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Transparency in the Age of Uncertainty: The Communication Strategies of Icelandic and US Authorities During the First Wave of the COVID-19 Pandemic

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Abstract

This paper compares the communication strategies adopted by national authorities in Iceland and the United States during the first wave of the COVID-19 pandemic (January–May 2020). The first wave was a critical point in the pandemic as the overall crisis responses were formalized during this period in both countries. Using qualitative content analysis of televised briefings, we examine how each country's approach reflected guiding principles of effective crisis communication; transparency of the communication and to promote civic engagement of citizens in the government's infection-control measures. Iceland largely followed an *Expert Appointee Prominence Model*, where health and civil protection experts led information briefings about the pandemic and politicians were usually not part of those briefings. This led to communication that was mostly transparent and clear. By contrast, the United States relied on a *Politician Prominence Model*, in which President Trump and other political figures were

Icelandic Review of Politics and Administration Vol. 21, Issue 2 (231-258)
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Article first published online December 16th 2025 on http://www.stjornmalogstjornsysla.is
Publisher: Institute of Public Administration and Politics, Gimli, Sæmundargötu 10, 102 Reykjavík, Iceland

Stjórnmál & stjórnsýsla 2. tbl. 21. árg. 2025 (231-258) Fræðigreinar
2025 Tengiliður: Eva H. Önnudóttir, eho@hi.is
Vefbirting 16. desember 2025. Birtist á vefnum http://www.stjornmalogstjornsysla.is
Útgefandi: Stofnun stjórnsýslufræða og stjórnmála, Gimli, Sæmundargötu 10, 102 Reykjavík

DOI: https://doi.org/10.13177/irpa.a.2025.21.2.7

central to communication, often overshadowing or contradicting expert voices. While US briefings did include health experts, political framing and inconsistent messaging reduced transparency and credibility. Both countries sought to empower citizens and foster solidarity, but Iceland's messaging was overall more consistent and community-centered, while US communication was marked by mixed signals and limited attention to diverse community needs. The results show that the Expert Appointee Prominence model, as followed in Iceland, was much more effective in communicating transparent information and to promote civic engagement than the Political Prominence Model used in the United States, where politicians took the lead.

Keywords: COVID-19; first wave; communication of the authorities; Iceland; US.

Introduction

The early months of the COVID-19 pandemic created an unprecedented test of governmental communication strategies worldwide. In this paper we compare the communication strategies of national authorities in Iceland and the United States in their response to the unfolding COVID-19 pandemic in 2020, or more specifically from January to May that year (during the first wave). By doing a comparative analysis of the two country's approaches, the aim is to illustrate the key differences between them by identifying some of the observable failures and successes in their communication strategy. In doing so, the analysis is based on two guiding principles for effective communication which are to maximize transparency and to promote civic engagement among citizens in government efforts to fight the pandemic. We analyze the authorities' communication and assess how effective it was based on recommended strategies, such as engaging in clear messaging, striving for maximum credibility and communicating with empathy (Hyland-Wood et al. 2021), and contrast the authorities' approach in their communication strategies based on whether they can be placed within the *"Expert Appointee Prominence Model"* or *"Politician Prominence Model"*. In the former model experts are in the forefront of disseminating vital information to the public, and the politicians support and endorse their recommendations. The latter model is characterized by the politicians receiving consultation from experts while remaining at the helm of communication as leaders and the faces of the crisis (Kahn 2020).

Since the overall crisis responses to the COVID-19 pandemic were formalized at the start of the pandemic, analyzing the communication strategies in the first wave gives us a clear picture of the strategies used both in the time period of this analysis and how authorities built on these strategies throughout the pandemic (Coman et al. 2021). The ultimate goal then being to examine which country's approach was more effective at communicating public health guidelines based on the previously mentioned guiding principles and whether there was a difference depending on whether experts or politicians were at the forefront.

As the COVID-19 pandemic continued to progress there was an increasing recognition of the importance of good public communication in facilitating the public's compliance with public health guidelines (Devine et al. 2021). Existing research literature that analyses risk communication strategies in relation to COVID-19, as well as past outbreaks, has broadly underscored the importance of governments maintaining a high degree of transparency, building trust, being timely when providing information, having a direct communication channel with the public, and involving different stakeholders (Abraham 2009; Kim & Kreps 2020; Zhang et al. 2020). An unfortunate aspect of the fight against COVID-19 at its start was a lack of effective public communication by many national governments around the world. Contradictory messaging within governments resulted in a great deal of public confusion which opened the way for misinformation to spread (Coman et al. 2021; Ferreira Caceres et al. 2022). Thus, an effective risk communication strategy is vital for governments to fight outbreaks early on, to rally the public to a common cause and to combat misinformation.

Although Iceland and the US are immensely different in terms of size, culture, economy, and style of government, comparing the way in which information was communicated from the top in both countries can shed light on how their crisis communication differed due to different styles of their leaders and who was at the forefront of the communication. The selection of those two countries is based on the method of comparing different cases that are faced with the same explanatory factor which is the crisis (Gerring & Cojocaru 2016; King et al. 1994). Of course, even if one should be careful about attributing causalities, the different political culture, system, and societal nature of Iceland and the US are factors that could explain differences in their style of communication.

One major difference between the two countries during the first wave of COVID-19 was that Iceland can be placed within the Expert Appointee Prominence Model, where experts were at the forefront of disseminating vital information to the public, and the politicians supported and endorsed their recommendations (Gylfadóttir et al. 2021; Kahn 2020; Ólafsson 2021). The US on the other hand saw President Trump being much more at the forefront, and the communication strategy in the country being defined in terms of the Politician Prominence Model, which is characterized by politicians receiving consultation from experts whilst remaining at the helm of communication as leaders and the faces of the crisis (Callahan 2021; Kahn 2020). According to Kahn (2020), the Expert Model is preferred by most politicians because they recognize the limits of their own scientific knowledge, while politicians who seek higher office are more likely to adhere to the Politician Model because they want to portray a picture of themselves as effective and prominent leaders. However, this can be a delicate balance, as leaders' survival during crisis situations can partly depend on their success to present themselves as credible and effective crisis managers (Hayek et al. 2025). When and how much they delegated to experts is here considered as part of leadership skills, and the question we ask in this paper is whether the differences in expert versus politician-led approaches shaped the effectiveness of the authority's crisis communication, focusing on two overarching concepts: 1) transparency, and 2) civic engagement.

To the best of our knowledge, most studies that have been published to date about the crisis communication responses to the COVID-19 pandemic have either relied on content analysis, quantitative methods and broad summaries (e.g. Hayek et al. 2025; Lilleker et al. 2021; Song et al. 2025) or focused more in-depth on single countries or comparisons of countries that are similar (e.g. Christensen et al. 2023; Ghersetti et al. 2023; Haug 2024; Johansson et al. 2021). Analyzing in depth, with a qualitative approach, the communication strategies of two very different countries — here Iceland and the US — offers new insights into whether, and in what ways, it matters who leads crisis communication, and how this is reflected in the effectiveness of their communication strategies. In this setup, the background characteristics of the cases are unlikely to account for the specific situation or its impact — here, the shared challenge of the COVID-19 pandemic. In the next section we discuss our theoretical framework and research questions. After that we discuss our research design and present our results. We conclude with a discussion.

