Safe reuse and redistribution of medicines

Report from a FIP insight board

2026



FIP Development Goals

International Pharmaceutical Federation

Colophon

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2 Introduction

Across health systems, access to safe, effective and quality-assured medicines remains fundamental to achieving equitable health outcomes. At the same time, health systems face increasing pressures from rising medicine costs, inequalities in access to treatment, medicine shortages, humanitarian needs, and the financial and environmental consequences of pharmaceutical waste. Against this backdrop, there is growing interest in whether medicines that would otherwise remain unused or be destroyed could, in appropriate circumstances, be safely reused or redistributed to patients who need them.

The safe reuse and redistribution of medicines is therefore an increasingly relevant global issue, sitting at the intersection of access to medicines, health equity, patient safety, pharmaceutical supply-chain governance and environmental sustainability. Several countries and organisations have developed approaches intended to address these challenges, including medicines repository systems, solidarity pharmacies, structured donation programmes, and redistribution arrangements within healthcare institutions. Solidarity pharmacies are initiatives that aim to improve access to medicines for people experiencing financial or other barriers to treatment, including through the collection and redistribution of eligible donated medicines or arrangements that facilitate access through established pharmacy supply channels. However, these models differ considerably in their purpose, governance, sources of medicines and the safeguards applied.[1]

Medicine reuse can broadly involve making unused and unopened medicines available to another patient where their quality can be assured and appropriate safety and regulatory requirements are met. Redistribution or re-dispensing may provide the mechanism through which eligible medicines are supplied to another patient or healthcare setting. The source of the medicine is critical: medicines may originate from regulated pharmaceutical supply-chain actors, healthcare facilities, patients' or private homes, or formal and informal donation routes. Each source presents different considerations regarding storage, handling, provenance and traceability.

This distinction matters because reducing medicines waste alone does not establish that a medicine is suitable for reuse. Once a medicine has left a controlled supply chain, questions may arise about exposure to different temperatures, humidity, packaging integrity, tampering, contamination, authenticity and continuity of storage. Conversely, medicines that remain within a regulated healthcare or pharmaceutical supply chain may provide greater opportunities for redistribution because provenance and storage history can be more readily established. Any future model must therefore balance potential benefits in access and waste reduction against the fundamental requirement to protect medicine quality and patient safety.

International experience is that reuse, redistribution and donation are related but distinct concepts. For the purposes of this report, reuse refers to making eligible unused medicines available for further use, redistribution describes the movement of medicines between individuals, organisations or healthcare settings, and donation refers to the provision of medicines without payment. These activities may overlap, but they involve different regulatory, ethical and operational considerations. Donation programmes may involve newly procured medicines, surplus stock within regulated supply chains or, where permitted, medicines returned from other sources. Establishing clearer terminology and boundaries is therefore an important component of future policy development.[2]

The issue has particular relevance for vulnerable populations, frail health systems and humanitarian settings. Solidarity pharmacy and repository models have emerged in some countries as mechanisms to support people experiencing poverty, lack of insurance or other barriers to accessing medicines. In humanitarian emergencies, conflict and disruption to established supply routes can further restrict access to essential medicines, increasing the importance of coordinated and reliable supply arrangements. At the same time, poorly coordinated or inappropriate donations may create additional challenges, including products that do not correspond to local clinical needs, medicines approaching expiry, inadequate documentation, and additional disposal burdens for recipient health systems.

For pharmacists and pharmacy organisations, this creates a complex policy question. The profession has a responsibility both to support equitable access to medicines and to safeguard the integrity of the medicines supply chain. Any future approach therefore needs to consider not only whether a medicine is unopened and

within expiry, but whether its authenticity, storage history and quality can be verified, whether appropriate governance and standard operating procedures have been followed, whether professional oversight is available, and whether legal and regulatory frameworks are clearly in place.

