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‘I hope you like jabbing, too’. The Covid vaccination campaign in Italy and the measures to promote compliance

Stefania Profeti

From the start of 2021, the vaccination campaign against SARS-CoV-2 was high on the agenda of governments everywhere and the Italian government was no exception. After a shaky start and the handover of power from one executive to another executive supported by a different parliamentary majority, the roll-out of the new vaccines proceeded at a rapid pace, so much so that by the end of 2021, Italy was in fourth place in the ranking of European countries in terms of coverage of the population. Progress of the campaign was, however, marked by a number of criticalities, especially after the Draghi government and the Extraordinary Commissioner for the Emergency, Francesco Paolo Figliuolo, had begun to contemplate more ‘intrusive’ measures aimed at reducing ‘vaccine hesitancy’ and ensuring citizens’ compliance. Emblematic in this sense were the street protests of the so-called ‘no-vax’ in the wake of the decision to extend the areas of application and the degree of obligation surrounding the EU-inspired Green Pass digital vaccination certification – protests that became increasingly numerous and disorderly from the summer of 2021. They reflected an increasing degree of polarisation on the vaccine issue in a public debate that was framed in terms of a trade-off between individual freedom of choice and the protection of public health. In this article, we shall describe the progress of the anti-Covid vaccination campaign in Italy with a particular focus on the measures adopted by the Government to encourage citizens’ compliance and to combat reluctance. Some of contextual factors, useful for understanding what happened, will be mentioned only in passing as they are considered in more detail by the other articles making up this special issue.

The article is structured as follows. After considering, in the next section, the problem of engaging with the vaccination campaign using the analytic framework provided by studies of compliance, in the section after that we shall describe how the targets of the vaccination campaign came to be defined and the infrastructural facilities for administering the doses established. These were crucial from the point of view of reducing as far as possible the barriers to accessing the vaccine. Then, in the subsequent section, we shall describe the measures the Government took to overcome popular resistance to the vaccines and to maximise compliance, considering them in terms of their degree of ‘intrusiveness’. We shall concentrate especially on the Green Pass, which was the measure that attracted most comment both at the level of the Government and the legislature and among the public. In the final section, we conclude by highlighting the strengths and weaknesses of the campaign and by offering an assessment of the coherence and the timing of the Government’s measures.

The vaccination campaign and the problem of compliance

Vaccination is one of those policy areas where the issue of compliance, or the degree of correspondence of the behaviour of those targeted by the policy with the advice and expectations of decision makers (Étienne 2010), is of maximum importance when it comes to the policy’s success or failure. In the case of vaccination campaigns that aim to immunise large numbers of people, succeeding in winning the engagement of a large majority of citizens, combatting ‘passive non-compliance’ and minimising ‘active resistance (McCoy 2019), is undoubtedly one of governments’ main priorities. To that end, governments are required to evaluate the measures they might take not only in terms of their manifest objectives, but also in terms of the boundaries and the characteristics of the ‘target population’ that the measures themselves help to delimit and define (Ingram e Schneider 1993).

In particular, analysing the vaccination campaign from the perspective of the literature on the phenomenon of compliance (Weaver 2014) it is possible to identify two types of barrier standing in the way of obtaining the desired behaviour on the part of those to whom the policy is directed:

- The first concerns the limitations on the resources and capacities possessed by members of the target population – resources and capacities that can obstruct compliance even though the individuals in question have no reservations concerning the vaccines (Gerend *et al.* 2013). Classic examples of such limitations include old age, disability, living in remote areas, lack of time, language barriers and so on (Ozawa *et al.* 2019). In such cases, the organisation of vaccine roll-outs, the ease with which bookings can be made and the provision of a ‘personalised’ service (Gofen and Needham 2014), can all make a difference.
- The second has to do with the attitudes of suspicion or hostility citizens may harbour towards the vaccines, and which may range from hesitation and scepticism to more extreme attitudes such as outright rejection. Vaccine hesitancy may be more or less intense depending on whether it arises from opinions (which can change) or deeply rooted beliefs (which are more difficult to overcome). For example, a low propensity to get vaccinated has been associated with perceptions that one is unlikely to contract the disease (Lindholt *et al.* 2020), with fears about the safety of the vaccines and with attitudes of diffidence towards political institutions, health providers (Guglielmi *et al.* 2020; Brewer *et al.* 2017) or the scientific community in general (Goldenberg 2016). On the other hand, attitudes of outright rejection of the vaccines have often been explained in terms of specific sets of beliefs such as believing conspiracy theories (Jolley and Douglas 2017), certain kinds of religious belief (Bramadat *et al.* 2017), or very conservative political and ideological beliefs and those found among people located at the extreme ends of the left-right spectrum (Debus and Tosun 2021; Engin and Vezzoni 2020).

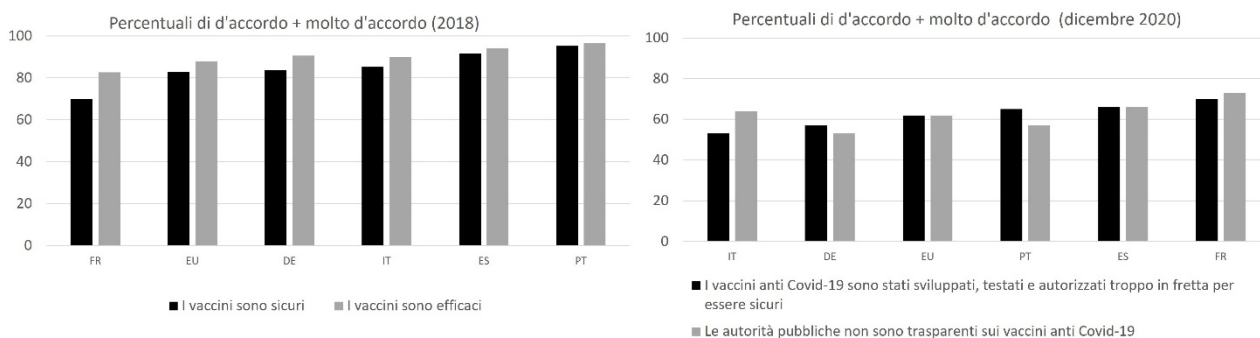
Empirically, these potential barriers (the limited capacities of the target individuals and vaccine hesitancy or rejection) may coexist in the same people. They affect not only the extent of compliance on the part of citizens but – together with other factors such as political dynamics within government, inter-party relations, relations between levels of government as well as public perceptions – create a problem for governments called upon to choose what Weaver called a ‘compliance regime’, i.e. ‘the chosen instruments for inducing compliance, their setting and their targets’ (2014, 252). In his general classification of compliance regimes, inspired by the typology suggested by Schneider and Ingram [1990], Weaver classifies the measures potentially available to governments on the basis of their degree of ‘intrusiveness’, that is, on the basis of the extent to which they leave the desired behaviour up to the free choice of individuals while seeking to influence it. At the lowest end of the scale of intrusiveness there is the provision of information with the intent to persuade, perhaps accompanied by warnings. In the middle, there are measures that release resources and increase the capacities of individuals with the intent to help them to engage in the desired behaviour, as well as positive and negative incentives that make a certain course of action advantageous. At the highest end, there are more coercive measures associated with regulations and obligations and their associated sanctions (Weaver 2014, 252). At the same time, as revealed by the recent literature on policy tools (Capano and Howlett 2020), in most cases compliance regimes draw not on just one kind of measure, but rather on a mixture of more and less intrusive measures, calibrated (and recalibrated over time) by decision-makers on the basis of the characteristics of the target individuals; on the measures’ demonstrated effectiveness; on the progress of the problem to be resolved, and, not least, on the capacities of the government in terms of monitoring and enforcement.