1. Quality of crisis communication

The global nature of the COVID-19 pandemic emphasized the need to view crisis communication from a broad perspective containing a number of subfields and the need for a collective response and cooperation both within different branches of government and with different stakeholders (Johansson et al. 2023). Governments should above all prioritize transparency in communication, meaning among other things to disclose what evidence was used to guide public health recommendations, who was consulted, whether different scenarios were considered and what were the possible trade-offs (Hyland-Wood et al. 2021). Another key concept is civic engagement, which means among other things to include meaningful stakeholders in order to encourage greater credibility and ownership of decisions and to increase the chance that people will follow the recommended guidelines and restrictions imposed by the authorities (Hyland-Wood et al. 2021; Renn 2008). This is opposed to a so-called deficit model, in which communication is a one-way street educating an 'ignorant' public (Meyer 2016).

Based on these two key-concepts, transparency and civic engagement, Hyland-Wood et al. (2021, p. 7) recommend ten strategies for effective communication which are:

1. Engage in clear communication
2. Strive for maximum credibility
3. Communicate with empathy
4. Communicate with openness, frankness, and honesty
5. Recognize that uncertainty is inevitable
6. Account for levels of health literacy and numeracy
7. Empower people to act
8. Appeal to social norms
9. Consider diverse community needs
10. Be proactive in combating misinformation

As Hyland-Wood et al. (2021) point out, it is essential in times of crisis to provide specific and *clear information* about what to do and what not to do, in a transparent concise manner. Engaging in clear communication means that messages should for example focus on concrete actions and specific periods, and proper terminology should be used depending on whether the information provided is an explanation for certain decisions or whether those are guidelines that should absolutely be followed. When a course is changed, for example when some restrictions are eased but not others, it should be made very clear what will be acceptable and what not. Clear communication also means that information should be asserted by one or more speakers without contradiction. Examples of communication which is consistent is when important information and advice relating to COVID-19 is essentially the same throughout a given press conference, no matter who is speaking and is not contradicted by another communicator, and when the information being articulated by communicators is the same as stated by others, including government institutions.

Maximum credibility during a health crisis means including trusted and authoritative agents, which are for example public health and medical experts, when communicating key messages. Even if such roles are in many cases part of the pre-existing public health governance it must be guaranteed that the governments will listen to them in order to strive for maximum credibility. This approach will communicate that the policies and decisions are guided by professional evidence, and this is especially important when trust in government is low. *Communicating with empathy means* that leaders should listen to the needs and concerns of the people and different sub-groups within their society. Expressing empathy, compassion and showing emotions increases their credibility. If people believe that the leaders are concerned about their wellbeing the more likely they are to respond favorably to any guidelines or advice given.

Openness, frankness and honesty in communication means that the bases of actions are explained, for example why they are necessary, helpful or harmful. This should be done even with incomplete information as a perception of obfuscation and that information is withheld can undermine the credibility of the authorities and foster belief in misinformation and rumors. This goes hand in hand with that *uncertainty should be recognized*; that illusions of certainty should not be fostered. While it can be tempting to over reassure to reduce public fear and calm people down, it can easily backfire and reduce the credibility of future messages of the authorities.

When communicating to the public about a crisis such as the pandemic it is essential to *account for levels of health literacy and numeracy*. This means that information should be conveyed in such a manner that it can easily be understood by the public, so they can learn how to protect themselves. Public health measures should be communicated in a direct manner and easily understandable language without too much scientifically loaded vocabulary. Both qualitative and quantitative terminology should be used when explaining probabilities and risks, such as for example how infectious COVID-19 is. An example by Hyland et al. (2021, p. 6) is that the risk is said to be very high (qualitative) or that seven out of every ten are at risk (quantitative).

It is not enough to only guide people to act, they must be *empowered to act*. That means that practical and physical barriers to appropriate behavior should be considered, and actions taken to reduce or remove them. For example, it needs to be economically sustainable to stay in quarantine. Empowering people to act also means that the authorities and other relevant agents should do what they can to make the behavior easier or possible, such as providing hand sanitizers at store entrances or floor markings that promote physical distancing. Message framing, such as 'we are all in this together' is also of importance to foster empowerment among the public. A shared threat can create a sense of togetherness among the public, that they look beyond their differences, and they are empowered by a collective sense of responsibility. For that reason, it is critical that the authorities appeal to public solidarity and endurance.

Appealing to social norms is in some way related to appealing to solidarity, but different in the sense that social norms refer to what actions or behavior is acceptable or appropriate. Appealing to social norms, such as 'it is the right thing to do' or 'that everyone is doing it' can be a strong promoter for why people should follow the guidelines of the authorities but can also backfire if certain groups feel alienated or marginalized in society. *Diverse community needs* should be considered, both because they may not be affected by the pandemic in the same way or the interventions to the same degree. Certain groups, such as the elderly, people with disabilities or people that belong to different language groups can offer valuable insights concerning their group that should be considered. Information should be made accessible in various ways and in some cases different actions aimed at different groups.

During the pandemic there was an increase in misinformation, and conspiracy theories about the pandemic were (and are) believed by some groups of people (Bierwiaczonek et al. 2022). For that reason, Hyland-Wood et al. (2021) argue that it is vital that the authorities are *proactive in combating misinformation*. Transparent and clear communication strategies of the authorities are an effective way to combat misinformation. It is important that information is exposed to fact-checking, that inaccurate information is exposed and that people are reminded about differences in accuracy and credibility of online information. Under no circumstances should the authorities promote misinformation.

2. Methodology and research design

This section outlines how the principles of effective crisis communication are applied to our study as well as how examples were selected within the set timeline. The timeframe is from January to the end of May during the first wave of the COVID-19 pandemic in 2020. This is a significant period because it covers the time from when the pandemic was just beginning, towards when many assumed that the peak had been reached during the first wave in the spring.

2.1 Unit of analysis

In Iceland, the main unit of analysis was the Directorate of Health and the Department of Civil Protection and Emergency Management, who were both charged with providing information to the Icelandic public, in addition to the country's Chief Epidemiologist who operates within the Directorate of Health. The Chief Epidemiologist, together with the Director of Health and the head of the Department of Civil Protection and Emergency Management, came to be known as the "Trio". In the United States, the unit of analysis was the federal government under the Trump administration, which took the lead role in communicating information about COVID-19 to the country nationwide In both countries, the agents were charged with overseeing the administration's response to the pandemic and communicating all important updates to the public (Ólafsson 2021; The White House 2020).

2.2 Data selection and timeframe

The analysis is based on the televised briefings that were held on behalf of the relevant authorities in each country (the information briefings of the Trio in Iceland and the press conferences by the WH Coronavirus Task Force in the US).

