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ORIGINAL ARTICLE

The Framing of the Terrorist Threat in Health Contingency: Implications for Response

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Abstract

Terrorist attacks threaten the security of states and individuals, and often spur widespread state responses once they have occurred. Recent research has focused on health contingency in relation to terrorism and unveiled divergence in terms of how European countries approach this task. To understand more about this divergence, it is relevant to investigate how states define the issue of terrorism in contingency policies. The current study utilized theories of framing as part of policymaking and document analysis with a thematic analysis approach, to scrutinize to what extent terrorism was framed as a security issue in health contingency in relation to terrorist attacks in Norway and France, and how this affected policy outcomes. The analysis unveiled that a securitized frame was not prominent in the Norwegian approach to health contingency. In the French material, however, terrorism was described as a threat to national security. Second, terrorism response within the healthcare field was described as a form of "nonmilitary defense," clearly positioning the healthcare system in the response to this national security threat. The framing of terrorism in policy documents was linked to diverging policy responses in the two countries. The most distinct difference is that victims of terrorism hold particular rights in France, but not in Norway. This entails that in France, the definition of terrorism, and whether specific events are defined as terrorism or not, in part become decisive for the help received.

Keywords Terrorism · Health · Security · Document analysis · Policy analysis · Framing

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1 Introduction

> "'Through the press, we learned that, at this stage of the investigation, the attack wasn't classified as a terrorist one. We're beyond shocked. They're trying to make us believe that it's just a right-wing extremist.' 'We're very angry,' he added."
> - Spokesman of the CDKF, Agit Polat, interviewed by Le Monde after the 23 December, 2022 shooting at a Kurdish cultural center in Paris (Seelow and Ayad 2022).

Terrorist attacks threaten the security of states, communities, and individuals, while concurrently representing a challenge for social and healthcare systems. State responses to such events need to cross different fields, including security, law enforcement and health. At the same time, and as illustrated by the quote above, terrorism continues to be a contested phenomenon for which there exists no agreed upon definition (Schmid 1992; Young and Findley 2011). How terrorism is perceived by authorities—that is, the problem definition integrated in policymaking (see e.g., Bacchi 2016; Kingdon 2014) is central for understanding which policy options are deemed available when attacks are responded to. In terrorism prevention, there has been a recent turn toward combining an increasingly securitized discourse with a focus on a wider range of social aspects (Berner 2022). Less is known, however, about the representation of terrorism when countries plan for the response to terrorist attacks in a wider socio-political context, and in relation to health contingency specifically.

The point of departure for the present study was an overarching need to learn more about why countries plan to meet health needs after terrorist attacks the way that they do, given that there are transnational differences in approach to crisis management and post-terrorism follow-up, even in Europe (Dyregrov et al. 2019; Stene et al. 2022). There is a pressing need for more systematic knowledge about the immediate to long-term response and psychosocial follow-up of affected populations. Policies on health crises responses across Europe have arguably been subject to an intended integration and collaboration, including countries' responses to infectious diseases, the threat from chemical and biological weapons, and terrorist attacks (Bengtsson et al. 2019; Rimpler-Schmid et al. 2021). Still, there is a continuous challenge to this integration that countries, even within the European Union, diverge in terms of how they organize and conceptualize health policies in an international perspective (Steurs et al. 2018). In the case of responses to terrorist attacks, it has been documented that there are differences in how the healthcare systems of European countries respond in their aftermath (Stene et al. 2022). These differences have been linked to variation in the organization of healthcare systems and different approaches to the implementation of international guidelines (Nilsen and Stene 2023). At the same time, applying a purely technical and medical approach may leave us with an incomplete understanding of why countries differ in their approaches to emergency preparedness and terrorism response in the healthcare field (Stoeva 2022). A stronger

integration of political science and health research in recent years has exposed that priorities in healthcare are not based on best practices hailing from the medical field alone but are also shaped by other social and political factors (McInnes et al. 2012; Shiffman and Shawar 2022; Stoeva 2016, 2022).

In an initial analysis[1] of plans for terrorist response in the healthcare field in France and Norway, an empirical puzzle emerged: In France, a securitized approach to the health response was evident, which was not found in Norway. The health response to terrorist attacks in France was described utilizing references to national security and clear examples of integration of health and security sectors. This was not re-found in the Norwegian documents. Exploring how issues are framed in policy enables a deeper investigation into policy variation (Koon et al. 2016). Given the stronger focus on terrorism as a security threat in the French documents, this study attempted to explore how this specific framing affected variation in policy responses after terrorist attacks. A first step in doing so was to explore in-depth how these differences were visible in terms of how terrorist attacks were interpreted and represented in policy documents. In the following, I will therefore draw upon theories of framing as part of policymaking (Benford and Snow 2000; Shiffman and Shawar 2022; Stone 1989). Second, the analysis focused on how this framing mattered for the policy prescribed.