Applying this framework to the issue of vaccines, there is a lack of consensus concerning the relationship between the coerciveness of measures and the extent of actual compliance. Nevertheless, most of the literature on vaccine hesitancy and the advice given out by the international health organisations such as the WHO converge on the position that less intrusive measures are preferable to more coercive measures – not only because they are more effective, but also because they are less costly from a political and organisational point of view. On the one hand, making it completely impossible to opt out of a vaccination programme, creates the risk that it is perceived as an imposition, with the risk of increasing resistance and creating hostile attitudes towards it even among those who are merely hesitant (Omer *et al.* 2015). On the other hand, especially when credible systems of control

and enforcement are lacking (as is likely to be the case when it comes to mass vaccination campaigns), coercive measures like legal obligations to be vaccinated can create moral hazards by, for example, driving the target individuals to look for escape routes such as putting medical staff under pressure to issue false certification concerning medical conditions that allow exemptions (Leask and Danchin 2017), or else having recourse to outright fraud. Finally, at least in democratic regimes, the sanctions associated with failing to comply with vaccination obligations are typically financial (i.e., fines) sometimes combined with restrictions on access to public services (such a transport and education) with potential repercussions in terms of equity at the point at which they are applied (*Ibidem*).

In terms of the framework outlined so far, the SARS-CoV-2 immunisation campaign added certain elements of complexity (Borgonovi 2020). On the one hand, knowledge of the virus was limited; the dynamics of its transmission were still poorly understood, and therefore in reacting to it, it was impossible to draw on the experience of other, tried and tested, kinds of intervention. On the other hand, the need to respond to what was an emergency situation meant that the vaccines had been subjected to clinical trials and then approved extremely rapidly – implying uncertainty about their impact on transmission, their possible side effects and their suitability for different sectors of the population (Manski 2021). This meant that governments were forced to make decisions in conditions of considerable ambiguity – conditions that not only obliged them to make periodic adjustments as the pandemic emergency unfolded and as scientific evidence became available, but which also made it difficult to carry on consistent communications campaigns, with the result that vaccine hesitancy risked being greater than is the case when it comes to vaccination campaigns of a more routine kind. If we compare the Eurobarometer data for December 2020, at the start of the vaccination campaign, with data for 2018, we can see that in Italy as in other EU countries with the exception of France, the level of trust in vaccines was rather high in 2018. In December 2020, over half of respondents expressed doubts concerning the safety of the anti-Covid vaccines, given the rapidity with which they had been developed and authorised for commercial production, and expressed the perception that the competent authorities had not been completely transparent concerning the risks and benefits of the vaccines (Figure 1).

Figure 1. Attitudes towards vaccines in general (2018) and towards the anti-Covid vaccines (December 2020) in Italy and in selected EU countries.



Source: author’s elaboration of European Commission data (2020).

Definition of the target population and the reduction of barriers to access: the organisation of the vaccination campaign from the primroses to the General

On 2 December 2020, the Government presented the outlines of Italy’s vaccination strategy to Parliament, which approved the plan on 2 January 2021. Besides providing an estimate of the number of vaccines likely to be available during the subsequent months, the document outlined the essential elements of the implementation strategy that would drive the vaccination campaign, setting out its phases and corresponding priorities as well as the overall organisational framework that would support it.

Both the temporal sequence and the order of priority of the target groups closely followed the recommendations the EU had made to member states in October 2021,¹ in that it envisaged four phases, to be adjusted on the basis of the availability of the vaccines, and giving initial priority to the categories most at risk given their employment, their state of health and their age (Table 1).

Table 1 Evolution of the target groups and the phases of the vaccination campaign in Italy

	Vaccination plan 2/1/2021 (campaign launch)	Revised Plan 8/2/21 (reduction of supplies; Astrazeneca advised for 18-54 year olds)	Vaccination plan 12/3/2021 (Plan of new Commissioner)	Ordinance n. 6 of 9/4/21 (Opinion of EMA and AIFA re. Astrazeneca for over 60s)
<i>Priorità</i>	Phase 1: health and social care workers, residents of long-term care facilities, persons over 80; Phase 2: 60-79 years, persons at risk (e.g., with severe comorbidities, immunodeficiency) of all ages, teachers and high-priority staff in educational institutions; Phase 3: persons with moderate comorbidities of all ages; essential service workers/workers at risk (teachers, forces of law and order, prison staff); Phase 4: rest of the population.	Phase 1: unchanged; Phase 2: priority based on age and health: 1. Heightened fragility; 2. 75-79 years; 3. 70-74 years; 4. Persons with heightened clinical risk if infected; 5. 55-69 years; 6. 18-54 years (in parallel with phase 1 if essential service worker or worker at risk (teachers, forces of law and order, prison staff).	Completion of phase 1 extended to all staff of old people's homes Priority on the basis of age and health: 1. Heightened fragility; 2. 70-79 years; 3. 60-69 years; 4. Persons with moderate comorbidities; over 60s; 5. Rest of the population. In case of availability of vaccines not recommended for priority categories, vaccination of essential service workers/workers at risk to proceed in parallel.	Categories abolished; age retained as sole criterion. Second doses guaranteed. 1. Over 80s; 2. Heightened fragility (including cohabiting relatives and caregivers); 3. 70-79 years; 4. 60-69 years (with AstraZeneca); 5. Rest of population using age criterion for access to bookings.