A total of 30 videos were selected (15 from Iceland and 15 from the US). In the US, the first briefing was held on January 31, and the second one on February 26. After that, briefings were broadcasted infrequently until March 15 and then nearly every day from March 16 to April 27. Thereafter, briefings on behalf of the WH Coronavirus Task Force again became more infrequent. Meanwhile in Iceland, briefings were held once every day from the first briefing in February to May 4, after which they began to be held three times a week until May 25. Given this difference in time, it would have been impractical to adhere to the same exact timeframe for both cases. Another reason for the slightly different timeframes is that although a particular week may have significance in one country, this may not have been the case in the other (such as when the total number of cases passed a certain threshold). For these reasons, examples were selected based on how significant a particular day was regarding key events, while also ensuring that they were spread over the general timeframe of January to May. We list the meetings in Tables 1 and 2, together with a total count of presenters and thereof the number of elected politicians present at those meetings. In our analysis, we cite the meetings by their labels (e.g. IS, February 26 or US, January 31).

Table 1. List of briefings selected for Iceland and key events

Label (with date, all in 2020)	Key events	Number of presenters	Number of elected politicians as presenters
IS, February 26	First information briefing in Iceland.	3	
IS, February 28	First case of COVID-19 confirmed in Iceland.	4	
IS, March 2	Whole of Italy was declared a risk-area. Previously it had only been limited to a few regions.	4	
IS, March 6	First two cases of person-to-person infection in Iceland.	3	
IS, March 14	The first briefing after the first restrictions on gatherings introduced the day before.	4	
IS, March 19	All countries declared dangerous and all Icelandic citizens and residents of Iceland that are returning from abroad must quarantine for fourteen days.	4	
IS, March 24	Restrictions on gatherings brought to just 20 people.	4	
IS, April 2	The contact tracing app Rakning C-19* is launched.	4	
IS, April 6	Announcement was made to extend restrictions until April 13.	5	
IS, April 21	Announcement was made to ease restrictions on gatherings from 20 to 50.	2	
IS, April 24	New rules were introduced for all incoming travelers.	3	
IS, May 4	Easing restrictions on gatherings in schools from 20 to 50 people.	3	
IS, May 18	Swimming pools allowed to operate at half capacity.	3	
IS, May 25	Easing restrictions on gatherings at schools from 50 to 200 people. Last information briefing during this period.	5	2
IS, May 28	The struggle with COVID-19 reviewed - An information meeting under the heading: 'The Struggle with COVID-19'	6	1

* Rakning C-19 was a contact-tracing smartphone application used to identify those who have been in close proximity to a newly infected individual.

Table 2. List of briefings selected for the United States and key events

Label (with date, all in 2020)	Key events	Number of presenters	Number of elected politicians as presenters
US, January 31	First travel ban is introduced, and HHS declares public health emergency.	7	
US, February 26	Trump designates Mike Pence as Chairman of WH Coronavirus Task Force and CDC announces first case of community spread in California.	5	2
US, February 29	New members added to the WH Coronavirus Task Force.	5	2
US, March 2	Task Force begins to initiate regular discussions and the first case in New York is detected the day prior.	7	1
US, March 6	US passes 200 cases of COVID-19.	6	1

Table cont. »

US, March 14	CDC issues no sail order for cruise ships, and the day prior Trump had declared a national emergency.	8	1
US, March 18	Trump invokes Defence Production Act.	6	2
US, March 24	US sees most deaths in a single day up to that point (163).	5	2
US, March 27	US is the country with the most cases.	7	1
US, April 3	US reports over 270,000 cases and 7,000 deaths.	7	3
US, April 19	US passes 40,000 deaths.	4	3
US, April 27	US passes 1 million cases of COVID-19 one day after.	13	2
US, May 11	First press briefing on COVID-19 after gap.	3	1
US, May 22	First press briefing on COVID-19 by Trump since May 11.	3	1
US, May 29	Last press briefing on COVID-19 by Trump.	1	1

2.3 Content analysis - defining key concepts

Qualitative content analysis was used to analyze the patterns of communication strategies in those briefings. This is a type of research method that is used to identify the occurrence of specific themes within media texts in a systematic way (Devereux 2014). Unlike quantitative content analysis which counts the frequency of specific words and variables, qualitative content analysis is more interpretative because it looks for the obvious as well as the less obvious patterns in the content. Such as to illustrate the intentions of communicators, narratives, framing of stories, and cultural patterns of groups. Qualitative content analysis is therefore particularly suitable for analyzing and comparing the broader communication strategies of Iceland and the US since it focuses on a critical examination of the larger discourse rather than the counting of certain words and phrases.

Using Hyland-Wood et al's (2021) ten recommendations for effective communication in crisis, we highlight four themes in our analysis; 1) maximum credibility, 2) transparency, 3) civic engagement and 4) combating misinformation. In table 3, we list the ten criteria and we place clear communication, empathy, openness, frankness and honesty, and recognizing uncertainty under the heading of transparency, while we place accounting for levels of healthy literacy, empowering people to act, appealing to social norms and considering different community needs under civic engagement. The two factors, maximum credibility and that the government should be proactive in combating misinformation are kept as separate factors. The reason we keep those two as separates is that while they can both be considered important for transparency and civic engagement, there is a different approach in how those are estimated. Maximizing credibility is mainly based on whether public health and medical experts are part of communication strategies, and combating misinformation is communication that is directed at specific facts or events. The other strategies all have to do, in one way or the other, with the information and communication style of the authorities (the content) and for that purpose they are grouped together under the headings of transparency (maximizing it) and civic engagement (promoting it).

Table 3. Coding frame

Maximum credibility
Strive for maximum credibility
Are public-health and medical experts part of the communication strategies
Transparency
Engage in clear communication
Concrete actions and specific periods
Clear when the course is changed
Consistent terminology / coding (e.g. color coding)
Consistency in messaging between different actors
Communicate with empathy
Express concern and understanding
Show compassion
Communicate with openness, frankness, and honesty
Explain the bases of decisions
Recognize that uncertainty is inevitable
Do not over reassure
Civic engagement
Account of levels of health literacy and numeracy
Information conveyed that can easily be understood
Empower people to act
Appeals to public solidarity
Appeal to social norms
It is the right thing to do / Everyone is doing it
Consider diverse community needs
Are they considered and/or different actions taken
Combating misinformation
Be proactive in combating misinformation
Is misinformation exposed or endorsed

When analyzing the videos of the press briefings, attention was paid to how well or inadequately speakers met the specific criteria and sub-criteria of maximum credibility, transparency, civic engagement and whether communicators effectively fought misinformation. To determine whether a given communication aspect achieved those, specific

examples are outlined for each concept observed. The definitions are intended to be specific enough to be empirically valid, while also not too narrow to prevent any meaningful interpretation. While watching each briefing, the most relevant quotes and actions were written down and the time that they occurred. Of these, the most notable examples from each country are featured in the paper insofar as they were descriptive of the country's communication strategy. All Icelandic quotes were translated into English for the purposes of analysis and presentation. After the thematic analysis had been drafted, we used Avidnote.com, an online AI tool, to run a thematic analysis based on our coding frame (Table 3) and its results aligned almost perfectly with our own thematic analysis. The high level of convergence provides validation for the reliability and consistency of our findings. Information about the sources for all the videos are listed in an Appendix.