2 Study Context

The focus of this study was policy documents setting out core elements of terrorism preparedness prior to and during three major terrorist attacks in France and one major attack in Norway. The two countries were chosen as cases for comparison because intial analyses suggested that they differed from one another along this one important dimension; the descriptions of the health response post-terror, while otherwise sharing many similarities by both being European countries with high state capasity for responding to crises, and with strong, universal healthcare systems.

The Norwegian plans and guidelines studied were relevant for the response to the July 22, 2011, attack in Oslo and on Utøya island. The French documents analyzed were relevant for the January 7–9, 2015, attack in Paris; the November 13, 2015, attack in Paris; and the July 14, 2016, attack in Nice. Whereas the attack in Norway was an example of domestic terrorism, with a terrorist with sympathies to the extreme right, the attacks in France were all linked to a cluster of jihadi attacks. The two countries had different histories of terrorism prior to the attacks under scrutiny. Whereas France had a longer history of larger and smaller terrorist attacks, organized from several ideological positions, the July 22, 2011, attacks were the most violent attacks in Norway since World War II and stood out in the country's

[1] All documents were initially analyzed as part of a comparative study of different aspects of healthcare contingency in relation to terrorism. In this project, the planning for contingency in Norway and France was studied focusing on why countries plan the way they do and how these plans come to be. For more information see Nilsen and Stene (2023).

history (D'Amato 2019; START (National Consortium for the Study of Terrorism and Responses to Terrorism), 2022). Furthermore, there are historical differences between the two countries in terms of involvement in military actions domestically and abroad. Despite being a founding NATO member, Norway has mostly attempted to keep a position of neutrality in military questions (Rottem 2007) with an identity as a "peaceful nation" being a central guiding discourse for its involvment in international relations (Leira 2005). France, on the other hand, has had a more central role in both colonial and world wars, and a complex history of terrorism, which according to D'Amato (2019) have contributed to it being "one of the most experienced European countries in dealing with terrorism" (pp. 65–66).

3 Theoretical Framework

3.1 Framing

When we speak of framing in social science research, this can have several meanings. Here, I follow Shiffman and Shawar (2022), who use framing in the meaning "the ways that political elites and publics understand and portray public issues.." (p. 1978). These frames will clearly originate from diverse actors and discourses, but the purpose of this paper is not to discuss the emergence and existence of frames per se. Rather, this study is focused on the utilization of one specific frame in one specific context: how policymakers and affiliated stakeholders represent terrorism as *a security threat* in *national healthcare policy.* Different ways of framing health issues in a global perspective have been suggested. In this lies an understanding of there not being one inevitable framing of an issue, but that a political "problem" can be understood and framed in different ways (Benford and Snow 2000; Shiffman and Shawar 2022; Stone 1989).

Policies can be understood as solutions to problems that needs resolve within a certain amount of time (de Leeuw et al. 2014; Milio 2001). In this understanding of what policymaking is, lies an inherent need to define the problem at hand to find the best possible solutions and to decide which problems to prioritize over others. This is at the essence of framing. Stone (1989) indeed calls the framing process a competition of "causal stories." By this, she means that the framing process is a negotiation of an issue's causes, but also defines who is responsible for addressing it and who the "victims" are. The aim of this process is defining a problem to guide policymaking (Kingdon 2014). Framing is hence not only about placing blame, but also about finding remedy to a problem (Benford and Snow 2000; Kingdon 2014; Stone 1989).

Framing can be used intentionally to push issues onto political agendas (Benford and Snow 2000). One example could be the securitization of certain diseases to defend a high use of resources or the use of exceptionalist means to handle the threat that these diseases are assumed to pose (Hanrieder and Kreuder-Sonnen 2014; McInnes and Rushton 2012). While such analyses typically focus on how diverse actors contribute to agenda-setting, the description of "problems" in policy processes also exists implicitly in policy documents (Bacchi 2016). This framing is of particular

interest for what is studied in the current paper. As noted by Bacchi (2016): "'problems' do not sit outside policy processes waiting to be solved. Instead, they are produced as problems of particular kinds *within* policies and policy proposals. That is, every policy proposal contains within it an implicit representation of what the problem is represented to be" (p. 1). This understanding of framing, or "problem definition," is highly relevant in the current study, given that the focus is on framing *within* policy documents, specifically. Understanding more about this underlying definitional process of the health response to terrorism is relevant to understand why countries diverge in their approach to terrorism response.