2.1 FIP policy context

FIP's existing Statement of Policy on Good Practice in Donations of Medicines was adopted in 1997. Since then, pharmacy practice, pharmaceutical supply chains, regulatory frameworks and technologies supporting medicine quality assurance and traceability have evolved considerably. Growing attention to equitable access to medicines, pharmaceutical waste, environmental sustainability and humanitarian needs, alongside emerging models of medicines redistribution and reuse, has prompted consideration of whether FIP's existing policy adequately addresses contemporary challenging and practices.

This work aligns with FIP Development Goal 18: Access to medicines, devices and services, introduced as part of the FIP Development Goals launched in 2020. DG18 focuses on strengthening equitable access to medicines, medical devices and pharmaceutical services. Exploring safe and appropriately regulated models of medicine reuse and redistribution may contribute to this goal by identifying opportunities to improve access, particularly for underserved and vulnerable populations, while safeguarding medicine quality and patient safety.

This initiative was further informed by enquiries from FIP member organisations, including in France and Brazil, highlighting interest in medicines reuse, redistribution and re-dispensing, as well as 'solidarity pharmacy models'—which, as noted above, seek to improve access to medicines for those facing financial or other barriers, through donated medicines redistribution or facilitated access via established supply channels[1]—and their potential contribution to equitable access. These enquiries raised important questions about the distinction between medicines donation, reuse and redistribution, the circumstances in which such practices may be appropriate, and the regulatory, professional and quality assurance safeguards required.

In response, an initial literature review explored the available evidence, international approaches and examples of practice relating to medicines reuse and redistribution. Its findings informed the development of a FIP policy brief, which highlighted variation in approaches across different settings and identified important considerations relating to medicine quality, storage, traceability, regulation and patient safety. The brief also identified important evidence gaps and the need for further examination of the conditions under which medicines reuse and redistribution could be considered safe, appropriate and feasible.

Following the development of the policy brief, the FIP Board supported further exploratory work to better understand existing practices, regulatory approaches, potential benefits, risks and necessary safeguards. This wider project aims to inform the revision of FIP's policy on medicines donations through evidence synthesis, stakeholder engagement and examination of international practice. Key areas of focus include clarifying terminology and scope, examining regulatory and operational approaches, identifying relevant case studies, and gathering perspectives from FIP member organisations and other stakeholders.

The insight board was convened as part of this exploratory process, providing an opportunity to complement the literature findings with practical experiences and perspectives from international stakeholders. Its discussions are intended to help identify areas of consensus, outstanding questions and priorities for further investigation, thereby informing the next stages of evidence development and policy consideration.

2.2 Purpose of the FIP insight board

FIP convened a virtual insight board on 12 August 2026, bringing together pharmacy leaders, practitioners, academics and experts with experience in pharmaceutical regulation, supply chains, public health, health equity, sustainability, and humanitarian and emergency response.

The insight board aimed to complement the initial literature review and policy brief with practical insights and international perspectives on medicines reuse, redistribution and donation. In particular, it sought to

explore how different approaches operate in practice, the associated regulatory, ethical, quality and safety considerations, and the potential opportunities to improve equitable access to medicines without compromising patient safety or public trust.

The discussions were also intended to identify evidence gaps, areas requiring further investigation and potential roles for FIP in supporting member organisations and informing future policy development.

2.3 Objectives of the insight board

The insight board sought to:

- Explore current international approaches to medicines reuse, redistribution and donation.
- Identify key risks, safeguards and operational considerations associated with medicines reuse.
- Better understand relevant legal, ethical, regulatory and public considerations.
- Identify opportunities for pharmacy to improve equitable access to medicines while maintaining patient safety and public trust.
- Inform the development of an updated FIP policy statement and potential future guidance for FIP member organisations.

The discussion also considered cross-cutting issues identified through the preparatory work, including: definitions and scope; international models and case studies; regulatory and liability considerations; storage, traceability and quality assurance; public trust and patient acceptability; sustainability and medicines waste; humanitarian and emergency response; and, the minimum safeguards that might be required for any future reuse model.

Participants contributed perspectives from China, Croatia, India, Lebanon, Sweden, the UK, Zimbabwe and international humanitarian practice. The meeting used facilitated breakout discussions followed by plenary reporting, enabling participants to compare national and professional experiences and identify areas of convergence as well as issues on which approaches differed.