Source: Author's elaboration

During February, a number of differences with respect to the situation as it had initially been envisaged made it necessary to revise both the phases and the target categories. On the one hand, there was a sudden reduction in supplies of the RNA Pfizer vaccine, which it had been intended to roll out to the priority categories in phases 1 and 2. On the other hand, the recommendation of the health authorities (the European Medicines Agency – EMA – and the Italian Medicines Agency – AIFA) to use the Astrazeneca viral vector vaccine only for persons between 18 and 55 and for over 55s in good health, meant that the vaccination of people initially included in phase 3 – workers in the priority categories – was brought forward. The constant changes of opinion concerning the Astrazeneca vaccine (subsequently rebranded Vaxzevria) in the wake of the side effects discovered in the youngest age category led to further adjustments to the orders of priority with the abolition of the criterion concerning employment category and the retention, instead, of age (Table 1). From June, the campaign to get the entire population vaccinated got underway with the vaccines being made available to everyone and further extended to 12-15 year olds.

Regarding the organisation of vaccination centres, the plan published in January envisaged that in the first phase the centres would be housed in medical facilities and hospitals and in not-more-precisely-specified mobile units to serve people in priority categories who were unable to travel to the vaccination centres. The recommendations concerning the subsequent phases were much more generic and gave the Extraordinary Commissioner for the Emergency (at that stage Domenico Arcuri in post from March 2020) responsibility for defining operational standards and lay-outs, while the regions were responsible for coordinating the work of the staff (if necessary involving general practitioners and paediatricians). The regions also had responsibility for deciding where vaccination centres were to be located and for everything concerning supervision and execution at the centres. As vague were the provisions concerning the IT systems supporting the logistic and booking arrangements. The gaps in the plan were filled by the initiatives taken by the Commissioner who, on 13 December 2020, held a press conference to make an announcement concerning an architectural and a communications aspect of the campaign. The latter would be developed around the concept of primroses and driven forward under the slogan, 'Italy will be reborn with a flower'. In essence, the package outlined by Arcuri envisaged the construction of temporary pavilions of wood and fabric, in

the shape of primroses, where such pavilions would be used to administer doses in the squares of towns and villages once phase 1 of the plan had been completed. A logo including a primrose would feature on totem displays and in official communications as a symbol of the gradual reawakening of social life following the long winter of the pandemic.

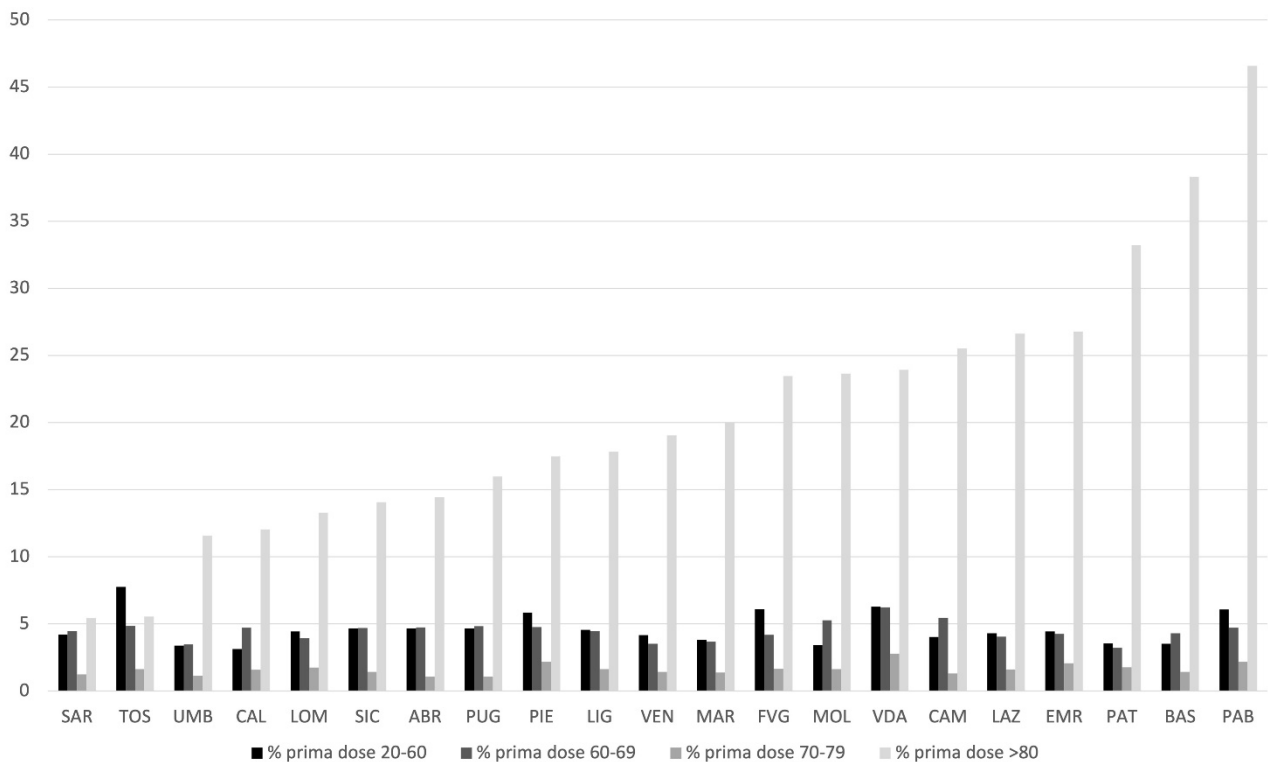
However, the life of the primrose project was cut short by the fall of the Conte government at the end of January and it would leave behind only the logo. The assumption of office by the new Draghi government on 13 February led to Arcuri's replacement as Extraordinary Commissioner by General Francesco Paolo Figliuolo, from 2018 logistics commander of the Italian army. Criticised on a number of counts (excessive cost: €400,000 per pavilion; inefficient layout in terms of capacity, distancing and rapidity of vaccination; competitive tendering and related construction delays),² the primrose pavilions were never viewed kindly by the regions, which would have had to apply for them. Consequently, with the arrival of Figliuolo the primroses were set aside in favour of a more pragmatic approach in line with the one adopted by other European countries, especially Germany – an approach involving the use of existing spaces and buildings (barracks, gyms, stadia etc.) alongside drive-throughs staffed by the military. Meanwhile, a national protocol agreement with general practitioners was reached, such agreement not having until then been realised except by one or two regions acting on their own initiative.³ The stated objective was to accelerate the vaccine roll-out, to increase the number of vaccination centres and to ensure that the priority criteria for administering the vaccines were applied more uniformly in view of the muted launch of the campaign and the haphazard approach of the regions.⁴ Many of them, once phase 1 was underway, had begun focussing on the younger age categories given the difficulties of reaching the over 80s. Consequently, by the end of February, the proportions in the most-at-risk age categories who had received a first dose varied considerably from one region to another (Figure 2), even though the variation was also a product of other factors besides. For example, in Sardinia, the very low percentage of the over 80s vaccinated was due at least in part to the delay in making available vaccination schedules and the bookings platform, which by the middle of February had still not been activated. In Tuscany, the same low proportion was due to the regional administration's initial decision to do away with online bookings for the over 80s in favour of booking through their GPs, with obvious delays arising from the difficulties in making initial contact with people of such advanced ages. At the same time, the good results achieved by the autonomous province of Bolzano were due to the fact that in Alto Adige, vaccination of the over 80s began half way through January. This was because of the numerous refusals of the vaccine on the part of medical staff (which meant that there were correspondingly numerous surplus doses of the Pfizer vaccine available to give to older people). The commendable results achieved by Basilicata were due its very decentralised system of vaccine roll-outs, one centred on its local districts.⁵

