German Red Cross
National Headquarters

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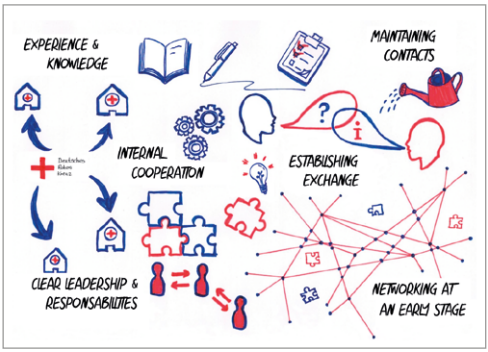

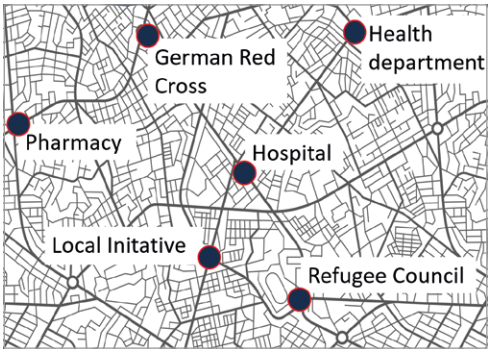

Good Practices and Lessons Learned from the GRC-refugee assistance 2015/16

Networking and cooperation in times of crises

10
Resource management
Research Writings

Research Writings

The purpose of the Research Writings is to continuously publish the results of scientific research of the German Red Cross. The Division for Research on Civil Protection at GRC National Headquarters launched an investigation of research requirements in 2012 spanning the entire organisation and involving all regional branches. During this process, three essential topic areas were identified as desirable research focuses: Resilience, societal development, and resource management. Since 2019, documentation of operational situations has been published in Volume 7.[1]

The Research Writings address these topics and offer impetuses for the continued strategic development of the organisation.

[1] The colours are reflected in the respective cover picture.

Research Publication Series – Networking and Cooperation in Times of Crises

Good practices and lessons learned from the GRC-refugee assistance 2015/16

Volume 10 of the research publication series deals with the partnership between the GRC and various stakeholders that emerged during the refugee assistance in 2015/16, especially those involved in providing healthcare to refugees. The findings in this volume come from the research project "Security Cooperation and Migration" (SiKoMi), which is funded by the Federal Ministry of Education and Research (BMBF) as part of the programme "Research for Civil Security 2012-2017" (topic area: Civil Security – Migration Issues). The project aims to analyse the partnerships that emerged at that time and to make findings usable for future deployment situations. For this purpose, knowledge from practice, including qualitative interviews, and from a nationwide internal GRC survey is being gathered and evaluated.

This third part, "Good practices and lessons learned from the GRC-refugee assistance 2015/16", summarises the project results and focuses in particular on the lessons learned from the deployment. These findings can provide a basis for further action in future missions.

Research Publication Series - Networking and cooperation in times of crises

Good Practices and Lessons Learned from the GRC-refugee assistance 2015/16

Legal Information

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Volume 10 – Networking and cooperation in times of crises
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DRK-Service GmbH, Berliner Straße 83, 13189 Berlin, Germany

Authors
Sarah Bhatti, Elisabeth Olfermann, Mahssa Sotoudeh, Matthias Max
Contact research@drk.de

Title photos
Sarah Bhatti (top left), Elisabeth Olfermann (top right), Mareike Günsche/ DRK (bottom)

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Content

1 About the Division for Research on Civil Protection

The Division for Research on Civil Protection at the German Red Cross (GRC) National Headquarters deals with observations and analyses of social development processes in connection with experience gathered from missions all over Germany. It participates in various research projects with the aim of optimising concepts in disaster management and plays the central role – as an intermediary – between science and the active stakeholders in civil protection. Based on the needs of the association, which are identified as part of an ongoing process, the GRC analyses processes of change in society within a scientific context with relevance for the tasks of the GRC in its mission to ensure civil protection.

The research results of the GRC are continuously published in the research publication series. They serve the association's strategic development and are available as a PDF for free download.

For further information, please visit: **https://www.drk.de/en/research/**

2 Introduction to the contents

People are forced to flee their countries of origin for many reasons. These include violence, acts of war, human rights violations, poverty and the consequences of climate change (Bundeszentrale für politische Bildung, 2017). Often, these experiences in the country of origin are associated with inadequate healthcare, which persists during flight (UNICEF, 2017). These experiences and stresses have immediate and long-term effects on the health of people with refugee experiences and influence their physical and psychological well-being. Appropriate healthcare provision for refugees[2] is therefore one of many important tasks for host countries (Frank et al., 2017).

In 2015, the number of people seeking protection increased significantly in Germany, as in many other European countries. The Federal Ministry of the Interior, for Construction and Home Affairs recorded 890,000 asylum seekers entering the country in the year 2015. This increase also posed special challenges for the German health system. On the one hand, some of the arriving refugees needed acute medical care. On the other hand, mental health services and the care of chronic diseases in particular could hardly be managed, not least because access to comprehensive and all-encompassing medical services was and still is restricted by law (Frank et al., 2017).

In the following digression the topic of flight and health as well as the legal provisions in Germany will be described, in order to be able to better classify the subsequent statements and results.

Digression: Flight and health
Refugees are often described as a uniform group, but they are an extremely diverse group of people. Gender, age, marital status, region of origin, reasons for fleeing, level of education and occupation, religious affiliation, individual attitudes and values as well as health – the group of refugees is made up of different individuals. Among other things, a one-sided perception bears the risk of neglecting the diverse care needs of those in search of protection (Fetz, 2018). In addition, there is a lack of representative data on the health status of arriving refugees in Germany (Frank et al., 2017). However, it has been clearly proven that the average mental health of refugees is worse than that of the German population average (BAfF, 2020). This can be explained by a com-

[2] In this volume, the terms refugee, people seeking protection and asylum seekers are used synonymously. They include all groups of people who have fled to Germany from another country, regardless of their reasons and whether they are granted protection status in Germany.

bination of extreme events before and during the sometimes very long flight. In addition, there are worries about their own survival and that of close relatives, as well as a variety of challenges after arrival (Frank et al., 2017).