Five overarching questions structured the insight board discussion. These were:

1. What models of medicines reuse, redistribution and donation currently exist, and how are they regulated?
2. What safeguards would be essential for the safe reuse of medicines?
3. How can pharmacy improve equitable access while maintaining trust and safety?
4. Where should FIP draw boundaries between reuse, redistribution and donation?
5. What role should FIP play in supporting member organisations in this area?

This report synthesises the insights shared during those discussions. It identifies areas of common concern, differences between national and practice contexts, examples of existing approaches and potential considerations for FIP's future work. The findings should be read as stakeholder insights intended to inform subsequent evidence review, consultation and policy development, rather than as formal FIP policy or recommendations.

3 Current models of medicines reuse, redistribution and donation

Participants described considerable variation in how medicines reuse, redistribution and donation are approached across different countries and healthcare systems. Rather than identifying a single model, the discussions demonstrated a continuum of practice. This ranged from settings where medicines that have reached patients are not reused, through to structured redistribution within controlled healthcare systems and formal donation or humanitarian supply arrangements.

A recurring distinction throughout the discussions was whether a medicine had remained within a controlled, quality-assured supply chain or had already reached an individual patient. Participants considered this distinction important because it affects the extent to which the medicine's provenance, storage conditions and integrity can be assured.

3.1 Patient-returned medicines: generally restricted or prohibited

Participants from the UK, China and Lebanon described patient-returned medicines as unsuitable for routine reuse once they had left the controlled supply chain. The concern was not simply whether a pack remained unopened or within its expiry date, but whether there was reliable evidence about what had happened to the medicine after supply to the patient. Storage in the home, exposure to heat or moisture, and the possibility of tampering or deterioration were all relevant to whether quality could still be assured.

In the UK, medicines distribution was described as operating through a regulated wholesale chain, with restrictions on moving medicines back into supply once they have reached the end user. Participants from Lebanon similarly described community pharmacies as not accepting patients' unwanted medicines for redistribution because storage conditions could no longer be verified. China was also described as prohibiting patient-returned medicines from being re-entered into routine supply.

These experiences drew an important boundary between an apparently usable medicine and a medicine whose quality can be demonstrated. The discussions suggested that intact packaging alone does not resolve the assurance problem once the medicine has left professional control.

3.2 Redistribution within controlled healthcare systems

Participants distinguished patient-level reuse from redistribution that takes place while medicines remain within controlled healthcare systems. China was described as developing redistribution between medical institutions, including within medical consortia and regional arrangements for medicines affected by shortages. Breakout-room reporting also referred to redistribution between healthcare facilities in Croatia and within hospitals or healthcare facilities in India.

This was regarded differently from medicines returned by patients because the medicine may remain within a documented and professionally governed supply chain. Storage conditions, provenance and responsibility can therefore be more readily established. The discussion did not suggest that such redistribution is automatically risk free, but it indicated that maintaining the controlled chain changes the nature of the quality-assurance challenge.

The distinction also has implications for terminology. A system that moves unused stock between healthcare institutions is materially different from a system that accepts medicines back from individual patients, even though both may be described broadly as medicines reuse or redistribution.

3.3 Donations and humanitarian supply

Donation was widely discussed but was not considered synonymous with reuse. Participants described charitable and humanitarian donation arrangements across several settings. In China, programmes involving companies or charitable organisations were described as supporting eligible patients, while in Lebanon donations to primary healthcare centres may be coordinated through the Ministry of Public Health, non-governmental organisations (NGOs) and intermediary organisations.

Participants emphasised that the intention to improve access is not, by itself, sufficient to donate appropriately. Medicines need to correspond to local clinical need and formularies, have adequate remaining shelf life, be understandable to the receiving healthcare workforce and patients, and be supported by appropriate storage and distribution capacity. Otherwise, a donation can transfer the burden of storage or disposal to the receiving system rather than improving access.