3.2 The Link Between Health and Security

To contextualize the discussion of a securitized framing in health contingency, a short introduction to the two central concepts, health and security, as well as the link between the two is in order. Health has been defined as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (World Health Organization 2009, p. 1). While health can be theorized at both individual and collective levels (Antonvsky, 1996), the facilitation of health at population level is the focus of public health, which can be defined as a system whose aim is to protect population health (Keck and Erme 2007). According to the Ottawa chapter, there are important prerequisites of health, including peace, stable eco-systems, social justice and equity, and health promotion hence not only involves the prevention of disease as such, but also the facilitation of a healthy environment, socially, physically, and so on (World Health Organization 1986). How this can and should be facilitated is, however, a complex question. Taking health, rather than disease as its starting point, Antonovsky's salutogenic model of health posits that health promotion starts with the establishment of an environment fitted to deal with inevitable stressors at both individual and systemic levels (Antonovsky 1979, 1996; Vinje et al. 2017). Integral to the salutogenic model is the sense of coherence (SOC) construct, which consists of the three aspects meaningfulness, comprehensibility, and manageability (Antonvsky, 1996). More specifically, this means that in order to encounter a stressor without moving further away from health on the health/disease continuum, the individual or community must have resources that makes the stressor appear manageable, comprehensible, and meaningful (Antonvsky, 1996, pp. 15–16). Importantly, though, Antonovsky argues that the resources needed for a strong SOC will vary across situations and cultures. This is central when analyzing framings of terrorism as a health concern transnationally.

Like health, the security concept is complex and has developed with time. The concept has expanded in terms of who its referent object is, what its issue areas are, its spatial application and how threat or danger is being conceptualized (Daase 2010, pp. 23–24). In its traditional understanding, the concept was focused on global security dilemmas involving the security of states whose soverignty was threatened militarily. This focus was challenged by the development of societal security, which emerged both to enable the study of the security of different entities, as socities and nations are not necessarily always states, and also as a criticism of the lack of focus

on the security of social groups in the traditional security paradigm (Bilgin 2003; Daase 2010). Finally, the concept of human security is focused on threats to the individual, enabling the theorizing of the individual, rather than the state or the society, as the subject of securitization (Newman 2020). With the expansion of the security concept, there has also been a shift from the avoidance of risk to the management of risk in current security policies (Kessler and Daase 2008).

Acclaiming health as central for people's security has a long history (Maclean 2008). It is acknowledged that civilians' health status can be affected by political violence both directly and indirectly (Percival 2020), and that protecting civilian health in the aftermath of collective violence is a core state responsibility. The interaction between health and security in these cases can be seen as going in both directions. On the one hand, there has been discussions of a "medicalization of security" (Elbe 2011; Nunes 2013), where the concept of security is defined in part based on the effect of security threats on population health. This then points to how considerations hailing from medicine have entered security agendas. On the other hand, one can also clearly see the relationship as going in the opposite direction, where there is a simultaneous securitization of medical responses. The latter exemplified, e.g., through the involvement of military personnel in health response (Michaud et al. 2019; Thomson et al. 2019; Wenham 2019).

It is well-established that within diverging conceptualizations of security, terrorism is understood as a security threat. How terrorism is conceptualized as a security threat when being responded to through policy measures is, however, still a question that renders scrutiny. As highlighted by the post-9/11 discussion between Liotta (2002) and Smith-Windsor (2002), terrorism as a security threat can probably best be understood as existing both within individual-focused, human security understandings of security, vulnerability, and threat, but also within a state-centric, national security paradigm. Linking terrorism as a security threat to health outcomes has been evident in the literature in recent decades, however, predominantly focusing on the particular threat posed by bio-terrorism, in a global health security framework (Feldbaum et al. 2010; Maclean 2008). Inquiries into whether and how health and security are integrated in national policy and when states respond to terrorist attacks remain scarce. Furthermore, there are continued debates pertaining to the definition of terrorism, including which characteristics should be determinant for labelling an event as a terrorist attack (Schmid 1992; Weinberg et al. 2004; Young and Findley 2011). This also has implications for states' handling of terrorism and adjacent phenomena, such as violent crime.

Overall, a state's ability to handle threats to its population and to its territories depends on its institutional, technical, administrative, and political capacity (Ostergard and Griffin, 2018). Preparing to meet health needs in the aftermath of terrorism is part of public health emergency preparedness, which has been defined 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" (Nelson et al. 2007, p. 9). Which definitions and representations of terrorism that guide this work is important for understanding more about why countries plan the way they do, but further scrutiny into this matter is needed.

4 Methods

The current study focused on analyzing policies relevant for health contingency in relation to terrorism. The empirical data were plans and guidelines at the national level in France and Norway, which advised or directed the healthcare response meeting needs in the civilian population after four specific terrorist attacks. Given that this study focused on how states deal with terrorist attacks in the health system, the plans studied were all at the national level. This means that they included overarching contingency plans and general plans for psychosocial follow-up, but not for instance the contingency plans of specific healthcare institutions, plans at subnational levels of government or detailed guidelines for somatic trauma care.