An important issue in the healthcare provision of newly arrived refugees is how to deal with infectious diseases. According to the Robert Koch Institute (RKI), asylum seekers are basically affected by the same infectious diseases as the German population. However, due to the often arduous circumstances that people from conflict and war zones experience on their way to Germany, the lack of or insufficient proof of vaccination and cramped living conditions in communal shelters, asylum seekers are exposed to a higher risk of infection. In order to prevent the spread of infectious diseases in the shelters or to be able to initiate specific treatment at an early stage in the event of an infection, refugees undergo a health examination according to section 62 of the Asylum Act (RKI, 2015). The exact scope of the examination is the responsibility of the federal states (section 62 (1) sentence 2 Asylum Act [AsylG]).

During the first 18 months of residence in Germany, further examination and treatment benefits are regulated in the Asylum Seekers' Benefits Act (AsylbLG). Subsequently, refugees (without a residence title) are entitled to the benefit framework similar to that of the statutory health insurance (BAfF, 2020, p. 23). Within the AsylbLG, however, only limited medical care is initially provided (Frank et al., 2017), which includes maternal health services and vaccinations, "acute illnesses" and "painful conditions" (§ 4 (1) clause 1 AsylbLG).

However, these terms are not clearly defined and have to be interpreted, so that chronic diseases and dental prostheses hardly receive any (legal) attention here (Frank et al., 2017). The federal states or the authorities they designate by federal law are responsible for implementing the entitlement to benefits. Psychotherapeutic services are also affected by this open-ended formulation (BAfF, 2017). The processing time of applications by the respective social authorities can also be very long, so that asylum seekers are hardly granted psychotherapy treatment in the first 18 months of their stay (BAfF, 2020). According to this, they are entitled to benefits analogous to the statutory health insurance (§ 2 AsylbLG) and are thus also regularly entitled to psychotherapy, but corresponding professionals with a health insurance licence are difficult to find. In addition, the costs for the often necessary language mediators are not covered. This leads to long waiting times and high rejection rates for psychotherapy treatment (BAfF, 2017). In summary, it becomes clear that healthcare provision for people seeking protection is not only subject to different regulations depending on the federal state, but can also be structured differently, depending on the location and the shelter.

In order to be able to provide shelter and care for people seeking protection, civil protection organisations were involved in the refugee mission 2015/16, including the German Red Cross (GRC). In addition to setting up emergency shelters, the GRC was involved in providing medical care for the refugees in many places. In the process, the GRC repeatedly worked together with various stakeholders in the healthcare sector, for example with health authorities, hospitals and self-employed specialist physicians in medical practices.

Within the framework of the research project "Security Cooperation and Migration" (SiKoMi)[3] the GRC examined the forms of cooperation with healthcare stakeholders who have emerged in refugee operations. The exemplary collection, reconstruction and evaluation of the forms of cooperation and networking strategies that emerged at that time will provide a practice-oriented basis for action for future deployments and make the experience usable. The study of the refugee mission in 2015/16 was carried out using the following locations as examples:

- Lower Saxony: Camp Fallingbostel-Ost[4] and the State reception authority of Lower Saxony (Landesaufnahmebehörde Niedersachsen) Bramsche-Hesepe
- Rhineland-Palatinate: Reception center for asylum seekers (Aufnahmeeinrichtung für Asylbegehrende [AfA]) Trier
- Berlin: Emergency shelter Karlshorst, emergency shelter Lichtenberg and Berlin State Office for Health and Social Affairs (Landesamt für Gesundheit und Soziales Berlin [LAGeSo]) Turmstraße

Those involved in the research project conducted extensive, guideline-based interviews with various stakeholders in these regions. The GRC interviewed its own associations as well as stakeholders involved in healthcare provision, in this case health authorities and the German Armed Forces. In total, the GRC conducted 20 individual and group interviews with 26 interviewees. Subsequently, the interviews were systematically analysed. In addition to these qualitative interviews, a nationwide internal GRC survey was conducted, with a focus on experiences of working with healthcare providers. The survey

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[3] SiKoMi is funded from 1 September 2018 to 31 December 2021 by the Federal Ministry of Education and Research (BMBF) as part of the programme "Research for Civil Security 2012 - 2017" (topic area: Civil Security – Migration Issues). The joint project is led by the University of Wuppertal. In addition to the GRC National Headquarters, those involved in the project are the German Police University and time4you GmbH communication & learning – a company involved in the design and implementation of learning and knowledge portals. Other associated partners include the GRC regional branches of Lower Saxony and Rhineland-Palatinate, the district branches of Berlin-Müggelspree and Fallingbostel as well as stakeholders from other organisations and authorities such as the police, local authorities and private security.

[4] In this research publication series, the case region is referred to as Camp Fallingbostel-Ost, even though it is actually located in the Osterheide administrative area with its administrative centre in Oerbke. It was given the name because of its proximity to the next largest town, Bad Fallingbostel, so that the name has become established in common parlance and in the media.

was distributed in spring 2020 via an online link in the GRC association. After cleaning the data collected, 274 valid questionnaires remained. The results are therefore not representative of the GRC as a whole, but they can show indications and trends, and reflect the experiences.

Preliminary findings from the interviews and the survey were discussed in individual and group discussions with Red Cross members from different sectors and branches. In an inter-organisational workshop, which was attended by representatives of the GRC, the police, private security as well as local authorities and cities, the various findings were consolidated and expanded.