> *"We might be thinking we're doing something positive. However, if we're donating medicines that have short expiries [or] medicines that are not on their formulary, they can end up on the black market as well."*

This reinforced the importance of needs-based, coordinated donation informed by the receiving setting rather than assuming that surplus medicines will necessarily be useful.

3.4 Country context shapes the model

Participants repeatedly emphasised that approaches cannot be separated from the systems in which they operate. Regulation, reimbursement, medicine affordability, supply-chain maturity, shortages, conflict and the organisation of healthcare all influence whether reuse or redistribution is necessary, feasible or desirable.

> *"Our contexts are different, and more so… where funding is now a challenge."*

The range of experiences also cautioned against treating a model developed in one jurisdiction as directly transferable to another. The implication for international guidance is therefore not to prescribe a single operating model, but to identify principles and safeguards that can be interpreted within national legal and health-system arrangements.

4 Safeguards for safe reuse and redistribution

Across the discussions, medicine quality and integrity emerged as a fundamental consideration. Participants focused on what level of assurance would be required before a medicine could safely be supplied to another patient, alongside the governance, professional oversight and accountability needed to support that decision.

4.1 Establishing medicine quality and integrity

Participants repeatedly returned to the difficulty of establishing what has happened to a medicine once it has moved beyond a controlled supply chain. Packaging may remain unopened and a medicine may still be within its expiry date, but these factors alone were not considered sufficient to demonstrate that it remained suitable for use.

Storage history was a particular concern. Participants discussed exposure to inappropriate temperatures, moisture and light, alongside the additional requirements associated with medicines requiring cold-chain storage. These concerns were especially relevant to medicines stored in patients' homes, where conditions may be unknown and cannot necessarily be reconstructed when a medicine is returned.

This created an important distinction between the physical appearance of a medicine and the ability to provide meaningful assurance of its pharmaceutical quality. One participant highlighted the potential role of future technologies in addressing this gap:

> *"Some research [could] try to discover some tools, some devices that can show you whether a drug has been exposed to the sun, to high temperatures… which makes it un-useful, even if the box is still untouched."*

The discussion therefore suggested that any future reuse model would need to define what evidence is sufficient to establish appropriate storage and product integrity. Where this cannot be demonstrated, the discussion identified a clear limitation on the circumstances in which reuse could safely be considered.

4.2 Traceability and authentication

Traceability was discussed as a related but distinct safeguard. Track-and-trace systems, barcodes and electronic records may help establish where a medicine originated, how it moved through the supply chain and whether the product is authentic. China and Lebanon were discussed as settings in which traceability systems can support medicine authenticity and access.

However, traceability does not necessarily answer every question about product quality. A medicine may be identifiable and authentic while its subsequent storage conditions remain uncertain. In addition, confirming a medicine's authenticity is not necessarily sufficient to establish its suitability for reuse. There should be adequate evidence of its storage and handling history, with clear responsibility for deciding whether it can safely be redistributed. Participants' discussion therefore pointed towards the need to consider provenance, authenticity and storage assurance together rather than treating a single technological solution as sufficient.

4.3 Operational standards and quality assurance

Participants emphasised that high-level principles would need to be translated into practical operating standards. Any reuse or redistribution model would require clear criteria for what can be accepted, how medicines are received and assessed, what documentation is required, who can make decisions, how rejected medicines are handled and where responsibility sits when uncertainty arises.

The discussion therefore moved beyond whether reuse should be permitted in principle to the operational question of how safety could be demonstrated consistently. Standard operating procedures (SOPs), quality-

assurance processes and clear routes for escalation were viewed as important in preventing decisions from relying solely on individual judgement.

4.4 Professional oversight, accountability and liability

Professional assessment was considered essential where a decision is required about whether a medicine remains suitable for use. At the same time, participants questioned the position of pharmacists and other professionals if they are expected to make exceptional decisions without a clear regulatory basis.

"Patient safety is a key prerequisite, as well as also protecting the integrity of the profession of pharmacy."

The discussion linked patient protection with professional protection. A future framework would therefore need to make clear not only what pharmacists should assess, but the authority under which they act, the limits of their responsibility and how liability is addressed.

