***Preparing for the unexpected*: A comparative study of policies addressing post-terror health reactions in Norway and France**

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Abstract

Terrorist attacks occurring in generally peaceful and stable democracies are typically followed by a number of political responses designed to meet the needs of those directly affected and of the general population. Because terrorist attacks affect several interrelated parts of society, including health, justice, and security, political measures will often need to be multifaceted and dynamic. Additionally, such emergencies may incite reforms to existing systems. More comparative research is needed in order to gain a better understanding of these responses and how they develop. The main aim of the current study was therefore to investigate how governments in generally peaceful democracies address the civilian population's needs as related to health and wellbeing after a terrorist attack. More specifically, we looked at intentions for action, as expressed through policies and plans, addressing concerns related to health and wellbeing in the population post-terror.

Using document analysis, we analyzed the plans for post-terror response in Norway and France respectively and comparatively, related to the 2011 attack in Norway, and three attacks that occurred in 2015 and 2016 in France. Walt and Gilson's (1994) model developed for the analysis of health policy, which focuses on the four concepts context, process, content, and actors, was employed for this purpose. Through this analysis, the intention was to shed light on how different countries respond to intentional, manmade disaster, and the degree to which these processes reflect the health systems in which they are implemented and the nature of the terrorist incidents. Differences between terrorist incidents and countries will be discussed, including organizational differences in healthcare, varying political histories with regards to terrorism, and differences between the attacks themselves and the affected populations. This comparative case study will provide a better understanding of the complexity of policy responses to terrorist attacks across countries, as well as challenges and opportunities for research and health management of such disasters.

Introduction

Over the last decades, Europe has experienced several events of larger and smaller terrorist attacks, leaving healthcare needs in the population in their wakes. When terrorist attacks occur in generally peaceful democracies, they are typically followed by a number of reactions from political institutions and structures, designed to meet the needs of those directly affected, of the population at large, and of the state under attack. In the decades following the 9/11 attacks in the United States in particular, increased attention has been devoted among both scholars and policymakers to debates regarding emergency preparedness in the aftermath of terror (see e.g. Askenazy et al., 2019; Beitsch et al., 2006; Dyregrov, Djup, Barrett, Watkins, & Kärki, 2019; Glad, Stensland, & Dyb, 2021; Perry & Lindell, 2003). Terrorist attacks affect several interrelated parts of society, including health, justice, and security, and policies to address these effects may therefore be multifaceted. Furthermore, policies may also develop and change after a terrorist attack. In parallel with initiatives already established prior to a disaster, new measures, or reforms of existing systems are often initiated after crises in attempts to better meet existing and future needs (Kingdon, 2014; Shuey, Qosaj, Schouten, & Zwi, 2003). In this sense, disaster-related policies are dynamic, not only in terms of the challenges they are intended to address, but also with regards to their temporal development.

In the case of healthcare contingency following terrorism and other disasters, there exist international guidelines with suggestions for how to organize healthcare in the event of a terrorist attack (see e.g. Bisson et al., 2010; Brymer et al., 2006), yet little is known about the extent to which these guidelines are followed and how they are implemented. More research is thus needed to gain a better understanding of these policy processes, including what drives them and how they develop. Applying an explorative approach, the objective of this article is therefore to study how governments in two generally peaceful democracies prepare for terrorist attacks through policies and plans for the implementation of post-disaster measures. More specifically, our focus is on measures intended to address health concerns in the population post-terror, and how the design of these may be influenced by and reflect the national political framework under which it is to be implemented. A comparative perspective enables us to take into account whether and how different political and historical contexts may lead to distinct policies and differing approaches to similar challenges.

Aims and objectives of the study:

The main aim of the current study was to investigate how governments in generally peaceful democracies prepare for addressing the civilian population's health needs after a terrorist attack, and which factors contribute to shaping the chosen approach. More specifically, the aim was to look at intentions for action, as expressed through policies and plans and other measures meant to address concerns related to health and wellbeing in the population post-terror. The study responded to the following research question: *How are health related needs in the civilian population understood and addressed in national policy plans for disaster follow-up generally, and post-terror response more specifically, in Norway and France?*

Case selection

This study compared policies and plans addressing post-terror response in Norway and France. Given that an objective was to study how terrorist incidents affect populations and institutions in non-conflict societies, the cases selected represent states which have had incidents of political violence, although otherwise being stable and relatively peaceful democracies. This distinguishes terrorist attacks occurring in these countries from attacks in unstable states or conflict settings, in terms of the capacity of the state to respond to terrorism (Lutz & Lutz, 2007). As will be

discussed below, however, the countries have different histories with regards to their experience with terrorism, with France having experienced more events of terrorism than Norway (Global Terrorism Dataset, n/a).

A short introduction to the cases will follow, including an outline of four central parameters in this comparative study: the terrorist attacks under scrutiny, previous history of terrorism, the political systems, and the healthcare systems.

The terrorist attacks

Norway and France have experienced some of the larger (in terms of fatalities) terrorist attacks in Western Europe in the recent decade (Global Terrorism Dataset, n/a). The attacks under study affected victims and targets in a wide age span, with the attacks on Utøya Island and in Nice victimizing children and youth in particular. Furthermore, the attacks all spurred broad responses aiming to address health concerns in victims and beyond, however within different healthcare systems, in terms of how they are organized. Given that the events occurred in stable democracies, one should expect state capacity to respond to the attacks to be high, including the response from the healthcare systems. At the same time, democracies will not necessarily perform in similar ways post-disaster. On the contrary, previous studies have found that the positive effect of democratic governance on post-disaster human costs is also dependent on factors such as institutional quality in the democratic state in question (Ahlbom Persson & Povitkina, 2017). Comparing measures implemented in different countries is therefore important.

For this project, policy documents planning for the response after four terrorist attacks were studied, of which one occurred in Norway in 2011 and the other three in France in 2015 and 2016. For a brief introduction to the four attacks under scrutiny please refer to table 1 below.

Table 1 Overview of the Terrorist Attacks

Place and date of attack	**Perpetrators**	**Mode of attack**	**Directly affected**
Oslo and Utøya island, Norway on July 22 2011	One terrorist with sympathies to the extreme right and an "anti-Islamist" ideology. The terrorist had a pronounced aim of targeting the Labor Party in an attempt to protect Norway against what he perceived to be liberal policies towards Islam. He was arrested and sentenced to preventive detention for acts of terror, premediated murder and attempted murder.	• Bomb attack at the governmental quarters • Shooting spree at summer camp of the Norwegian Labor Youth	• Government officials • Passers-by at governmental quarters • Youth camp participants 77 people were killed, of which 69 at the summer camp.
Paris, France on January 7-9 2015	A group of attackers. The attackers were shot and killed by the police, and the Al Qaeda branch in the Arabian Peninsula later claimed responsibility.	• Shooting spree at satirical newspaper Charlie Hebdo • Attack on a kosher supermarket • One other hostage situation • Two other shooting incidents	• Satirical journalists • Kosher supermarket customers • Passers-by 18 people were killed, of which 12 at the newspaper and 4 at the kosher supermarket. 16 held hostage, of which 15 at the supermarket.

Paris, France on November 13, 2015	A group of attackers. The attackers were killed during the police operation, and responsibility for the attacks were later claimed by the Islamic State (IS) militant group.	• Suicide bombing in the area around the football stadium Stade de France. • Shootings in four different locations, predominately bars and restaurants, in central Paris • Suicide bombing at restaurant in central Paris. • Shooting/attempted suicide attack (?) at the concert venue Bataclan.	• Guests and passers-by at the football stadium • Guests at bars/restaurants and passers-by in central Paris • Concert goers at Bataclan While some concertgoers managed to escape through emergency exits, 130 people were killed and hundreds wounded in these attacks. Hundreds of people were held hostage inside Bataclan for several hours.
Nice, France on July 14 2016	One attacker, who was shot and killed by the police. His link to terrorist organizations are disputed. The Islamic State (IS) claimed responsibility for the attack	• Lorry attack	• Crowd watching a fireworks display in celebration of the French National day. • 86 people were killed as a result of the attack, of which ten were children, and hundreds others were injured (BBC, 2016).