Selected findings from these different sources are presented below, followed by the formulation of good practices and lessons learned for future deployments.

At a glance...

- In 2015, the number of persons seeking protection in Germany increased. The healthcare provision of these people is restricted by law and initially only covers “acute illnesses” and “painful conditions” among others.
- Psychotherapeutic services are an important part of healthcare provision for persons seeking protection. In addition to other care services they fall under the Asylum Seekers Benefits Act. Even though the provision framework is the same for all asylum seekers, the practical implementation varies depending on the federal state.
- The GRC was involved in the accommodation and care of refugees. Particularly in the area of healthcare provision, it worked together with multiple other stakeholders.
- The various forms of cooperation were investigated in the SiKoMi research project in order to use the different experiences in future situations. For this purpose, the GRC conducted interviews with the stakeholders involved and a nationwide internal organisational survey. The preliminary results were discussed, verified and extended with various practitioners.

3 Challenges and management measures

The data from the sources listed above were evaluated in terms of content and analysed in terms of what lessons and management measures can be drawn from the 2015/16 refugee relief. On the one hand, it became clear that very different experiences were made and strategies applied at the participating locations, and that different challenges existed. On the other hand, it is also evident that certain experiences were repeated or particularly emphasised, i.e. thematic focal points can be identified. These include the following areas:

- Healthcare on site
- Cooperation and networking at an early stage
- Coordination and communication
- Dealing with experiences and knowledge

Accordingly, there were similar challenges regardless of location, although the solutions described differed. The experiences and lessons learned are presented below along these topic areas and supplemented by examples from the interviews and survey. Some of the examples are described in more detail than others: While it was possible to ask questions during the qualitative interviews to get a more complete picture, this was not possible during the online survey. In contrast, the quantitative survey data provides an overview of the experiences of a larger number of people. The data from the different sources complement each other by providing both exemplary insights and overarching trends and thus reveal potentials or needs that could become relevant for future situations.

3.1 Healthcare provision on site

Within the SiKoMi project, the GRC viewed the health care provision for refugees and focused on the cooperation with health care stakeholders. The following section will present the areas and forms in which the survey participants or the GRC were involved in health care in the different locations of the case regions, whether this was assessed as appropriate and what lessons and insights can be derived from this.

In some locations run by the GRC, such as in the emergency shelters in Berlin, the interviewees reported that the GRC had set up first-aid stations, also known as “Med. Points”. These stations were usually manned around the clock by the first responders. In addition, medical consultations also took place there. Through these “upstream centres”, it was possible to avoid overloading the doctors working in independent practices

from the surrounding area, who were only able to accept a few new patients for capacity reasons. Refugees were also only admitted to hospital in an emergency, as expert staff carried out an initial medical examination and treatment on site, which relieved the burden on hospitals and the emergency service. However, it was also important to ensure that no parallel structures were created by establishing the first-aid stations. Also, more complex cases, which could not be attended to by the first-aid stations, were referred to specialist doctors. Further relief for the existing structures was provided by the cooperation with doctors, some of whom were retired, and who volunteered to offer regular consultation hours in the emergency shelters. According to one interviewee, this deployment was carried out immediately and professionally.

Furthermore, the participants of the survey were asked whether they would rate the healthcare provision for refugees at that time as appropriate and effective. However, this assessment did not refer exclusively to the care provided by the GRC, but to the care as a whole, in which many different actors were involved.

Figure 1 shows that a relatively high proportion of respondents were unable to make an assessment (19%) and did not provide any information (9%). Of those who responded to this question, the majority (61%) rated the healthcare provision for refugees as appropriate and effective. Only 11% denied this statement.

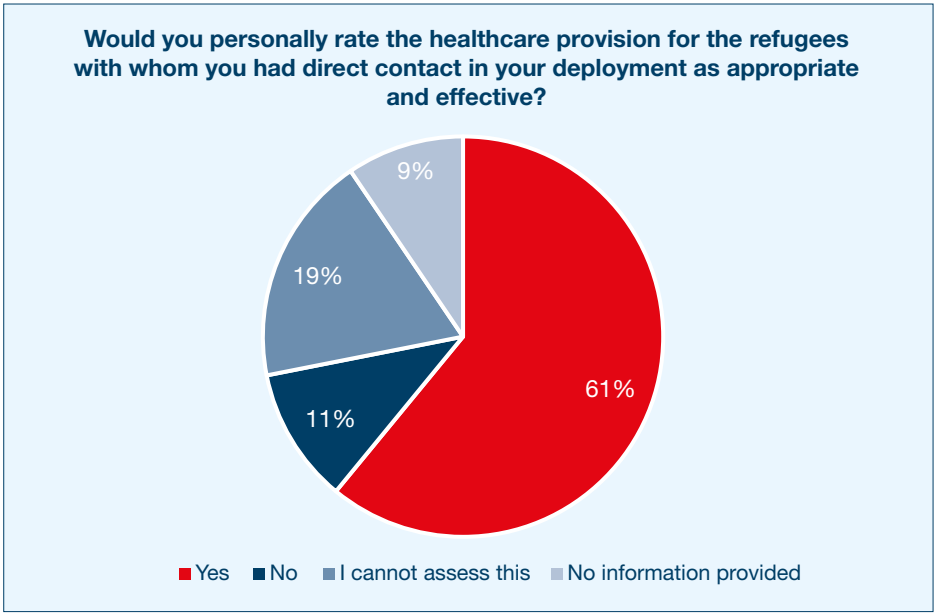

Figure 1: Assessment of healthcare for refugees

In free fields, reasons could be given why the healthcare was not perceived as appropriate. Many reasons were given, the content of which corresponded to the aspects from the interviews and the feedback discussions. The points of criticism can be summarised in the following areas:

- The general **system of healthcare provision** for refugees in Germany was partly criticised as superficial, as it was not sufficient and only provided for emergency care. Necessary additional services were not covered and diagnoses were therefore not pursued further.
- Furthermore, **information gaps and communication barriers** between different stakeholders and authorities were identified as problems. In addition, there had been ambiguities regarding responsibilities and the assumption of costs, as a result of which medical care had not been provided at all or had been delayed. Such **bureaucratic hurdles** and billing problems led to some refugees not being accepted as new patients in independent practices.
- Another reason was a **lack of resources**, which partly refer to a lack of funding, but mainly focus on staff shortages and an **inadequate infrastructure of** specialist doctors, particularly in rural regions. In many places, healthcare provision for the population was already at full capacity before the refugee assistance in 2015/16. Especially with regard to infant care and psychological treatment options, the situation has worsened, according to one interviewee.
- The **mental healthcare provision for the refugees** was assessed critically and a high need for change in future situations was identified. According to the interviewees, on-site psychological counselling could not be offered everywhere, due to limited capacities. Many psychologists in independent practices did not give appointments to refugees due to “overflowing schedules”. The lack of a long-term perspective for legally prescribed healthcare provision measures was also criticised. For example, long-term psychotherapeutic care is structurally barely considered, also with regard to the assumption of costs of the necessary language mediators.
- The **lack of language mediators** for healthcare provision in general was seen as problematic. Although this was less pronounced in the shelters, it was more prevalent for appointments in practices or hospitals. Especially at the beginning of the situation, it had not always been possible to organise an accompanying person for translations, so that the refugees to be treated could not always have been fully informed about medical measures. This circumstance was considered ethically problematic. Over time, more and more volunteer language mediators were recruited from the population to accompany the refugees to medical appointments.
- **Cultural barriers** between refugees and stakeholders in the healthcare sector also made it difficult to provide an adequate medical history. Some of the participants in the survey also reported experiences of resentment, due to doctors in independent practices refusing to accept refugees as patients.

As already mentioned, there was a lack of psychosocial support for refugees in many places. During the interviews, it was reported that - especially due to the duration of the situation - there was also a need for emergency psychosocial care for the GRC staff. The interviewees also emphasised that the burden was particularly high for language mediators, as they were directly confronted with the refugees' reports of violence and their suffering. In some cases, the need for psychosocial emergency care was met by GRC deployment staff with the appropriate additional qualifications. However, these were primarily active at the beginning of the deployment and not later on.

In summary, the healthcare of refugees was predominantly assessed as positive, but at the same time some of the respondents also cited points of criticism at various levels. This multi-layered picture can also be explained by the fact that the implementation of healthcare provision varies according to the federal state and the location (see digression in chapter 2), as well as being influenced by factors such as the infrastructure and individual attitude and ability of the staff.

At a glance...

- Healthcare provision for the refugees varied depending on the location. Overall, the provision was assessed as appropriate and effective. It was made more difficult by personnel and financial shortages that affected the work of the GRC.
- In some cases, the legally restricted access to healthcare meant that important treatments could not be carried out. This situation was exacerbated by language barriers, bureaucratic hurdles and lack of clarity about responsibilities and cost absorption.

3.2 Cooperation and networking at an early stage

In order to ensure the provision of healthcare to those seeking protection and to overcome the associated challenges, the GRC worked together with a wide range of stakeholders. Figure 2 shows an example of a constellation of stakeholders at the Camp Fallingbostel-Ost.

In addition to the internal cooperation of the GRC, which was expressed through coordination measures of the regional branch and personnel support from other district branch-

Figure 2: Constellation of stakeholders in Camp Fallingbostel-Ost

es in the registration of refugees, and the close cooperation with the German Armed Forces, the GRC worked with numerous other stakeholders from different fields.[5]

The way in which cooperation with external stakeholders came about and the nature of this cooperation varied greatly. The cooperation with a birthing centre, for example, came about through personal contacts with a midwife employed there. The emergency medical personnel, who primarily supported the (pre-)screening as salaried staff, were recruited by the GRC district branch Fallingbostel via an online platform and deployed as needed. Arrangements were made with a pharmacy at short notice to provide the refugees with the necessary medication. The networking was highlighted as positive by the interviewees. The basic mood of the stakeholders involved was described with the then much quoted guiding principle "We can do it", so there was a strong positive basic mood.

The survey also determined which stakeholders from the healthcare sector in particular had worked together at the place of deployment and to what extent this cooperation was new. In Figure 3, the left column lists all stakeholders that were available for selection. The stakeholders are organised in descending order according to the frequency with which they were mentioned. While the red bar indicates that cooperation already existed, the blue bar indicates that it was new.

When analysing the answers, it becomes clear that cooperation with the fire brigade was mentioned particularly frequent, whereby only a small part of the participants stated that the cooperation was new. A similar trend can be seen with regard to aid organisations, i.e. the Malteser Emergency Service, St. John Accident Assistance and the Wokers' Samaritan Federation. There seems to have already been cooperation with traditional civil protection actors in earlier situations. With regard to other actors, there were mixed experiences, so that although the majority indicated already existing cooperations, in many places there were also new ones. This applies, for example, to Caritas, Diaconia (Diakonie) hospitals and the German Armed Forces. A similar tendency can be found for the cooperation with health authorities, which was named as the second most frequent stakeholder. Cooperation with doctors, dentists and psychologists in independent practices as well as with pharmacies, on the other hand, was often described as new. Cooperation with psychosocial care institutions and midwives was also new in many places.

Retrospectively, the interviewees identified early networking on site, at best before the actual deployment, as an important factor for successful cooperation. If the stakehold-

[5] The lists of stakeholders are based on information from interviews conducted several years after the deployment. The lists therefore do not claim to be exhaustive. The connections shown do not imply any statement about intensity or quality, but merely reflect the cooperation stakeholders mentioned. Nevertheless, it is clear from the figure that the GRC worked with a large number of stakeholders at the time.