Relevant documents, i.e., documents that were either valid when the attacks occurred, or that described initiatives which commenced shortly after the attacks, were localized through three steps. The first was a review of academic and gray literature covering health and psychosocial follow-up after terrorist attacks,[2] the second involved reviewing web pages of relevant ministries and directorates in Norway and France,[3] and finally the third involved personal communication with relevant stakeholders from the respective authorities. Stakeholders were not interviewed regarding the subject matter but was consulted to ensure that all relevant documents were retrieved. Importantly though, only documents that were available to the public could be analyzed. In the case of terrorism response, also within the healthcare field, there can be classified documents, and documents that are no longer available due to replacements. While the primary focus was on plans existing prior to the terrorist attacks, it was also deemed relevant to include some documents that were released after the attacks. Times of crises often involve learning and rapid change (Ziskin and Harris 2007), and in both countries, it was evident that new documents developed in the aftermath were central to the response in the short or long term. However, given that the focus of this study was on planning and prescribed policies, and not, e.g., evaluation or implementation, documents outlining the latter were not included in the analysis. The Norwegian documents were analyzed in their original language, whereas the French documents were translated into English prior to analysis. When extracts from the data material are included in the results section, the translation into English was made by the author for the Norwegian documents, and by an external translator for the French documents.

In the initial analysis, document analysis was utilized (see Bowen 2009), using a combination of content analysis and thematic analysis (see Braun and Clarke 2006), following Bowen's (2009) recommendations. When first reading systematically through the material, the overarching theme of *security and threat* emerged

[2] An overview of gray literature consulted in the initial stages of the project are listed in Supplementary Information 1. All documents analyzed specifically for this article are referenced in the results section and included in the reference list.

[3] Norwegian Ministry of Health and Care Services (Government of Norway 2021), the Norwegian Directorate of Health (Directorate of Health 2021), the French Ministry of Solidarity and Health (Ministry of Health and Solidarity 2021), and the French Government (Government social networks 2021, 2023).

inductively, including apparent differences between the two cases studied when it came to the extent to which links between security, threat and health were discussed in the plans and guidelines. This was the basis for exploring what this securitized framing consisted of, and the next step of the analysis focused on practical, operational and theoretical references to security, safety and threat. The resulting material was in turn analyzed inductively, using thematic analysis in a "contextualist" approach, as discussed by Braun and Clarke (2006, p. 81). This is a form of thematic analysis which views the data both as a representation of how ideas and discourses shape the understanding of terrorism as a problem for society and for the healthcare system, while also keeping in mind the material "reality" that these understandings exist within. Preparedness plans are part of the infrastructure that countries has to respond to terrorism and similar disasters and are therefore in their essence "material" (McInnes et al. 2012, p. 84). At the same time, they reflect discourses, ideas and culture surrounding the issue in question. To capture both the underlying ideas, but also the specific policy outcomes a contextual thematic analysis was deemed reasonable.

In the analytical process, these analytical questions were asked to the material: "to whom is terrorism identified as a threat?," "what does the threat from terrorism consist of?," and "how is this threat addressed in the analyzed documents?." No set theoretical framework was utilized in the initial stages of analysis. Based on the theme of security and threat, however, literature on the linkages between health and security was consulted in further analysis (e.g., Hanrieder and Kreuder-Sonnen 2014; McInnes 2015; Nunes 2013, 2014; Rushton 2011). Finally, and given the previously documented variance in policy approach between the two countries (Stene et al. 2022), theories on framing (Benford and Snow 2000; Koon et al. 2016; Stone 1989) were deemed useful to explore not only how terrorist attacks were presented in the documents, but also how this was linked to policy outcomes. Two sub-themes were identified. The first theme encompassed the *representations of terrorism using a securitized discourse.* The second theme were the *practical and operational implications* of the framing of terrorism. The results of this analysis are presented in the coming section.

5 Results

5.1 The Framing of Terrorism as a Security Threat in Healthcare Plans in Norway and France: A Collective and Individual Threat

Terrorist attacks are often planned for in broader disaster response plans, combined with some terrorism-specific documents. There was a stronger reliance on terrorist-specific plans and measures in France than in Norway. Indeed, there were only two terrorism-specific documents in the Norwegian material, both of which were published after the attacks (Directorate of Health 2011; Ministry of Local Government and Modernisation & Ministry of Health and Care Services 2014). The main purpose of the documents analyzed were to outline the protection of the health and lives of individual citizens, ranging from the entire population to only those directly

affected by attacks. Furthermore, a particular concern was threats to the stability of the healthcare system. The latter through the risk of over-extension and lack of resources. There was also a specific focus on terror threats from chemical, biological, radiological and nuclear (CBRN) weapons in both countries (Ministry of Health and Care Services 2007; Prime Minister's Office 2019). In this sense, the French and Norwegian documents adopted a similar approach. The two countries diverged substantially, however, when it came to the extent to which and how terrorism was discussed as a *security threat* in the health documents. This was evident through the sheer amount of text spent on discussing the health response to terrorism from a security perspective. Whereas such discussions were close to absent in the Norwegian material, it was rather prominent in the French documents. Second, it was evident through the way a securitized language was utilized to describe the health threat from terrorism in France, but not in Norway. As outlined in the discussion of the health concept in Sect. 3.2, health can be conceptualized and promoted at both individual and system levels. When terrorism is framed in health contingency, the focus is both on the role of the victims of terrorism, but also on the healthcare system.

