordable and good-quality programs, in an environment that is respectful of their rights.
- In this sense, States should reorient their priorities, setting aside repressive approaches and investing those resources in educational programs and health services.
- Finally, a discussion based on reliable information should take place to evaluate the impact of drug policies on public health and substance use, and to address stigmatization and discrimination against people who use drugs. That includes evaluating, analyzing and discussing whether the way we understand abuse and dependence is pertinent to different sociocultural contexts and characteristics of drug users, as well as to the diverse substances used, the forms of consumption, the markets where they are obtained, and the contexts of use and its effects.

## **Recommendations related to cultivation**

- In the countries where cannabis crops are eradicated, officials should put a stop to this practice, which worsens situations of poverty and vulnerability and has not had the desired effect of reducing the size of the cannabis market. Instead, States should promote equitable economic development in rural areas where marijuana crops are present, in accordance with the Sustainable Development Goals adopted by the United Nations in 2015.
- Aerial or land-based spraying of highly toxic pesticides – such as paraquat and glyphosate – should never be conducted due to its devastating impact on the local population’s health and on the environment.
- Frameworks for the creation of legal and regulated markets for the medical, industrial and adult uses of cannabis should:

- Give small producers preferential access to the market, including by eliminating the criminal records of those who have been convicted of the offense of growing cannabis.
- Provide technical assistance and any other resources needed to guarantee the successful participation of small producers in the cannabis industry.
- Create spaces in countries with a tradition of growing cannabis for small producers and affected communities to participate in the design of laws and related regulations, as well as in the formulation of mechanisms for implementation and evaluation.
- Develop laws, regulations and market strategies to ensure that small producers can participate in the market, guaranteeing equal conditions, to the extent possible, and adopting measures focused on equity and protection.

### **Recommendations related to medical marijuana**

- Given the high social and economic costs that prohibition has had for producer and transit countries, regulation should be aimed at recognizing and seeking to remedy this through the effective inclusion of growers and small manufacturers in the emerging market. To achieve this, legislative measures are needed that safeguard the participation of these populations, along with the provision of economic development and technical assistance.
- The role that home growing has played in terms of access to medical marijuana must be recognized, and the regulations that are formulated should allow for it.
- The countries that have yet to regulate this market, but which will very likely pass some sort of related legislation in the coming years, should take advantage of the experience of those already making progress on this issue, with the aim of effectively incorporating criteria on public health, social justice, reparations and sustainable development into their laws.

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## Annex 1 Medical marijuana in Latin America: The possibilities of experimentation

Legislation	Means of access	Product	Content / Potency	Points of Sale	Requirements	Regulatory Agency
<b>Argentina</b> Law 27.350 (2017), Decree 738 (2017) and Res. 1537-E/17 Health Ministry	Importation: via the National Administration of Drugs, Foods and Medical Devices (Agencia Nacional de Medicamentos, ANMAT). National production: The National Institute of Agricultural Technology (Instituto Nacional de Tecnología Agropecuaria, INTA) and the National Scientific and Technical Research Council (Consejo Nacional de Investigaciones Científicas y Técnicas, CONICET) are in charge of cultivation; production carried out by the National Agency of Public Laboratories (Agencia Nacional de Laboratorios Públicos, ANLAP)	Oils and other derivatives	No differentiation is made regarding the cannabinoid content	This is still not regulated. Among the law's objectives is to "guarantee access, free of charge, to hemp oil and other cannabis derivatives to any person who is incorporated into the program, based on the conditions established" in the detailed regulations adopted after the law was passed	Limited to "refractory epilepsy." To be able to participate in the National Program for the Study and Research of the Medical Use of the Cannabis Plant and its Derivatives (Programa Nacional para el Estudio y la Investigación del Uso Medicinal de la planta de Cannabis y sus derivados), one must be listed on the National Registry of Patients Receiving Treatments with Cannabis (Registro Nacional de Pacientes en Tratamiento con Cannabis)	National Program for the Study and Research of the Medical Use of the Cannabis Plant and its Derivatives (Programa Nacional para el Estudio y la Investigación del Uso Medicinal de la planta de Cannabis y sus derivados), which is in the Health Ministry
<p>Observations: Law 27.350 was a response to the demands of people who use medical marijuana and their family members. It creates a research program in which cannabis is to be provided free of charge, although this is not being fulfilled. It establishes importation and national production; in the latter case, public agencies are in charge, although they carry out projects with private investors. It does not include home growing. The detailed regulations adopted after the law was passed narrowed the legislation's scope, limiting it to cases of refractory epilepsy that have been listed on a registry (which was done in order to avoid violating criminal law). The majority of cases remain outside the scope of this regulation and face the risk of being penalized.</p>						
<b>Brazil</b> RDC ANVISA/MS 17 (2015) and RDC ANVISA/MS 66 (2016)	Only the importation of pharmaceutical or medical products	Drugs such as Mevital that are sold by means of the pharmaceutical industry	It differentiates between THC and CBD, but not their percentages	Importation and in pharmacies	Prescription from a legally authorized professional. Limited to specific illnesses. Based on the registry of patients using medical marijuana.	Health Ministry – Brazilian Health Regulatory Agency (Agência Nacional de Vigilância Sanitária, ANVISA)
Observations						

