Ca' Foscari
University
of Venice

Master's Degree programme

in Comparative International Relations

Final Thesis

PUBLIC HEALTH AND THE MANAGEMENT OF EPIDEMICS: A HISTORICAL ANALYSIS (15th-21st CENTURIES)

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Academic Year
2022 / 2023

RIASSUNTO

La tesi propone come obiettivo l'analisi della gestione delle epidemie nelle città porto durante l'età moderna e della pandemia di COVID-19, analizzandone parallelismi e differenze. La situazione attuale mi ha spinta ad interrogarmi sulla storia delle epidemie, che si è dunque concentrata sull'età moderna, momento in cui si sviluppano le prime forme di sanità pubblica. La profondità storica mi è sembrata un utile strumento per analizzare il caso attuale. Questo infatti mi ha portata a provare ad offrire una prima analisi della gestione della pandemia di COVID-19 e del ruolo degli strumenti politici e amministrativi a fianco di quelli medico-scientifici. Quindi, l'analisi ha come punto di partenza la gestione delle epidemie nelle città porto di Venezia, Genova e Marsiglia. Questi importanti centri di snodi commerciali, e quindi a rischio epidemico, hanno aperto la via alla creazione di istituzioni sanitarie per prevenire la diffusione delle malattie epidemiche. Ai fini della ricerca si esamineranno sia fonti primarie recenti, tra cui i Decreti Legge e i discorsi tenuti in conferenza stampa prima dai Presidenti del Consiglio dei Ministri Giuseppe Conte e successivamente Mario Draghi, sia fonti primarie storiche, in particolar modo la prima raccolta di leggi sanitarie della Repubblica di Venezia del 1770, compilata da Giovan Antonio Boncio.

Nella prima parte della tesi, viene presentato il contesto in cui si sviluppano le prime epidemie: i primi segni storici di un mondo globalizzato. Importante ruolo nella diffusione delle malattie fu giocato dallo Scambio Colombiano, che incentivò il trasporto di nuovi animali e nuovi vegetali tra le Americhe e l'Eurasia, e dalle migrazioni globali che comportarono lo spostamento di migliaia di persone. Proprio in questo periodo si svilupparono le prime forme di stato moderno, attori importanti nella gestione delle epidemie, che esercitavano il proprio controllo tramite le istituzioni sanitarie e gli strumenti di prevenzione che erano anzitutto atti a preservare l'equilibrio economico-politico.

Nella seconda parte della tesi vengono analizzate le misure adottate dalla Repubblica di Venezia, di Genova e dalla città porto di Marsiglia.

La Repubblica di Venezia durante l'età moderna era un punto di riferimento per tutte le città porto, specialmente in materia di salute. Essendo un crocevia di beni e culture differenti, Venezia era molto esposta alla circolazione di nuove malattie e per questo necessitava di un'organizzazione sanitaria capillare. La Serenissima fu la prima a istituire un Magistrato alla Sanità per monitorare la diffusione delle malattie e promuovere contromisure. Il Magistrato alla Sanità era caratterizzato da tre

Soprintendenti alla Salute o Commissari alla Salute. Alle dipendenze del Magistrato troviamo altre figure tra i quali i Novellisti, i Guardiani alla Salute e i Fanti. Venezia fu un modello di gestione delle epidemie in quanto, oltre a stabilire una Magistratura permanente nel 1440, adottò diverse misure tra le quali la creazione dei Lazzaretti, l'utilizzo delle quarantene e l'impiego delle Patenti di Sanità. Fu proprio a Venezia che venne redatta la prima raccolta di leggi sulla sanità da Giovan Antonio Boncio nel 1770 in un'opera intitolata "*Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità*". Le leggi sanitarie contenute in questo scritto, risalenti a un periodo dal 1400 al 1800, sono state molto importanti per la stesura della mia tesi, in particolar modo ai fini comparativi con la pandemia di COVID-19. Rilevante nell'analisi della gestione delle epidemie nella Repubblica di Venezia è il ruolo dell'informazione, elemento fondamentale nella panoramica della protezione dalle epidemie. Infatti, viene sottolineato come le informazioni di tipo sanitario venissero usate per "secondi fini", ad esempio per svantaggiare economicamente altri porti, seguendo la logica della "Gelosia di Commercio" di Hume.

L'esempio della Repubblica di Genova ha evidenziato, oltre alla presenza del Magistrato alla Salute come per il caso della Repubblica di Venezia, come il controllo delle epidemie abbia avuto un riscontro anche nell'organizzazione dello spazio urbano e nella sfera privata dei cittadini. Infatti, per monitorare lo stato di avanzamento del contagio dell'epidemia, la Repubblica di Genova fu divisa in distretti capitanati da un Commissario alla Salute. Furono creati quaranta distretti all'interno dei vecchi muri di Genova e sei al di fuori. In prima battuta, il territorio fu diviso in quattro zone, ogni zona suddivisa in dieci contrade. I Commissari avevano il compito di dividere ogni contrada in vie, dando loro un nome e per ogni via veniva nominato un capostrada, che aveva il ruolo di controllare le case delle persone sottoposte a quarantena e di riferire al Commissario tutte le informazioni, il quale, a sua volta, faceva riferimento al Magistrato alla Salute. In questo modo il controllo effettuato era capillare e interferiva con la sfera privata dei cittadini.

L'ultima città porto presa in esame è Marsiglia. Rilevante fu soprattutto il ruolo giocato dal suo Ufficio di Sanità, soprannominato "*Bureau de renseignements*" ovvero "ufficio informazioni", a causa della profonda strumentalizzazione delle informazioni che circolavano al suo interno. Infatti, quando le navi arrivavano al porto di Marsiglia, i capitani dovevano recarsi all'Ufficio di Sanità per rilasciare una dichiarazione riguardante il viaggio trascorso. I capitani comunicavano eventuali problemi di salute e

fornivano dettagli su eventi accaduti durante il viaggio, ad esempio tempeste, danni o feriti. Tuttavia, eventuali segnalazioni circa la presenza di navi nemiche, corsari, mercanti inglesi o pirati barbareschi, fornivano ulteriori informazioni di natura economica, militari, politiche e diplomatiche che venivano successivamente riportate al governo centrale. Anche in quest'ultimo caso, quindi, si evidenzia come le istituzioni sanitarie venissero manipolate per fini economici e politici. Concludendo, questi tre esempi segnalano come già in epoca moderna il concetto di salute pubblica stesse prendendo forma e con esso, le soluzioni per proteggerla.

Successivamente, una breve parentesi sulla nascita delle prime Convenzioni e Istituzioni Sanitarie Internazionali ci condurrà alla successiva analisi del caso contemporaneo della pandemia di COVID-19. Nel sesto capitolo viene esaminata la Convenzione Sanitaria Internazionale di Parigi del 1903, che portò a una maggiore cooperazione internazionale, così come l'Ufficio Internazionale dell'Igiene Pubblica, fondato a Parigi nel 1907, che ebbe un ruolo cruciale fornendo alla comunità internazionale informazioni sui nuovi metodi di quarantena. In seguito viene menzionata l'Organizzazione Sanitaria Pan-Americana che fa parte dell'Organizzazione Mondiale della Sanità (OMS), la quale giocherà un ruolo fondamentale nella gestione della pandemia di COVID-19.

Nell'ultimo capitolo di questa tesi, si analizza la gestione della pandemia di COVID-19 che trovò la popolazione mondiale impreparata a gestire il nuovo virus contagioso partito dalla cittadina di Wuhan in Cina. Per far fronte a questa emergenza globale vennero attuate contromisure e restrizioni promosse da organizzazioni internazionali, dall'Unione Europea e, nel nostro caso, dallo Stato Italiano. A partire dalla scoperta del primo caso positivo, il Presidente del Consiglio dei Ministri in carica nel 2020 Giuseppe Conte, emanò il primo Decreto Legge il 23 febbraio 2020, con il quale vennero sospesi i principali servizi e iniziò ad essere applicata la quarantena per le persone positive al COVID-19. Il Decreto del 23 febbraio fu il primo di molti che segnarono il periodo della pandemia in Italia.

L'11 marzo 2020 fu il primo giorno di lockdown nazionale che prevedeva la chiusura di tutte le attività e l'impossibilità di movimento se non in determinati casi quali motivi di lavoro, di salute o per altri motivi ammessi dalle normative in vigore. Per far fronte a questo nuovo virus per il quale non era disponibile un vaccino, furono messe in atto severe politiche di controllo per tutelare la salute pubblica, che è un diritto fondamentale dell'uomo. Tra i metodi maggiormente utilizzati troviamo la quarantena,

la vaccinazione, il Green Pass e l'app Immuni.

In questo capitolo viene anche sottolineato come, nel 21esimo secolo, la salute sia un bene prezioso e un diritto fondamentale tutelato dalla Dichiarazione Universale dei Diritti dell'Uomo e dalla Costituzione Italiana. La salute pubblica non è considerata come un diritto del singolo ma come un diritto della collettività. La Dichiarazione del Millennio delle Nazioni Unite del 2000, tra i vari argomenti trattati, afferma che la tutela della salute, oltre ad essere un interesse internazionale, avviene con la prevenzione. Ad esempio, durante la pandemia di COVID-19, la lotta al virus e la ricerca di un vaccino si sono "internazionalizzate", grazie ad una collaborazione scientifica, medica e divulgativa che ha trasceso i confini geografici. Inoltre, l'emergenza pandemica ci dimostra come in determinati casi sia possibile far prevalere certi diritti fondamentali su altri, come nel caso del diritto alla salute. Infatti, secondo i Principi di Siracusa del 1948 e precisamente gli articoli 25 e 26, la salute pubblica può essere invocata come motivo per limitare determinati diritti al fine di consentire a uno Stato di adottare misure che affrontino una grave minaccia per la salute della popolazione. Questo è stato proprio il caso dello stato italiano che, a causa dell'emergenza pandemica di COVID-19, per tutelare la salute pubblica, ha limitato alcuni diritti fondamentali, come la libertà di circolazione. Di conseguenza, a causa delle misure adottate dallo Stato e dalla comunità internazionale, considerate incostituzionali e in contrasto con i diritti fondamentali, sono sorte alcune manifestazioni e gruppi come i No Vax e No Green pass che rivendicavano i diritti fondamentali.