4.5 Preventing falsified and substandard medicines

Participants also considered what happens when formal access routes fail. Experience from Lebanon during periods of severe shortage and conflict was used to illustrate how patients may turn to informal exchange, including through social media. Such routes can weaken traceability and create opportunities for falsified, counterfeit or otherwise unsuitable medicines to circulate.

The discussion highlighted a tension relevant to emergency settings: restricting supply routes may protect quality, but severe shortages can drive patients towards less controlled alternatives. Participants therefore emphasised the importance of maintaining regulated and professionally supervised routes wherever possible.

4.6 Clinical and local relevance

Safeguarding was understood to extend beyond the pharmaceutical quality of the product. Redistributed or donated medicines also need to be clinically relevant to the receiving population, consistent with local formularies and practice, labelled in a language that can be understood, and supported by the infrastructure required for safe storage and use.

This was particularly important for cross-border donation. A medicine that is technically usable may still be inappropriate if the receiving system cannot store it, prescribe it appropriately, identify an equivalent product or safely dispose of it if unused. Safety was therefore discussed as a property of the whole pathway, not simply of the medicine itself.

5 The role of pharmacy in improving equitable access whilst maintaining trust and safety

Participants viewed equitable access as a wider health-system issue rather than an objective that could be achieved through medicines reuse alone. Pharmacy was seen as having an important role in improving access, affordability and navigation, but only where patient safety, authenticity and public trust remain protected. However, it is not just pharmacy's role, but that of the wider health system.

"It's not an issue that just sits in pharmacy."

Government policy, financing, reimbursement and health-system design all determine whether patients can obtain essential medicines and whether redistribution is needed as an access mechanism. The UK discussion, for example, referred to universal or subsidised access to prescribed medicines and national mechanisms for access to high-cost therapies. In such a context, the rationale for patient-level reuse may differ substantially from a setting where patients face significant out-of-pocket costs or shortages.

This led to an important point in the discussion: reuse should not automatically be equated with equitable supply. The underlying reasons why a patient cannot obtain a medicine need to be understood before redistribution is presented as the solution.

Within those wider systems, participants identified practical ways in which pharmacy teams can improve access. These are listed below.

5.1 Improving affordability and navigation

Lebanon provided an example of pharmacists using generic or alternative brand substitution within a regulated prescription framework to help patients obtain more affordable medicines. Participants also described pharmacists and pharmacy technicians as important in helping patients navigate available schemes, identify alternatives and understand how to obtain medicines safely.

This positioned pharmacy not only as a potential point of redistribution, but as a source of medicines expertise that can help prevent avoidable access problems before reuse is considered.

5.2 Strengthening stewardship and equity for vulnerable populations

One breakout discussion framed pharmacy's role in terms of stewardship: stewardship of limited resources, quality assurance and the profession itself. This connected medicines access with the responsibility to use available resources effectively while protecting standards.

"Leaving no one behind is the approach."

Participants also highlighted the need to consider the circumstances of vulnerable populations. Financial barriers, health literacy, cultural factors and the organisation of local services can affect whether an access model is genuinely equitable. The discussion therefore suggested that equity should be considered in the design of the system, rather than assumed because medicines are being made available at lower or no cost.

5.3 Maintaining trust, transparency and patient acceptability

Participants considered the role of pharmacy in public trust particularly where a medicine has been reused or redistributed. Patients may reasonably want to understand where a medicine has come from, how its quality has been assured and why it is being offered to them.

> *"A lot of it relies heavily on transparency… informing [patients] and having consent that they are receiving medications that might have been redistributed or recycled."*

This raised a broader equity consideration: access should not be improved by creating a lower perceived or actual standard of medicines for people who have fewer resources. Traceability, professional oversight, transparent communication and appropriate patient involvement were therefore discussed as important to maintaining confidence.

5.4 Preventing waste upstream

Participants also connected equitable access with responsible use of finite medicines resources. Better prescribing, medicines optimisation, stock management and patient education may reduce the quantity of medicines becoming surplus in the first place.