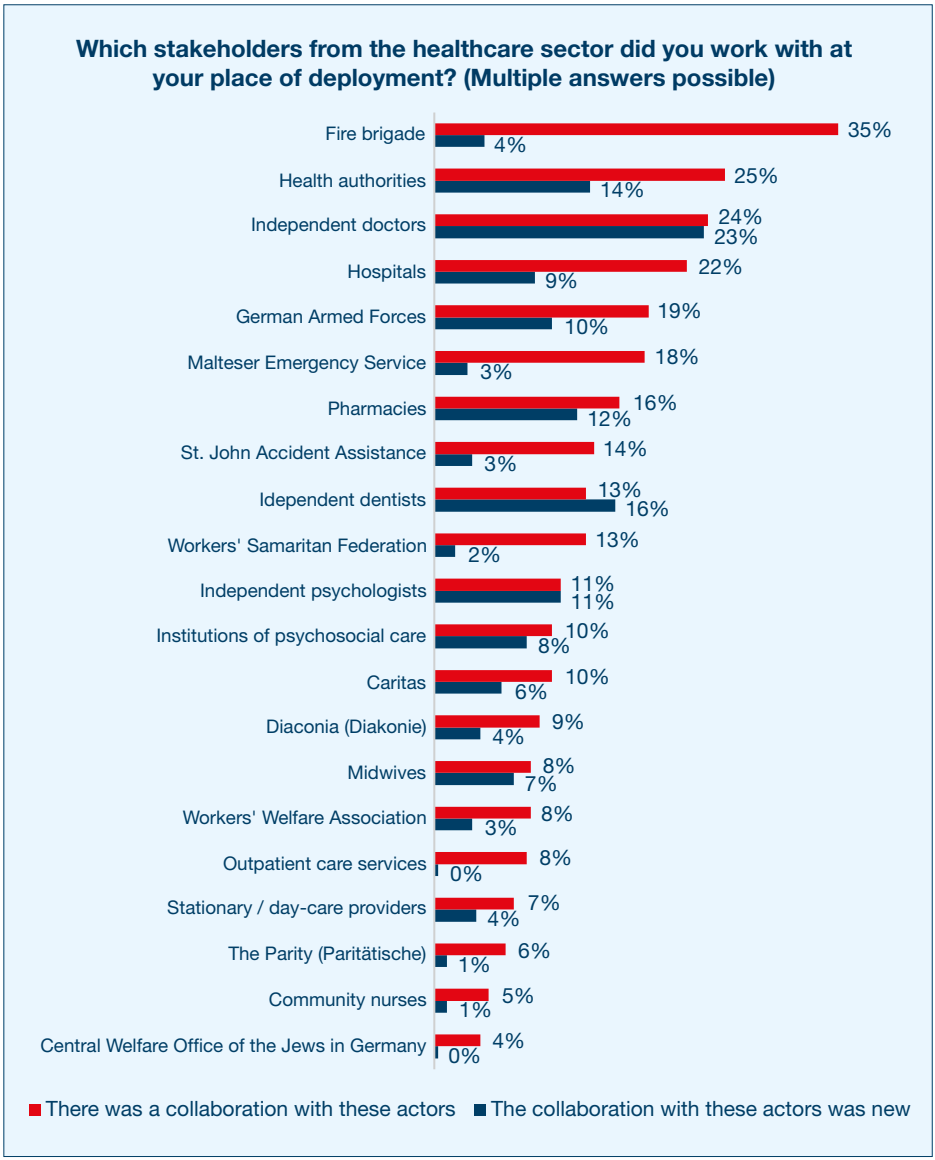

Figure 3: Cooperation with stakeholders in the healthcare sector[6]

[6] Since multiple answers were also possible for this question, i.e. one person could give several answers, the sum of the answers exceeds the 100% mark. The questions are marked accordingly in the following evaluation with "multiple answers possible".

ers were already familiar with each other, areas of responsibility and organisational structures would usually already be known and cooperation would be easier, as certain negotiation processes would not have to be carried out first. In particular with other civil protection organisations, a tried and tested cooperation that had existed for years was built upon, meaning that more time and energy could be directed towards the actual situation. Through regular exchange and the associated sustainable small-scale networking, the official channel routes and the "time needed to establish contact" were shortened. An already existing common "language" also facilitated the coordination and joint work. In terms of cooperation with external stakeholders, another positive factor highlighted was the integration of professional competences, which has been a great support for the refugee relief of the GRC. These skills were incorporated in different ways, i.e. partly integrated into existing GRC structures, partly positioned alongside the GRC structures. For example, a psychosocial centre for refugees contributed knowledge on the psychosocial treatment of people seeking protection, and a specialised association contributed work experience in caring for refugees with disabilities. In Bavaria, the German Armed Forces, who were active in the context of the "Helping Hands" administrative assistance (Amtshilfe), were able to be well integrated into the processes of the Bavarian Red Cross. According to one survey respondent, this had greatly facilitated the work processes. In Berlin, an association of Muslim psychosocial emergency care was consulted because it could contribute expertise on the Muslim religion and culture. These examples illustrate that the GRC could benefit in different ways from external stakeholders and their specific expertise in refugee relief, especially when this knowledge was not (yet) available within the GRC in that form.

Digression: Ways of networking

In the case regions described above, numerous forms of cooperation have emerged in the context of healthcare provision for refugees. The following is a summary of the most frequently mentioned ways of networking, which were also rated as particularly significant during the interviews.

One networking strategy that has been described again and again at all case sites is that of the **"unofficial channel"**, which refers to establishing contact independently of formal communication channels. Since the refugee relief was very fast-moving and difficult to keep track of, this method of establishing contacts turned out to be a particularly successful strategy for measures planned at short notice, because it was usually possible to build on an existing relationship of trust and those involved also knew the respective areas of responsibility and competences. Cooperation has been established elsewhere through **personal contacts** – both between GRC members and external stakeholders. In Fallingbostel, for example, personal contacts led to cooperation with a midwife who looked after pregnant women in the shelter. Since the midwife in

turn worked in a birthing centre, a new networking connection between the GRC and the birthing centre also developed.