Nell'ultimo paragrafo della tesi vengono infine esplicitate le differenze e le somiglianze tra la gestione delle epidemie in età moderna e durante la pandemia di COVID-19 nel 2020.

In età moderna, specialmente nel caso della città porto di Marsiglia, si è notato come le istituzioni sanitarie fossero strumentalizzate e utilizzate per "secondi fini" e come il controllo della popolazione fosse capillare. Un'importante fonte di paragone è stata l'analisi della "*Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità*" che ha evidenziato la puntualità e la pervasività delle leggi sanitarie veneziane, che non si limitavano solo alla gestione delle epidemie ma coprivano tutti gli aspetti della salute: dal controllo delle acque, agli animali, ai cibi. Questa importante fonte primaria ha anche permesso la comprensione delle tipologie di sanzioni applicate nell'antico regime: dalle pene corporali, anche per piccoli reati, fino alla pena di morte.

Quest'ultima è un elemento di totale divergenza rispetto all'epoca contemporanea: si pensi in particolare ai Decreti Legge riguardanti la pandemia di COVID-19 che prevedevano come "pena" una sanzione amministrativa. Tuttavia si può notare come alcuni strumenti utilizzati nella Repubblica di Venezia, tra cui la quarantena e le patenti di sanità, possono essere in un certo senso simili al Green Pass e all' odierna quarantena utilizzata per gestire il virus di COVID-19. Così come nell' Italia dell'emergenza pandemica entrambi i Presidenti del Consiglio dei Ministri, prima Giuseppe Conte e poi Mario Draghi, hanno utilizzato discorsi di carattere emotivo per convincere la popolazione a rispettare le regole, anche in età moderna i sacerdoti proponevano nei loro sermoni rimandi a scene di sofferenza provocate dalla peste per convincere la popolazione che la preghiera fosse l'unica cura al morbo.

Così come nella Repubblica di Genova durante l'età moderna si è assistito a un rafforzamento dell'organo governativo per fronteggiare le epidemie, anche nel contemporaneo caso della pandemia di COVID-19 lo Stato Italiano acquisisce un maggior ruolo nel controllo dell'emergenza incrementando servizi straordinari di controllo del territorio da parte delle Forze dell'ordine, specialmente nelle fasi iniziali, quando non disponeva di soluzioni di carattere medico scientifico.

Per concludere, questo lavoro ha avuto lo scopo di mettere in evidenza come le prime pratiche di salute pubblica fossero già state avanzate in età moderna, in particolare nella Repubblica di Venezia, di Genova e nella città porto di Marsiglia, modelli di gestione delle prime epidemie. Da questo studio comparativo e storico è emerso inoltre come alcune pratiche di prevenzione quali l'utilizzo della quarantena e delle patenti di sanità siano state utilizzate anche per la gestione del COVID-19, isolando i casi positivi e introducendo l'uso del Green Pass. Durante la gestione della pandemia del 2020, l'Italia è stata sottoposta a una suddivisione territoriale di zone a rischio, per poter meglio controllare la diffusione del virus. Pratica simile, ma molto più invasiva, era stata utilizzata nella Repubblica di Genova in età moderna: la città fu suddivisa in contrade in modo che per i Capistrada fosse più semplice controllare le case infette. Come era accaduto per la Repubblica di Venezia e di Genova e per la città porto di Marsiglia, anche lo Stato italiano durante la pandemia è stato protagonista di un accentramento di poteri in capo all'Esecutivo al fine di gestire l'emergenza. Naturalmente, questo studio ha evidenziato anche le differenze tra i due casi, la principale di esse consiste nella tipologia di pena, in quanto nell'Antico Regime veniva utilizzata la pena di morte. Nel 21esimo secolo, il metodo di protezione della salute

pubblica è migliorato grazie alla cooperazione internazionale, alla nascita di organizzazioni internazionali ad hoc e al progresso scientifico e tecnologico.

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INTRODUCTION

This thesis examines the management of epidemics in the context of the Early Modern Age. This work analyses the instruments used to manage epidemics and the role of information and economics in health issues. This dissertation attempts to offer instrument to analyse also the contemporary management of COVID-19 pandemic. The ultimate aim of my thesis is to underline the similarities and differences between the management of epidemics during the Early Modern Age, specifically in port cities, which were important commercial hubs and therefore at higher risk of epidemic outbreaks, and the most recent management of COVID-19 pandemic. The current situation has prompted me to question the history of epidemics, which was therefore focused on the modern age because that was the moment in which the first forms of public health developed. In fact, historical depth was a useful tool for analysing the current case, clearing the field of simplifications and easy comparisons. In fact, this led me to try to offer an initial analysis of the management of the COVID-19 crisis and of the role of political and administrative instruments alongside medical-scientific ones. To do this, recent primary sources will be analysed, including the Decree laws and original speeches given by the Prime Minister of Italy and subsequently a comparison will be made with the health laws of the Republic of Venice, highlighting differences and similarities.

This work relies on the existing literature concerning the history of epidemics. The main approach that will be used is the qualitative one using the data gathering method. The main research question of my thesis is the following: How did the management of epidemics in the Early Modern European port cities emerge and what are the differences and similarities with the current management?

The problem of managing epidemics is present in contemporary debates due to the COVID-19 pandemic. Authorities attempted to manage epidemics since the Early Modern Age. As a matter of fact, some aspects of the COVID-19 pandemic management bear similarities to the techniques used to face the plague outbreaks. Since the COVID-19 pandemic emerged, different experts have focused their attention on the past epidemics. As underlined by the existing literature, the European seaports in the Early Modern Age can give an interesting perspective on epidemics management, giving me the possibility to offer a first analysis of the management of the COVID-19 pandemic.

The thesis first provides an historical background and explains concepts such the Columbian Exchange, Globalization, the birth of Modern State and Foucault's concept of control and biopolitics. It then moves to an in-depth analysis of the management of epidemics in ports and free ports, especially the cases of the Republic of Venice, the Republic of Genoa and of Marseille. Finally, after outlining the nineteenth- century advent of an international sanitary system, this work draws a comparison with the current COVID-19 pandemic's management analysing the role of state and international institutions, the measures implemented and the instruments used in both contexts.

The thesis will do so by analysing primary sources such as the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* compiled by Giovanni Antonio Boncio, who was the collaborator of the tax lawyer, in 1770 and the decree laws and original speeches given by the Italian Prime Minister during COVID-19 pandemic. The importance of information, economic and state control in health issues will be highlighted along with the importance of public health in the past and in the present.

The interest for this issue came from a university lecture held by Professor Giulia Delogu about this topic, from which I later developed this idea of comparing the management of epidemics during the Early Modern Age with the current situation. I also asked myself whether the management of the COVID-19 outbreak has been influenced by the past, so I started to research the first forms of epidemics management date back to the Early Modern Age. The historical context of the first part of my thesis is the Early Modern Age. This period is characterised by globalization, involving also the transfer of diseases. During this period, especially in ports, the first forms of epidemic management started. Especially in the case of the Republic of Venice, which will be one of the first port cities to develop a public health policy. Also, other port cities such as the Republic of Genoa and Marseille will be involved in the management of epidemics. The Early Modern Age is the period in which the world actually started to become global and interconnected.

In the second part, the main historical context will be the contemporary age since the COVID-19 management will be analysed.

As for the secondary literature on the subject, this thesis relies on the works by David Cook in the analysis of the Columbian Exchange, Foucault' lessons in 1977 at the France College, explaining the concept of control and Reinhard analysing the characteristics of the Modern State. Concerning the Republic of Genoa, the main sources analysed will be the works of Danilo Pedemonte and Paolo Calcagno. The case

of Marseille will be studied based on the existing literature, especially the works of Gilbert Buti. In the analysis of the case of the Republic of Venice, the main authors that will be taken into consideration are Giulia Delogu, Carlo Maria Cipolla and Nelli Elena Vanzan Marchini for the historical part and the management of epidemics and Alex Bamji for the usage of health passes. I also relied on primary sources such as the text of Antero Maria da San Bonaventura published in 1658 titled *Li Lazaretti della città, e riviere di Genova del MDCLVII* and the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* compiled by Giovanni Antonio Boncio in 1770. The second part of this work, in which the analysis of COVID-19 pandemic will be tackled, various European Union regulations, Italian regulations, Ministerial Decrees and original speeches held by the Prime Ministers will be used as primary sources and contemporary newspaper articles as secondary sources. Among the main concepts that should be clarified in order to better understand my thesis is state control in health issues and its definition as provided by Foucault. He defined the state control in health issues as the meeting point between the private sphere and power. Another important concept is that of epidemics, defined as the rapid spread of a disease to a large number of people in a given population within a short period of time. Finally, the concept of management implies all the techniques and the control operated by the State or the Church in order to control the spread of disease.

The research design will be qualitative interpretative. The topic of my thesis, especially regarding the second part of COVID-19 epidemics, could be considered empirical since it refers to a phenomenon that I experienced in the first person.

The main approach that will be used will be qualitative. The thesis will be characterised by a comparative case study between the management of epidemics during the Early Modern Age and the management of COVID-19 pandemic during the current time. The principal method used for my analysis will be data gathering, especially desk research analysing newspapers, reports and official correspondence.