The events represent different types of terrorist incidents where the attacks in Norway, which was initiated by a Norwegian attacker, with Norwegians being both the main victims and targets, were clear examples of domestic terrorism (see e.g. Sandler, 2014). The attacks in France were, albeit to varying degrees, more transnational in character. Although several of the attackers were French citizens the attacks were arguably transnational, given the support provided and/or responsibility claimed by terrorist organizations abroad. The attacks vary in terms of the degree to which they appear to be targeted. The January attacks in France appears to be the most targeted attack, predominantly seeking to target satirical journalists and kosher supermarket customers. The other three attacks are all more indiscriminate, in terms of the profile of those directly exposed to the attacks.

History of terrorism

The two countries are set apart by their previous history of terrorism. The Norwegian attack represented a singular event without precedent in the country's recent history, whereas the French attacks, represented three sets of events in a longer history of repeated recurrence of larger and smaller terrorist attacks in France (Global Terrorism Dataset, n/a).

The political systems

In Norway, there are three levels of government that is central in the context covered in this study. At the national level, ministries in the government, as well as directorates under their auspices are central. At the sub-national level, counties hold important responsibility. In 2011, there were 19 counties in Norway. At the local level, the municipalities are the key units. There were 430 municipalities in Norway in 2011 (Statistics Norway). Whereas primary care, such as general practitioners is provided through the municipalities, specialized care is organized through four regional health authorities (RHF). In France, the important levels of government, given the context covered in this article, are similarly the national level, with the ministries and

directorates, the sub-national level, most importantly the Security and Defense Zones, and locally the Departments. There were seven Security and Defense Zones in metropolitan France, as well as five overseas, in 2016, and 101 departments. In addition, the Regional Health Authorities (ARS) are central in the provision of post-disaster healthcare.

Healthcare system

The two countries both have universal healthcare. In Norway, this is organized as tax financed healthcare, with a high degree of public financing, whereas the healthcare system in France is based on a social health insurance model covering nearly the entire population (Chevreul, Berg Brigham, Durand-Zaleski, & Hernández-Quevedo, 2015; Ringard, Sagan, Sperre Saunes, & Lindahl, 2013). Both countries spend a high share of GDP on healthcare, in 2018 this number amounted to 10.2% for Norway and 11.2% for France. An important difference between the two healthcare systems is the sheer size, in terms of population covered. The healthcare system in Norway is a semi-decentralized system providing services to a population of approximately 5 million, which inhabits one the least densely populated countries in Europe. The healthcare system in France, on the other hand, provides services to a population of approximately 66 million, living in metropolitan France, which includes the mainland and Corsica, as well as territories overseas. The French system is more centralized, as compared to Norway, but with increasing responsibility placed on regional and local levels. When it comes to access to healthcare both countries have geographic and social differences (Chevreul et al., 2015; Godager & Iversen, 2013; Ringard et al., 2013).

Health policy in the wake of political violence

Policy is a plan that "...sets priorities and guides resource allocation" (Milio, 2001, p. 622). Processes to determine policies could be understood as policy cycles, in simple terms typically including a problem, a solution, and an evaluation, or more specifically involving agenda setting, policy formation, policy implementation, and policy review (de Leeuw, Clavier, & Breton, 2014, p. 5). Furthermore, the temporal aspect is central in these processes as policies are intended to resolve a specific issue within a certain amount of time (de Leeuw et al., 2014). To some extent, policy plans, like the ones analyzed for the current study, are normative, in the sense that they prescribe what policy makers and stakeholders intend for reality on the ground to look like.

Although the literature is rather well-developed with regards to the steps that policy processes should include, it is not necessarily equally clear what will need to be included in the different steps to meet the needs of a post-disaster situation (Khan et al., 2018). Emergency preparedness in the public health sector, and what specific problems it should find solutions to, what the available solutions are, and the timing with which these should be implemented, have been debated issues (Khan et al., 2018; Nelson, Lurie, Wasserman, & Zakowski, 2007). In the case of terrorist attacks, and similar disasters, there exist internationally developed guidelines for how to intervene, including the TENTS guideline (Bisson et al., 2010) and guidelines for field application of the method known as Psychological First Aid (Brymer et al., 2006). This would suggest that we should expect the content of the measures prescribed to be similar in both cases under study. However given the different political and healthcare systems, we could expect that the context of these provisions and the actors responsible for providing them would differ. Furthermore, terrorist attacks represent a particular form of disaster, through being man-made disasters that are politically aimed (Hoffmann, 2006). This could have implications for the problems that the policy process needs to solve, and for the solutions available. Following large-

scale terrorist attacks for instance, the scale of the events and the unexpectedness with which they occur may affect both the challenges and solutions at hand.

According to Nelson et al. (2007) public health emergency preparedness could in general be understood as: "..the capacity of the public health and healthcare systems, communities, and individuals, to prevent, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine capabilities" (p. 9). This is, however, a broad definition, suggesting that policy processes should be able to solve a number of broad problems in the aftermath of disaster. More empirical studies are needed to map out the specifics of such processes, and how the abstract needs they are meant to cover are operationalized in actual plans.

Methods

Research design

The data utilized for this study, included policy documents from the French and Norwegian authorities. Relevant data were identified in accordance with the research questions, as being national policy plans focused on the potential health consequences and healthcare needs in the civilian population post-terror, and how to respond to them. More specifically, the documents analyzed were plans and guidelines. Documents that were either valid at the time of the attacks, or that described measures initiated shortly after the attacks, were included in the analysis. The relevant documents were identified and collected through the following steps:

1. Review of academic and grey literature studying post-terror response in France and Norway to identify relevant plans, programs, and involved actors.
2. Review of the web pages of The Norwegian Ministry of Health and Care Services (The Government of Norway) the Norwegian Directorate of Health (The Directorate of Health), the French Ministry of Solidarity and Health (The Ministry of Health and Solidarity), and the French Government's main web page (Government social networks), to identify plans focused on terrorism follow-up. Web pages were surveyed in English, as well as in the respective languages of each country.
3. Personal communication with relevant stakeholders from the authorities in the two countries, who provided quality control of the relevance of documents already collected and who provided additional documents where necessary.

As for the documents published after the attacks, individual assessments were made regarding their relevance, since the period after a crisis often can be characterized by changes to policy. Given the aim and research question of this study, it was relevant to include some documents published post-disaster. At the same time, the objective of the study was to study planning, not implementation. Evaluations and other similar documents were therefore not included in the analysis. To further limit the scope of the study, only policy documents particularly addressing terrorist attacks and/or similar disasters were included. Additionally, only documents that were publicly available could be analyzed. In the case of terror response there may also be plans and documents that are classified. These could not be retrieved for analysis in this study.

Please refer to Appendix 1 for an extensive list of all documents reviewed and analyzed for the current paper. The Norwegian data were analyzed in their original form, as Norwegian is the authors' mother tongue. The French documents were subject to a review and selection process administered by the second author, who is fluent in French, before being translated into English by an external translator prior to the full analysis of these documents.