3. The set-up of public briefings in Iceland and the US

A key difference between Iceland and the US during the first wave of the COVID-19 pandemic lies in how public communication and decision announcements were structured. In Iceland, experts — primarily the Chief Epidemiologist, the Director of Health and the Director of Civil Protection and Emergency Management (the Trio) — held regular information briefings focused on explaining the development of the pandemic and the scientific basis of the response. Government decisions, such as changes to gathering limits or economic support measures, were then communicated separately in dedicated press conferences led by political authorities (Ólafsson 2021). In the US, by contrast, these roles were merged: federal political leaders and public-health officials typically appeared together in the same White House press briefings, where scientific updates, political messaging, and policy decisions were presented in a single setting. Although many concrete public-health measures in the US — such as stay-at-home orders, business closures, and school shutdowns — were decided at the state level, the national government nevertheless issued several major actions of its own, including federal emergency declarations and nationwide travel restrictions (Gosting & Hodge 2020; Kettl 2020).

In Iceland, most of the information briefings took place at the headquarters of the Icelandic Association for Search and Rescue. Although the first three briefings were quite informal, they soon began to take on a more structured flow which remained the same for subsequent examples. In this general structure, the Director of Civil Protection and Emergency Management would begin every briefing by introducing himself and the Chief Epidemiologist and the Director of Health, as well as any guest speakers if they were present. The guest speakers were usually representatives from the health care system (e.g. medical directors), from other government institutions (such as the Directorate of Labor) or other voluntary organizations (such as the Association of Senior Citizens).

Most briefings on behalf of the WH Coronavirus Task Force took place in the James S. Brady Press Briefing Room in the White House where there was a single podium and speakers would take turns speaking into the microphone while the rest stood behind them on stage. The US press briefings were less structured than the Icelandic ones in

the sense that it was not always the same people that were present or agents of the same institutions, and they did not necessarily always follow the same format. In the meetings there were usually representatives from the health care authorities, but there were also business leaders and politicians. Sometimes the politicians (usually Trump or Pence) took the lead and sometimes the health care experts took the lead.

4. Thematic analysis

In this section, we first describe the general narrative of the communication strategies in Iceland and the US. We then summarize a comparison of the two countries, focusing on how well their strategies fulfilled the criteria of maximum credibility, transparency, promoting civic engagement, and combating misinformation.

4.1 The narrative of the Icelandic information briefings

At the first information briefing there were two speakers, Þórólfur Guðnason, the Chief Epidemiologist, and Rögnvaldur Ólafsson, Deputy Chief of Police. Guðnason spoke about the latest numbers on cases globally and stated that the virus was spreading and would likely come to Iceland. The briefing was well organized in terms of information sharing and communication and emphasis was placed on clarity, consistency, and empathy with the public – especially towards those in quarantine. There was discussion about conflicting information about quarantines for those who arrived from abroad and the response was that those would be clarified.

In the briefing on February 28, the three members of the Trio were all present, along with a guest speaker from Landspítali University Hospital. In that briefing, the general structure was followed as Reynisson, the Director of Civil Protection and Emergency Management, introduced himself and the others, and the Chief Epidemiologist Guðnason began the briefing to talk about the first case of COVID-19 within the country: "today the Infectious Disease Department (i. Veirufræðideild) confirmed the first case here in Iceland … about 50 tests have been conducted, and this is an individual who is 50 years old, Icelandic, and was on a ski trip in Northern Italy" (IS, February 28). Afterwards, when Möller, the Director of Health, spoke of the effects of the virus, she admitted that there were many unknown aspects surrounding COVID-19 but emphasized that "80% don't get symptoms, but around 5% get seriously sick" and by that reflecting openness and honesty about uncertainties. Next, Reynisson announced that the Department of Civil Protection and Emergency Management was declaring a 'danger alert level' and what exactly that meant as a concrete action: "now we've moved up to a so-called danger alter level … although there is just this one case which we're prepared to tackle, we're preparing ourselves if there is further spreading".

At this early stage, talk of restrictions on gatherings and international travel was not yet being discussed by the Trio. On March 2, a reporter asked if Icelandic citizens should cancel flights for the spring holiday or wait and see. Reynisson replied that he was going to "wait and see" about his planned flight to Portugal in April (IS, March 2). When another reporter asked if people should cancel weddings, Guðnason underscored

Reynisson's hesitancy by stating "we have the power to implement tougher restrictions but there is no reason to do that right now because we don't have any cases of domestic transmission … however, if domestic cases rise then we need to re-evaluate that". Prior to giving this answer, Guðnason pointed out uncertainties when he stated "the threat level changes daily and it's hard to say exactly how the future will develop". A crucial moment came at the end of the briefing on March 2, when Reynisson finished by encouraging viewers to follow the major news-outlets since "they [the news-outlets] know everything we know, and we report to them information as soon as possible. When these new cases were confirmed, the media knew of it in advance and was able to get it out there on the air, so it was without any delays that this information was made available to the public … we will continue to work like this with the media and we encourage everyone to follow along and seek information from the right places". This last statement thus gave some insight into the larger communication strategy of the Trio, where it was revealed that a part of their operation involved coordinating with the major news outlets about the latest information rather than announcing it for the first time during the briefings.

However, it was also during the briefing on March 6 when the absence of a cabinet minister began to present some issues with regards to effective communication. According to one of the reporters, prior to the briefing on March 6, a law had been passed wherein those who were in mandated quarantine were ensured a salary during the process (IS, March 6). When the reporter asked if those who knowingly travel to high-risk areas and come back will also get paid while quarantining, Reynisson replied "I think this is a question for the government ministers above us or the ministries because we don't have any technical solutions on this matter". Such instances were rare, however, throughout the following briefings. The three main speakers continued to be transparent about what they themselves knew as health and safety experts, and answered questions directly, even if they did not have all the information.

In an information briefing in mid-March (IS, March 14), Guðnason was asked about testing and when anyone could get tested. He initially did not address the question directly, saying "we have certain directions for tests and want to base it on certain symptoms and that's just being done so we don't lose control of the tools we have to analyze this virus … if everyone shows up, we won't have enough swabs and other equipment for sick patients. So we will continue to be aggressive [in contact tracing] and we likely won't face a shortage".

In late March, the lack of a cabinet minister during one of the briefings again presented some issues, as well as non-transparency on the part of one of the guest speakers. When the Medical Director of the Capital Area Health Centre, Óskar Reykdalsson, appeared as a guest speaker on March 24 on behalf of the country's health care centers, he was asked if people who freely go into "protective isolation" would also get paid as those who are directed to quarantine. Just prior to this question, Guðnason (the Chief Epidemiologist) had stated "we have advised people with serious lung conditions to go into [volunteered] protective isolation" (IS, March 24). Reykdalsson, could not answer

whether those individuals would also get paid in the same way as those who are directed by the government to quarantine or if they could get a doctor's note about their condition, only stating "doctor's notes are done in such a way that you just tell the truth and can confirm it, so it's possible to write such a note, but such people aren't sick … but we write that which we can confirm". When the same reporter kept pressing the Medical Director if it was indeed true then that these groups would not get paid, Reynisson (Director of Civil Protection and Emergency Management) stepped in to answer "we just need to look into that, we had representatives from the Directorate of Labor and it's a good question that we will answer on covid.is. [website for information COVID-19]".