Cooperation also took place through **targeted liaison efforts by the GRC**, e.g. in the form of appeals in the local press. This had the advantage that support needs could be communicated in a targeted manner and the required support arrived directly at the GRC. Conversely, **external stakeholders**, especially unaffiliated volunteers, **proactively contacted the GRC**.

Further networking connections arose by **establishing contacts through third parties**. For example, the GRC in Berlin turned to its Psychosocial Emergency Care team to take care of a case. The latter confirmed that it could take over the deployment, but suggested contacting a Muslim partner association, which then took over the deployment. This spontaneous and occasion-related cooperation ensured that those affected received appropriate and sensitive counselling and support, taking into account aspects of Muslim culture and tradition.

In the course of the interviews, another form of networking was also described, which came about through **higher-level authorities**. For example, the Berlin Senate Department organised a staff meeting on the situation of medical care for refugees, in which the GRC was involved, as well as other stakeholders such as the health authority. Other partnerships arose through **networking platforms**, as reported in the case of Fallingbostel: The emergency doctors who were needed for primary medical care could be acquired via an online platform and deployed as salaried personnel as needed.

GRC staff were able to initiate further cooperation through **spontaneous meetings in the neighbourhood**. This form of networking was particularly relevant in relation to unaffiliated volunteers and short-term cooperation. For example, a university of applied sciences was located in the immediate vicinity of an emergency shelter in Berlin, so that contact developed “automatically”, as the stakeholders met regularly in everyday life. Along the way, some employees and students of the university of applied sciences became active and got involved in the shelter.

Forms of cooperation also arose because the GRC was **working with other stakeholders at the same location** or **because of already prescribed responsibilities**.

At a glance...

- The GRC cooperated with different stakeholders in order to be able to guarantee the healthcare of persons seeking protection.
- The professional skills and expertise of the actors were integrat-ed into the GRC structures and enriched the management of the situation.
- Early networking between the stakeholders – ideally in the run-up to a crisis – can simplify cooperation, as it can draw upon shared experience and coordination processes. In particular, the GRC had already worked together with traditional civil protection stake-holders in previous situations.

3.3 Coordination and communication

The refugee mission in 2015/16 was characterised, among other things, by its fast-moving nature and the associated lack of clarity, which sometimes led to confusion about responsibilities and decision-making powers. It quickly became apparent that the coordination and planning of responsibilities and tasks of the stakeholders involved played an important role and that both positive and negative experiences were made in this regard, which are briefly recounted below.

Thus, participants reported a cross-organisational division into work areas, which proved to be an appropriate working strategy. Care was always taken to ensure that the actors of the individual areas met regularly to exchange information on current events, including those in the various organisations. This meant that work could continue seamlessly, even if someone was absent.

In addition, the cohesion between the different aid organisations, but also the interaction with the German Armed Forces, was mentioned as particularly positive. In some places, new team constellations have emerged, new contacts were created and old ones strengthened. According to one interviewee, “one’s own sensitivities and affiliation to different organisations took a back seat”.

In addition to the above-mentioned good experience with the cross-organisational distribution of tasks and an extensive dissolving of organisational affiliations, the need for leadership responsibility or joint deployment command was emphasised. There was still a need for expansion at this point, according to the participants. This is because responsibilities and authorisations in particular have emerged as points of contention between the stakeholders. For example, one participant reported that in the cooperation with the German Medical Council (Ärztekammer) and the German Armed Forces, leadership responsibilities and decision-making authority first had to be “comprehensively discussed”. There had also been competitive behavior between the GRC and other aid

organisations at some locations, as there had been positively and negatively connoted areas of responsibility.

Challenges regarding lack of and non-transparent responsibilities were also mentioned with regard to access to information. One of the criticisms was the unsatisfactory transfer of information, which reinforced the unclear responsibilities. According to one participant, for example, cooperation between the Bavarian Red Cross and the Federal Office for Migration and Refugees has been made more difficult by shifting responsibilities and organisational malfunctions within the Federal Office. This assessment was also confirmed in the qualitative interviews. For example, GRC staff from Berlin reported that non-transparent responsibilities impaired direct communication between organisations and authorities. GRC staff from Trier also told of challenges due to bureaucratic hurdles, which were perceived as "paralysing" there, as well as unclear responsibilities, especially with regard to financial issues. The reasons given here were that the GRC showed a more spontaneous willingness to make decisions and take action compared to stakeholders from the administration. There were also discrepancies between professional and organisational competences, as well as authorisations and decision-making powers. In addition, due to the permanent time pressure, contracts were not always fully formulated, which led to misunderstandings, especially afterwards.

In coping with the challenging situation, not only coordination but also cooperation at the interpersonal level played an important role, as this shapes communication and the working atmosphere. The working atmosphere and mutual respect were important, both within the organisation as well as in cooperation with other stakeholders, as the findings from the interviews and the survey show.

Thus, forms of cooperation that were negotiated in an unbureaucratic and spontaneous manner were considered very positive. This was especially the case if the GRC already knew the other stakeholders from previous deployments. This made it possible to build up mutual trust and to clarify questions "through unofficial channels". In addition, the "high intrinsic interest of all participants in the success of the cooperation" contributed to a good working atmosphere, according to a participant in the survey. The improvement of the refugee situation had been the common goal, so that the aid organisations involved had worked together in a cooperative, solution-oriented, trusting manner and without "commercial interest". This was also shown in the mutual support offered when capacities were lacking.