Document analysis

When conducting cross-country comparison of policies, the use of typologies can be a useful tool for organizing the information and focus on central points in the analysis, as such endeavors will generate near to endless amounts of information Burau and Blank (2006, p. 64**)**. Walt and Gilson (1994) suggest a model for the analysis of health policy specifically, in which the focus is on the four interrelated concepts context, process, content, and actors. These four concepts were implemented in our analysis, although used with the specific type of event in mind, that is disasters, more specifically incidents of terrorism in otherwise generally, peaceful democracies.

All documents listed were analyzed applying document analysis (see e.g. Bowen, 2009). Document analysis is a form of qualitative analysis, where the data analyzed consist of documents, rather than for instance interviews, but where similar techniques are employed as in other forms of qualitative analysis. For the purpose of this study, the documents under scrutiny were analyzed using a combination of content analysis and thematic analysis (see e.g. Braun & Clarke, 2006), as recommended by Bowen (2009).

The initial coding scheme was developed deductively based on Walt and Gilson (1994)s model for health policy analysis, with the four central codes being 'Context', 'Process', 'Content', and 'Actors', which could be applied to the material through a qualitative content analysis. These codes were operationalized with the specific type of events in mind, as described in Appendix 2. Additionally, there was a need to customize sub-categories in order to adequately address the research questions and the specific type of policies studied. The content analysis was therefore expanded to a thematic analysis employing both the initial four codes and inductive sub-categories developed during initial coding of the material.

The analytical process in qualitative studies is an ongoing process, which starts at the initiation of data collection and continues throughout coding. In the current study, this process was conducted as follows: The first author read, reread and performed the initial coding of the material. This involved employing the deductive coding scheme, based on Walt and Gibsons (1994) model, and developing the inductive sub-categories. To increase the internal validity of the analysis and counter researcher bias, the second author then read the data material independently, before reading the first author's analysis to check it for coherence and soundness. The analysis, including coding and categories were then subject to repeated discussions, where the authors' backgrounds from political science and medicine, respectively, were drawn upon to ensure an interdisciplinary analysis of the material. The Norwegian and French document corpora were analyzed separately, before a final comparison of the analyses were conducted in which a particular focus was on similarities and differences between the two countries, and how these could be understood.

Results

In the following we will present the results of the document analysis, organized according to the four codes of the employed model. For each concept in the model, we will describe the analysis of the countries respectively. We will start out by outlining the context of the terrorist attack preparedness and follow-up in the respective countries, before presenting the relevant actors involved, the content of the measures prescribed, and relevant process features. Even though most of the material analyzed for this article, has a wider scope than terrorist attacks alone, the focus is on measures that were relevant in the event of a terrorist attack on national soil. A comparative summary of the two cases is presented in the table below.

Table 2 Comparative Summary of Analysis

	Norway	France
Context	• Local municipalities have much responsibility and flexibility to adapt healthcare responses. • Little focus on terrorism, more on disasters in general. • References to plans and experiences from other countries	• More centralized responsibility in larger geographical units, with disaster specific networks being pre-existing and regularly gathered and trained. • Specific focus on terrorism, as well as other disasters. • References to previous experiences in France, little from other countries.
Actors - providers	• Several ministries involved, but no interministerial units. • Multidisciplinary primary care based acute and long-term care.	• Interministerial units established to respond to terrorist attacks. • Specialized mental healthcare practitioners provide acute care and support.
Actors - target population	• Main focus is on survivors or directly affected individuals. The term 'victim' is not used to any significant extent. • Particular groups in need of attention includes children, youths, and minorities.	• Main focus is on victims and their families, including the bereaved. • Particular groups in need of attention include children.
Content	• Disaster contingency is a continuation of the regular healthcare system: operations should be kept as normal as possible. • Good planning, risk analysis, and training is central. Important tasks include the transmission of information to the public and involved actors. • Information, basic care and practical help more important in emergency phase than therapeutic measures, with watchful waiting being a guiding principle. However, in the aftermath of the attacks a more proactive approach was selected.	• Outlines specific organization of healthcare system in the emergency phase. Patients in need of continued care beyond the emergency phase are to be directed into the regular healthcare system. • Stronger focus on the organization of the healthcare system in events of disaster, than on the actual measures to be provided, but training of involved actors is central. More specific on actual measures in terrorism specific documents, including the importance of security in rescue missions and care. • Information and identification of victims stressed as important. • Emergency care provided by specialized teams, expected to follow state-of-the-art practices (although these are not necessarily specified).
Process	• Responsibilities and organization in a crisis situation is based on the principles of responsibility, subsidiarity, and homogeneity. • Immediate and long term follow-up covered.	• Established mechanisms for power-up the healthcare system in case of disasters. • Strongest focus is on the immediate to post-immediate aftermath.

Context

Norway:

In Norway crises and disaster management within the healthcare system was to a large extent organized and controlled within existing structures at different levels of government. The work was guided by three central principles: responsibility, subsidiarity, and homogeneity. The former relates to how the institution that is normally responsible for a given service, is responsible for contingency planning for this service. The principle of subsidiarity refers to how a crises is to be handled at the lowest possible effective level. Finally, the principle of homogeneity refers to how the organization that handles a crisis situation should be as similar as possible to the regular organization. Given these principles, local government at municipality level, held central roles. It is acknowledged that Norwegian municipalities are diverse, for instance with regards to their geographic and demographic context, and that contingency planning to some extent need to be tailor-made with the local context in mind. For example, there will be differences in how healthcare is organized depending on how close the municipality is to a hospital. If a municipality is close to a hospital, and emergency/ambulance

services are well developed, those in need of hospitalization will quickly be transferred to specialized healthcare. However, some places in Norway are far from hospitals and/or have limited capacity in emergency services, and care will thus need to be organized differently. Municipalities are required to cooperate in times of crisis, but it varies whether this cooperation is controlled legally, or whether it is based on expectations and/or recommendations from the national authorities.

The documents reflect development in the field of crisis and disaster management within the health sectors in Norway in the years prior to the terrorist attack. In a document from 2008, it is claimed that changes in our societies and in our ways of living, such as technological changes, organizational changes, deregulation, increased pressure for economic optimization, and an overall increase in complexity in society over all, has led to new challenges for contingency work. In the same document an increased focus on the need for psychosocial follow-up at the time of disaster and accidents, was claimed. It appears as if the guideline from 2011 to some extent is meant to meet parts of this need. This guideline is based on St.prp.1 nr 1 (2006-2007) in which a need to strengthen psychosocial follow-up after crises, disasters, and accidents, was identified. A preceding guideline was published in 2008, whereas the 2011 update was published about a month after the terrorist attack, but was finished before the attacks and was thus central in the work following the attack.

The Norwegian material is for the most part not terrorism specific, but cover a wide array of disaster and crisis situations, with the exception of two documents that were published after the terrorist attacks. This is reflected in both the needs that are identified, and the knowledge and experience on which the documents are based. Furthermore, terrorist attacks do not appear to be considered the most important threat. In the guideline from 2008, it is stated that pandemics and negative effects of climate change are considered to be more likely threats to the Norwegian society.

An important learning point for the Norwegian approach to disaster and crisis management appear to have been the follow-up after the tsunami disaster in Southeast Asia in 2004, in which a significant number of Norwegian tourists were affected. This experience was mentioned in [Overordnet helse- og beredskapsplan] and [Veileder for psykososiale tiltak]. For instance, a national network for victims support groups was established after this disaster in a cooperation between the Red Cross and the Ministry of Health. National plans and guidelines from Sweden, the UK, Australia and the Netherlands, were also utilized as a knowledge base for the guideline on psycho-social follow-up after disasters. After the terrorist attack, knowledge on shootings and terrorist attacks, predominantly in the United States is referred to. For instance, it is stated that the mapping tools that were recommended after the terrorist attack, is based on experience from the US following 9/11 and Hurricane Katrina, but tailored to fit the Norwegian context and after the specific disaster.