Towards the beginning of April, Guðnason and Möller began to speak of the country reaching its peak in the current 'wave' and that more cases lay ahead in the coming weeks (IS, April 2). As the Easter holiday was also nearing at this time, Reynisson advised viewers not to travel and stay away from family members who may belong to some risk group (IS, April 6). In response to a question from a reporter if families could still meet for dinner, Reynisson replied "that all depends on the nature of the family … it's not responsible to invite a big family over for dinner if in that group there are individuals in a risk group, and the more, the greater the risk. Let's just keep it to moderate groups". Thus, despite the supposed peak the country was now facing, restrictions were still not so far reaching as to ban all gatherings between people living in different households. Although the implication from Reynisson's recommendation would be that small gatherings amongst healthy individuals was fine, at the end of the conference, he finished by advising viewers to "relax, stay home, have a virtual meeting with extended family, dinners with friends through virtual meetings, and enjoy your loved one's company and continue to be responsible". The message now being that dinners should take place virtually, regardless of if it is with one's extended family or friends. The information about meeting with family and friends, on-site, online in small groups or not, was seemingly inconsistent in this meeting and the message was unclear.

As the end of April approached the country seemed to be on a downward slope with regards to the number of cases being confirmed daily. Guðnason began the briefing on April 24 by stating no new cases were confirmed over the previous day (IS, April 24). This stood in contrast to a previous briefing just a few weeks prior in early April where the number of confirmed daily cases had been just short of 100 (IS, April 2). In light of this, Reynisson announced at the beginning of the briefing on May 4 that these briefings would now be held three times a week rather than daily as they had been since March (IS, May 4).

Despite the general optimism that prevailed in late April to May, Guðnason continued to emphasize basic public health guidelines where he both addressed uncertainties and appealed to people to be careful: "although it's going well it's important to underscore these same things we've been saying all along, that individual behavior is probably the most important factor in preventing more infections in society", and in the following conference on May 4: "the work is not yet over. Despite finishing one chapter we need to continue to be vigilant and be ready to take on community-transmission … the

two-meter rule is still valid" (IS, May 4). The briefing on May 18 was thus characterized by a light and optimistic mood, and most of the time was used to talk about the re-opening phase. However, in speaking about the country's swimming pools re-opening, Guðnason remarked that it was "a bit worrisome to see how badly people followed the two-meter rule". This sentiment was underscored by one of the guest speakers when he stated: "young people aren't quite respecting the two-meter rule … seems they're just looking at their phones" (IS, May 18). Reynisson ended the briefing on a similar note and appealed to peoples' responsibility saying that "every individual has a responsibility and needs to be responsible…this work is still in our hands".

By May 25, Guðnason was still reading zero new cases (IS, May 25). On this day, the Minister of Health, Svandís Svavarsdóttir, and Minister of Justice, Áslaug Arna Sigurbjörnsdóttir, were also present. Since there were no new cases to report on, most of the time was spent giving speeches about what lessons the country should draw from this experience. The Trio nonetheless took time to reflect on the necessity to maintain basic public health guidelines in their last briefing on May 25, such as that even if the two-meter rule was now optional it would be important for everyone to maintain their individual hygiene practices (IS, May 25). As such, the last example analyzed in our analysis was not a briefing at all, but rather an event featuring members of the Trio, ministers, scientists, and other significant speakers, entitled "The Battle with COVID-19", signifying the feeling that the battle was over and now was the time for looking back on lessons learned and a bit of self-praise (IS, May 28). Despite underscoring the need to still be vigilant, none of the speakers on this day expressed doubt about the actions to re-open and remained concise.

4.2 The narrative of the US information briefings

In the first briefing in the US on January 31, the head of the Health Department, Azar, appeared at the White House along with other health experts such as Redfield of the Centres for Disease Control and Fauci of the National Institutes of Health to inform the press of the novel coronavirus. Neither President Trump nor Vice President Pence were present at this briefing and most of the speaking time was taken up by health experts. The speakers presented the latest updates about the number of confirmed cases globally and within the US and outlined the current response of the Centers for Disease Control (US, January 31). All speakers presented the information they had at their disposal in detail and in clear language, both with regards to how the virus works and the consequences of Trump's travel ban on Chinese travelers that he had recently implemented. The speakers also underscored each other's points and maintained consistency throughout the briefing. Azar, Redfield and Fauci all emphasized that at the time the risk to the American public was low, thus in hindsight over reassuring the American public. Neither Azar, Redfield, Fauci nor any of the other speakers made attempts to avoid the questions posed by reporters. They openly admitted uncertainties, that they did not know the accuracy of COVID-19 tests and that there were many "unknown" aspects of the outbreak. One of the only instances of non-transparency in this first briefing

centered around the issue of so-called "quarantine centers", wherein Azar admitted that they had been selected but did not state where they were located, only that they would be announced.

In the following briefings on February 26 and 29 and early March, most of the speakers seen in the first briefing were still present, but there were also new members from the WH Coronavirus Task Force such as Dr. Hahn of the Food and Drug Administration and Verma of the Centers for Medicare & Medicaid Services. Trump and Pence were also henceforth prominent speakers, and Trump would continue to be the leading speaker in most subsequent briefings. When speaking about the latest information on COVID-19, most speakers continued to be transparent and clear about the present number of cases within the US and both Azar and Fauci did not shy away from stating that there was a real possibility of an increase in cases (e.g. US, February 26). Azar, Trump, and Pence all stressed that the risk to the American public was currently low. However, Azar and Fauci added that the degree of risk had the potential to change quickly, and the virus may come back next year in a cycle-like fashion.

Nevertheless, as early as February 26 examples of communication wherein it was not clear what was meant, or speakers would contradict the earlier statements of Task Force members started to appear. For example, in the briefing on February 26, Trump essentially compared the coronavirus to the flu by stating "I spoke with Dr Fauci on this … the flu kills from 25,000 to 69,000 a year, and so far, if you look at what we have with the 15 people, they're recovering" (US, February 26). However, as recently as in the briefing on January 31, Fauci had dismissed such comparisons by saying "you can predict pretty accurately what the range of mortality is [with influenza] the issue now with this [COVID-19] is that there are a lot of unknowns and the number of cases has steeply inclined each and every day" (US, January 31). Likewise, in this same briefing on February 26, Dr. Schuchat underscored Azar's statement that things could change quickly by stating "we do expect more cases" (US, February 26). This stands somewhat in contrast to what Trump had said only moments before when he stated "we're ready to do what we have to do as the disease spreads, if it spreads".

Towards the end of the briefing on February 26 a reporter asked Trump if American citizens should buy face masks and what the US was doing to boost the production of such personal protective equipment. Trump avoided directly answering what individuals should do and simply stated "I don't think we're ever going to be near that ... our borders are very controlled". When a reporter later asked Trump if the federal government was planning on testing more people given the higher number of testing in other countries, Trump refrained from revealing his administration's plans about whether they were considering increasing testing and did not reveal who needed to get tested but switched the subject over to personal hygiene measures, while at the same time casting doubt on their efficacy by stating "we're testing everybody that we need to test … now you treat this like a flu … you wanna wash your hands a lot, if you're not feeling well, if you feel you have a flu stay inside, but there are certain steps that you can take that won't even be necessary". Thus, while avoiding giving a direct answer about who exactly is being

tested, it is also unclear from Trump's remarks how one should approach public health guidelines at this point in time when he stated such steps may not even be necessary (e.g. US, February 29 and US, March 2).