When the role of victims of terrorism was described in the French material, a language was applied in parts of the health documents where terrorist attacks were described as *threats to the security* of French nationals, not just the cause of distress in individuals or health concerns in the population (e.g., in Prime Minister's Office 2019, p. 1). Because victims of terrorism in this sense were presented as representatives for the nation, certain services were framed as being owed to them (Prime Minister's Office 2019). This arguably lifts the focus from the effect of terror acts on the individual's health, to how it affects a population collectively. To the extent that security in victims and beyond was addressed in the Norwegian material, it was only done with a focus on how terrorism fundamentally alters perceptions of security in individuals, but not as a threat to the collective or the nation, as such. For example, in a document released shortly after the terrorist attacks in 2011, it was stated: "The terror attack will fundamentally alter the sense of security. This requires special attention in the follow-up of the directly affected" (Directorate of Health 2011).

Second, and further along the lines of perceiving the health effects of terrorism as collective, the French approach was also more explicit in defining terrorism as a threat to the healthcare system itself, and through that a security threat for the state and public institutions. The need to protect these institutions was even conceptualized as a form of state security, and the securing of healthcare personnel, of intervention sites, and of healthcare institutions were discussed at-length in several of the documents (Directorate-General for Health 2018; Ministry of Health and Solidarity 2006; Prime Minister's Office 2019). One example of how this vulnerability of the healthcare system was understood, can be found in the so-called White plan, which is a document outlining crisis management for healthcare institutions such as hospitals:

> "Malicious behavior is part of the daily realities of society. Health facilities, open spaces with a permanent reception mission, must be organized to ensure safety and benefit from effective preventive actions, in the interest of all, to

> maintain vigilance, reduce vulnerabilities and prepare protocols and exercises in order to cope, when the time comes, in a manner that is appropriate to the alert" (Ministry of Health and Solidarity 2006, p. 111).

Additionally, and beyond being a potential target for terrorism, the healthcare system was also described as a part of the defense against or response to terrorism. Indeed, the term "nonmilitary defense" was used in the French documents to describe the activities of the healthcare system in crisis and disasters, and it was stated that there should be consistency between general protection plans and military defense plans (Ministry of Health and Solidarity 2006). More specifically, the (medical and psychosocial) care of victims of terrorism was considered part of ensuring the population's *security*. In a document where the subject matter was stated to be "the care of the victims of terrorism" and which outlines health and social care for this group, it reads: "In view of the persistence of the threat of terrorism in our territory, the State services are being mobilized to ensure the security of our compatriots." (Prime Minister's Office 2019, p. 1). This notion was echoed in the contingency plan for hospitals and similar health institutions (The White plan), where again these institution's role in defense was reiterated:

> "We will bear in mind this definition of defense: 'The purpose of defense is to ensure at all times, in all circumstances and against all forms of aggression, the security and integrity of the territory, as well as the life of the population' (Section 1 of Order 59–147 dated January 7 1959)." (Ministry of Health and Solidarity 2006, p. 14).

In this understanding of healthcare as a form of defense in France, was also an implicit conceptualization of healthcare as an important part of society's resilience. The actions of the healthcare system were in part rather explicitly, seen as having direct counter-terrorist objectives. For instance, it was stated that one of the main aims of terrorist attacks is to disorganize society. Hence, a coherent health response was seen as important as:

> "maintaining and better still, improving care in the context of an attack aimed at disorganizing society by spreading insecurity and even terror, is of particular importance. Indeed, they oppose the goals of terrorism in a way that is the beginning of resilience" (Directorate-General for Health 2018, p. 18).

In Norway, contingency in general was linked to the concept of "societal security" (mentioned e.g., by Directorate of Health 2008). This was part of an understanding of there being a continuum between times of peace and war, where crisis management in peaceful times serves as the basis of contingency during conflict (Directorate of Health 2008). Beyond these few references to societal security, however, there was no significant discussion in the Norwegian material of the role of the healthcare system in national security more broadly.

As outlined in this section, a securitized framing of the terrorist threat was more prominent in the French documents than in the Norwegian material, and the presentation of the threat posed by terrorism was focused more on the collective level in France, compared to Norway. This included both representing civilian victims

of terrorism as representatives of the nation when being victimized and the healthcare system as a central state function that is a potential target for terrorism, while simultaneously being part of the defense against this national security threat. Policy implications of this will be presented next.