The specific needs associated with experiencing a disaster or crises, are in particular spelled out in the guideline for [Helhetlig omsorg] from 2002 and the [Veileder for psykososiale tiltak] from 2011. This is also covered to some extent in the documents that were produced in the aftermath of the terrorist attack. In particular, the focus is on psychosocial needs. In the oldest of these guidelines, it is asserted that the need for care and services will depend upon the magnitude and type of event (such as the number of affected). This is supported in the 2011 guideline, in which it is claimed that comprehensive knowledge of the disaster is important to plan necessary help in the immediate aftermath. In the document from 2014, it is furthermore stated that there will also be individual variation in how crisis and disasters are experienced, including levels of PTSD, and no time limit can be set on crisis reactions and experienced grief. It is specified that psychosocial follow-up should in some instances be considered healthcare, but not necessarily

so. This have implications for the legislation controlling the follow-up, and points to that psychosocial care in the aftermath of terrorism may go beyond the documents considered in this analysis. Finally, it is specified in the newest document (from 2014), that services are required by law to be adequate, but what this entails in terms of extent, duration and the level of help will need to be considered in every instance.

Whereas the oldest of the documents assert that those who are affected by accidents and disasters *often* get their course of life changed, the document from 2011 is somewhat more moderate stating that crisis, disasters and accidents are *potentially* [emphasis added by us] traumatizing events for individuals, family and communities. Furthermore, that most people will be able to handle crisis situations without help, however, in some events psychosocial measures might be needed.

France:

In France, disaster and crises contingency is to a considerable extent organized in plans and networks that are activated at the time of disaster. Several of these are rigged to mobilize locally, but also have the opportunity to expand to regional, departmental, or zonal levels, or to seek reinforcements when necessary from neighboring departments or other administrative units. This reflects how exceptional health situations are intended to be met with a graduated approach. It is specified in some of the documents that the mechanisms they describe are to be activated in exceptional situations only, and not in the case of increases in the need for healthcare which could be anticipated. At the same time, it is a stated intention to create a "continuum" between "normal" functioning of the health system and the operational response to large-scale crisis.

The most important central planning mechanisms for organizing and controlling the disaster and crises contingency work are the ORSAN and ORSEC plans. Whereas ORSAN is a health plan, ORSEC is a security plan. The ORSAN plan is an integrated preparation system, which lays out the organization of the health system in the case of an "exceptional health situation". More specifically, its aim is to organize how the health system should power up in all types of exceptional events that could place the system under strain or disrupt its operation, and predefine regional or zonal patient care paths in these instances. Whether a zonal or regional path is chosen depends upon the type of event. The ORSAN plan formalizes regional coordination of existing mechanisms in the three health sectors (ambulatory, hospital and medico-social sectors, public and private), as well as coordination between the system and the different plans, including, but not limited to the ORSEC mechanism. It is specified in the plan that the number of victims and a large influx of patients are important measurements for the gravity of an event.

The ORSEC plan is classified, and could hence not be analyzed for the purpose of this study, but it is described to some extent in the other documents, predominantly in [Doc 8], the ORSAN plan and the White plan. The ORSEC mechanism is a departmental relief organization program in the event of a disaster that organizes the civil security response in emergencies. This includes how to rescue a large number of victims, manage a large number of casualties, and protect the population, the environment, and material assets. The plans have both departmental and zonal components. One of the emergency plans developed under the ORSEC mechanism is the NOVI, which organizes the rescue of a large number of victims in the same place.

In addition, any public or private health facility is required by law (according to the Public Health Policy Act of 2004), to have a White Plan to be activated when there is a need for immediate mobilization of any means necessary to handle a health emergency. Furthermore, every department is required to have an Expanded White Plan, which is to be activated as a last

resort, if the nature of the event requires it. The Expanded White Plan outlines all human and material resources in the department that can be mobilized in the case of a health crisis. The White plan scheme is linked to the ORSAN mechanism, as are the Blue plans that are the specific contingency plans of medico-social institutions. Finally, there is a set of plans called the governments' "pirate" plans, most prominently Vigipirate. These are inter-Ministerial plans aimed at handling terrorist attacks or threats, but they are not health specific.

Although the French approach largely is based on central plans, it is acknowledged in the documents that local circumstances, available resources, and the events under question will vary. As such, it is for instance specified in the ORSAN plan that a central objective is to seek out the most effective approaches in any given territory. Similarly, it is specified in the White plan that the Expanded White plans are to be based on knowledge of risks and experiences specific to the department in which it is valid, as well as resources available for mobilization in that department. This is also understood to be important in order to be able to anticipate crises to some extent. Linked to this it is also asserted that the management of crisis cannot be improvised, although crises in themselves often are unexpected.

The documents reflect that terrorism is assumed to be a persistent threat in France. For instance, it is stated in the White plan that it was updated in response to a context of growing health threats related to, among others, so-called "malicious acts". This is also evident from the comprehensive documents [7 and 8], both of which were released after the terrorist attacks under scrutiny, but still included in the analysis as they came in the fairly recent aftermath and hence could be considered to be important for the measures taken after the attacks. In [Doc 8], significant attention is paid to how terrorist attacks are becoming increasingly complex, both in terms of the weapons employed in them, and that they are more often multisite attacks. In the same document it is even suggested that the public should be more directly involved and receive training in responding to a terrorist threat or attack, in an effort to increase resilience. Here, lines are drawn to how the public is trained in cardiopulmonary resuscitation (CPR).

There are also examples of measures that are specific to victims of terrorism. Although much of the French material covers disasters, crises and accidents more generally, there is for instance mention of how victims of terrorist attacks benefit, as part of their health insurance scheme, from exemption from all health costs directly related to the act of terrorism, including the costs of psychiatric follow-up consultations made necessary following the act of terrorism. For these reasons documentation becomes important, as does procedures for identifying victims and classifying acts as terrorism.

A wide array of events are mentioned as important learning points for the French approach. In the Public Health Plan it is referred to how experiences from recent crisis situations such as storms, floods, SARS and heatwaves have demonstrated the need for a structured system for prevention and crisis management. It is also evident that experiences from the 1995-1996 terrorist attacks in Paris have been important for the development of the current French approach, as has experiences from subsequent attacks on French soil. Furthermore, experiences from the approach to terrorist attacks abroad are mentioned as important learning points, as are experiences from conflict situations. In general, parts of the French material reflect how terrorist attacks are considered to be war-like experiences. One example of this is a particular measure in France in which victims of terrorism are considered "civilian victims of war and to wards of the nation". This entails that victims of terrorist attacks committed after January 1, 1982, may be entitled to a military invalidity pension and benefit from the provisions of the Code of Military Invalidity and War Victims' Pensions (CPMIVG) applicable to civilian victims of war. In [DOC 8], it is claimed that France is situated in a "tense security and geopolitical context" in which it

makes sense to use experience from war situations for the benefit of "the service of the community and the resilience of the Nation".

The specific needs after experiencing a disaster is specified in most detail in [DOC 8], and in the CUMP documents. Part of the rationale behind the establishment of CUMPs is that it is asserted that beyond the physical injuries that can be the result of disasters, one may also see psychological injuries that require preventive emergency care. At the same time it is recognized that victim care after major events is homogenous. The latter is also reiterated in [DOC 8], where it is stressed that the subjective character of the trauma encounter and the subsequent reactions must be considered. In docs 7 and 8, the needs described are terrorism specific. In [DOC 8] it is e.g. specified how terrorist attacks have a high potential for trauma due to the human intentionality involved and the lethal means employed. It is stated that the mental and physical injuries following being targeted with a "weapon of war" is complex, and that follow-up thus can be complicated. This document makes references to the distinction between the French and the Anglo-Saxon traditions.