From early to mid-March, Task Force members such as Pence, Fauci, Redfield and Birx provided updates on the general situation in relatively transparent and clear terms. When answering questions by reporters that required a scientific understanding of how the virus affects people, Pence would usually ask more qualified individuals to come up to the podium and answer on his behalf (e.g. US, March 2; US, March 6 and US, March 14). However, when it came to questions such as when people could get tested, wherein Trump and Pence did most of the talking, answers were sometimes less transparent. On March 6, during a television interview, Trump had stated that "anybody who wants a test could get a test" (Valverde 2020). However, this claim was not reiterated by Pence during the briefing on that same day. When a reporter asked Pence when those who felt they needed a test would be able to get a test, Pence only spoke broadly of his administration's actions with regard to working with large companies to provide testing kits (US, March 6). When a different reporter posed the same question to Pence, he again avoided the question before asking Hahn of the Food and Drug Administration to answer the question. Hahn similarly avoided the original question and stated "If I were with a patient who came in and wanted a test, I would recommend to that provider to contact their local public health group". It is thus not revealed when or if those who wish to receive a test could get a test, despite Trump's earlier assertions.

Still, throughout March, most speakers on stage continued to be transparent about the latest information that they had and made sure to underscore each other's points (e.g. US, March 14 and US, March 18). For example, on March 18th, Birx admitted that they did not fully understand surface-level transmission in the past and that is why the updated guidelines published by the White House recommended that one should not expose oneself to surfaces outside the home. In the briefing on March 14, Fauci and Birx had also made sure to highlight the reasons behind the new travel restrictions from Europe and the importance of continuing to practice social distancing.

By March 24 the tone of the briefings somewhat shifted from virus containment to the economic recovery and gradually re-opening society. Trump began the briefing on March 24 with optimistic and over reassuring messages about how he hoped to see large sections of the country open up by Easter "as we [the US] near the end of our historic battle with the invisible enemy" (US, March 24). Trump, however, did not go into detail about what information he based this newfound hope on when a reporter asked him if the doctors on stage [Fauci and Birx] thought it was a realistic timeline. Rather, Trump replied "we're looking at a timeline, we're discussing it … we're gonna look at it, we'll only do it if it's good and maybe we do sections of the country", after which he clarified "I just thought it was a beautiful timeline". Being present at this briefing, Fauci and Birx still took up a considerable amount of speaking where they spoke openly about the fact that cases would indeed continue to surge and the fact that there were still many "dark spots" throughout the country that they didn't know about. In doing so, the statements

of Birx and Fauci contradicted the hopeful messages communicated by Trump about nearing the end of the battle.

Towards the beginning of April, the issue of facemasks was also becoming more prevalent. Trump began the briefing on April 3 by reading that the Centers for Disease Control was now recommending that Americans wear a facemask due to the fact that asymptomatic transmission was shown to be playing a larger role than they had previously thought. "The CDC [Centers for Disease Control] is advising the use of non-medical cloth face covering as an additional voluntary public health measure" after which Trump looked up and added "so it's voluntary, you don't have to do it … they suggest it, but this is voluntary. I don't think I'm gonna be doing it" (US, April 3). Thus, while on the one hand the Centers for Disease Control recommended that Americans wear face masks, the head of state indirectly dismissed its necessity by stating he would not wear one himself.

As the middle of April approached, doctors like Fauci, Birx, Redfield, and Azar began to make fewer appearances as compared to earlier briefings. The briefing on April 27 was among the first to be held outside in the Rose Garden. As in previous briefings in late March, Trump gave mostly hopeful messages about how the country was now doing enough testing to begin re-opening (US, April 27). Birx was likewise present to give a short power point presentation about the re-opening phase where she laid out the administration's testing plan, although it only took up a short amount of time. Trump continued to demonstrate his willingness to re-open the country during the briefing on May 11 when he stated "don't forget, people are dying the other route [remaining in lockdowns] you can go with the enclosed route … people are dying with that too, you look at drug addiction, you look at suicides, people are dying that way too" (US, May 11).

By the time of the last two briefings on May 22 and 29 (which were the first to be held since May 11) few of the original WH Coronavirus Task Force members were still present. In addition to the previous emphasis on re-opening the economy, Trump began the briefing on May 22 by identifying houses of worship as "essential places that provide essential services" whereupon he pointed out the supposed hypocrisy between some governors allowing liquor stores and abortion clinics to remain open, but not churches. Trump further added that he would "override" governors who refused to comply with his new declaration (US, May 22). Upon finishing his speech, Trump then left the room without taking questions. A visible lack of consistency between administration officials on the subject of masks also became apparent when it was shown during this briefing that Birx, along with one other unidentified person, were wearing a mask, while Trump, WH Press Secretary McEnany, and other political figures were not. After Trump's speech, Birx took up most of the briefing and presented a summary of new hospitalizations, testing levels, and a slideshow of "influenza-like illnesses" in the US, which were shown to gradually decrease with each month. Birx echoed Trump's optimism but also noted rising cases in some states and counties, highlighting a more cautious stance.

During the last briefing (or speech) in this analysis, Trump delivered a short speech outside at the Rose Garden to talk about China and announce that the US was terminating its

relationship with the WHO. After the speech was over, Trump again left without taking questions and so did all members who were present with him during the speech (US, May 29).

4.3 A comparison of the information briefings in Iceland and the US

4.3.1 Maximum credibility

In both countries, public health care and medical experts were part of the communication strategies of the briefings analyzed in this paper. However, there were major differences at times in the presence and leadership of politicians in the meetings. In Iceland, politicians were mostly absent in the information briefings, while in the US the meetings were often led by either President Trump or Vice President Pence.

While the negligible presence of political figures allowed the Trio in Iceland to communicate the information which they had in detail and follow a structured routine, this setup occasionally presented challenges when reporters would ask questions about distinctly political matters. Naturally, neither Reynisson, Guðnason or Möller were equipped to answer such questions in any detail and thus could only reply "that is a question for the government ministers above us" (IS, March 6) or "we have yet to get answers about that from the ministry" (IS, March 19) when such questions came up. However, due to their response that this was a question for the ministry, confusions about policies or political decisions were minimized in those meetings. This was not the case for the US press conferences. The presence of politicians, and with Trump and Pence taking the lead in those meetings, information from health care experts was frequently contradicted by the politicians, the public was over reassured (by downplaying real risks), and misinformation sometimes fueled. Based on this, we conclude that the element of maximum credibility was fulfilled in the briefings in Iceland, while the US ones fell short on that criterion. The reason the US fell short is mainly due to that the politicians, at times, undermined and contradicted health care experts at those meetings.

4.3.2 Transparency in communication

The communication strategies of the US and Iceland began on a similar path, offering relatively clear public health messages and with most speakers remaining transparent and concise. In both the US and Iceland, doctors such as Fauci and Guðnason devoted a lot of time to talk about domestic case numbers for the country as a whole and within specific regions. They did so in a direct and easily understandable manner and did not try to avoid answering questions from reporters about what they knew at the time. As time went on, however, the countries diverged sharply.