The Early Modern Age was a period in which the control and managing of epidemics was born as well as the time when the concept of Public Health started to be developed. During recent times, the COVID-19 pandemic has made it necessary to analyse the instruments used during the Early Modern Age. However, epidemics do not entail only health issues but a series of other topics such as information, economics, rights and culture. In the conclusions of my thesis, it will be possible to understand how the first attempts to the management of epidemics had similarities to the management of

COVID-19 pandemic. However, instruments, methods, intentions and penalties used during the Early Modern Age are different. Nevertheless, it is interesting to underline the impact and the importance of these first efforts to the contemporary situation.

1.GLOBALIZATION IN THE EARLY MODERN AGE

The Early Modern Era is the period in which the world started to become global and interconnected. Globalization is a "long-durée" process which started in the 15th century when the political, cultural and social preconditions were set. Globalization, described as the process of growing interconnectedness, deals with the increase of links and with the emergence of the world as a single scheme (Conrad, 2017, p.92).

The process started in the 15th century through the European "discovery" of the two Americas which led to European expansion, the beginning of colonialism and global trade connections. For instance, the creation of trans-Pacific trade networks that linked the Americas to Asia, allowed the creation of the world market. All of these processes, such as the creation of global sea routes, the emerging of the world economy, the growth of large states, the diffusion of technologies, new patterns of migration, the expansion of communication and the spread of ideas are characteristics that foreshadow globalization in the Early Modern Age. Of course, connections have positive and negative sides, such as slavery, war, empire and epidemic diseases. However, cross-borders networks make goods and ideas available creating new spaces where people can form alliances and demand reforms in the complexity of a globalised world (Conrad, 2017, pp.98-100, 124-126, 213).

If the period of the Early Modern Age, with the voyages of Columbus and Vasco da Gama, the establishment of the modern state and the set of the preconditions for Human Rights and Public Health was the origin point of globalization, it was also characterised by its negative sides, such as the transmission of diseases and environmental damage (Bordo, Taylor, Williams, 2005, p. 2-3,13-14).

The Early Modern Age was characterized by important biological and environmental changes, migrations and urbanization. According to Marks (2015, p.50), after the Columbian Exchange the modern world was facing "the depletion of natural resources, the culturing of nature, vast environmental change, and an increasingly intensive use of the land" (Marks, 2015, pp.50-51). This environmental impact was caused by the exploitation of land, the world hunt for gold and silver, the deforestation with the consequent release of carbon dioxide (CO_2) into the atmosphere and the farming of different animals which released methane (CH_4) into the atmosphere (Marks, 2015 pp. 41-44).

Global migrations also characterised the Early Modern period. The main patterns of

migrations were transatlantic migrations including those by European settlers and the slave trade, Russian migration to Siberia and Chinese migration to southeast and central Asia. The main reasons were to find new land to cultivate, labour and to find new territories to control (Hoerder, 2015 pp.3-17, 19-21). Migration between the 1400s and 1800s created the basis for new ethnic and cultural identities (Eltis, 2002, pp. 33-71). The first diaspora of people occurred across a transatlantic zone and a trans-Eurasian zone. The transatlantic zone was characterised by the enslaving of Africans by the Europeans to exploit the resources of America. In the trans-Eurasian zone, two different migration patterns turned out: a Russian diaspora across the Ural Mountains into Siberia and a Chinese resettlement in southeast and central Asia.

European colonialism and the expansion of European empires into America were the main forces for transatlantic migrations in the Early Modern Age. The acquisition of land across the Atlantic led Europeans to stipulate land tenure arrangements stating that, in those lands, indigenous peoples performed intensive labour service.

The collapse of indigenous peoples from exposure to Eurasian disease led Spanish and Portuguese colonists to rely on African slave labour by the second half of the 1500s. African slaves mainly came from coastal regions; the Atlantic slave trade lasted for about 350 years from 1450 to 1831 and it was the largest transatlantic migration ever (Parker, 2010, pp.110-143).

The Early Modern Age was a period characterised also by urbanization. With the term urbanization we can understand the growth of cities and the movement of people from the countryside to the cities. This process led to the reorganization of urban spaces and to the spread of urban attitudes and values. Cities were "affected by change but they contributed to further change […]" (Burke, 2015, p.107). There was an increase in the flows of people, goods and information, with cities playing an important role as nodes in communication networks such as the city of Venice (Burke, 2015 pp.107,128-130). Venice is important in this analysis because it was a major commercial centre and the fundamental link between the East and the West. Venice was a place where people met and where goods arrived from all over the world. All these cosmopolitan features made it more exposed to epidemics (Delogu, 2022, pp.13,23).

In this thesis I will analyse the management and control of epidemics starting with the analysis of the instruments and rules used by the port cities in the Early Modern Age. I will focus especially on the cases of the port cities of Venice, Genoa and Marseille. These three port cities were economically and commercially important because they

were fundamental commercial hubs that received vessels from all over the world. For this reason, they were all exposed to epidemics. To face epidemics, the governments of these three port cities created systems to control the infectious diseases and the populations. We will subsequently compare the management of epidemics in the port cities to the more recent case of COVID-19 pandemic, analysing Ministerial Decrees and original speeches given by the Italian Prime Minister followed by a comparison and analysis of the first collection of health laws realised between 1770 and 1793 in Venice.

In the next section an explanation on the first circulation of diseases will be given.

1.1 FIRST CIRCULATION OF DISEASES

In this section we will focus on the circulation of diseases before the Early Modern Age to later analyse the globalization of diseases emphasized by the Columbian Exchange in the Early Modern Age. Diseases have always existed and will continue to characterize our society. However, the modes of transmission, the defence capacity of human beings and medical science has changed. For instance, in 87000BCE in African riverbanks the vivax malarial was present and became endemic. Malaria spread in the societies living near rivers in southern Eurasia and North Africa.

Diseases were present also in more recent history. For instance, during the Middle Ages, the Black Death 1347-50 had a crucial role in shaping European societies creating internal transformations and economic competition. The bubonic plague broke out in the East and it was caused by the fleas of black rats, and later the plague extended to central Eurasia through the expansion of Mongol hegemony (Webb, 2015 pp.54-59).

The Middle Ages was also marked by Tuberculosis and Leprosy. Lastly, also the Influenza or "sweating sickness" was a disease that characterised the society of the time (O'Neill, 2008 pp.270, 273-275).

However, as mentioned before, the turning point was the Columbian Exchange that integrated Eurasia, Africa and the Americas for the first time with important consequences at every level: social, political, cultural, economic and obviously also environmental and biological. Diseases, such as smallpox, circulated from Eurasia to America. Smallpox is an infectious disease caused by the virus variola major (Manela, 2015 pp.258-259). Smallpox was spread to the New World by the Europeans settlers

(Webb, 2015 p.64). The first documented smallpox epidemic erupted in the Caribbean in 1518 brought by Europeans settlers (Cook, 2015 p.109). Later, between 1650 and 1800 the Slave Trade also caused the spread of diseases such as Yellow Fever in the South Atlantic. Yellow fever was caused by an African mosquito, Aedes aegypti (Webb,2015 pp.67-68).

In the Early Modern Age, medical knowledge was lacking and the impact of epidemics was devastating. In the societies of the time, divine or supernatural intervention was believed to be the primary cause of diseases. For instance, when bubonic plague erupted in the 14th century, societies looked at the infection as a punishment by God. For this reason, many societies performed ceremonies, sacrifices, and processions to "calm the gods". Other responses to epidemics were prayers and the practice of isolation of the sick, a more scientific method and used also nowadays (Alchon, 2003, pp.9-15). The majority of scientists of the time based their treatments on the concept of "purification of the air" through aromatic herbs by prescribing Theriaca, gold or wine. They also resorted to the "magic powers" of bezoar, which were kidney stones in the bowels of exotic animals (Zanca, 1987, pp.102-144, 124, 111).

On *the Information of the Health Magistrate of Venice* released in 1759 and signed by notary Gariboldi Giuseppe it is noted how "*Non è che volendo il Signor Iddio gastigare li peccati de' principi e de' popoli col più terribile de' flagelli, ch'è quello della peste, qual egli cava talora da' suoi tesori, non abbia modi infiniti di deludere le umane prevenzioni. Sovrano assoluto del nostro essere, può egli tutto ciò che vuole; ma come è un continuo miracolo della sua onnipotenza la preservazione d'ogni individuo, nella quale però vuole che cooperiamo ancor noi col cibarsi, così riservandosi i tempi della sua giustizia, intende, che noi ci andiamo assicurando quelli della sua misericordia*.[1]" (Gariboldi, 1865) underlining that plague was understood as a scourge of God and it did not take into consideration any scientific explanation.

1.2 THE COLUMBIAN EXCHANGE

The Columbian Exchange and globalization had positive and negative sides, in fact at

[1] English translation: "It is not that in wanting the Lord God to punish the sins of princes and peoples with the most terrible of scourges, which is that of the plague, which he sometimes draws from his treasures, he does not have infinite ways of deluding human prejudices. Absolute ruler of our being, he can do whatever he wants; but as the preservation of each individual is a continuous miracle of his omnipotence, in which however he wants us to cooperate to eat, thus reserving the times of his justice, he means that we go on ensuring those of his mercy".

the same time they sped up the spread of diseases as well as the transfer of knowledge between different political, religious and social systems (Cook, 2015 p.103).

The Columbian Exchange and globalization are two phenomena that influence each other. Their combination led to important consequences integrating Eurasia, Africa and the Americas. Among them was a faster circulation of diseases.

The Columbian Exchange refers to the biological impact of the discovery of the New World and the following global travels between the New and the Old World. The exchange of unknown plants, animals and diseases between the two worlds impacted societies. When the phenomenon intensified the biological negative consequences strongly started with the spreading of syphilis in Naples and later with the spreading of yellow fever, typhus and malaria in Europe (Cook, 2015 pp.103-107).