Besides leading to the measures of reorganisation described above,⁶ the new national-level guidelines concerning the target groups, and the decision of the new Commissioner to revise the vaccination plan (in the expectation that from March supplies of the vaccine would be less intermittent) led to the publication of more explicit and more ambitious targets. These aimed at administering at least 500,000 doses per day by the end of April, and at the achievement of a coverage (60% of the population including the under 16s, by the end of July, 70% by the end of August; 80% by the middle of September) that would provide so-called 'herd immunity'. Meanwhile, the month of April saw the publication of stricter guidelines, on the basis of which the regions were called upon to adhere to a revised principle for the distribution of doses ('one person, one dose'). They were also to meet weekly vaccine roll-out targets, and to be more scrupulous in giving priority to people with fragile health and to the elderly (focussing first on 70-79 year olds, then those in their 60s and then everyone else).⁷ From 3 June, the date of which the mass roll-out of the vaccines began, the Commissioner called upon the regions gradually to decentralise the network of large vaccination centres. The size of such centres had facilitated the rapid and efficient roll-out of vaccines to those most willing to get vaccinated. Now the centres were to be located closer to residential areas and to involve more fully the collaboration of general practitioners and pharmacies. Other measures to lower

barriers in the way of access included the ‘over-the-counter’ initiative, taken by almost all regional administrations, whereby it was possible to be vaccinated without having to book in advance. This initiative, taken both by the regions spontaneously and after prodding by the Commissioner, was aimed especially at reaching adolescents. These would shortly be having to take high-school exams, and then, later on, in the autumn, to return to school.⁸ For similar reasons, it was decided to introduce more flexible criteria around bookings for the second dose, making it possible to receive it in a region other than the one in which the citizen was resident, this in order not to discourage those wanting to receive the dose while on holiday.⁹ With the same objective in mind, in several regions there were a number of further initiatives taken during the summer, including the erection of mobile vaccination centres on beaches, on ferries and at airports.¹⁰

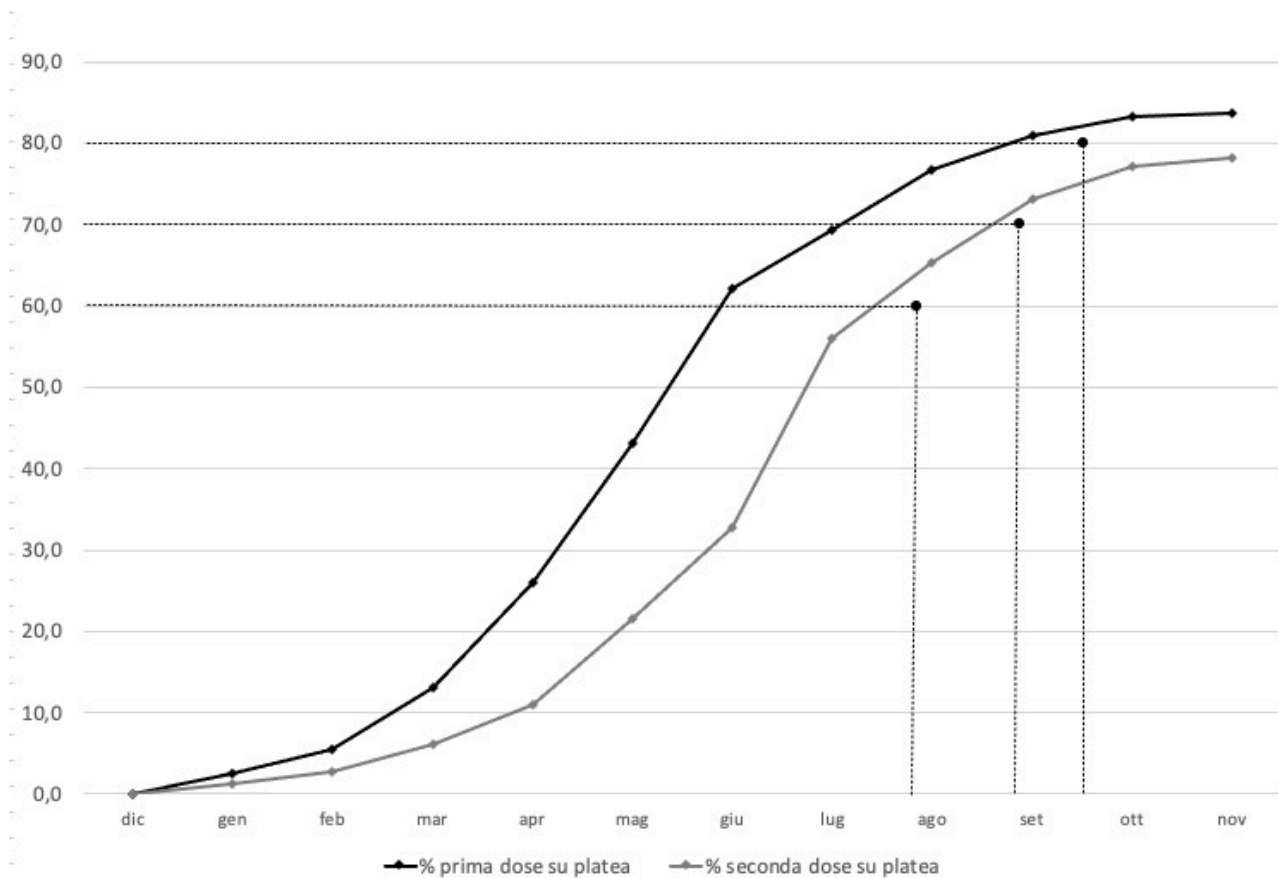
Although there were not insignificant regional variations in the speed of the vaccine roll-out, overall the campaign proceeded more rapidly from April onwards, so much so that the first target set by Figliuolo’s vaccination plan was reached within the envisaged time frame while the intermediate target was reached, as envisaged, by the end of August. From then on the roll-out proceeded more slowly, so that the final target of 80% coverage by the middle of September was reached only as far as first doses were concerned, not in terms of both first and second doses (Figure 3). However, the 80% target had been set aside during the summer with the arrival of the Delta variant, which became the predominant strain circulating in July and which proved much more transmissible, raising significant questions concerning the effectiveness of the vaccines, at least from the point of view of preventing viral transmission. From August, 90% began to be taken as the target that would have to be reached in order to be able to consider the virus as endemic. Meanwhile, from July a number of studies began to appear which pointed in the direction of a sharp decline in the efficacy of the vaccines in preventing transmission after six months following completion of the first cycle. Consequently, the idea that a third, booster, shot would be necessary began to acquire support. It was underpinned by a circular from the department of health, which advised and authorised the roll-out of third doses, first to those over 80 and to the staff and residents of nursing homes and subsequently to health workers, those in poor health and the over-60s. In view of the spike in infections in the autumn, a third dose was authorised for the over-40s from 22 November, and for the over-18s from 1 December, provided five months had elapsed since completion of the first cycle. Finally, with the rapid spread of the Omicron variant (which was estimated to be present in around 30% of the cases in Italy at the end of December), the consequent spike in infections was met with the decision to extend the third dose to everyone aged 16 and over (besides those aged 12-15 in poor health). Meanwhile, the period from completion of the first cycle was reduced to 4 months from 10 January 2022.