The most obvious difference between the US and Iceland was the large presence of political figures as speakers in the US and their absence in Iceland's case. Although non-political figures also took up a significant amount of speaking time in the US, based on the examples which were used in this analysis, much of the reason as to why communication in the United States became less transparent, less clear, and less concise can be largely attributed to statements from the president which contradicted the messages of other speakers on stage or was otherwise not always clear and transparent. This was

most obviously seen during question time where Trump's responses were sometimes quite confrontational or did not align with the messages being put forth by health care experts. On the other hand, the lack of any senior political figures in Iceland presented challenges as well, as the doctors and police making up the Trio could not answer specifically political questions in detail. However, political questions by reporters in Iceland were also quite rare and public health communication by the Trio remained as transparent, clear, and concise in the later briefings as in the first. There were simply far fewer instances in Iceland's case wherein speakers directly contradicted one another, made unclear statements, or failed to be transparent about what they knew.

4.3.3 Civic engagement

The Icelandic authorities sought to make information clear and accessible, recognizing different levels of health and numerical literacy and to engage different stakeholders, and by that promoting civic engagement. The authorities emphasized empowering individuals to act responsibly—through hygiene, distancing, or joining initiatives like reserve volunteer teams (i. bakvarðasveitir). Communication also highlighted solidarity and shared responsibility among the public, particularly around sensitive moments such as Easter or restrictions in nursing homes. Vulnerable groups and diverse needs were sometimes addressed, but not always in a systematic way, leaving room for improvement from the perspective of inclusivity. Overall, Iceland's strategy framed stakeholder participation as a balance of individual empowerment, collective responsibility, and community solidarity.

In the US, promoting civic engagement also focused on accessibility, empowerment, and appeals to solidarity, but the execution was more uneven. Information was often presented in a way intended to be understandable to the public, though technical or political language sometimes limited accessibility. Communication encouraged individuals and institutions to prepare and act — whether through personal precautions or community measures — and frequently appealed to unity and social norms, emphasizing national solidarity and shared sacrifice. However, consideration of diverse community needs (such as rural areas, minority groups, or vulnerable populations) was inconsistent, and political rhetoric sometimes overshadowed public health messaging, reducing clarity and inclusivity.

Taken together, both Iceland and the US shared an emphasis on empowering individuals and fostering solidarity, but Iceland's approach was more consistent and community-centered, with health experts visibly leading communication and clear efforts to maintain public trust. The US case, while containing strong elements of empowerment and solidarity, was weakened by mixed messaging, political framing, and limited attention to diverse needs.

4.3.4 Combating misinformation

The strategy of the authorities in Iceland to combat misinformation was in the form of explicit corrections with broad reliance on science and transparency. Health experts

frequently presented data, models, and clear explanations to guide public understanding, which indirectly should reduce the impact of false information. At times, misinformation was explicitly addressed — such as correcting misleading claims or countering stigma linked to travelers from abroad — and information briefings included discussions on how to respond to misleading narratives even if this was not always systematic. By contrast, in the US, communication leaned more heavily on indirect countering of misinformation. Public health experts often relied on presenting factual updates and scientific explanations, without systematically exposing or refuting false claims.

Taken together, both countries emphasized facts and expert credibility as tools against misinformation, but Iceland showed greater willingness to openly correct false claims, while the US response remained more fragmented and politically influenced. Iceland's consistent reliance on health experts as the face of communication strengthened its corrective approach, whereas US messaging was weakened by political–expert contradictions and the lack of a systematic, proactive effort to debunk misinformation.

5. Discussion

Good and clear public communication is an essential part of fighting disease outbreaks (Ghio et al. 2021; Hyland-Wood et al. 2021). In a situation such as the COVID-19 pandemic where the full cooperation of the public is needed to make progress, being able to convince the public of the legitimacy of public health measures issued to fight the outbreak is of utmost importance. This has, however, shown itself to be easier said than done. This comparative analysis of Iceland and the US during the first wave of the COVID-19 pandemic highlights how different communication strategies shaped transparency and civic engagement, as well as maximizing credibility and their style in combating misinformation.

Iceland's strategy of placing experts at the forefront — the Expert Appointee Prominence Model — proved particularly effective in maintaining credibility and consistency. The Trio's briefings demonstrated high levels of transparency, addressed uncertainties openly, and cultivated solidarity among citizens. Weaknesses did emerge, especially when political questions arose that experts were unable to answer in detail, yet these instances were relatively rare and did not undermine overall communication effectiveness. By contrast, the US case illustrates the challenges of the Politician Prominence Model. While experts initially provided clear and evidence-based guidance, their messages were frequently overshadowed, contradicted, or reframed by President Trump and other political leaders. This pattern reduced credibility and transparency, fueled confusion, running the danger of less civic engagement, and left space for misinformation to spread. Although appeals to solidarity and empowerment were present, they were often diluted by political rhetoric and inconsistent attention to diverse community needs.

The comparison between Iceland and the US underscores three broader insights. First, effective crisis communication benefits from the visible leadership of experts who can present evidence-based information with consistency and transparency. Second, political leaders play a crucial but delicate role: their support can strengthen credibility if

they endorse expert advice, but their prominence risks undermining civic engagement when messages are inconsistent or politicized. Third, combating misinformation requires not only presenting facts but also actively correcting falsehoods in a systematic and proactive way. Iceland's willingness to correct misleading claims contrasted with the US's more fragmented approach, illustrating the importance of sustained efforts to safeguard public understanding in an "infodemic" environment.

As argued by Kahn (2020), elected officials are ultimately responsible for the outcomes of crisis responses, and they decide how much decision-making authority they will delegate to experts or others. Kahn also makes the point that in the US, as a presidential system, the personality of the elected official can determine which model is used: the Expert Appointee Prominence Model or the Political Prominence Model, while in parliamentary systems the Expert Model is more likely to prevail as a default. While it is difficult to make any firm claims about causality, it cannot be overlooked that Trump's personality or his own decisions can have played a large role in the fact that the Political Model was, for the most part, followed in the US. Whereas in Iceland, as a parliamentary system, the Expert Model was dominant from the outset.

This study faces several limitations. This paper is mainly concerned with analyzing the nature and design of the messaging itself rather than more political questions of task delegation, under what circumstances politicians are compelled to use their own judgment (e.g. when scientific knowledge is lacking), or the implications for trust and compliance with the authorities' crisis management (Adabor 2024; Devine et al. 2021; Kahn 2020). While those factors are important, it is beyond the scope of this paper and would have diverged from the focus on analyzing how public health messages were communicated to national publics.

The analysis is restricted to the first wave of the pandemic, and a qualitative sample of 30 briefings, meaning that longer-term developments and shifts in communication strategies remain outside its scope. While we identify patterns of communication effectiveness arguing that those can be explained by the different choices about who communicates — experts or politicians — additional factors and a more complicated story might have been at play. For example, the fact that the first year of COVID-19 (2020) was an election year in the US (presidential election) and not in Iceland. The election year in the US might explain why President Trump took on a clearer leadership role than the Icelandic government did and that he faced more criticism from his political opponents than was the case with the elected authorities in Iceland, with the election there scheduled over a year later. This is based on the tendency for political campaigns to become more critical and even negative close to an election (Poljak & Walter 2024). Furthermore, the two countries' different political systems might have impacted the outcome of the communication strategies, given that the division of responsibilities of managing the crisis was more complicated in the US federal system that it was in Iceland's unitary system. That does not change the fact that in both cases the situation involved a global pandemic, which placed pressure on national governments to take the lead in communicating information about the outbreak. And as has already been

pointed out, the quality of this communication can be crucial for sustaining public trust, securing compliance with regulations, and promoting the population's overall well-being.