This places immediate reuse downstream of a broader stewardship approach. Preventing avoidable waste may sometimes be preferable to designing complex systems to recover medicines after they have left controlled supply.

6 The role of FIP and member organisations

Participants saw a role for FIP in providing international leadership while recognising that regulation and implementation must remain nationally led. The discussion did not point towards a rigid universal model. Instead, participants emphasised common principles, practical implementation support, evidence generation and tools that member organisations could use within their own regulatory environments.

6.1 Establish international principles while allowing national adaptation

Participants supported international guidance that could define core principles for safe reuse and redistribution while allowing countries and regions to determine how those principles should operate within their legal and health-system arrangements.

This balance was important because the insight board participants had highlighted substantial variation in existing practice. International guidance could provide a common safety baseline without assuming that the same operational model would be appropriate everywhere.

"We don't want to put pharmacists at risk in any way. We don't want to break the law in any way."

The discussion therefore positioned FIP's role as supporting safe professional practice and informing national development, rather than replacing national regulation.

6.2 Move from policy principles to implementation support

A particularly strong theme was the need to translate policy into practical implementation. Participants distinguished a high-level policy or position statement from the tools required by member organisations and pharmacy teams to apply it.

"The challenge we have now seen on the ground is the implementation."

Potential implementation support discussed included SOP principles, decision pathways, minimum quality requirements, checklists, education, and examples showing how different systems operate. This could be as practical as tracing a consignment, reviewing the supporting records or checking how a product recall would be handled. Participants considered these practical resources important because broad principles alone may not answer the decisions faced by professionals on the ground.

The discussion therefore suggested that future FIP work should consider policy and implementation together. Guidance would need to be sufficiently clear to support decisions while remaining adaptable to different regulatory and resource settings.

6.3 Strengthen the evidence base

Participants encouraged further evidence generation on safety, effectiveness, medicines waste, equitable access and implementation. Evidence was seen as important not only for developing guidance, but for enabling member organisations to engage credibly with ministries and regulators.

The insight board also identified areas where further research may be valuable, including technologies that could provide additional assurance about storage conditions and medicine integrity. This reflects an

important limitation in current discussions: some potential models depend on assurance mechanisms that may not yet be routinely available.

6.4 Use international examples without assuming transferability

Country and humanitarian case examples were viewed as useful for showing the range of possible approaches and demonstrating how principles have been interpreted in practice. At the same time, participants cautioned against presenting a successful model from one jurisdiction as a template for another to automatically follow.

Case studies could therefore be used to illustrate choices, safeguards and implementation challenges rather than to prescribe a single model. Including examples where patient-return reuse is prohibited would also help demonstrate that the international landscape is a continuum rather than a progression towards one preferred system.

6.5 Education and continuous professional development

Participants identified education as another area where FIP and member organisations could contribute. Topics raised included safe disposal, handling of expired or hazardous medicines, traceability, shortage management, therapeutic substitution and patient communication.

The discussion from Lebanon was particularly relevant to shortages and emergencies, where pharmacists may need support to understand therapeutic alternatives and equivalence when usual products are unavailable. Education could therefore support both routine stewardship and preparedness for exceptional circumstances.

6.6 Advocacy and engagement with policymakers

Participants emphasised that professional guidance alone may have limited impact where the legal or policy environment does not support implementation. Member organisations were therefore seen as having an important role in engaging ministries, regulators and other decision makers.

> *"The findings of these kinds of discussions can be put across to the policymakers... [and] implement the SOPs according to the country requirements. So, in that way, the professional associations can play a vital role."*

This suggests a complementary relationship between FIP and its member organisations: FIP can develop international principles, evidence and advocacy resources, while national organisations interpret these within their own systems and engage the authorities responsible for regulation and implementation.

6.7 Partnerships and coordination of humanitarian support

Participants also discussed FIP's relationships with WHO, UN bodies, NGOs and humanitarian organisations. In emergency settings, these relationships could help member organisations identify appropriate partners and reduce reliance on informal or poorly coordinated donation routes.

The potential role is therefore broader than producing guidance. FIP may also be able to convene organisations, connect pharmacy expertise with humanitarian planning, and support the profession's contribution to medicines access and emergency preparedness.