A terrorist attack can lead to a major crisis due to the number of victims, its psychological impact and its media coverage. The point of how the media context and the socio-political context in general, can affect the room for intervention in the aftermath of disaster is mentioned in the White plan document. In [DOC 8] it is reiterated that the characteristics of terrorist attacks evolve, making them increasingly complex, and how this puts novel strains on the healthcare system and the professionals within it. When it comes to the characteristics of attacks it is recognized that they are heterogeneous, and can occur in any location, both urban and rural. For the above stated reasons, it is argued in this document that the response to terrorist attacks with multiple victims is somewhat different than what is common in traditional disaster medicine. The issue of multisite attacks is also mentioned in the White plan. Furthermore, it is also recognized that disorganizing care structures can be an objective of the terrorists.

Actors

In the context of terrorism preparedness and follow-up, a wide array of actors will be involved in different parts of the process. In the current section we will describe the most central coordinating and operational actors that were involved in providing disaster preparedness and follow-up within the health sector. Furthermore, we will outline how the central target populations for this work were defined in the documents.

Norway:

Providers

In Norway, the responsibility for contingency and follow-up associated with terrorist attacks was described as being dispersed horizontally between different ministries at the national level, but also vertically at different levels of government. A significant responsibility was held at the local (municipality) level.

Key coordinating actors

At the national level, the Ministry of Health have the overall responsibility for contingency planning and crisis management in the health, healthcare, and social services sectors, whereas its subordinate Directorate of Health are responsible for ensuring that the different actors in the healthcare and social sector interact in a crisis situation and in contingency planning. In addition, the Ministry of Justice and the Police Directorate are important in the event of disaster.

The Ministry of Justice was the coordinating ministry after the terrorist attack, as is standard procedure in the event of national crises in Norway.

County level government is responsible for coordinating contingency planning in cooperation with the municipalities, and giving advice. Specialized healthcare to the entire population is the responsibility of the Regional Health Authorities (RHF). In the oldest applicable plan, it is specified that this responsibility expand to times of disaster or crisis. Specialized healthcare is provided through agreements with the various health authorities (HF), which consist of public hospitals and health institutions, or private actors. The institutions included in the HFs have varying functions and tasks in a crises and this will be specified in their local contingency plan.

Finally, the principle of subsidiarity is central in crises management in Norway, meaning that a situation should be handled at the lowest effective level of care. Local government at municipality level thus have central roles as they are responsible for providing primary healthcare, including general practitioners (GPs) and out-of-hours emergency primary care, to anyone staying (permanently or short-term) within the municipality. This responsibility expands to crises situations, disasters, and potentially even war, and municipalities are thus required by law to have contingency plans.

Key operational providers

In the emergency phase, the emergency medical communication centrals, which are under the auspices of the RHF, were central as they typically will receive the first notice of a terrorist attack, and can mobilize resources both within their own region and from other regions. Local rescue centrals were led by the police and were to organize the rescue mission. Municipalities would typically take part in rescue work.

In the event of a crisis, municipalities were to convene their crisis management team, whose role was to coordinate crisis management within the municipality. Furthermore, most municipalities had a psychosocial crisis team to be mobilized in the case of a crisis or disaster. Their role was to provide psychosocial care to individuals, families, and local communities. Even though the establishment of a reception and information center for the relatives of those directly affected was under the responsibility of the police, the psychosocial crisis teams could be central in operating these centers. In the aftermath of the 2011 terrorist attack, it was recommended that survivors from the attack on Utøya Island should get a contact person in the municipality, who could provide support and guide them into the healthcare system. The profession of this person was decided locally. For survivors from the government quarter, this follow-up was provided by occupational health services.

The operational healthcare can broadly be divided into two sections: primary healthcare, which included healthcare provided in the municipalities, such as general practitioners, and secondary healthcare, provided through the Regional Health Authorities (RHF), including hospitals and other specialized healthcare providers such as psychiatric outpatient clinics. As mentioned, the emergency medical communication centrals and ambulances were also organized under the RHFs.

Private actors could be involved, if the municipalities were buying healthcare services from such actors, but would typically not be very central in crisis work. Volunteer organizations could be mobilized for rescue and other crisis work, pending on a previous agreement with the municipality in question. They could also be involved at national levels. For instance, there is an agreement between national authorities and the Red Cross, in which the Red Cross holds responsibility for setting up victim support groups in the aftermath of disasters. Religious actors, most prominently from the Norwegian church, have played important roles in psychosocial

follow-up in Norway. Finally, there is a stated intention of facilitating military-civilian cooperation in times of crises and disasters.

Target populations

The identified target population varies somewhat with the scope of the document. In more overarching and general documents, such as [Overordnet helse- og sosial beredskapsplan], measures are intended to be directed towards «the population", without any further specification. However, for the more particular measures the central target population is specified to be survivors or those directly affected, including the bereaved. The term 'victim' is not used extensively.

Groups identified as potentially in need of special attention were children and youths, minorities, and in particular refugees.

France:

Providers

Responses after terrorist attacks were inter-ministerial endeavors in France. Furthermore, coordination was spread across different levels of government, including the national level, the regional levels of the health regions and the defense and security zones, and the more local level of the departments.

Key coordinating actors

Key actors at the national level were the Ministries of Health, and its underlying directorates, the Directorate-General for Health and the Directorate-General for Hospitalization and the Organization of care. The Directorate-General of Health was responsible for centralizing alerts of health emergencies, and securing their management in coordination with other relevant ministries and institutions. Attached to it, was also the Operational Center for the Reception and Regulation of Health and Social Emergencies (CORRUSS), which was responsible for the operational national health management of the crisis via the Health Crisis Center (CCS). Furthermore, the Ministry of the Interior, the Prime Minister's Office, the Ministry for Foreign Affairs, and the Ministry of Justice were central. In the case of a disaster, an inter-Ministerial Crisis Cell (CIC) was to be activated by the Prime Minister, bringing together all the ministries concerned. The CIC was the central structure of a national crisis management in France, and was usually led by the Minister of the Interior for a crisis occurring within French borders and the Minister for Foreign Affairs for crises abroad.

In the event of a terrorist attack in France, the Prime Minister may decide to activate the Cross-Government Victim Support Unit (CIAV). The composition of CIAV reflects who the key coordinating actors in the follow-up after terrorist attacks in France are. Represented ministries are typically the Ministries of Justice, the Interior, Foreign Affairs and Health. In addition, victim support associations, the Guarantee fund for victims of acts of terrorism and other offenses (FGTI), and a representative of the Paris Public Prosecutor can be asked to be member of the CIAV. At the end of the crisis phase, the Minister of Justice may decide to convene the inter-Ministerial Victim Follow-Up Committee (CISV). The CISV is the decision-making body responsible for defining and steering the organization of the post-crisis victim support system.

At the sub-national level, the regional health agencies (ARS) were central. They organized the management of medical and psychological emergencies, which is part of the urgent medical aid system, including being responsible for the region's medical and psychological emergency units (CUMP). The Regional Health Agency ensures the adaptation and power-up of the provision of

care if necessary, as well as the coordination of medical care for victims at the regional level. The ARSs also organized the patient care path, after the emergency phase.

The other important administrative division of the French territory, which is relevant in the case of disasters, are the defense and security zones. The defense zone, with its zonal prefect, is described as taking part in the management of a disaster or crisis situation, when the means needed to manage the situation exceeds the resources of the department in which the event has happened. The zone prefect was responsible for non-military defense and crisis management. The defense and security zone was also central in the coordination of civilian and military efforts in the event of a disaster. In addition, regional zone agencies (ARSZ) were important. The regional zone agency are described as contributing to the mobilization of the national medical-psychological emergency network by ensuring the mobilization of the medical and psychological emergency units in its zone, with the support of the zonal medical and psychological emergency unit.