The Americas had been isolated from Eurasia for 12000 years. These two continents had different plants, animals and diseases. Europeans raised cattle that did not exist in the Americas and this, once these two worlds came into contact, led to a fast spread of diseases which were transmitted through animals. For instance, when Columbus arrived in the Caribbean with vessels full of domesticated animals, that were disease vectors, the native Americans population got sick of swine flu the next day. Twenty-three years later Bartolomé de Las Casas affirmed that because of the spread of the swine flu, Hispaniola (now Haiti and Dominican Republic) was depopulated because one third of the Native Americans have died. He wrote in his Address to the Regents Cisneros and Adriano in 1516 that: "*Hispaniola is depopulated, robbed and destroyed…because in just few months, one third of the Indians they had in their care have died.*" (Guerra, 1988, pp.287-318) underlying the ferocity of Europeans in conquering and exploiting these lands.

This event can be an example of the effects of globalization of diseases. The same process can be understood through the example of smallpox, a disease that Native Americans were not resistant to, that erupted in central America around 1550 (Lewis, Simon and Maslin, 2018 pp.152-154).

The combination of the Columbian Exchange and globalization was a turning point because it sped up the transmission of diseases among continents. The spread of diseases was caused by the intensification of global relations through global travels. It is important to underline that this process developed in the framework of Mercantilism. Mercantilism is a set of theories and practices based on the strengthening of the State and the competitiveness in commerce. This competitiveness was important for the

State to assume control in the economic field and take action to develop new commercial routes. Another important characteristic was the population that was seen as the base of political power because it embedded the military strength.

Mercantilism was based on the concept that a nation's power was based on the prevalence of exports over imports. Spain benefited from mercantilism for the accumulation of precious materials such as gold and silver, taken almost exclusively from the colonies of the New World. Mercantilism resulted in the creation of the triangular trade in the North Atlantic, in which raw materials were imported to the metropolis in the colonizer country and then processed and redistributed to other colonies (Magnusson, 2015 pp. 54-100, 217-225). In this perspective, the importance of economic and global travels, to conquer new lands and gain raw materials, were the main boost for developing new responses to the spread of diseases in order to preserve the population and guarantee commerce.

These new global and social interactions, amplified by the Columbian Exchange, created a "destructive process", as underlined by Webb (2015) in his analysis, which had an enormous social, economic and political impact in the period between the 14th to the 19th century.

Between the 19th and 20th centuries, states and countries developed international efforts to face epidemics by fostering international agreements and international institutions. For instance, the International Sanitary Convention signed in Paris in 1903 and the International Sanitary Convention signed in Washington in 1905 (Webb, 2015 pp.72-73). These contemporary topics will be better analysed in chapter 6.

In the next section, the birth of the modern state will be analysed in order to later analyse the answers of the states to the globalization of diseases.

1.3 THE MODERN STATE

After this brief overview about the spread of diseases caused by the globalization of commerce, mobility of people, animals and plants, it is crucial to understand and analyse how states decided to protect themselves from diseases and which measures were implemented to ensure health. Especially from the Early Modern Age, with the birth of the modern state and the outbreak of epidemics, the states developed new ways to control the population and preserve it from infections, in order to maintain commerce open and to strengthen their political and economic power. In order to better

understand the role of state control in the management of epidemic, an overview about the historical development of the modern state (Reinhard, 2010) will be provided. Also, the thought of Michel Foucault is a productive interpretative tool in order to understand the development of strategies of health management.

States have emerged in Europe as an indirect consequence of the anthropological necessity to regulate the power relations between individuals which are naturally divided into groups. Nevertheless, as theorized by Otto Hintze, every form of power is linked to a form of abuse. In order to increase state power, political institutions were created to implement decisions and to exercise territorial control and coordination (Reinhard, 2010).

George Jellinek and Max Weber defined the modern state with five characteristics (Weber, 2002) (Jellinek, 2013) it has a territory in which it can exercise its influence and domain; it is characterised by a unitary population; it holds sovereignty through and does not recognise anything above it; it has the monopoly of the use of force inside the state, as regulated by executive and judicial powers, and exercised by the police, and finally the monopoly of the use of force outside the state, exemplified by the right to start war against other.

In the 18th century, political transformations and revolutions, such as the American, the French, and the Haitian revolutions, changed the characteristics of the state, becoming the starting point for a political and social transformation. These revolutions paved the way for the idea of a representative government based on the principle of sovereignty of the people and human rights (Rodriguez, 2015).

Thanks to the Atlantic revolutions between the 18th and 19th century, the modern state acquired three more characteristics such as rule of law and constitutional government. Furthermore, the state became embedded with nationalism and democratic ideals where the sovereignty of the population, the fundamental human rights and the elections are recognized (Reinhard, 2010).

The case of Venice, which will be analysed later, is useful to understand the role of the State, in this case a republic, in the management of epidemics and the concept of control in the Early Modern age. In order to better understand how the concept of control is intended here, an overview of Foucault's conceptualization of this notion will be given.

At the Collège de France in Paris, Foucault held a course in 1977-78 titled "Sécurité,

Territoire, Population" (Senellart, Michel, et al., 2004) in which he tried to explain the new concept of biopolitics through the shift of government from "*État territorial*" which means territorial state to "*État de population*" which means population state. He also explored the concept of control through the police.

Foucault describes biopolitics as the meeting point between the private sphere and power, since controlling the conditions of human life becomes a political affair. The old symbolism of power, based on the right to death, is overturned into a new one, in which power guarantees life.

The philosopher explains that at the base of the advent of the modern state there is the disciplinary mechanism characterised by laws, punishments and by a series of techniques of control of the population.

Nevertheless, it is important to underline that Foucault explains the difference between discipline and security (or prevention). For example, in the case of smallpox, Foucault identifies the success of vaccination as a system of security and prevention that also characterises our contemporary society, but the system of epidemic regulations or statistics could be described as a disciplinary system that tracks differences in the population between the 17th and 18th century. According to Foucault, the object of the disciplinary system is to normalise and make the population accept this government control. This concept is related to the 17th and 18th century since from the 20th century, with the advent of international systems, organizations and laws, this type of system changed into an international one based on prevention and cooperation to protect public health as an important human right. However, it is important to explain it because with the COVID-19 pandemic some of its aspects have been reintroduced: states restored for a limited time a system of control during the pandemic in order to prevent its diffusion.

Foucault explained that the art of governing and the modern states are characterised by four main elements: war, diplomacy, military army and police. According to Foucault, this new way of governing was based on manipulation and control that he described as the real characteristic of the modern state. The police had an important role, which he describes it as "*art de gérer la vie et le bien-être des populations*" which means that the police were the art of managing people's lives and well-being (Senellart, Michel, et al., 2004, p.319). From the 17th century the police were understood as a set of means through which the state can maintain order. The police had the role of controlling the population, for instance by gathering data about the number of people in order to

understand the power and the force of the state. The police were responsible for people's health because people should be healthy to work. They needed to manage epidemics such as smallpox, however daily health was also important.

According to Foucault, the modern state is composed of economy, society, population, diplomacy, police and military apparatus in which the obedience of the population is at the base. This constant sense of obedience for citizens, will lead to the Atlantic revolutions in which the principle of sovereignty of the population will be affirmed (Senellart, Michel, et al., 2004).

In this thesis the starting point is the role of state control in the management of epidemic during the period of Early Modern Age with particular attention to interconnected places such as the three port cities taken as case study. I decided to focus on the cases of Venice, Genoa and Marseille because these three port cities were hit by epidemics during the Early Modern Age and for these reasons developed control and management measures to contrast infections and to protect the economy. They are also an important starting point for the later comparison to the contemporary management of COVID-19 pandemic. Venice was an important centre for commerce and circulation of goods, communications and information, in addition to being an example for the development of Public Health leading to the creation of the address book of the Health Magistrate's laws which contains all the sanitary laws emanated from the 16th century to the 19th century. Genoa was also an important port city that during epidemics promoted a reorganisation of urban space and control in the private sphere of citizens. Lastly, Marseille is an important example because it was hit by a terrible epidemic of plague in 1720 which led to a strengthening of government control on population.

The concept of control is relevant also for the contemporary era analysis of the COVID-19 pandemic. In this state of emergency, States have witnessed the fall of the scientific paradigm theorized by Thomas Kuhn in his work *The Structure of Scientific Revolutions* published in 1962 in which the term paradigm indicates the universally recognized scientific achievements that provide a model of problems and solutions. The main components of the scientific paradigm are ontology, questions to ask, investigation techniques and tools and valid solutions (Peruzzi, 2019). However, during the COVID-19 pandemic, States restored for a limited time a system of control during the pandemic in order to prevent its diffusion, but which also created a series of problems which the states were not ready to address.

2.PORT CITIES AND FREE PORTS IN THE EARLY MODERN AGE

I will start my analysis about management and control of epidemics with the example of port cities and free ports in the Early Modern Age since they were exposed to infections.

"As an object, a port exists as the result of complex relations between distinct elements of various types: economic, cultural, social, political and geographical. The intensity and level of interrelated causes, effects and relations, are never determined in a unilateral way. The nature of the object can be understood not only through the most important elements that make up the system, but also through the different features of these elements and the relationship between them" (Osswald and Amorim, 2007, p.57).

Port cities are characterised by the relations between different elements and they engaged different spheres such as the economic one or the cultural one, however the one that is relevant for our case study is the relationship between port cities and health, in particular the control of epidemics in the port cities during the Early Modern Age. However, the health sphere is not isolated in a self-contained area, but it is related to other phenomena such as economic strategies, control of communication and growth and strengthening of government apparatus.

Before starting with the analysis of the first case study, Venice, a small overview about port cities and experiments of freeports during the Early Modern Age will be outlined.