7 Drawing boundaries between reuse, redistribution and donation

A central finding was that reuse, redistribution and donation should not be treated as interchangeable concepts. Participants considered clearer terminology important because the source of a medicine, the pathway through which it moves, and the mechanism by which it is supplied have different implications for quality assurance, regulation and professional responsibility.

7.1 Clarifying the concepts

The discussion suggested that reuse and redistribution describe what happens to a medicine, whereas donation more directly describes the basis on which it is transferred. The categories can therefore overlap. A medicine could be redistributed between settings and also donated without charge.

This distinction matters because describing all three activities together can obscure materially different levels of risk. Redistribution of stock that has remained within a regulated healthcare system presents different assurance questions from the reuse of a medicine that has been stored in a patient's home. Similarly, donation may involve newly supplied medicines and therefore does not necessarily involve reuse at all.

"The reuse, the redistribution and donations should not be treated as the same thing."

Participants did not establish final definitions during the meeting. Rather, the discussion highlighted terminology as an area requiring further work from FIP so that future policy can clearly specify which activities fall within scope.

7.2 The source and pathway of a medicine create the safety boundary

The strongest practical boundary emerging from the discussion concerned whether medicine quality, storage history and integrity can be assured. Participants were generally more comfortable discussing redistribution within regulated and traceable systems than medicines that had already left those systems.

This shifts the question from whether a medicine is simply 'unused' to whether sufficient evidence exists to support its safe supply to another patient. The same physical pack may therefore present a different governance problem depending on where it has been and what information accompanies it.

This assurance-based boundary also helps explain why patient-returned medicines were restricted in several of the settings represented, while institutional redistribution or formal donation could still occur. Future definitions will therefore need to capture not only the destination of medicines but their source, chain of custody and degree of professional control.

7.3 International guidance should keep donation related but distinct

Participants recognised that donation already has its own established considerations, particularly in humanitarian and cross-border settings. The board therefore discussed the value of developing clearer guidance around reuse and redistribution without collapsing these activities into donation.

"We need to create guidance, really, international guidance, around reuse and redistribution, very separate from donations."

Keeping the concepts distinct would allow future FIP work to identify the safeguards specific to medicines being reused or redistributed while maintaining alignment with wider principles governing appropriate medicines donation.

8 Humanitarian and emergency contexts

Humanitarian emergencies brought many of the tensions identified elsewhere in the insight board into sharper focus. Participants recognised that shortages, conflict and disruption to normal supply routes may require flexibility, while repeatedly emphasising that urgency does not remove the need to protect medicine quality, patient safety and professional accountability.

8.1 Emergency circumstances may require different approaches

Participants discussed the difficulty of applying routine systems during severe shortages or declared emergencies. In these situations, pharmacists may face decisions about alternative products, redistribution or supply routes that would not normally arise.

The discussion did not support abandoning standards. Instead, it raised the question of how standards and professional responsibilities can be adapted transparently when usual systems cannot operate as emergency systems.

> *"Sometimes we face emergencies and really tricky situations where we have to make decisions with which we would like some guidance to make sure that we're not acting outside of our scope."*

This suggests a need for guidance that identifies the level of flexibility that may be appropriate, who can authorise it, and how professionals are protected when acting in good faith within an exceptional framework.

8.2 Professional judgement needs an appropriate legal framework

Participants considered professional judgement important in emergencies but did not see it as a substitute for legislation and regulations. The UK discussion raised the possibility of declared emergency arrangements that allow pragmatic professional decisions while maintaining standards and providing clarity around accountability.

This is particularly relevant where normal regulatory requirements may prevent movement or supply of medicines that could otherwise help address an urgent shortage. Participants' concerns suggest that any flexibility should be explicit rather than leaving individual pharmacists to decide whether they should act outside usual requirements.

8.3 Shortages can drive unsafe informal routes

Experience from Lebanon illustrated how severe shortages can change patient behaviour. Where medicines cannot be obtained through formal channels, patients may seek them through social media or other informal networks. Such routes can undermine traceability and create opportunities for falsified or substandard medicines.