Finally the departments, and their departmental prefects, were also central in the management of crisis situations. The prefects were the representative of the central Government in the department, and responsible for public order and the protection of populations. The departmental prefect is the Director of Emergency Operations (DOS) and oversee all relief and policing missions, through the departmental director of the fire and rescue service.

Key operational providers

The key operational actors in the emergency phase were the fire and rescue services, which is responsible for managing emergency relief, together with the police and gendarmerie (military police). The French fire brigade has an integrated health and medical rescue service (SSSM). There is also a "specialized extraction groups" of fire brigade personnel, who are trained to intervene in securitized zones. Medical teams are integrated into these units in order to be able to provide early treatment to those affected, in the zone where regular rescue teams cannot enter due to safety restrictions

Pre-hospital care was the responsibility of the Urgent Medical Aid Service (SAMUs), and their attached mobile emergency and resuscitation teams (SMUR). Each health facility, in which a SAMU is based, will have a medical and psychological emergency unit (CUMP), composed of previously trained mental health personnel and professionals, such as psychiatrists, psychologists and nurses. Their role was to ensure medical-psychological care of victims in the immediate and post-immediate phase after terrorist attacks and other disasters. In the case of large scale events, the national network of CUMPs could be used to mobilize CUMPS beyond the ARSs and the defense and security zones. One of the CUMPs within a region is designated as the “regional CUMP” by the ARS. This unit holds the responsibility of coordinating the other departmental CUMPs and enhanced departmental CUMPs. In addition, a zonal CUMP is established within the reference health facility where the zonal SAMU is based.

Furthermore, other healthcare providers under the auspices of the ARS, most prominently the hospital services, were central. In addition, external resources not within the scope of the ARS, including army medical centers, the French Defense Health Service (SSA), and army teaching hospitals could be involved. Private actors would for the most part not be directly involved in disaster work, but could be involved indirectly through taking off load to relieve healthcare workers that were directly involved.

Finally, other departmental victim support services, such as victim support associations and approved civil security associations could function as partners to the CUMPs, a cooperation that was controlled through formalized partnerships. Victims support organizations that were

approved by the Ministry of Justice were organized in the France Victimes federation. Volunteer organizations such as the Red Cross and the Secours Catholique, could be involved in socio-psychological relief.

There was a specific fund for the compensation of victims of terrorism in France, The Guarantee Fund for the victims of Terrorism and other Offenses (FGTI). However, victims of terrorism could also be entitled to reparation under the Code of Military Invalidity and War Victims' Pensions. Through the latter, they could benefit from social welfare and administrative assistance from the local services of the National Office for Veterans and Victims of War.

Target populations:

Like in the Norwegian documents, the French material also refers to how protection of the population or the public is a central aim. In the more overarching, disaster specific documents, victims of disaster or even just patients (including adult, pediatric and specialized pediatric) are defined as the target populations of the measures. In the case of terrorist attacks more specifically, the measures described are directed towards victims of acts of terrorism and their relatives. The latter include bereaved families. The children of deceased or injured victims who are not able to care for them, are mentioned specifically. In general the task of compiling a list of victims of terrorism, including who are entitled to compile this list, is the subject of significant attention in the French documents. The reason for this is that it is vital both for reaching the victims, but also for ensuring that the right individuals receive the compensations and help that they are entitled to. Specific attention is also given to the families of deceased victims in cases where the families live abroad, and witnesses on the scene, who are not direct victims, but still affected.

Content

In the following we will outline the measures prescribed in the documents for providing follow-up after terrorist attacks in the two countries, respectively.

Norway:

A central point of departure for the Norwegian measures is preparing for providing "necessary and proper healthcare" *even* in the event of a crisis or disaster. This is understood as being a continuation of the everyday contingency that is present in the healthcare system. Under some circumstances this would involve reorganizing or expanding regular operations, for instance due to the system being overwhelmed or there being a lack of resources due to an influx. In this sense, there is a sentiment in the Norwegian material suggesting that operations should be kept as normal as possible, and follow regular structures to the extent it is practicable, even in a crisis situation. In [Rettleiar om helse- og sosial beredskap i kommunene], it is even specified that this guideline mostly treat periods of war and peace the same, because the challenges for the healthcare system and social services in principle will be the same under both circumstances. At the same time, it is specified that crisis organizations should be established rapidly.

There was a focus on the need for good planning, including risk analysis taking local circumstances into account, as well as prior training of those involved. There are suggestions in the material about specific skills that personnel should be trained in. It was stressed that providing care to those affected by disasters and accidents is a comprehensive task. In the oldest of the included documents, it is specified that the comprehensive care that needs to be provided after disasters involves psychological, physical, social, spiritual, and material dimensions. Coherence between the different involved actors is highlighted as important, as is their ability to cooperate with flexibility and efficiency. There are specifications of the requirement for contingency planning, and what these plans should include, but not a very specific description of

how the municipalities for instance should organize themselves. In [Rettleiar om helse- og sosial beredskap i kommunene], it is stated that municipalities can choose to have separate contingency plans or to integrate these into their regular operational plans. The municipalities held a wide range of responsibilities in crisis, ranging from maintaining health and social services, to assisting the police in rescue missions, keeping the general public informed, reporting about the situation to other levels of government, etc. At the same time, they were required to continuously consider whether these tasks could be provided with the resources available in the municipality, or if they needed to call for reinforcements from other municipalities, or other levels of government. When the crisis situation was considered to be over, it was also the responsibility of the municipality to ensure that the situation for its inhabitants returned to normal.

Information is reiterated as an important feature of the post-disaster work. This include discussions on how information should be distributed to relevant actors at all levels of government and operational crisis management, but also how it is central for those affected and the public in general, to receive reliable, sufficient and realistic information, which does not leave room for speculation. Interaction with the media, both by authorities, and by individuals affected by the disaster is thus discussed in the documents. Additionally, information to the bereaved in the case of fatalities is discussed.

The municipalities held a significant share of the responsibility for setting up these teams for psycho-social follow-up in the event of disaster and deciding how they should operate. At the same time, the Norwegian material is quite detailed on the measures to be provided in the immediate aftermath of a terrorist attack or other disasters. In particular, the work of the psychosocial crisis teams, and other central actors is described in detail, including what is understood as psycho-social measures and what their purposes are, but also how the involved actors should go about providing psychosocial follow-up in the aftermath of a disaster. The [Veileder for psykososiale tiltak] also includes a discussion of specific measures and the extent to which specific interventions are supported in scientific literature and by expert opinions. It is underlined that there are few studies on the effects of specific interventions in the early aftermath of disasters, and that measures implemented often are based on expert opinions, although the importance of taking evidence-based knowledge into account is stressed.

In the immediate aftermath, information, basic care and practical help are highlighted as particularly important in order to grasp the needs of each affected individual and facilitate natural healing. Some documents are quite specific in giving advice about how helpers should act when approaching those directly affected in the immediate aftermath of a disaster or accident. The principle of watchful waiting is central in the Norwegian material, and therapeutic interventions are recommended only in exceptional circumstances. It is pointed out that whereas physical injuries should be treated immediately, psychological screening is not necessary in the immediate aftermath. It is highlighted that the psychosocial crisis teams should be careful not to replace the regular social networks of those affected. When it comes to treatment of physical injuries, it is referred to how criteria are set out at each hospital for when and how they should trigger a disaster warning, which could be associated with a call-back of personnel and coordination and cooperation with other hospitals.