5.2 Policy Outcomes: The Role of Security and Safety in Health Responses

The different forms of framing terrorism in healthcare documents in the two countries studied, had diverging policy outcomes. The framing of the role of victims of terrorism could be linked to policies focused on acknowledgement of victims, the framing of terrorism in descriptions of the role of the healthcare system could be linked to the operational handling of terrorism response.

First, there was an important distinction between the countries in terms of whether victims of terrorism were presented as a distinct group, with distinct rights. In line with the overall framing of terrorism as a threat to the collective security of the nation, victims of terrorism were considered "veterans or victims of war" in France and held rights as such (Prime Minister's Office 2019). More specifically, this means that:

> "they can benefit from social welfare and administrative assistance from the local services of the National Office for Veterans and Victims of War (ONAC-VG). A public institution under the supervision of the Ministry for the Armed Forces, the mission of ONAC-VG is to provide its nationals with the protection and material assistance they are owed as recognition from the Nation" (Prime Minister's Office 2019, p. 27).

Among the many tasks held by this institution, were to support victims of terrorism when applying for military invalidity pensions and procedures for adoption as a ward of the Nation. It also provided financial support, including securing that all health expenses directly related to the terrorist attack were covered (Government social networks, n.d. (b)). Closely linked to these rights held by victims of terrorism, there was a strong focus in the French material on the importance of defining events as terrorism, since this leads to certain policies being relevant. The Paris Public Prosecutor holds a central legal role in this regard:

> "In parallel with the organization of emergency relief and care, as well as measures taken to preserve public safety by the State representative in the department, the judicial response is placed under the direction of the Paris Public Prosecutor as soon as he or she decides to take jurisdiction with regard to classifying the events as terrorism." (Prime Minister's Office 2019, p. 9).

No similar arrangement was found in Norway. Here, the victims of terrorism were considered victims of violent crime, with rights to compensation accordingly (Nilsen et al. 2016). An act can be defined as terrorism in the legal system in Norway, as was e.g., the case after the 2011 terrorist attacks (Oslo District Court 2012). This did, however, not have any specific implications for how terrorist attacks were handled in health and social systems, if compared to other types of large-scale crises.

In line with perceiving threats to health institutions as an integral part of the national terrorism threat, there was also a particular focus in overarching, national plans for health and civil security in France on securing the healthcare institutions, as these were considered vulnerable for attacks. In the White plan setting out preparedness for French health institutions it even reads: "Security begins with the protection of the receiving facilities and their personnel" (Ministry of Health and Solidarity 2006, p. 46). In a terrorism-specific document, it was further argued:

> "Securing the hospital, which by definition welcomes the public, is a matter that the management of the facility will take into consideration. The answers are not clear-cut, but remain difficult to formulate. Reflecting on these issues together with security services is, of course, essential" (Directorate-General for Health 2018, p. 201).

Second, and in line with the framing of healthcare as a form of national defense, there was a broader use of terrorism- or disaster-specific measures in France and a civil/military integration in the response to terrorist attacks, whereas there was a stronger focus in Norway on keeping disaster response, including the response to terrorist attacks, within the regular structures of the healthcare system. Although military-civilian cooperation in the event of disasters was addressed in Norway, it appeared less developed and not as specific, as in France. There was mention in the Norwegian material of a health emergency council ("Helseberedskapsråd") which is a unit for cooperation between the healthcare sector and the armed forces to coordinate contingency, broadly speaking. In this sense it was recognized that there are overlapping tasks and interests between the two fields (Ministry of Health and Care Services 2007). In the French material, however, the integration was more explicit and appeared to have stronger practical implications. There was close coordination between civil security and health measures, made evident by the interaction of the ORSEC (civil security) and ORSAN (health) plans (Directorate-General for Health 2018; Ministry of Social Affairs Health and Women's Rights & Directorate-General for Health, 2014). It was for instance stated that "[t]he operational response deployed by relief services and emergency medical assistance services immediately after the commission of acts of a terrorist nature is governed by the provisions of the ORSEC plans (organization of the civil security response)" (Prime Minister's Office 2019, p. 12).