Figure 2. Proportions of the population having received the first dose by region of residence and age, 28 February 2021 (as % of those, in each category, eligible to receive the vaccine).



Source: author's elaboration of data at: <https://github.com/italia/covid19-opendata-vaccini>.

Figure 3. Cumulative change in vaccine coverage to 21 November 2021: first and second doses (as % of those eligible to receive the vaccine).



Source: author's elaboration of data from <https://github.com/italia/covid19-opendata-vaccini>.

The measures to combat vaccine hesitancy and the evolution of the Green Pass

In the Italian case, the vaccination campaign was launched in a context of great popular expectations combined with considerable feelings of uncertainty. If in December 2020 over two thirds of Italian citizens (68%) considered the vaccines to be the only solution to the pandemic, and if a similar proportion (67%) thought it likely that they would be infected at some time in the future, then only a third (34%) expressed a willingness to get vaccinated immediately. Around a third expressed clear hesitation at the prospect of being vaccinated in the immediate term, preferring to wait to see the effects of the vaccine in others and to acquire more information about the vaccines then available (European Commission 2020).

With the aim of breaking down resistance, and in view of initial uncertainty concerning the vaccines' availability, the Conte II government had avoided any recourse to coercive measures, relying exclusively on the 'soft' instruments of communication and persuasion. Examples were the above-mentioned concept of primroses, designed to transmit reassuring messages about the future, and a series of advertisements, aimed at raising levels of public awareness, that were all focussed on family affections and designed to present vaccination as something necessary to protect oneself and others. The type of official communication remained the same even after the Draghi government took office. Messages remained ones focussed primarily on the sphere of emotional ties (one thinks, for example of the '*Riprendiamoci il gusto del futuro*' ('Let's take back our zest for the future') campaign of the summer of 2021) rather than on the safety of the vaccines and their effectiveness, as the European institutions had advised.¹² On the one hand, this style of communication reflected a long-standing feature of Italian policy making in the area of vaccines, namely, an inability effectively to manage the means of communication and information provision (Attwell *et al.* 2021). On the other hand, at least in the initial months of the campaign, the novelty of the anti-SARS-CoV-2 vaccines, the degree of uncertainty concerning their suitability for different segments of the population, and the sometimes contrasting opinions of experts themselves concerning their efficacy, all placed considerable obstacles in the way of the development of strategies of persuasion and evidence-based communication. The cack-handed management of communication in the above-mentioned Astrazeneca case on the part of both the national and European authorities including the medicines regulation agencies (EMA and AIFA), constitutes a striking example of this difficulty.¹³

The fall of the Conte II government and its replacement by the government led by Draghi, together with an increase in the availability of the vaccines and greater regularity in the delivery of consignments, marked a change of emphasis around the compliance regime, with the use of a greater range of measures. Unlike the regimes in place in other European countries and more widely, the Italian regime did not give much space to the so-called 'positive incentives', i.e. to benefits – often financial – designed to make the prospect of vaccination more attractive as was the case with the vouchers used, for example, in the US, Greece and Serbia; the lotteries used in the US, Russia and Hong Kong, or the food parcels used in Romania, Indonesia and the Philippines.¹⁴ A proposal, launched in Parliament to provide a holiday voucher of €1,000 to the vaccinated never saw the light of day. Besides that, the examples of positive incentives were confined to one or two sporadic initiatives at local or regional level, such as the monetary incentives to general practitioners who succeeded in getting 90% of their patients vaccinated (in the case of Piemonte) or to paediatricians who managed 70% (in the case of the local health authorities in Bologna). Rather, from April until the end of 2021, the Government concentrated on a mix of regulatory measures where the setting was constantly adjusted with the aim of gradually enlarging the target population and progressively increasing the strictness of the measures.