Overall, it is reiterated that help needs to be customized to the individual, and that there are no guidelines for a general follow-up, neither physically, psycho-socially, nor psychologically, of everyone who happens to be affected by the same disaster or accident. However, in documents that were produced in the immediate aftermath of the 2011 terrorist attack, it is evident that these previous lines were not necessarily fully followed. For instance, a recommendation after the terrorist attacks was that municipalities were to proactively establish contact with everyone

directly affected by the terrorist attack on Utøya island, in order to get an overview of individual needs and provide information about how to seek help. A designated contact person in the municipality were to initiate this contact. Furthermore, it was recommended that all survivors were to be offered a standardized screening at three time points in the first year following the attack. This model for follow-up was developed specifically for the aftermath of the terrorist attacks, although it was specified in the documents that the model was a *recommendation* and that it should be adjusted to local circumstances in the municipalities.

For psychosocial and psychological/psychiatric follow-up in the longer term, specific therapeutic approaches were recommended. In the general guideline, it is suggested that psycho-social follow-up should be integrated into the regular healthcare system as much as possible. For instance diagnostics and treatment of long-term illness should be treated within the regular healthcare system, and is not the responsibility of the psychosocial crisis teams. At the same time, about three years after the terrorist attacks, a letter was sent from the Ministry of Healthcare and the Ministry of Local Government and Modernization, to stress the need for long-term follow-up, specifying the resources that were available to the municipalities in this work.

France:

The central components of the French approach were provision of emergency services and medical-psychological care in the immediate to post-immediate aftermath, as well as the organization of the healthcare system in the event of a disaster, including how the system should power up during a crisis situation, and then go back to regular operations when the emergency is over. There is focus on patient care paths, where the aim is to direct victims into the regular healthcare services when the emergency phase is over. It is stated that the response to health crises should be based on a graduated approach in which the need for more resources determine the nature and volume of the mobilization. There is built in a possibility for reinforcement into several of the mechanisms, which reflects the gradual approach. This is seen for example in the relationship between the departmental and regional CUMPS, or the White Plans of individual healthcare institutions and the expanded White Plans of the departments. Furthermore, events can be handled at both territorial and national levels, but there is an aim for the management to be somewhat homogenous, although local circumstances must be taken into account.

The content in the French plans, including the ORSAN plan, the White Plan, and the CUMP documents, is to a large extent focused around details on the organization of care, rather than the actual content of the healthcare that is to be provided. A central aim of the documents hence appear to be laying out how the actors within the healthcare system can power up in an event that puts an unusual strain on its operations, and how they can do this in coordination with other existing plans and mechanisms. Furthermore, which resources, including internal and external material and human resources, are available to this end, and how they can be mobilized. Since the documents to an important extent outline mechanisms that are specific for disaster or crises situations, they generally also outline how these mechanisms relate to the regular healthcare system. For instance, the CUMP documents focus extensively on how personnel are to be mobilized to the CUMPs, and compensated for this work, which is outside regular operations. It is also specified when the system should go back to normal operations after a period of disaster mobilization.

The ORSAN mechanism is central in the provision of post-disaster care, as it is a framework for planning how the healthcare system should provide care in exceptional situations through the private sector, pre-hospital phase, and in healthcare facilities. In addition, all health facilities, whether public, non-profit or private, must have a White Plan. The ORSAN plan consists of five components, of which three are regional and two are zonal. Most relevant in the event of

terrorist attacks is the ORSAN AMAVI component, which is regional and regulates the healthcare in situations involving a high number of non-contaminated casualties. In addition, the zonal component ORSAN BIO can be relevant in the case of terrorist attacks involving a biological risk. There is also a zonal component regulating situations involving NRC risks (ORSAN NRC). In the document it is stated that depending on the nature, geographical scope and severity of the event in question, the ORSAN plan can be implemented partly or in full

There is an overall extensive focus in the materials on training of healthcare professionals. The ORSAN plan, for instance, sets out guidelines for how health professionals should be trained for these situations. In the case of the CUMPs, the training is in part organized nationally

Some of the documents are specific when it comes to the event of terrorist attacks. These are more detailed when it comes to the contents of the actual interventions, but also here there is a significant focus on the organization of the healthcare system in the event of a terrorist attack. It is stressed that a number of health, judicial, and administrative measures must be combined, in order to meet the needs of those affected by terrorist attacks. It is outlined how the involved actors should react in the case of terrorism, including the responsibility held by the departmental prefect for ensuring the immediate mobilization of emergency relief and medical assistance, and security at the site of the attack. This immediate mobilization is organized according to the ORSEC mechanism, and its underlying plan, the NOVI plan for provision of relief to large number of victims. Furthermore, it is specified how medical and psychological care of victims should take place in parallel. The identification of victims, and information to victims and their families is highlighted as important. It ensures rapid collection and centralization of information necessary to support victims and their families, and ensures personalized and uninterrupted follow-up of those concerned.

Medical-social care was the responsibility of the CUMPs. The activities of the CUMPs are defined as “medical activities”. It is specified that its interventions should be rapid and it includes medical-psychological care to victims, in what is defined as “the immediate and post-immediate” aftermath (specified as ranging from a few days to a few weeks), as well as guiding patients into further care paths beyond these phases. The care is to be provided “in accordance with the best practices defined by the learned societies concerned”, but it is not further specified what is considered best practice. Furthermore, it is specified that they should issue a descriptive medical certificate of medical and psychological injury to the victims they care for and provide them with an information sheet, which explains the role of the CUMP, outlines very briefly which reactions can be expected in the aftermath of experiencing a traumatic situation and how to get in touch with the healthcare system.

Process

When analyzing process components of the planned follow-up, the focus has been on timing of measures suggested, and how the organization and harmonization of the disaster specific measures are handled with and within the regular healthcare system.

Norway:

There is a strong focus in the Norwegian material on how provision of healthcare services in the event of crises, disasters, or even war, should be a continuation of the regular provision of services, and that health contingency should be integrated into other contingency plans and be part of regular operations. For instance, it is stated that the healthcare service is defined as a contingency organization, which is accustomed to handling emergencies and with set routines for how and when to activate a disaster alarm in the case of an event with many victims. Overall,

responsibilities and organization in a crisis situation is based on the principles of responsibility, subsidiarity, and homogeneity, as previously outlined.

When it comes to the timing of measures suggested and the different phases in the aftermath it is recognized that time is a central challenge when disasters are to be managed, and that the management of an emergency requires that routines should be known to all relevant actors beforehand. The documents cover typical reactions after disasters, including the differences between needs in the immediate aftermath and the longer term, as well as what helpers should know about people's reactions and what can be beneficial. In the 2011 guideline, watchful waiting is introduced as an important principle. Here it is also acknowledged that extensive resources often are mobilized in the immediate aftermath, but that many of those affected by crises experience a lack of follow-up. In the 2014 document it is acknowledged that knowledge gathered internationally shows a need for follow-up two-five years after a disaster.

France:

Also in the French documents, it is made clear that the crisis specific mechanisms and plans have their foundation in the regular regional and zonal framework. However, there is a separation between the crisis mechanisms and regular operations where the linkage between the two is a particular focus on patient care paths, guiding patients from the emergency specific measures to the regular system. It is stated that the use of the crisis specific mechanisms are reserved for situations where the health system cannot act alone and/or is in need of reinforcement. It is described as a central aim of the ORSAN plan to outline how resources can be allocated from the regular system, for instance through adjusting the care paths of routine patients, in order to reserve resource for the disaster response.