Port cities refers to cities that, especially during the Early Modern Age, were characterised by new dynamics for information, communication, citizenship and government (Trampus, 2019, p.14). Port cities have always been focal points of international economic development and social and political change. Seaports are not only important as infrastructures but as systems created by cultural and economic forces. They are the gateway for land and sea and important agents for globalization playing a key role for technological innovations development and urbanization process (Unger, 2006, pp.85-104). Port cities should not be considered only as economic structures, but also as meeting spaces for different cultures. They were also places of mobility and transit creating connections between different commercial networks and exchange of scientific and industrial information (Trampus, 2019, pp.15, 18-19).

Port cities were also considered as a way to encourage the use of sea power since they were built on the seacoast, on estuaries, and on rivers through accurate city planning.

The institution of free ports appeared in the sixteenth century. Free ports were particular port cities which became "accelerators" (Trampus, 2021, p.64) of history in the sense that they were laboratories for political, economic and social changes. Free ports, as

opposed to simple port cities, were fiscally important because of their customs allowances and tariff reductions that made them more attractive to merchants. Free ports were also characterised by the strong social, cultural and institutional interpenetration between the harbour and the urban space. This interpenetration led to a real integration between the port and the city in order to implement specific strategies (Trampus, 2021, pp.62-64). However, this interpenetration was observed also in port cities even before receiving the status of free port (Trampus, 2019, p.20), such as the case of Venice that became a free port only in 1829. During the Early Modern Age, Venice was a strategic commercial hub between the East and the West in which raw materials were processed and then resold (Delogu, 2019, pp.41, 43). From this description of port cities and free ports, it is possible to understand the link between port cities and health: mobility of people leads to the spread of diseases, which has an impact on commerce and on the economy. For this reason, the link between health and commerce will be analysed in the next paragraph.

2.1 THE IMPORTANCE OF HEALTH FOR COMMERCE

"*Se l'anima de Sati è il commercio […] l'anima del commercio è la salute*" means "If the soul of States is commerce, the soul of commerce is health". This phrase was written by the *Provveditorati alla Sanità* (Health Superintendent) of Venice during the plague epidemic of Marseille in 1720 (Andreozzi, 2009, p.225). This statement is emblematic because it underlines the main reason for which health controls were implemented, that is to protect commerce. Commerce was the engine of the economy and the state, so it had to be preserved. Furthermore, commerce could not take place if health, reliability and security were at risk.

In the early 1700s health controls and services were crucial to guarantee commercial traffic in order to reduce costs and risks. Reliability and security were important requirements at the base of commerce and a fortiori in a context of epidemics in which goods and vessel's members could be vehicles of diseases. As affirmed by the Health Magistrate, traffic was not possible without health controls.

It is interesting to note that health controls in the port cities in the 18th century were not neutral, but could be selective to make some commercial roots preferable compared to others for sanitary reasons, changing the market. For example, sanitary information could be used as a commercial weapon to disadvantage other port cities (Calafat, 2015).

Or, the pretext of health prevention, could be used as a way for the government to control population and to pursue economic and political goals, for example the application of 14 days of quarantine for ships coming from Livorno to disadvantage it (Calcagno, 2022).

The perception of risk depends on society and during the Early Modern Age people were not aware of natural, physical and medical causes of diseases' transmission. For these reasons responses were not medical, but political and referring to a specific economic, social and cultural context. During the Early Modern Age, medicine was insufficient and therefore political methods were used to face unknown phenomenon. Port cities, as we will see with the cases of Venice, Genoa and Marseille, had to face epidemics using methods of health control. However, these methods were also used for other objectives in order to save commerce and state (Andreozzi, 2009, pp.225-229).

3. THE REPUBLIC OF VENICE

During the Early Modern Age, the Republic of Venice was an important commercial hub between the East and the West. A huge number of global and luxury goods among them porcelain, spices such as cinnamon, sugar, saffron and clove, pearls and ostrich feathers arrived in Venice (Antinucci, 2014, pp.42-43, 47, 54). What is interesting is that raw materials arrived in Venice and were subsequently processed and transformed into manufactured goods. For instance, in the protochemical industries soaps were produced with olive oil and a particular ash from Syria. There were wool and silk industries, luxury industries that produced jewels, furniture and clothing. A good that became the symbol of Venice was the Theriaca. Theriaca was a drug made of pepper, cinnamon, saffron, nutmeg, rose, myrrh, ginger, dittany, valerian, honey, old wine, opium and viper meat (Cozza, 2017). As affirmed by the physician Orazio Guarguanti da Soncino in 1596, Theriaca had originally been used as an antidote against snake bites, however Theriaca was "[…] *un rimedio mirabile, quasi ad infinite malatie: come à conferuar la sanità, a render la vita tranquilla, & à prolungarla, à rinuigorire tutti i senfi, & non solo à di scacciare i mali presenti, mà à preseruarci si curamente, che noi non cadiamo nelle malattie*[…]" (Guarguanti, 1596, p.6) which means that Theriaca was used to treat other diseases, to prolong life and to prevent people from getting sick. Theriaca was prepared by cooking some ingredients using the technique in a baine-marie in order to maintain the humidity and then ingredients were chopped together

(Campolongo, 1614, pp.3-12). Later it was diluted in wine or water (Guarganti, 1956, p.11). Venice became the privileged seat for Theriaca in light of commercial relationships with the East and for the circulation of medical knowledge between the Islamic and Christian world. The Theriaca from Venice had a good reputation because of its excellent ingredients and it was in demand in central Europe and in the East. To promote Theriaca, every August a fair was organised in the Venetian squares to attract merchants and customers that could check the qualities of ingredients (Vanzan Marchini, 2022, pp.263-268).

Even though, during the Early Modern Age Venice was undergoing a relative decline (Costantini, 2004, pp.25-28) it continued to be an important reference point both commercially and culturally (Panciera, 2014, pp.71-72).

As in the case of other port cities, Venice was also exposed to epidemics, especially during the period of Black Death 1347-1351. However, Venice could not interrupt commercial traffic because of epidemics, therefore measures to protect health and to face the spread of infections were implemented.

The authorities of Venice decided to nominate "*tre sapienti deputati alla conservazione della salute*" which means "three experts dedicated to health's conservation" were nominated to manage the emergency and one of the measures implemented was the burial in distant locations of people who died of plague.

During the Early Modern Age, Venice was the first Republic to establish a Health Magistrate to monitor the spread of epidemics in all the Mediterranean and to promote solutions to control it (Delogu, 2022, p.23). After the outbreak of the Bubonic Plague, Venice nominated the three experts dedicated to health's conservation in order to respond to the population's fear of the disease. However, in 1440 a new commission was established with the aim of studying the real medical causes of malaria and this could be considered as the first step toward the institution of public health as a policy concern. For this reason, a first attempt to control the epidemics through the creation of the *Uffizi di Sanità* (health offices) was done in Venice. The ministers who composed the first health offices were a notary, a scribe, a *massèr*, a captain and five members of the infantry. The notary had a bureaucratic role and he had to control what happened in the lazarets. The scribe was responsible for accounting registers, keeping track of the people in the lazarets and of health passes. On the other hand, the *massèr* had more practical activities and he had to register all the goods delivered to the office (Vanzan Marchini, 2022, pp. 45-47).

In 1486, the Republic of Venice founded the first permanent Health Magistracy, which became a successful model followed by other European countries. The Health Magistrate was composed of three Health Superintendents or Commissioners of Public Health and two above-Superintendents, all of whom had a political role (Cipolla, 1976 pp.11-12). In the *Information of the Health Magistrate of Venice* released in 1759 and signed by notary Giuseppe Maria Gariboldi, it is possible to assert that these five officials were supported by a jurist, the chief physician of the Magistrate and a surgeon. There were also other figures who supported the Health Magistrate such as the *Novellisti,* who had to control the arrival of vessels and the Health Guardians who had to supervise the vessels stopped for quarantine. Another figure was the Infantry, that was similar to Health Guardians with the distinction that the Infantry were always in contact with vessels under quarantine and they could be infected (Gariboldi, 1759, pp.14,18-20). The jurist had to guarantee the jurisdiction of the Health Magistrate, while the surgeon's main task was to visit infected people in the lazarets (Vanzan Marchini, 2022, pp.49-54).

The main task of the Health Magistrate was to find solutions to stop and prevent the contagion by controlling a dense information network (Cipolla, 1976, p.12).

The health official needed to control people and goods in order to prevent the circulation of disease. The Health Magistrate could decide the punishment for those who contravened the rules, as from 1504 it acquired the right to torture and inflict corporal punishments (Vanzan Marchini, 2011, p.78).

In 1770 Giovan Antonio Boncio compiled a collection of laws: the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità*. The rules were divided into themes and in alphabetic order to make it easier for health officials to consult it (Vanzan Marchini, 2022, p.60). This 18th century manuscript is divided into four volumes and one index conserved in the State Archives of Venice and has been edited by Nelli Elena Vanzan Marchini in 1995. The manuscript is the most organic and complete instrument for studying the history of health legislation in Venice. It contains all the laws and the measures from the 16th century to the 18th century. It is divided into 206 classes in alphabetic order: particular attention was paid to the counterfeiting of food and the quality control of food and water. An entire entry is dedicated to urban hygiene, pollution and street cleaning. An entire chapter focuses on the use of quarantine, on the role of health offices and lazarets. However, the section that is interesting to analyse for my thesis is the one about pestilence, which is in the third volume. I will provide here

some examples of laws.

One of the first laws released in 1489 is: "*Uomini e donne ammorbare siano manifestate a piovani contrade, in pena ecc.*[2]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.175). Already from the first example it is possible to notice the use of the punishment, that is not yet explicit, against the transgression of the laws, but what is interesting to note is that people had to declare their medical condition to the *piovani. Piovani* had a key role in the collection of personal data and with the eruption of the Black Death the Health Magistrate forced them to denounce cases of illness and death to better control the situation in the Republic's territories.