On the one hand, vaccination was made obligatory for a limited number of professional categories considered to be at risk: initially health workers (from 1 April) then all staff (including those not health-related) employed in residential care facilities (from 10 October) and finally staff in education and the forces of law and order (from 15 December). Responsibility for monitoring was placed in the hands of the organisations concerned, and in the event of non-compliance, the sanctions

ranged from re-deployment to compulsory time away from work and ultimately suspension without pay. The idea of a generalised measure of coercion made no headway. This was due to the difficulty involved in putting in place an effective and timely system of monitoring and sanctions (in other words credible instruments of enforcement) beyond the aforementioned professional categories. It was also due to the opposition of the political parties represented in Parliament (including some of those supporting the Government especially the Lega (League)) to any suggestion of compulsory vaccination for the whole population. This was so despite the fact that expressions of support for the idea came both from the social partners (from the summer of 2021 in the case of the main employers' organisations, as well as from the trade unions provided it excluded the sanction of dismissal) and from the public (with over 60% being in favour in polls conducted between May and September 2021).¹⁵

On the other hand, the instrument the Government relied upon the most to change the behaviour of those most resistant to the vaccine – and so reconcile the resumption of economic and social life with containment of the virus – was the so-called Green Pass (Gp). First proposed by the EU on 17 March 2021 as a means of reconciling the free movement of people with conditions of safety, this digital certification initially had exactly the same purpose in Italy: DI. N. 52/2021 (the so-called 're-opening decree'), passed in April, was the first measure regulating applicability of the Gp. It made possession of the Gp obligatory only for travel between regions and for attendance at certain types of public event where social distancing was difficult, such as concerts or sporting events. In this initial form, the obligation to carry a Gp – issued to the vaccinated, those having recovered from Covid and those having a negative result from a test taken in the previous 48 hours – was not very intrusive. As it was designed to guide individuals' behaviour without prohibiting anything and without relying on financial incentives, it came to be seen by many observers – not entirely appropriately – as belonging to the category of nudge (Thaler and Sunstein 2008). However, in subsequent months, its use was gradually extended and its possession made increasingly obligatory (Figure 4) with the result that a number of party political spokespersons (especially Giorgia Meloni of Fratelli d'Italia (Brothers of Italy, FdI) and also representatives of the Lega) began suggesting that it was 'obligatory vaccination in disguise'.

More specifically, the first extension to the Gp requirements came with the arrival of the summer holiday season when, on 23 July 2021, DI N. 105 provided that from 6 August the document would be necessary in order to gain access to indoor restaurants and bars as well as other social settings. The measure – which was introduced following the introduction of a similar measure in France a few weeks earlier with the result of increasing the number of vaccinations by over a million the day after President Macron's announcement – triggered the first street protests, the opposition of FdI and the barely disguised irritation of the Lega.¹⁶ Expressions of hostility mounted throughout August, when DI. no. 111/21 extended the Gp obligation to all those employed in education and to those using long-distance public transport, and culminated in September when DI. N. 127/21 extended the obligation to all public- and private-sector workers from 15 October. Responsibility for monitoring compliance was placed in the lap of the relevant operators and employers and there were to be pecuniary sanctions both for them and for clients/employees found to be non-compliant (Figure 4). Moreover, workers who were not compliant were to be considered as absent without leave, meaning that they would lose pay, as was already the case for those categories for whom the vaccination was obligatory.

However, the gradual increase in the number of circumstances in which the Gp was obligatory was accompanied by a corresponding increase in the number of 'concessions' such as the extension to the period of validity of the pass and of the tests necessary to obtain it; recognition of rapid antigen tests; the price controls applied to the latter (Figure 4). If these 'opt-out' clauses were understandable in light of the political controversy surrounding the vaccines issue (cfr. Russo and Valbruzzi in this issue), especially given the polarisation of public opinion and the local elections due to be held on 3 October 2021, it is also true that they considerably reduced incentives to comply. Thus it was that, aside from slight increases in the numbers vaccinated the day before and the day after the various

measures came into force, the impact of the Gp on the numbers of new vaccinations seemed to decline over time while there was an exponential growth in the number of rapid antigen tests carried out (Figure 5).

Dl. N. 172 of 26 November sought to address this problem by limiting more clearly the activities allowed to the non-vaccinated, this by providing for a ‘*Green Pass rafforzato*’ (‘Enhanced Green Pass’) available only to the fully vaccinated and those having recovered from Covid who would be allowed to engage in all the activities hitherto allowed to Gp holders. In contrast, the ‘basic’ Gp, obtainable with nothing more than a negative test, would give access only to the work place, to local and long-distance public transport, as well as gyms, swimming pools and recreational venues. The validity of both types of Gp would be reduced from 12 to 9 months. A further tightening of the provisions concerning the Gp took place during the Christmas period when there was an explosion of infections due to the spread of the Omicron variant and a collapse in the availability of tests (especially rapid antigenic tests), the demand for which continued to rise dramatically (Figure 5). With the passage of Dl. N. 221 of 24 December 2021, the Enhanced Green Pass became necessary for all activities – including access to public transport and with the sole exception of access to citizens’ places of employment – and its validity was reduced from 9 to 6 months.

A few days later, in the middle of the fourth wave of infections, a further measure was introduced, one that finally placed the Gp in the category of instruments reflecting the highest degree of compulsion. Thus it was that Dl. N. 1 of 7 January 2022 stipulated that, from 15 February, the obligation to be in possession of an Enhanced Green Pass, obtainable only with vaccination, would be extended to all employees, public and private, who would be at least 50 years of age from 15 June 2022. The measure also made vaccination compulsory for everyone, whether or not they were in employment, who was over the age of 50. The reason offered for the choice of this particular age threshold was the greater probability, as compared to someone younger, that a person over 50 catching Covid would end up needing to be hospitalised.¹⁷ The decree, approved unanimously in Cabinet, but the result of a lengthy and acrimonious process of negotiation between the governing parties (with the Partito Democratico (Democratic Party, PD), Forza Italia and Italia Viva favouring a general vaccination obligation, the Lega and the Movimento Cinque Stelle (Five-star Movement, M5s) opposing it), led to the conjoining of two different instruments reflective of two different types of enforcement. On the one hand, the obligation on workers to be in possession of an Enhanced Green Pass would be enforced by the monitoring and sanctions already provided for (i.e. with responsibility for monitoring lying with the employer, and suspension without pay and/or fines from €600 to €1,500 in cases of non-compliance). On the other hand, responsibility for monitoring compliance with the obligation to be vaccinated was given to the Agenzia delle entrate (Government Revenue Agency) with violators liable to one-off fines of €100. The paltry size of the sanction compared with the much larger fines introduced in other European countries that had embraced obligatory vaccination – countries such as Greece, where the obligation applied to those over 60 and attracted fines of €100 per month for non-compliance, and Austria where the non-vaccinated over 18 were to be fined €600 every three months. The comparison led some observers (including legal experts and members of the scientific community) to speak of a ‘polite obligation’, that is, a measure that was nominally coercive but in practice assimilable to the category of ‘inducements’, especially if compared with the greater deterrent effect of the penalties attached to the failure to be in possession of an Enhanced Gp, which was the real instrument used to encourage vaccination among those most resistant to it.¹⁹

Figure 4 Chronology describing the successive waves of legislation concerning vaccinations and the Green Pass and the areas to which it applied.