The discussion therefore highlighted a potential unintended consequence of access failure: maintaining an inflexible formal system does not necessarily prevent medicines from moving; it may instead move that activity into less controlled settings. Emergency preparedness should therefore consider how regulated routes can remain responsive enough to reduce reliance on unsafe alternatives.

8.4 Therapeutic substitution and professional support

Participants also discussed the need for pharmacists to make sense of unfamiliar products or alternatives during shortages. This may include understanding therapeutic equivalence, different brands, cross-border products or labelling in another language.

Professional guidance and education could support safer substitution and help pharmacists communicate alternatives to patients. This was identified as an area where international and national professional organisations could provide practical support during crises.

8.5 Cross-border donation requires local coordination

Participants were cautious about international donation of physical medicines without strong local coordination. Differences in formularies, medicine names, languages, licensing requirements, storage capacity and clinical practice can turn a well-intended donation into waste or risk.

Regional or country-to-country arrangements supported by trusted intermediary organisations may sometimes be more workable because they can better reflect local need and regulatory requirements. However, even well-intended donations can become a burden where storage, distribution arrangements, trained personnel or disposal capacity are inadequate. The ability to receive and safely manage the medicines is just as important as the donation itself. Participants emphasised the value of connecting donors and humanitarian organisations with those who understand the receiving health system.

Overall, the humanitarian discussion reinforced the wider findings of the insight board: context matters, safety remains the central issue, and implementation guidance needs to help professionals make defendable decisions when ordinary systems are under pressure.

9 Conclusions and summary recommendations

The insight board showed that there is no single international model for medicines reuse and redistribution. Practice ranges from complete prohibition of patient-return reuse to structured redistribution within controlled healthcare systems and humanitarian supply chains. Despite these differences participants converged on several principles: patient safety must remain paramount; medicine integrity and traceability are foundational; national context matters; reuse, redistribution and donation require clearer definitions; and implementation support is as important as policy.

"The right way is stewardship of resources, stewardship of quality assurance, and stewardship of the pharmacy profession."

The discussion also placed the issue within a wider set of pressures facing health systems: medicine shortages, affordability, inequitable access, conflict and humanitarian emergencies, and the environmental and financial consequences of medicines waste. Future work should therefore avoid framing reuse as an isolated waste-reduction intervention. It should instead consider when reuse or redistribution is appropriate within a broader strategy for safe access, stewardship and resilient medicines supply.

"If we keep safety at the front, then I think we can explore all of these issues."

Proposed actions emerging from the insight board

1. Develop clear FIP definitions for reuse, redistribution and donation, recognising where the concepts overlap and where distinct safeguards are required.
2. Develop international principles for safe medicines reuse and redistribution, separate from, but aligned with, guidance on medicines donation.
3. Highlight minimum safeguards for medicine integrity, storage, traceability, authentication, professional oversight, documentation and quality assurance.
4. Develop practical implementation resources that member organisations can adapt to their national and regional regulatory contexts.
5. Compile country case examples showing different models in humanitarian settings, including those where reuse is prohibited.
6. Develop guidance for emergency and humanitarian contexts, including how professional judgement, and regulatory flexibility and liability should be addressed during declared crises.
7. Support education for pharmacy teams on safe disposal, hazardous medicines, shortage management, substitution, traceability and patient education to reduce avoidable waste.
8. Strengthen evidence generation on safety, access, sustainability, waste reduction and implementation outcomes.
9. Support member organisations with advocacy tools for engagement with ministries, regulators and policymakers.
10. Engage WHO, UN bodies, NGOs and other relevant organisations so that pharmacy expertise contributes to emergency preparedness, medicines access and humanitarian supply discussions.
11. Explore medicines waste as a related strand of work, including unopened, in-date medicines that are currently destroyed despite shortages and affordability pressures, while keeping patient safety central.

These proposed actions reflect themes raised during the insight board and should be refined through further evidence review, stakeholder consultation and FIP governance processes before being presented as formal policy or guidance.

References

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