Since many of the provisions described in the French documents are mechanisms that are specific to the crisis phase, they often cover a rather limited temporal period in the aftermath of the terrorist attack. For instance, in the case of the work of the CUMPs it is specified that their responsibility is the immediate to post-immediate phase, and that the intention is for those in need of further healthcare or support, to be guided into the regular healthcare system. In this sense, the urgent medical aid system is in some ways a separate entity, with responsibility in a limited temporal phase. The needs of those affected by terrorist attacks or disasters in the longer run are generally not discussed at any length in the documents, as this is assumed to be the responsibility of the regular structures within the healthcare system. There is a focus in the plans on the importance of detailing when the extraordinary mechanisms should be lifted, in order to bring the health system back to normal operations.

Discussion

What emergency preparedness in the public health sector can and should look like continues to be a debated issue (Khan et al., 2018; Nelson et al., 2007), and there is for instance no agreed upon framework for how national health systems should rig themselves for handling the human consequences of terrorist attacks. International guidelines suggesting important tenants of this work exist (see e.g. Bisson et al., 2010), however, there appear to be variation in terms of the extent to which these are followed nationally. In the current paper we have analyzed how two generally peaceful democracies in Europe was prepared for the health consequences of terrorist attacks occurring within their borders. Although there are several similarities between the two cases, for instance in terms of some of the measures prescribed, and their intended target

groups, there are also important differences between the two countries under scrutiny, and possible explanations to these similarities and differences will be discussed in the following.

The political system under which the planning for emergencies takes place will lead to challenges and opportunities that are unique to that specific political context (Perry & Lindell, 2003). The plans for meeting healthcare needs after terror will develop in a navigation of the intersection between healthcare needs, as identified for instance in international guidelines, research literature and previous experiences nationally and internationally, and the national political framework. The analysis presented in this paper, suggested several examples in the approaches to follow-up in Norway and France respectively, of how characteristics of the political systems and national history may contribute to shaping the response. One such example include the sheer size of the system, in terms of the population covered, but also how the systems organize themselves in non-disaster contexts. The French documents lay out rather detailed descriptions of how relevant actors should be organized in the case of disaster, for instance through the implementation of the ORSAN plan in the regional health authorities, or the White plan in hospitals. In these plans, it is to a large extent detailed how different actors should coordinate and cooperate, and how coordination and responsibility can be lifted to a higher level of government or administration, if the situation requires it. In the Norwegian documents, there is arguably signs of stronger local autonomy in terms of how governmental structures should organize themselves in the case of a disaster. For instance municipalities are autonomous when it comes to how they wish to integrate contingency plans into their regular plan work, and also how they cooperate vertically with other municipalities in times of crisis or disaster. The Norwegian population is significantly smaller than the French, however it is living in one of the least densely populated countries in Europe, with geographical dispersion. This could be part of the explanation for why local autonomy appears to be the selected approach in much contingency work.

At the same time, and although local autonomy appears to be stronger in Norway, the Norwegian documents are more detailed in terms of the specific measures to be implemented and the knowledge base for these. For instance, whereas the Norwegian guideline for psychosocial follow-up is rather detailed when it comes to what the crisis teams should do in the case of disaster, the CUMP documents are more specific in terms of the profession of the participants in CUMP, but not so much about what they are intended to do. The latter appear to be left more to the appraisals of the CUMPs themselves, and possibly even individual professionals, than what appears to be the case in Norway. In other words, whereas Norway has prioritized that the services should be close to the receiver's usual environment, France has prioritized that the services should have specialized mental health competence.

Counter to what could be expected, based on the existence of the international guidelines (see e.g. Bisson et al., 2010; Brymer et al., 2006) the content of the prescribed measures varied in the two countries. One of the most apparent differences is as alluded to above, the degree to which specialized healthcare is relied upon to provide psychosocial follow-up in the emergency phase. In the Norwegian guidelines it is stated that only exceptional cases will require psycho-therapeutic approaches in the first week after a potentially traumatic event, like a terrorist attack. This is part of the rationale behind why the psychosocial crisis team are composed of an interdisciplinary group trained to provide care and notions of safety in the immediate aftermath, but usually not for instance psychiatrists, prepared to provide psychiatric treatment. In France, on the other hand, the CUMPs consist of psychologists, psychiatrists, and psychiatric nurses specifically, in other words professionals who are specialized in providing psychiatric treatment and care.

Terrorist attacks are events with particular characteristics, compared to both other types of political violence, and other types of disasters (Alexander, 2002; Hoffmann, 2006). In both countries, there is a clear perception conveyed through the documents that as much as terrorist attacks are, in their essence, unexpected events, the response to such events by the authorities can by no means be improvised, but needs to be planned and trained for. At the same time, different terrorist attacks will have heterogeneous characteristics that will call for different forms of response in the aftermath. For instance, the attacks on Utøya Island in Norway, and the attacks in Nice in France, victimized a particular group by directly affecting many children and youths. This will be of importance for how the post-attack follow-up is planned. In both countries there was a focus on children and youths as specific target populations in need of particular attention and potentially targeted interventions. In France, however, there was also particular focus on children as indirect victims through the victimization of their parents. In Norway, there as a stronger focus on certain immigrant groups as specific target populations, than what could be detected in the French material.

As stated by Nelson et al. (2007), emergency preparedness in particular involve preparing for events that threatens to overwhelm routine capabilities. This sentiment is reflected in both the Norwegian and the French cases. However, some of the documents analyzed may not apply in all events of terrorism. In both countries, an important defining factor when considering a situation as a health crises is that it is a situation involving a large number of victims. This is, however not necessarily the case for all terrorist attacks.

Even though the countries have similar approaches to several aspects of healthcare contingency following terrorism specifically, it is also evident that different histories with regards to terrorism is reflected in the documents. When crisis occur, this can represent a possibility for policy development, through the introduction of new "problems" in the policy sphere (Kingdon, 2014). Terrorist attacks are more present in the French documents as potential threats, needing particular preparation, than is the case in the Norwegian documents that had been published prior to the attacks. It is reasonable to assume that this reflects more experience in France with events of terrorism, than what had been the case in Norway prior to 2011.

An important point to keep in mind is that planned measures and the actual measures being implemented in the healthcare system and beyond are not necessarily identical features, and policy plans should therefore not be understood as accurate representations of what occurs during crisis management. As pointed out by Perry and Lindell (2003), emergency plans should not automatically be understood as emergency preparedness, as the latter is a process in which the written documents are only one part. Significant parts of emergency preparedness can be informal processes that will not be visible in written documents. Still, planned measures are important in order to understand intentions and the background for actions. To the extent that plans are publicly known, they may also set precedent for expectations in the population. Furthermore, the two countries studied in this paper are not necessarily typical in terms of the extent of documentation of plans for follow-up. Compared to otherwise arguably comparable European countries there is a rather comprehensive documentation of plans and mechanisms both in the Norwegian and French cases. For an example of a country with more limited documentation, see the discussion of Belgium in Stene et al. (forthcoming). Still, studying cases which have rich documentations allow for a better insight into the thoughts and processes involved in healthcare contingency.

Strengths and limitations

As demonstrated in this paper, the systems for follow-up after terrorist attacks are complex and involve different phases, as well as a large number of actors in both Norway and France. In this article, we have covered the key features. As much as this gives a comparative overview of the

situation in the two countries, it will not capture all processes involved in crisis management after terrorism in the two countries. The current study focused on policies and plans at the national level. In both countries there will also exist relevant plans and guidelines at regional, local, or institutional levels. It is possible that measures that are described nationally in one country can be covered partly or fully at more local levels of government in another. The design of our study did not enable us to register this. At the same time, it is relevant to study what is prioritized and controlled at the national level of government, in the case of disaster preparedness.

Conclusion

[Here we will outline some implications of our study for further research and for policy]

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