DI 44/21 1 April

Obligatory vaccination for health workers (doctors and nurses)

■

DI 52/21 22 April

Defines and regulates the Gp; recognises the equivalence of certification issued by other states provided it is recognised by the EU. The certificate is available to those who have been vaccinated or who have recovered from Covid (validity 6 months) or who have a negative Covid test taken within the previous 48 hours. Necessary for attending concerts and football matches and for travel to regions in the red or orange categories.

■

DI 65/21, 18 May

The Gp can be issued after the first dose. If it certifies vaccination, the validity is 9 months, if recovery from Covid, 6 months, if a negative test, 48 hours. From 15 June it is necessary in order to attend weddings in yellow-coded regions as well as theatres (with increased maximum audience sizes) sporting events, conferences, trade fairs.

■

DI105/21 23 July

Gp requirements extended from 6 August: necessary for access to indoor restaurants and bars (if food/drink consumed on the premises); theatres; sporting events; spas; swimming pools; gyms; festivals; trade fairs; theme parks; conferences; examination centres; games halls; tenants' meetings if held indoors. Monitoring is the responsibility of the manager or organiser of the event with sanctions ranging from €400 to €1000 for both operator and client. Tests at capped prices (€8 for under-18s; €15 for over-18s) available in chemists until 30 September.

■

DI 111/21 6 August

From 6 September, Gp obligatory for teachers, head teachers and administrative staff in all schools and universities and for all students over 18 intending to attend classes. Monitoring is the responsibility of the institution. Same sanctions as those provided for by the previous decree. Obligatory for access to long-distance trains, planes, buses and ferries.

■

DI 122/21 10 September

Obligatory vaccination for all staff (whether health workers or not) of residential care homes from 10 October. From the same date, Gp is obligatory for access to schools (canteen workers, cleaning and maintenance staff, parents). Validity of Gp increased from 9 to 12 months. Gp obtainable with a negative saliva test. Rapid antigen tests valid for 48 hours, PCR tests for 72. Expiry of price cap on tests extended from 30 September to 30 November.

■

DI 127/21 21 September

From 15 October, Gp obligatory for all civil servants, holders of elected offices or high-ranking official positions, private-sector employees regardless of the type of employment contract. Monitoring is the responsibility of the employer. Employees not in possession of the Gp are considered absent without leave and lose the right to pay. Fines from €400 to €1,000 for employers, from €600 to €1,500 for employees. Price cap on tests extended to end December.

■

DI 172/21 26 November

Vaccination obligation extended to teachers and the forces of law and order. Distinction between basic Gp and Enhanced Gp (available only to the vaccinated or those recovered from Covid). From 6 December access to theatres, sporting events, indoor restaurants and bars, parties, discotheques and ceremonies is limited to Enhanced Gp holders. Basic Gp remains valid for access to places of employment and long-distance public transport. It becomes obligatory for regional trains, local public transport, hotels. It is not obligatory for the under-12s. Validity, however, reduced from 12 to 9 months. Validity of test results remains the same (48 and 72 hours). Introduction of enhanced compliance monitoring.

■

DI 221/21 24 December

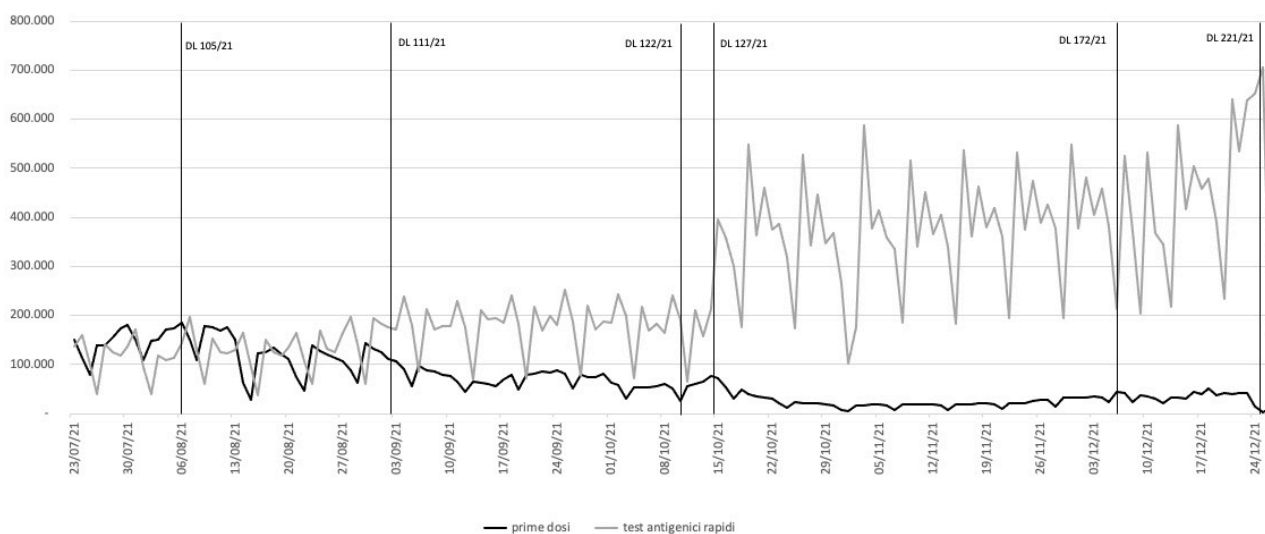
Increase in the number of settings requiring Enhanced Gp for access: from 25 December, also for the consumption of food and drink while standing at the counters of restaurants and bars; from 10 January for access to museums; exhibitions; swimming pools; gyms; health centres; gaming halls; recreational facilities. Visits to residential care homes require full vaccination plus booster, or full vaccination plus negative antigen or PCR test result within 48 hours prior to visiting. Validity of Gp reduced from 9 to 6 months from 1 February 2022. From 10 January third dose is available four months after completion of the first cycle.

■

DI 1/22 7 January

Vaccination obligatory for all over 50. Monitoring is the responsibility of the Government Revenue Agency. One-off sanction of €100 from 1 February for those not having completed the first cycle or received the booster dose within the period of validity of the Gp. **Vaccination obligation extended to all university staff.** From 15 February, Enhanced Gp obligatory for all workers over 50. Basic Gp necessary for access to personal services (from 20 January) and to public offices, post offices, banking and financial institutions and commercial activities from 1 February.

Figure 5: Comparison of the number of first doses administered and the number of rapid antigen tests administered daily 23 July- 26 December 2021 (vertical lines correspond to the entry into force of the various enhancements of Gp obligations).