In some locations, the way of communication with other stakeholders was perceived as excellent. This was mainly due to the trusting relationship and the recognition of the GRC as a full partner. Adhering to agreements and showing initiative additionally promoted a good working atmosphere between the different stakeholders. Camp Fallingbostel-Ost was mentioned as an example: employees of the GRC and the German Armed Forces regularly visited each other and had meals together. This informal exchange and personal contact greatly strengthened the joint work and contributed to a positive and trusting working atmosphere.

However, other participants also expressed criticism regarding the working atmosphere: Within the quantitative survey, the attitude of employees of aid organisations towards refugees in the shelter was described in isolated cases as “averse” or “rejecting”. The relationship between the employees of aid organisations had also been “derogatory” in parts. This was due to inter-organisational hierarchical ideas and competitive thinking. Another problem mentioned was the lack of acceptance on the part of politicians to recognise the GRC as an “independent aid organisation”. One person also reported that at the location where they worked, the GRC was never considered as a “full partner” by the competent authority.

At a glance...

- Coordinating the cooperation was of great importance during the fast-moving refugee mission. In the course of this, the need for a joint deployment command was emphasised, in order to distribute responsibilities transparently.
- The working atmosphere and mutual recognition were also important in overcoming the situation. In particular, unbureaucratic forms of cooperation as well as trusting and appreciative communication were described as positive experiences. In turn, inter-organisational hierarchies and a lack of acceptance on the part of authorities were cited as counterproductive to cooperation.

3.4 Dealing with experience and knowledge

In order to be able to act in an acute situation, it is necessary to have access to up-to-date information and to be able to draw upon knowledge and experience from past deployments. The handling of information, experience and knowledge therefore played a role in many locations during refugee relief operation.

As already mentioned in chapter 3.3, a lack of transparency and the associated lack of certain information was perceived as problematic. Within the framework of the survey, however, a general shortage of information was also strongly criticised. Here it was reported that information about the current situation, for example about the number of arriving refugees, was lacking on the part of the authorities, among other organisations. In addition, surprise was expressed that this problem was possible at all "[i]n times of the [sic!] internet and digital data transmission".

One interviewee from Berlin spoke of an incident in which someone from the emergency services had not been informed about the infection measures and medical needs in the relevant shelter. This misinformation led to a strong over-cautiousness regarding the person's medical protective equipment, which in turn caused uncertainty among the staff and refugees at the shelter. Within a clarifying conversation, however, the person was able to reflect upon their handling of the infection control measures.

In addition, one participant reported that specific knowledge, for example on the topic of child protection, was lacking, which was attributed, among other things, to a lack of communication by the Youth Welfare Office (Jugendamt). This knowledge could only be enriched in the ongoing cooperation with the Youth Welfare Office.

In order to promote an exchange of information and knowledge during the deployment, various measures were used; some of which were very low-threshold, but good experiences were made with them. Interviewees reported that regular team meetings paved the way for an exchange of experience and knowledge. It was important to find out from the actors involved what fears and needs exist, how they perceive the mood in the population and among the refugees, and how best to proceed. In addition, the transfer of experience was also consolidated through regular meetings in the Rhineland-Palatinate regional branch, with the participation of various district branches. District branches that wanted to set up a new emergency shelter, for example, could visit existing GRC facilities beforehand and get advice there. In this way, lived experiences could be passed on and processes continuously improved. Dialogue beyond the local institutions and their structures had also been promoted, according to the respondents.

As the findings quoted above show, many challenges have been overcome well, while elsewhere there is still a need for solution strategies. An important step in learning from past operations and making lessons learned useful for future operations is to give more capacity to aspects of knowledge storage, processing and sharing. Various findings were also collected in this regard. In Rhineland-Palatinate, for example, under the coordination of the regional branch, findings and knowledge from the refugee mission were compiled and published in a GRC publication and in the meantime also incorporated into the specialised service training of the disaster services, e.g. on the topic of networking.

At a glance...

- During the refugee relief, there was a lack of information and expertise in some places. This was partly attributed to non-transparent communication between the stakeholders and made cooperation more difficult.
- Low-threshold measures, such as regular team consultations, can ensure the exchange of knowledge and experience during a deployment.
- In order to learn from past deployments and to make the knowledge usable for future missions, knowledge must be stored, processed and passed on.

4 Good practices and lessons learned for future operations

The experiences described in chapter 3 show the complexity of the situation at the time and how differently the various locations and branches dealt with their local circumstances and the general supply situation. Based on the examples from practice, it becomes clear that many challenges could be overcome by adapting processes and cooperation partnerships, while there is still potential for development with regard to other areas.

The transfer of values from practice experiences in order to make them usable for future assignments is also described as the derivation of „good practices“ and „lessons learned“.

Good Practices
Within the framework of this research publication series, good practices encompass a wide range of approaches, strategies and solutions. What they have in common is that they have been successfully applied in practice, in a specific situation, or have been proven to be effective. These good practices however, do not offer a promise of success and are therefore not binding solutions that are equally valid in different situations and for all people.

Lessons Learned
Lessons learned in this research publication series are the references and insights from specific situations that are identified retrospectively and that result primarily from negative experiences and mistakes. They can cover different levels, i.e. they can name problems as well as point out resulting solutions.

In order to consolidate the insights from this project and make them more tangible for future assignments, the coping strategies and challenges described are now summarised by topic in terms of good practices and lessons learned.

In non-crisis times ...

- In the best case, networking with (potential) stakeholders should be done proactively before the deployment, even in non-crisis times, in order to be able to fall back on these contacts quickly and easily in acute cases.
- Networking at an early stage, as well as experience in joint work, has many advantages for the management of deployments, since, among other things, a relationship of trust can be built upon and organisational structures and responsibilities are

known. In this way, official channel routes and the “time taken to establish contact” were shortened.
- Essential structures and decision-making powers, work assignments and the handling of information as well as one’s own ideas about the deployment should be defined (in advance) and clearly communicated in order to facilitate the joint work.