Future studies might examine more systematically the institutional and political conditions under which governments choose an Expert Appointee Prominence Model or a Political Prominence Model. The contrast between Iceland and the US suggests that regime type, electoral timing, and political leadership style can each shape these choices. Comparative work across a broader set of countries — varying, for example, in constitutional structure, would help determine whether the patterns identified here generalize beyond these two cases or whether they are context-specific. There are other research avenues that can be explored, such as examining in more detail the consequences of different communication strategies for trust, well-being, and compliance, and how and when misinformation is corrected. Going into more detail about those here is beyond the scope of this paper.

In sum, this comparative analysis demonstrates that who communicates on behalf of the state during a public health crisis matters enormously for the credibility, clarity, and effectiveness of crisis messaging. Iceland's expert-led approach and the US' politically dominated model each reveal the strengths and vulnerabilities of different communicative choices under conditions of uncertainty. The broader lesson is clear: sustained transparency, consistent evidence-based communication, and a proactive stance toward misinformation are essential for effective communication in a global health emergency. As governments prepare for future crises, understanding how different communication strategies shape public engagement and trust will remain a central challenge — and a vital area for continued research.

Note

This paper is based on the BA thesis of Reynir Bragi Ragnarsson, *Transparency in the Age of Uncertainty*, which was submitted in the spring of 2021 at the Faculty of Political Science at the University of Iceland. The thesis received the Icelandic Political Science Association's award for outstanding thesis in 2022.

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Appendix

In Iceland's case, the recordings of the briefings were obtained for a small fee from RÚV, the Icelandic National Broadcasting Service. For the US, the website of the public service station "Cable-Satellite Public Affairs Network" (C-SPAN) was used to reach the White House press briefings (www.c-span.org).

A1. Sources for the Icelandic briefings

Label (with date, all in 2020)	Key events	See on:
IS, February 26	First Information briefing in Iceland.	www.visir.is/g/2020200229228/svona-var-fyrsti-bladamannafundurinn-vegna-koronuveirunnar
IS, February 28	First case of COVID-19 confirmed in Iceland.	www.visir.is/g/2020200228986/svona-var-thridji-upplysingafundurinn-vegna-koronuveirunnar
IS, March 2	Whole of Italy was declared a risk-area. Previously it had only been limited to a few regions.	www.visir.is/g/2020200309885/svona-var-fjordi-upplysingafundurinn-vegna-koronuveirunnar
IS, March 6	First two cases of person-to-person infection in Iceland.	www.visir.is/g/202014003d/svona-var-sjotti-upplysingafundurinn-vegna-koronuveirunnar
IS, March 14	The first briefing after the first restrictions on gatherings introduced the day before.	www.visir.is/g/202019722d/svona-var-fjortandi-upplysingafundurinn-vegna-koronuveirunnar
IS, March 19	All countries declared dangerous and all Icelandic citizens and residents of Iceland that are returning from abroad must quarantine for fourteen days.	www.visir.is/g/202022515d/svona-var-nitjandi-upplysingafundurinn-vegna-koronuveirunnar
IS, March 24	Restrictions on gatherings brought to just 20 people.	www.visir.is/g/202025142d/svona-var-24.-upplysingafundurinn-vegna-koronuveirunnar
IS, April 2	The contact tracing app Rakning C-19* is launched.	www.visir.is/g/202079146d/svona-var-33.-upplysingafundurinn-vegna-koronuveirunnar
IS, April 6	Announcement made to extend restrictions until April 13.	www.visir.is/g/2020140494d/svona-var-37.-upplysingafundurinn-vegna-koronuveirunnar
IS, April 21	Announcement made to ease restrictions on gatherings from 20 to 50.	www.visir.is/g/2020339692d/svona-var-51.-upplysingafundurinn-vegna-koronuveirunnar
IS, April 24	New rules introduced for all incoming travellers.	www.visir.is/g/2020471032d/svona-var-54.-upplysingafundurinn-vegna-almannavarna
IS, May 4	Easing of restrictions gatherings in schools from 20 to 50 people.	www.visir.is/g/2020926747d/svona-var-64.-upplysingafundurinn-vegna-koronuveirunnar
IS, May 18	Swimming pools allowed to operate at half capacity.	www.visir.is/g/20201606831d/svona-var-sjotugasti-upplysingafundurinn-vegna-koronuveirunnar
IS, May 25	Easing of restrictions on gatherings at schools from 50 to 200 people. Last information briefing during this period.	www.visir.is/g/20201950682d/svona-var-72.-upplysingafundurinn-vegna-koronuveirunnar-radherrar-maeta-a-sidasta-koronuveirufundinn-i-bili
IS, May 28	The struggle with COVID-19 reviewed - An information meeting under the heading: "The Struggle with COVID-19"	www.decode.is/gliman-vid-covid-19/

* Rakning C-19 was a contact-tracing smartphone application used to identify those who have been in close proximity to a newly infected individual.

A2. Sources for the US briefings

Label (with date, all in 2020)	Key events	See on:
US, January 31	First travel ban is introduced and HHS declares public health emergency.	www.c-span.org/program/news-conference/white-house-briefing-on-coronavirus-response/540621
US, February 26	Trump designates Mike Pence as Chairman of WH Coronavirus Task Force and CDC announces first case of community spread in California.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/542112
US, February 29	New members added to the WH Coronavirus Task Force.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/542445
US, March 2	Task Force begins to initiate regular discussions and the first case in New York is detected the day prior.	www.c-span.org/program/white-house-event/vice-president-pence-with-coronavirus-task-force-briefing/542492
US, March 6	US passes 200 cases of COVID-19.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/544403
US, March 14	CDC issues no sail order for cruise ships, and the day prior Trump had declared a national emergency.	www.c-span.org/program/white-house-event/vice-president-pence-with-coronavirus-task-force-briefing/544286
US, March 18	Trump invokes Defense Production Act.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/543449
US, March 24	US sees most deaths in a single day up to that point (163).	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/543836
US, March 27	US is the country with the most cases.	www.c-span.org/program/white-house-event/vice-president-pence-with-coronavirus-task-force-briefing/544053
US, April 3	US reports over 270,000 cases and 7,000 deaths.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/544304
US, April 19	US passes 40,000 deaths.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/545023
US, April 27	US passes 1 million cases of COVID-19 one day after.	www.c-span.org/program/white-house-event/president-trump-with-coronavirus-task-force-briefing/545385
US, May 11	First press briefing on COVID-19 after gap.	www.c-span.org/program/white-house-event/white-house-briefing-on-coronavirus-testing/546168
US, May 22	First press briefing on COVID-19 by Trump since May 11.	www.c-span.org/program/white-house-event/white-house-briefing/546983
US, May 29	Last press briefing on COVID-19 by Trump.	www.c-span.org/program/white-house-event/president-trump-news-conference/547269