In 1490, another law was published: "*Innibito a chiunque il venire o condur persone in questa città provenienti da luoghi infetti, si per via di mare come di terra*[3]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.175). The Health Magistrate prohibited the access to people coming from infected countries in order to protect the city and prevent a major spread of diseases. In the next paragraph, an instrument used by the Republic of Venice related to this aspect it will be analysed: the health pass.

In 1511, the Health Magistrate decided that it was prohibited for anyone to leave the infected houses through the following rule: "*Vietato a chiunque l'uscir dalle case infette quali sono chiuse et interdette, possa esser ammazzato impunemente*[4]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.178). In this law it is important to highlight the last statement which underlines the cruelty and the role of death penalty in the 16th century, which was used also for lighter crimes in the Early Modern Age. In this specific case the penalty for infected people who left their homes was death. However, it is noteworthy that in order to prevent a major circulation of disease people were forced to stay home.

Other interesting laws are those released in 1523, that can remind us of some contemporary regulations used during the COVID-19 pandemic: "*Fruttaroli non possano andar vendendo frutta per la città o nelle barche o su per li campi*[5]"; "*Inibito l'andar in giro per la città vendendo o comperando robbe*[6]", "*Vietato a persone infette*

[2] English translation: Infected men and women must be disclosed to the *piovani* or they were punished.
[3] English translation: Prohibited for anyone to come or bring people to this city from infected places, both by sea and by land.
[4] English translation: Prohibited for anyone to leave the infected houses which are closed and forbidden, who can be killed with impunity.
[5] English translation: Greengrocers cannot go selling fruit around the city or on boats or across the fields.
[6] English translation: It is forbidden to go around the city selling or buying clothes.

l'andar girando per la città[7]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.179). However, it is important to underline the differences, because in the Early Modern Age people who did not respected the rules were killed, as attested in the following example of 1576: "*Sia ucciso impunemente chiunque uscisse da case sequestrate, uccisore abbia lire 600*[8] […]"(*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.196). These few examples can demonstrate the way the Republic of Venice managed epidemics and pestilences in order to prevent the spread of disease, however they also underline the strict punishment to which the population was subjected if they did not respect the law: death. Nevertheless, the health legislation of the Republic of Venice did not cover only the epidemics and pestilences matters in fact, it was only a small entry in the list of laws collected by Boncio. The Venetian legislation was an example of precision and pervasiveness which incorporated very different and distant aspects forming the notion of what public health was, which was not only related to the management of epidemics. For example, there are entries focused on pigs and dogs: "*Vietato il lasciar pascolar porcini per la città, in pena ecc*.[9]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.269) and "*A Cani vaganti per la città siano uccisi, ad ogni sospetto d'infezione si ten. gano legati e chiusi, sieno ammazzati, per ogni cane ucciso il capitanio o ꝛ altri ufficiali conseguiscano lire 3.2 (vide capitanio, tariffe). In pena ducali 5, grossi- erbaroli, ciabattini e caffettieri tengano esposta sulla strada una mastella di acqua netta (vide erbaroli), pena suddetta possa esser intimata sul fatto da cadaun fante, non possa rimettersi che con ballottazione e colle strettezze (vide condanne). Curati, capi contrade, medici fratterne e chirur-ghi, che venissero chiamati alla cura di persone morsicate da cani rabbiosi, debbano parteciparlo al Magistrato (vide piovani, capi contrade, medici e chirurghi).*[10]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.1, p.324). In these two regulations the danger of disease transmission by animals such as pigs and dogs is emphasized. For this reason, pigs could not graze around the city, and stray

[7] English translation. Forbidden to infected people to go around the city.
[8] English translation: The infected people who left the houses must be killed with impunity. The killer should receive 600 lire.
[9] English translation: It is forbidden to let pigs graze around the city, in punishment, etc
[10] English translation: Dogs wandering around the city are killed, any suspicion of infection is held. they are tied up and closed, they are killed, for each dog killed the captain or other officers receive 3.2 lire (see capitanio, tariffs). Under penalty ducals 5, *grossi-erbaroli*, cobblers and coffee makers that keep a tub of clean water exposed on the road (see *erbaroli*), the aforementioned penalty may be intimated on the fact by each infantryman, he can only recover with a ballot and with strictures (vide condane). Curates, district heads, fraternal doctors and surgeons, who are called to care for people bitten by rabid dogs, must make the Magistrate aware of it (see Piovanni, district heads, doctors and surgeons).

dogs were killed. The health legislation of Venice, also covered the management and protection of public wells "*Capi contrade e facchini incaricati vegliare che le vasche suddette siano tenute monde e piene di acqua, spezialmente all'aperta de pozzi pubblici la sera per la notte. Fanti del Magistrato obbligati visitare li pozzi de respettivi sestieri onde assicurarsi dell'esecuzione (vide cani, cappi contrade e fanti).*[11]*"* (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.300). Also, public wells were under the control of the Health Magistrate that had to ensure their cleanliness through the supervision of the infantry and the district chief as water could also be a way of transmission of diseases.

In the second volume of *the Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* there is an interesting entry about the conservation and the sale of cheeses "*Possano tenere formaggi di ogni sorte, sì dolci che salati, nelle loro botteghe e sopra balconi delle stesse, eccetto li sentinadi, puzzolenti e marci, nemeno nelle botteghe, in pena ecc*.[12]" (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.2, p.108). Sellers had to sell only good cheeses, and could not sell the stinky and rotten ones arguably to avoid the people feeling bad if they ate mouldy cheeses. Thanks to these last few examples, it is possible to understand that the health legislation in Venice was not only cantered on epidemics management but it was attentive to every aspect: from animals such as pigs and dogs, to public wells and cheeses. This set of various aspects go to create the concept of public health that covers every aspect that can undermine people's health.

Back to the explanation of the procedures and instruments promoted by the Health Magistrate of Venice, when vessels arrived in Venice, Infantry and Guardians of Health had to control the country of origin in order to understand whether the vessel was at risk, whether it had stopped in other ports and the other vessels that it encountered at sea along the way. They then controlled the number of passengers and the goods, and checked the health passes (Gariboldi, 1759, pp.21-22).

Health passes were an instrument developed in Italy used to control epidemics. The health pass was a sort of passport attesting that all the vessels' members were healthy. All the ports and countries in which the ship has stopped were signed so they could be a

[11] English translation: District chiefs and porters in charge of ensuring that the aforementioned tanks are kept clean and full of water, especially in the open air of public wells in the evening for the night. Infantrymen of the Magistrate were forced to visit the wells of their respective districts to ensure the execution (see dogs, district chiefs and infantrymen).

[12] English translation: May they keep cheeses of all sorts, both sweet and savoury, in their shops and on their balconies, except for the *sentinadi*, stinky and rotten, not even in the shops, in punishment, etc.

double-checked in order to see if they came from a country affected by a disease. Every ship needed to possess the health pass (Bamji, 2019, p.7), but it remained a custom of the Mediterranean, and it never extended to the Atlantic. In order to enter the port and be able to unload its goods, each vessel had to show its health pass attesting the status of health of the crew and the list of places that the vessel had touched along its route. There were three cases in which the ship could fall into: when the vessel came from places with no current infections the health pass was clean and the ship could dock, if the vessel came from a suspicious country the health pass was and the crew was subjected to quarantine in the lazaret. Finally, if the ship came from a country at risk the health pass was invalid, the ship was sent back (Delogu, 2022, pp.31-32). The first lazaret was created in Venice in 1423, on a small island named Isola del Lazzaretto Vecchio. Then other lazarets were created in Venice and also in Genoa, Ancona, Livorno and Trieste following the example of Venice. The *Lazzaretto Vecchio* was more than 3 km away from Venice and the *Lazzaretto Nuovo* was more than 4 km away from the port city. They formed separate places in which ships were put into quarantine. In the *Lazzaretto Vecchio* more than 6030 goods could be stocked and 294 people could be contained. The newest one was larger, it also contained 6000 soldiers and 200 horses. The Health Magistrate established some rules in order to regulate sanitization and quarantine in the lazarets. The rules were different for every type of product and according to the type of health passes, the ship needed to quarantine for a different number of days in a range from 14 to 40 days, for instance wool needed to be quarantined for 40 days (Gariboldi, 1759, pp.26-34, 40-46). Among the laws contained in *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* compiled by Boncio, it is possible to find an entire section dedicated to the quarantine of goods. Here there is a list with all the goods subjected to quarantine: "*Merci soggette a contumacia. Lane di ogni sorte, zambellotti, ormesini, sete, moiacari, relle, canevazze, schiavine, boldroni, canevi, lini, panni d'ogni sorte, cordovani, moltoline, volame, bottane, rasi, tapeti, corde, penne di struzzo da letto e da scrivere, bombaci filadi e gottoni. Lane non lavate si possono spedire al purgo; lavate et asciutte che sieno, si ponno maneggiare senza pericolo; lavatori siano interdetti per il tempo che impiegano nell'opera (vide lane). A minor spesa, si pongano in acqua calda*[13]." (Le leggi di sanità della Repubblica di

[13] English version: Goods subject to quarantine. Wool of all sorts, *zambellotti*, *ormesini*, silks, *moiacari*, *relle*, *canevazze*, *Schiavine*, *boldroni*, *canevi*, linen, cloths of all sorts, *cordovani*, *moltoline*, feathers, buttons, satins, carpets, ropes, bed ostrich feathers and to write, *bombaci filadi* and *gottoni*. Unwashed

Venezia, Vol.I, 1995, p.455). It is easy to understand that the main goods subjected to quarantine were fabrics, especially wool. Unwashed wools were sent to the purge where they were cleaned, whereas the washed ones could be touched.