In France, the intervention after a terrorist attack was conceptualized as a process involving three coincidental steps. These were a "security" action, a "rescue" action, and a "health" action (sometimes collapsed into two categories of safety and care) (Ministry of Health and Solidarity 2006; Prime Minister's Office 2019). These were seen as integral parts of the intervention that needed to run in symbiosis with each other (Directorate-General for Health 2018). The securitization of healthcare intervention sites in the case of terrorist attacks was described in detail, as was how health personnel interact with security personnel, including police, fire-fighters, and military personnel. It was stressed that rescuing victims is the main purpose of rescue missions, but that security and counter-terrorism measures must take place in concurrence with this, and within a shared understanding (Directorate-General for Health 2018; Prime Minister's Office 2019). Further, it was also stated that the

medical care for victims of terrorism may be subject to interventions by specialized counter-terrorism units, which clearly signals an integration of health and security on the ground (Prime Minister's Office 2019). One such measure was to have healthcare personnel trained in "sharp" situations specifically, so that they can enter unsecured zones, hence differentiating these rescue workers from "conventional" rescue teams that can intervene outside the secure zone (Directorate-General for Health 2018). It is relevant to note that following the attack in Norway, a discussion took place when evaluating the health response, of the need for more integration between security forces and healthcare providers in situations such as terrorist attacks, including the value of drawing upon experiences from the armed forces (Directorate of Health 2012). In the same evaluation, it was also noted that special units within the police force (known as the Delta) indeed have training as emergency medical technicians, but this was not given further attention in the documents that were analyzed with regards to the planning.

Characteristics of the documents analyzed reflect the two countries' diverging history with regards to terrorism, as outlined in Sect. 2. The terrorism-specific documents analyzed in Norway were all directly linked to the response to the July 22, 2011, attacks. France had certain terrorism-specific documents that were not attack-specific. A particularity of the French approach was, e.g., the existence of a document, called "Collective assaults by weapons of war", which is the result of civil/military cooperation that clearly illustrates how terrorist attacks are considered "war-like" (Directorate-General for Health 2018). Here, it was stressed that experiences from conflict situations, exemplified e.g., through experiences from French involvement in warfare in Afghanistan, and the utilization of military medicine, should be considered relevant, also when addressing terrorism on home soil where so-called weapons of war are used.

6 Discussion

Antonovsky (1996) argues that health promotion is essentially about recognizing that "we are all, always, in the dangerous river of life. The twin question is: How dangerous is our river? How well can we swim?" (p. 14). Framing of the terrorist threat in policy documents is important in understanding how countries answer these questions, both because it sets the premises for which policy options are deemed suitable, but also because it taps into complex discussions of the definition of terrorism, hereunder which events are to be considered terrorist attacks, and the extent to which this should be guiding for health and social responses. The framing of a societal problem in policy documents is ultimately a question of how the burden of a given issue is perceived and appraised politically (Shiffman and Shawar 2022; Stone 1989). Given that the communication of risks and threats is significant in public health emergency response (Katz and Sorrell 2015), framing by government bodies is also important for how the public perceive an event, and for how they expect it to be responded to.

As this study has demonstrated, the framing of the terrorist threat in documents guiding the health response to terrorism was more securitized in the French material,

than in the Norwegian material. In the latter, the threat posed by terrorism to the population's health was for the most part not discussed explicitly, but rather treated as an implicit part of crisis response more broadly. This groups terrorism together with other forms of violent crime or disasters in general and how such events affect population health, regardless of the political motivation behind them. Furthermore, this entails that terrorism as a health concern should be responded to through regular procedures in social and healthcare systems. In the French material, on the other hand, the threat posed by terrorism to population health and toward health institutions were discussed explicitly and as integral parts of national security. This entails that the threat is in part conceived as collective, something that is reflected, e.g., in the practice of identifying victims of terrorism as civilian veterans of war. Furthermore, the healthcare system in France was framed as an integral part of the response to this security threat.

Frames are categorizations of social phenomena and are as such clearly not reproductions of reality. This also implies that different framings can be used for the same issue (Shiffman and Shawar 2022). The different representations of terrorism in the two cases studied, and the implicit perceptions of healthcare provision and the healthcare system as parts in handling this threat are clear examples of this. At the same time, the argument made here is not that terrorist attacks were framed solely as security threats in France, whereas they were not considered as such in Norway. Rather, that a securitized framework for planning responses to terrorist attacks in the healthcare field was more prominent in France, than in Norway, and that this was linked to certain policy outcomes. There is a vast literature within research on framing discussing why certain frames are preferred over others in given contexts (for an overview see e.g., Benford and Snow 2000). A central explanation can be linked to what Kingdon (2014) has referred to as resonating with a "national mood" (pp. 146–149, see also Stone 1989). Although it can be difficult to pin-point exactly where such a "national mood" originates (see Kingdon 2014, p. 149), in the case of terrorism response it could be reasonable to assume that a country's previous experience with terrorism specifically, disasters in general, or armed conflict could contribute to shaping such "moods."