During deployment ...
- While unbureaucratic working channels and agreements via unofficial channels” make it possible to act quickly, changing and non-transparent responsibilities and organisational structures as well as long and complicated bureaucratic processes make joint work more difficult.
- The cross-organisational division into different working areas and the creation of working groups with members from different organisations can be a sensible strategy in order to be able to use competences appropriately, among other things.
- Clear leadership responsibilities or a joint head of deployment and clear allocation of tasks are also necessary.
- The working atmosphere is negatively influenced by hierarchical ideas and competitive thinking and can lead to negative attitudes. These experiences show that aspects of appreciative communication should be considered in the design and implementation of interventions.
- For a positive working atmosphere and appreciative interaction, personal initiative, personal exchange, mutual recognition and common goals are particularly important.
- Mutual visits to learn from others’ experiences on the ground also proved particularly helpful.
- In the acute situation, regular meetings and briefings helped to pass on experiences, knowledge but also information about fears and needs quickly, and to (jointly) react to the situation.
- Information and specific knowledge were sometimes not immediately available and had to be collected through experience during the deployment.
- A need for psychosocial emergency care was identified for the deployment forces of the GRC and other organisations, which was not fully met. This was particularly important for language mediators, who are often very close to the fates and stories of the refugees.

After the deployment and general remarks ...
- By pooling, processing and publishing findings, they can be made available to others and used in the design further education and training courses, for example.
- Professional strengths and specific knowledge of other (local) stakeholders can be integrated into one’s own structures. This increases expertise in certain areas, especially if this knowledge is not (yet) available in the GRC.

- The GRC does not always have influence on all aspects that affect its work. For example, in the refugee assistance, in addition to a lack of personnel, a lack of financial resources and bureaucratic hurdles meant that healthcare, especially psychotherapeutic (long-term) care and medical language mediation, were not sufficiently guaranteed. However, an awareness of this circumstance is important in order to absorb and counteract problems or deficiencies as much as possible.

5 Summary and Outlook

The experiences and findings collected and evaluated clearly show how extensive the challenges were for GRC deployment services during the refugee relief operation in Germany in 2015/16. At the same time, however, they also show that different solution strategies were used. In particular, the good practices and lessons learned from the deployment are varied and relevant to a wide range of areas. The evaluation of these experiences can be important for future interventions, e.g. to make proven concepts compatible or to learn from misjudgements.

However, many of the experiences with regard to healthcare for people seeking protection also make it clear that the GRC cannot always influence certain aspects or fix existing deficiencies. This is because some of these are bureaucratic or laid down by law. However, awareness of related challenges can be developed here to counteract existing gaps as far as possible. Other deficits cannot be improved or remedied in the short term either, as they are partly structurally conditioned or certain behaviours and ways of thinking are firmly anchored. In some places, organisational structures would first have to be created or expanded in order to be able to better respond to information needs in a future situation.

In summary, the results show how important networking and cooperation are in times of crisis, be it with already known actors or with new ones. These different forms of cooperation were indispensable for dealing with the situation. Many other experiences and the lessons and coping strategies learned from them are closely linked to the topics of cooperation and networking, such as the need for coordination of responsibilities and transparent communication on equal terms. The findings also emphasise the importance of early and sustainable networking. A recent example from the currently ongoing Covid-19 pandemic shows how important and profitable this is. A GRC member reported in a workshop that in the corona deployment, the GRC is partly working with the same stakeholders as in the refugee relief operation in 2015/16. This would clearly show that cooperation is easier with these already known stakeholders.

In the context of this research publication series, it became clear that the refugee mission was very challenging and complex. For this reason alone, it is not possible to reproduce all the experiences made in the manifold practice. In addition, it is quite possible that the coping strategies and existing needs listed here have evolved and been addressed since the deployment at that time, or that this knowledge has already been incorporated into other publications, courses and deployments. The examination of ref-

ugee relief operation in 2015/16 within the framework of this project therefore represents a snapshot, although the insights can nevertheless sensitise people to the topic of networking and cooperation and provide a basis for further incentives for action. The operations of the past years show that cooperation with old and new stakeholders will continue to be relevant in the future, so it is valuable for the GRC to deal with this area more closely and on an ongoing basis.

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7 List of Figures and Tables

8 For quick readers

- As part of the SiKoMi research project, the GRC investigated the forms of cooperation with stakeholders in the healthcare sector that emerged during the refugee mission in 2015/16 on the basis of different case regions. For this purpose, the GRC conducted interviews with the stakeholders involved and a nationwide internal organisational survey. The project aims to make the experience gained usable for future situations.
- Healthcare provision for the refugees varied depending on the location. Overall, the provision was assessed as appropriate and effective. It was made more difficult by personnel and financial shortages that affected the work of the GRC.
- The legally restricted access to healthcare meant that in some cases important treatments could not be carried out. This situation was exacerbated by language barriers, bureaucratic hurdles and lack of clarity about responsibilities and cost absorption.
- The GRC worked with a large number of different stakeholders. Some cooperative relationships came about during the refugee relief, while the GRC had already worked with other actors in previous deployments, whereby the professional skills and expertise of the actors were integrated into the GRC structures and enriched the management of the situation.
- Early networking in non-crisis times was highlighted as a factor for successful cooperation, as it is possible to fall back on already existing structures, experiences and communication channels.
- The necessity of a joint deployment command was emphasised in order to distribute responsibilities in a transparent manner.
- Another factors identified for successful cooperation were a positive working atmosphere and mutual appreciation. Low-threshold formats such as regular team consultations or informal meetings can strengthen the interpersonal level and intensify the exchange of experience and knowledge.
- In order to make experiences usable for future situations, it must be collected, processed and shared. The production of publications and the adaptation of training content are two ways of doing this.

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