The fear of epidemics led to cooperation between port cities especially in the circulation of information. The Health Magistrate controlled an important information network both inside and outside of its dominions. The campaign of health information was done thanks to information channels of the time such as public places, churches and priests. Venice managed an important information network thanks to ambassadors, consuls, merchants and spies that enabled the knowledge of the different phases of epidemics and which countries were safe or not. From the 18th century, Venice stood out in information gathering, and all the free ports looked at Venice to discover the possible presence of epidemics. Through its proclaims, the Health Magistrate transmitted information about possible epidemics and prevention methods (Vanzan Marchini, 2011, pp.82, 107-108). Thanks to the efficiency of the management of health, Venice was healthy during the outbreak of plague in 1630-31 (Vanzan Marchini, 2022, p.12).

With the outbreak of the plague of Marseille in 1721 further reflections on the role of information can be added: in certain cases, fake news was released to have the control of sanitary narrative and to disadvantage certain port cities (Calafat, 2015, pp.1-7). A more detailed analysis of the importance of information networks in the context of epidemic control will be provided later in chapter 3.2.

The Republic of Venice called itself "The Barbican of Europe" in order to better describe its ability to protect the territory from epidemics, especially those coming from the Balkans zone (Andreozzi, 2015, p.117). An example on the managing of epidemics can be described with the case of Split, the dalmatian port under the control of Venice located in the Balkans.

The importance of Split lay in its role as a transit point for goods coming from the Ottoman empire. What is important to underline is the fact that Split was characterised by a clash of two different health policies: the Venetian one based on containment and the Ottomans one based on non-intervention.

In 1731-32 Split was struck by the plague, which according to the Venetian authorities was carried by merchandise coming from Jaice, an Ottoman domain. According to Venetian authorities, Split was affected by plague because their health policies were not

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wools can be sent to purge; whether washed and dry, they can be handled without danger; washers are banned for the time they spend on the work. At a lower cost, they are placed in hot water.

strict enough.

For these reasons, the Republic of Venice decided to send Simone Contarini, Governor General in Dalmatia and Albania in order to stop the epidemic.

Contarini found out that the main risk of spread of disease were people, animals and merchandise. According to this idea, Contarini tried to ensure that sea routes were safe, that the centre of Split was not infected by the periphery and that people and homes that were not infected stayed that way.

Contarini promoted the ventilation systems and quarantine, however he found out some obstacles: the tension between the centre and the periphery and the different perception of risk: for example, people were not willing to kill their pet animals even if they could transport plague or kept textile merchandise in their homes even if it was considered infected (Andreozzi, 2015, pp. 115-130).

This case is meaningful to observe how the Republic of Venice was important in the framework of health policies and it allows us to better understand the role of risk perception that was outlined before by Andreozzi (2009, pp.228-229). Different perceptions of risk can correspond to different health policies and exigencies. During the eighteenth century, the Health Magistrate controlled health throughout the Republic. It was helped by the medical staff but it had to control the lazarets, the health passes, the corpses, the decontamination, the quality of medicines and of inoculations.

In contrast to the initial phase, in which Superintendents had a repressive role, between the sixteenth and seventeenth centuries, they started to give importance to prevention using practices of isolation and control. From the eighteenth century, Superintendents started to gather data about the territories in order to better control population (Cipolla, 1986, pp.20-25). Health was no more only control but also prevention and assistance to people affected by diseases.

Even though the Republic of Venice had been a reference point for many years, during the mid-eighteenth-century Venice was no longer at the forefront. The Republic of Genoa and Trieste became more competitive and the Republic of Venice was no longer the main protagonist (Delogu, 2022, p. 67).

3.1 HEALTH PASSES

Health passes or *Patenti di sanità*, were used during the Early Modern Age and especially in Venice in order to control the safety of vessels and travellers.

Health passes were part of different public health strategies adopted by governments. Health passes were printed and characterised by a text and images, they could compare to the modern EU COVID certificate, better known as the Green Pass. This feature will be analysed in depth in the second part of the thesis in chapter 7.1.4.

Initially health passes were similar to presentation letters, during the sixteenth century they were printed with the name of travellers in which it was attested that people travelled from a safe place free from diseases.

Health passes were not used only in Italy but were issued by different port cities in the Mediterranean. Scholars use a wide range of terms to describe the passes: *fede di sanità, bolletta di sanità, bollettino di sanità, lasciapassare* (Italian); bill of health, certificate of health, health pass, health certificate, patents of health, papers of pratique (English); *patente de santé, billet de santé* (French); *gesundheitspass, pestbrief, passierschein* (German); *patentes sanitarios* (Spanish) (Harrison, 2012, pp.40-41).

Health passes were an important means for plague prevention strategies, but they were complemented by other practices used to face epidemics such as quarantine and sanitary cordons related to the restriction of movement and lazarets.

Health passes were an important instrument for travelling and for the Health Magistrate to understand the trajectories of commerce and the spread of disease. Health passes could have two main uses for the government: a health one and an economic one that will be better explained with the example of Marseille in chapter 5.4.

Health passes were especially used in the Italian peninsula and merchants were obliged to show them in order to enter cities. This instrument was even an important characteristic for the concept of prevention: in order to prevent the spread of disease, cooperation was fundamental.

Printed health passes were used for travel by land and sea in order to control the movement of people and goods. Passes can be divided into three categories: 'Health passes' that documented the movement of people, 'goods passes' documented the transport of merchandise, and 'ship passes' was a declaration about the captain and the other components and goods of a ship. The common point of the three types of passes was that they documented the movement of goods or people in order to understand if they were vectors of potential disease.

Health passes were printed, but then they had to be filled in by hand. They were characterised by four parts: a heading section which usually included an image of the

issuing authority; “a statement that the health pass had been issued free of charge; a reference to magistrates, officials or others with responsibility for health; a note of the city from where the pass was issued” (Bamji, 2019, p.8). Then, a printed statement that affirmed that the city was free from disease thanks to God. In the third section there was information about travellers and their destination. In the last part there was the location, the date and the name of the authority which issued the passes.


Nos Supra Prouiſores, Adiuncti, & Prouiſores Salutis Venetiarum.

G R A T I S.

Si parte di queſta Dominante ſana (Iddio lodato) & libera da ogni ſoſpetto di mal Contagioſo gl'in fraſcritti, con robbe, ò con mercantie, ò ſenza, come qui ſotto ſarà notato, a' quali in cadaun luogo oue capiteranno, ſe li potrà dar libera, e ſicura prattica. In quorum fidem, &c.

Dat. dall'Officio della Sanità di Venetia. Adì 20 Giug° 1713.

Anni 24 Pelo caſtº Statura ord
Anni 30 Pelo caſtº Statura ord
Anni 26 Pelo caſtº Statura ord
Anni Pelo Statura

FIGURE 1 Health pass (fede di sanità). Source: Wellcome Library, London, https://wellcomecollection.org/works/rjrr3sra/images?id=xxdtfvbj

Health passes had to be clear and their format and materiality was realised in a way in order to prevent fraud. It is interesting to notice the reference to God and religion in order to explain the fact that the city was not touched by the disease. Images were also used in order to make the forging of illegal copies more difficult. Passes were printed by a single official printer. Images on passes usually represented civic heraldry for example a coat of arms, two or three distinct designs or an elaborate composite image. Pictures often referred to the patron saint of the port city. Religious images were meaningful and related to the phrase ‘thanks to God’ that I quoted before.

It is interesting to notice that according to the country, the style of the script was different. For example, German passes used Gothic script whereas Italian and French passes used roman and italic script. As regards size, passes could be 8x10cm or 10x14cm and printed only on one side. Another important characteristic were seals applied on passes in order to certify their authenticity and annotations.

Health passes were an important instrument because they allowed for mobility even during an epidemic. They were a dynamic response of public health policy as opposed to static instruments such as quarantine and sanitary cordons. Health passes facilitated

mobility, which was important for commerce and the economy. Circulation of health passes created cooperation and trust. When arriving in cities where they were strangers, travellers used their health pass to inspire faith and trust. Passes were not necessarily linked to a single person as modern passports or Green Pass.

The passes also described the beard, the age, the height, hair colour and eye colour of the pass holder. The majority of travellers were men aged between 20 and 50. Although health passes provided this kind of details, sometimes they were unspecific. For example, they did not describe distinguishing marks such as scars or moles. These characteristics were recorded in other documents such as those for pilgrims and emigrants. Anyway, health passes were mainly important to know the number and the origin of the people who arrived at the port. Identity description was included to make the pass more important for travellers who were induced to show it to the local authorities. By analysing health passes, it has been possible to study the journeys made by travellers.

Health passes could be used for journeys of different length and both by sea and by land. It has been noticed from health passes that sea journeys were longer than land journeys. Finally, health passes testified the presence of travels internal to the locality or region. From health passes it is possible to understand the motivation of travel and peculiar details. For example, journeys to Rome were especially religious travel, whereas the majority of travels had a trade motivation understood by the annotation of goods and merchandise that was transported.

The release of health passes was a dynamic method for governments to manage risk and maintain control, always trying to keep travel and trade constant.

Health passes had an important communicative power and governments decided to make them official documents in order to make them a manifestation of state power. In this specific case, print was used by the government to control plague, issuing health passes. They were an instrument of communication since they provided important signals. Thanks to health passes, Italian states could state that their city was safe “and that they were committed to participating in an effective risk management system” (Bamji, 2019, p.30).

Issuing health passes required strong bureaucracies and for this reason they were first used in powerful states in northern Italy such as the Republic of Venice and plague epidemic became determinant for developments in the bureaucracy of epidemic’s management.

The health pass system was important as a first example of cooperation among states for public health reasons. In order to introduce this system, an exercise of power on other states was required. When Venice asked for health passes in order to enter their territory and continue commerce, other states had to adapt. Nevertheless, some smaller polities tried to realise a sort of fake health pass, but with a decree in 1576, Venice underlined that the pass had to be authentic (Bamji, 2019, pp. 1-30).