In her study of French terrorism response in the security field, D'Amato (2019) noted, "..by acknowledging the historical dimension of a current threat, it may be possible to expand our understanding of existing meanings of violence and related security practices" (p. 87). By that she refers to how France's long history of repeated terrorist attacks has shaped the country's current approach to counter-terrorism, including the relatively strict security practices involved. As is evident through the findings of the current study, a country's history of terrorism is also relevant for understanding practices and framing of violence in the healthcare field. There appears to be a line running between the development of counter-terrorism measures in France (as described by e.g., D'Amato 2019) and the health response once terrorist attacks have occurred. This suggests that both fields are influenced by overarching national discourses of terrorism, as outlined by D'Amato (2019) in the quote above. These discourses could then provide support for what Benford and Snow (2000) calls a frame's resonance, meaning the empirical credibility of a frame, or how the frame fits with what goes on in the

world (pp. 618–619). Norway had little to no direct experience with terrorism prior to the July 22 attacks, which could be part of the explanation why terrorism-specific measures were not highly developed in their health contingency. In an empirical context of little experience with terrorism, a highly securitized framing of the terrorism threat would most likely have limited credibility. France, on the other hand, found itself in a situation of repeated attacks. In this context, a broader securitization of the terrorism threat, including the more distinct handling of terrorism as a particular threat, arguably will have more empirical resonance. This can also be linked to Antonovsky's (1996) sense of coherence construct. The empirical contexts in France and Norway arguably provide divergent answers to the question of how to promote health in the case of terrorism. It should be noted that the Norwegian material dated longer back in time than the French material, since the Norwegian attack occurred a few years before the French attacks. This is important given that there is a general, continuous development in the field. Still, it is fair to assume that the differences between the two countries persist despite this.

There are two important practical implications of the difference in framing between the two countries. The first is that linked to the securitized framing of the healthcare field as integral parts of terrorism response in France, there is also a stronger involvement of security-based or military methodologies, in the prescribed healthcare response to terrorist attacks. The involvement of the military in global health and, not least, in disaster response is hardly anything new and occurs in many countries (Michaud et al. 2019; Wenham 2019). As previously discussed, a stronger integration between security forces and healthcare providers in situations such as terrorist attacks, were called upon in evaluations after the terrorist attack in Norway (Albrechtsen et al. 2017; Directorate of Health 2012). Although this integration can appear uncontroversial, the current study demonstrates that even in a European context, the involvement of military knowledge and methodology in the response to terrorist attacks will vary. Even though this militarization does not necessarily entail a threat to regular democratic procedures, its presence in policy suggests a blurring of the borders between "health" on the one hand and "security" on the other. This is important as the core objectives of military actors and health actors differ substantially (Michaud et al. 2019) and can at times have conflicting interests (Thomson et al. 2019).

The second important consequence of the more securitized approach in France is arguably that assistance from healthcare and social services to some extent is dependent upon how terrorism is defined, and whether an attack is understood to be an act of terrorism or not. As is well-known from terrorism studies, the definition of terrorism and what events that should be included in the definition is disputed (Schmid 1992, 2013). This discussion is highly relevant when a specific response to violence is dependent on its labelling as terrorism. When a type of disaster is identified as necessitating particular procedures and measures, such as a securitized response or a particular trajectory of response for victims, this opens for important questions pertaining to how states decide whether an event should be responded to through that framework or not.

7 Conclusion

The findings of this study suggest that the way the terrorist threat is framed is of importance for the policy options deemed available when responses within the healthcare field are planned. The framing used in health contingency documents to describe the threat posed by terrorism is more security-focused in the French material, than in the Norwegian documents. This includes both a framing of terrorist attacks as a threat to national security, but also an understanding of the healthcare system as an integral part of the response to this security threat. Concurrently, the suggested responses are both more terrorism specific and to a higher extent utilizing military methodologies in France, as compared to Norway. The most distinct difference is that victims of terrorism hold particular rights in France, but not in Norway. The French approach entails that the definition of terrorism, and whether specific events are defined as terrorism or not, become more central for the help received. This is not a trivial distinction, given that what constitutes a terrorist attack is not always straight-forward (Schmid 1992). As clearly illustrated by the quote from the spokesman of the Kurdish cultural center in Paris which experienced a shooting incident, it can have implications for those directly exposed to violence and is hence not simply a question of semantics.

At the same time, the lack of a securitized approach in the Norwegian documents can potentially be linked to the later identified lack of coordination between different actors involved in contingency in Norway (Albrechtsen et al. 2017). The French material clearly aligns health and security agendas, by explicitly stating that healthcare measures, and the activities of healthcare professionals have potential securitizing and even counter-terrorism outcomes. In Norway, this framework was not developed in policies of preparedness in the healthcare sector prior to the terrorist attack in 2011. Rather, the Norwegian approach integrates the response to crises into the regular activities of the healthcare system and established responses in the judicial system meant to cover the needs of victims of violent crime more broadly. The findings of this paper are relevant in the current push for stronger integration of health crises planning across Europe, in highlighting how the framing utilized to describe health threats in contingency documents, generate diverging contexts for disaster response in different European countries. To learn more about the importance of framing within policy documents, there is a need for further studies across a wider range of cases and types of health crises, as well as an expanded focus on a range of frames.

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