Source: Author's elaboration of data from <https://github.com/italia/covid19-opendata-vaccini>.

Conclusion

The events described in this article make it possible to draw two main conclusions that may be subject to change depending on future developments.

Following the rather haphazard beginning under the Conte II government, and despite the inevitable adjustments required by evolution of the pandemic, the vaccination campaign put in place by the Commissioner, Figliuolo, was characterised by more energetic coordination than hitherto between the relevant levels of government and resulted in a good level of coverage of the population. At the end of December 2021, the proportion of the eligible population having received both of the first two doses was around 80%, placing Italy in fourth place among European countries and behind only Portugal, Malta and Spain.²⁰ This result was undoubtedly facilitated by a decentralised and flexible roll-out strategy which – especially in the spring and autumn – was based on an increase in the number of vaccination centres and on the mobilisation of personnel and infrastructural facilities extending beyond the hospitals so as to encourage compliance by removing all possible obstacles in the way of those willing to engage with the campaign.

Meanwhile, the Gp – the instrument the Government relied upon to overcome the resistance of those most reluctant to engage – proved to be reasonably effective. If, as mentioned, around a third of citizens were uncertain about or opposed to the idea of taking up the anti-Covid vaccine in December 2020, then survey data referring to the adult population show that the proportion of those hesitant fell continuously throughout 2021, declining to 20% in June and 10% between the end of the summer and December (Moroni and Vezzoni 2022). This was in all probability the reflection of a natural increase in confidence in the safety of the vaccines as the campaign progressed, with the increasing involvement of general practitioners, who were considered the most reliable sources of information by over 35% of respondents by the middle of 2021 (Bucchi and Saracino 2021). But it is equally as plausible that the introduction of the Gp, and the constraints/costs associated with being without it, drove take-up of the vaccines first among the hesitant desirous of greater freedom to travel and a more active social life, and subsequently among those workers for whom the costs (monetary, psychological and in terms of time) involved in having to subject themselves to continuous testing in order to work, were too onerous.

Analysing this strategy from the perspective of the instruments of compliance, the "basic" Gp can be understood, yes, as a regulatory instrument, but also as one belonging to the theoretical category of negative incentives. This meant that it was a measure that introduced legal limitations and selective forms of exclusion for those defecting from the desired behaviour (vaccination), without however precluding the possibility of opting out (for example through having a negative test), even while making opting out increasingly onerous by gradually increasing the number of settings, up to and including places of work, that could only be accessed by those with the Gp. With the Enhanced Gp, especially after having made it a requirement to access workplaces for the over-50s, government policy began to move away from the category of incentives and more closely to approximate obligation *tout court* – this, not only by constantly increasing the range of activities from which the non-vaccinated were excluded, but also by imposing pecuniary sanctions (especially losses of earnings) difficult to sustain and much heavier than those associated with the out-and-out obligation to be vaccinated.

A number of possible problems arising from these measures have been highlighted. The first concerns the actual potential of the Enhanced Gp to drive take-up among the minority that has still not been vaccinated, given that – as revealed by a number of surveys – the pool of those amenable to persuasion has already run dry, while the percentage of the sceptical and the strongly opposed, resistant to all of the limitations and stimuli associated with the campaign, remains more or less constant (at around the rather small proportion of not more than 10% of the adult population) (Moroni and Vezzoni 2022). In other words, one wonders whether the use of highly coercive measures, ones that are therefore highly costly from the symbolic (and enforcement) point of view, is proportionate to the probably small reduction in the size of the non-vaccinated population (*Ibidem*). The question is especially pertinent given that the highest proportions of the unvaccinated – leaving aside children, for whom the campaign has only been running for a few months – were, at the time of writing, to be found in the youngest cohorts (especially those between 12 and 19 and between 30 and 50) rather than among the cohort targeted by the heaviest restrictions.²¹

Second, there is the question of the coherence of the set of tools adopted given the purpose they are meant to serve (Capano and Howlett 2020). The question is especially pertinent bearing in mind that the Gp was the object of the – sometimes frenzied – production of an accumulation of measures, often reformulated as time went on in light of the progress of the vaccination campaign, of the pandemic and of the available scientific evidence. Until the autumn, in the context of a limited spread of the infection, the purpose of the Gp was clearly that of maximising engagement with the vaccination campaign, on the assumption that it would be effective in ensuring collective immunisation. However, with the start of the fourth wave of the pandemic and the arrival of the Omicron variant, this assumption was undermined. It emerged that the vaccine was a useful weapon against the worst forms of the illness, but less so against its transmission. Given this, the decision to limit availability of the Enhanced Gp to the vaccinated, and to make vaccination obligatory for the over-50s, appeared to suggest that the pass was being used for more limited purposes than it had been originally, namely, to reduce the pressure of Covid patients on hospitals and on the health service generally. Meanwhile, it is extremely doubtful how effective the pass is in limiting the spread of the virus. In this regard, paradoxically, the tracing tools, such as testing (which does not give access to the Enhanced Gp), the use of adequate personal protective equipment, and measures of social distancing, seem more suitable. If, therefore, the Gp had originally been conceived as an instrument capable of delivering, almost on its own, both compliance and infection containment, then it would now appear more appropriate to rely on a more varied and coordinated set of instruments for achieving the two objectives.

Finally, and related to the last point, an important issue arises concerning the timing of the measures. Like the efforts to manage the pandemic generally (Capano 2021), so too the vaccination campaign was characterised for the most part, by a reactive approach. This involved periodic readjustments of measures that sought to keep up with the spread of the virus and the available information about the vaccines – this through a series of incremental changes heralding a complex

(and sometimes ambiguous) system of rules and regulations. The most recent example is the requirement for the over-50s to be in possession of the Enhanced Gp to gain access to their places of work. The date on which it was due to come into force (15 February 2022) seemed too late for it to have any impact on the fourth wave whose peak was expected to coincide with the end of January.

In concluding, it should however be acknowledged that a reactive and incremental approach characterised the development of the compliance regime not only in Italy but in a large number of countries in Europe and elsewhere. This was because they were seeking to grapple with problems of mass vaccination for which they were unprepared, with partial and changing information concerning the efficacy of the vaccines, and with a pandemic whose development was affected by the emergence of new variants (Coccia 2022). From this point of view, the 2021 vaccination campaign undoubtedly constitutes an interesting field of (especially comparative) research, for all those interested in exploring the capacity of governments to respond to the crisis and – looking ahead – in drawing lessons from it for future interventions of a similar nature.

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