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<b>Chile</b> Law 20.000 (2005) and Decree 84 (2015)	Home growing is decriminalized; the registries of cannabis-related pharmaceutical products, clubs for collective cultivation, and industrial production are authorized for medical use and scientific research	Flowers, resins, extracts, tinctures, oils and lotions	No differentiation is made regarding the cannabinoid content	Importation of products. Access through growing for personal use and collective cultivation	A diagnosis is required along with a doctor's prescription with inventory control. The prescription indicates the daily amount to be consumed in grams and must justify its medical use.	National Service for the Prevention and Rehabilitation of Drug and Alcohol Use (Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol, SENDA)
Observations						
<b>Colombia</b> Law 1787 (2016), Decree 613 (2017), and Resolutions 579 and 2892 (2017)	The State issues four types of licenses: 1) manufacturing; 2) use of seeds; 3) cultivation of psychoactive plants; 4) cultivation of non-psychoactive plants. Permits for pharmaceutical laboratories and finished products. 10% of the raw material purchased by manufacturing license holders must come from small and medium-scale growers.	Oils, resin, tinctures, extracts and magistral preparations obtained from cannabis	Psychoactive and non-psychoactive cannabis are differentiated based on THC levels above or below 1%	Directly from doctors to patients and in pharmacies	A doctor's prescription is required. Minors may receive provisions based on the doctor's discretion and with parental authorization.	Health Ministry, Justice Ministry, National Narcotics Fund (Fondo Nacional de Estupefacientes)
Observations						
<b>Mexico</b> Reform of the General Health Law and Penal Code (2017) and Official document SOO/1433/2018	With the proper authorization, the production and importation of cannabis for medical, scientific and industrial purposes is permitted	Medication with pharmacological derivatives, industrial hemp, food products and herbal remedies	Differentiates between cannabis with THC levels above or below 1%	Pharmacies and authorized establishments	A doctor's prescription is needed and state controls are established with regard to supply	Health Secretariat Federal Commission for Protection against Sanitary Risks (Comisión Federal para la Protección contra Riesgos Sanitarios, COFEPRIS)
Observations: To date, the reform of the General Health Law and Penal Code and the issuance of regulations have not taken place. Instead, some guidance was issued and used to authorize licenses with little transparency. The new government that took power in 2018 got rid of that guidance and so far, there are still no regulations on growing cannabis for medical purposes.						

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<b>Peru</b> Law 30.681 (2017) and Resolution 435 (2018)	There are three types of licenses for: 1) scientific research; 2) importation or commercialization; 3) production. These are granted exclusively to public entities and laboratories registered with and certified by the Health Ministry	Cannabis and its derivatives	It differentiates the presence of THC and CBD, but not by percentages	Pharmacies or drugstores	It creates a specific registry of patients who use cannabis. A doctor's prescription, from a special prescription pad, is required.	Health Ministry, Interior Ministry and Ministry of Agriculture and Irrigation
Observations						
<b>Uruguay</b> Law 19.172 (2013) and Decree 46 (2015)	Through licenses issued for research purposes or pharmaceutical uses by the Institute for the Regulation and Control of Cannabis (Instituto de Regulación y Control del Cannabis, IRCCA)	Pharmaceutical products and plant varieties	Psychoactive and non-psychoactive cannabis are differentiated based on THC levels above or below 1%	Pharmacies or imported	Doctor's prescription indicating the quantity and type of product and its form of administration. For Sativex® or Marinol®: "orange" prescriptions and import authorization from the Public Health Ministry.	Institute for the Regulation and Control of Cannabis (Instituto de Regulación y Control del Cannabis, IRCCA) and the Public Health Ministry
Observations						

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