According to Diamond (2019, p.412), during a period of crisis states try to follow some phases and one of them is the repetition of some measures or systems realised by other states (Diamond, 2019, p.412). In chapter 7.3 this behaviour will be better explained in the framework of COVID-19 pandemic crisis. In the Venetian context, during the Early Modern Age, Italian public health measures had a positive reputation and they were discussed and emulated by northern European states.

To conclude, public health measures during the Early Modern Age were characterised by regulation, monitoring and organisation and health passes embodied all these characteristics. Through this instrument governments could control the access to their states in order to control the spread of epidemic without stopping commerce.

3.2 THE ROLE OF INFORMATION

Information, fake news and disinformation plays an important role in epidemic management. In this chapter we will try to underline the role of health in the information framework and vice versa.

Communication and information could be used in a political and economic way using health or epidemic management as pretext, such as in the case of Venice or Livorno. Today it is easy to understand the link between information, communication and power however, it could be difficult to really perceive the fine link between these elements in the context of the early Modern Age. It is important to analyse this aspect because information played an important role during epidemic crises, especially in Venice (De Vivo, 2007, pp.1-17).

Port cities were nodal points (Delogu, 2020, p.312) which facilitated movement of people and goods. They were places of information circulation and control. The main actors of information circulation were the port cities because they were laboratories for epidemic control and development of public health policies. In fact, the majority of information that circulated was about diseases (Cipolla, 1986, pp.18-19).

It is interesting to see the collaboration and intersection between information and political and economic interests by analysing the case of cattle's epidemic that broke out in the Venetian Dalmatia in 1750. The Health Magistrate of Trieste and the one of Venice were always in contact in order to exchange information about this epidemic. The necessity of being informed and to have news about possible epidemics was important not only for gathering information and data, but also as a way to implement strategies in order to advantage one's own port.

Gathering information had two sides: the first was to collect the majority of news about epidemics keeping a constant correspondence, while the second one was the control and the filter of information from the government in order to not damage economic or political interests.

The creation of an emergency state during the epidemic could be the pretext to take measures, not only regarding security and public health, but also geopolitics. Information control could be used to realize change in institutions in order to reorganize the territory. An example can be found in the outbreak of plague in Dalmatia as presented in the previous paragraph. This event caused the preoccupation of Italian port cities provoking countermeasures but also changes at the jurisdictional level.

In the framework of the Dalmatian plague, a series of new stations and guards issuing health passes in the Coast of the Friuli were institutionalised. However, what is important is the fact that there was a jurisdictional change through the extension of a health control model to a territory that was fragmented before and that followed different rules. The Coast of the Friuli was thus adapted to the health regulations of the Austrian Coast (Delogu, 2020, pp.312-320).

Another issue is the role of disinformation during the Early Modern Age. Disinformation is intended as constructed narratives used to pursue political or economic intention internationally or nationally (Delogu, 2022 p.295). Information and disinformation are linked together especially in the health and disease framework where it is possible to analyse how disinformation worked and works also today.

The two main examples of disinformation are the fake news regarding Livorno's free port and the starting of inoculation.

In 1720 with the outbreak of plague's epidemic in Marseille, a new commercial risk started since this event could cause the limitation or interruption of some commercial routes. The reputation of a safe port was important to keep trade routes intact, since the

fear of the "*mal contagieux*" (plague) was around the corner.

It is at this moment that disinformation comes into play: governments, led by the "*jalousie du commerce*" (jealousy of trade) defined by Hume, started to spread fake news about other ports. Among commercial nations there is a common sense of jealousy for the commercial progress of neighbouring states. "Nothing is more usual […] than to look on the progress of their neighbours with a suspicious eye, to consider all trading states as their rivals, and to suppose that it is impossible for any of them to flourish, but at their expense" (Hume, 1758). The "jealousy of trade" by Hume seems to be similar to the "Jeaolusy of Kings and Persons of Soveraigne Authority" by Hobbes. Hobbes affirmed that the state of nature of humans is war and the only way to be free from state of nature is the creation of the state. On the other hand, jealousy of trade made clear the connection between economy and politics that lead the world to a commercial war (Hont, 2005, pp. 1-7). In our specific case, war was made using fake news and disinformation in order to disadvantage other port cities.

In the 17th and 18th centuries, disinformation led by economic and political intentions affected the ports of Genoa, Livorno and Marseille. The competition between the three ports was necessary to keep their economic activity and trade benefits. In light of this the port of Genoa started to spread fake news about the scarcity of health control in Livorno and its involvement in the contagion spread. However, the France consul in Livorno, Alphonse de Moy, stated that the measures adopted by Livorno in order to prevent the spread of plague were correct (Calafat, 2015, pp.1-7). This case is interesting because it shows how information, in this case fake news, can be used to achieve a particular economic or political goal. What is important is the role of health that in this case is used to reflect poorly on an enemy port. This is one of the several uses of health in order to control trade and commerce to pursue economic and political objectives.

Another example of manipulation of information in order to control people led by economic, political, moral and social imperatives is the example of inoculation of Smallpox between 1750s and 1760s.

Smallpox is one of the most ancient diseases appeared in Africa and then transported into Asia and Europe. For eleven centuries no remedy had been found, but in Asia a cure called Inoculation was discovered. This method was transferred also in Europe where the first smallpox inoculation was released in Great Britain in 1721 to Mary Wortley Montague inoculating her daughter after a visit to Istanbul. After its arrival in

Europe, some improvements were done once its success was verified. Inoculation was the injection of "artificial smallpox" in a healthy person in order to protect them from the deadly consequences of Smallpox. Inoculation followed three important principles without which it would have no reason to exist: catching the Smallpox is unavoidable, people can only get smallpox once and the last one is that the "artificial Smallpox" is not dangerous. To realise the inoculation a procedure and some precautions were followed. First of all, the patient should be healthy for 30 days. The patient age should be between 3 to 12 years old, the inoculation should be done in the tempered season and the substance to inject must be taken from a benign Smallpox and be fresh. The injection is done on the arm. The first inoculations in Venice were done in the *Sala dell' Ospedale de' Mendicanti* only in 1768 because Venice was lagging behind the rest of Europe. On that occasion, 22 children were inoculated and for each of them the symptoms were monitored. At the end none of the children died. Indeed, the inoculation had a huge success (Vicentini, 1767, pp.7-8, 12-13, 40, 44-70,75-133).

Nevertheless, inoculation was not accepted across Europe since there were uncertainties about its performance (Cigui, 2015, pp. 268-269, 284) and there were prejudices because this method was foreign and not Christian (Delogu, 2022, p.61) and a huge number of rumours about deaths from inoculation became widespread.

For this reason, doctor Giovanni Calvi published the *Tre consulti fatti in difesa dell'innesto del vaiuolo*, together with three important theologists from Tuscany: Francesco Raimondo Adami, Giovanni Lorenzo Berti and Gaetano Veraci. The text was an attempt to convince people to inoculate and to demonstrate the effectiveness of these methods. The peculiarity is that the text is characterised by scientific data together with religious opinions from the three theologists. At that time, as already explained, people tended to thank God if something positive happened or blame the Devil for negative events. For this reason, inoculation is presented in the text as an act of faith in order to convince all sceptics (Delogu, 2022, pp.307-313). They even wrote that "*Chi innesta è 52 volte più pio di chi lascia correre*[14]" (Adami, Berti, Veraci, 1762). The texts in *the Tre consulti* were written at the request of the Tuscan government and church hierarchy to convince the population to accept inoculation. Also, those who were against inoculation started to invent rumours characterised by religious beliefs and emotions. Precisely because emotions had a great power over the public, governments asked the

[14] English translation: Those who get vaccinated are 52 times more pious than those who let it go

Tre Consulti to put into their scientific text emotions and religious aspects as well (Delogu, 2022, p. 313).

To conclude, for many years Venice was the leader in managing epidemics through public health legislation. It started the creation of sanitary cordons, of lazarets and the practice of the quarantine. The use of health passes as instruments to control people and goods have been analysed in order to understand the spread of epidemics. Information also played an important role in shaping thoughts and beliefs through fake news in order to pursue economic and political goals.

Health seems to have multiple roles in addition to prevention and personal care. Health could be used as a pretext by the government to control population and to pursue economic and political objectives.

Here comes back the concept of Michel Foucault of political control. Some authors underlined that the measures implemented by Italian health institutions to limit the spread of plague were realised not only to protect population but also for other objectives, especially economic ones (Calafat, 2015, pp.2-3).

4. THE REPUBLIC OF GENOA

Among the most important port cities of the time, the Republic of Genoa played an important role together with the Republic of Venice, that we have already analysed, and the Republic of Marseille, that will be later analysed, especially regarding the specific case study about epidemic management.

The Republic of Genoa arose as a maritime commercial power in the 12th century thanks to trading colonies in the Mediterranean until the 16th century when it was a commercial empire and an important hub of commercial and information networks (Kirk, 2019, pp.153-155). Genoa had a crucial role between the 11th and 15th century especially with actions against the Muslim, intimidations against the enemies such as Pisans, Catalans or Muslims and active role during the Crusades. In fact, before the 11th century the Mediterranean could be considered an "Arab Sea" (Abu-Lughod, 2002, p.102).

In the Early Modern Age, the Republic of Genoa became an important financial centre controlling capital flows in Europe. Thanks to its past, Genoa was able to survive and even became an important commercial hub (Kirk, 2005).

4.1 HEALTH INSTITUTIONS IN GENOA

As was the case for the Republic of Venice, Genoa had to adapt to the epidemics of the Early Modern Age and implement new structures and forms of control.

It is not yet clear when the Health Magistrate of Genoa was first established, however in 1449 the presence of a health office is attested. In 1452, the doge Campofregoso and the Elderly Council started to create a commission of four citizens in order to undertake the right measures to protect the public health following the expansion of an epidemic from Lombardy (Cipolla, 1986, p.17).

However, it seems that also in 1347 there were health offices in Genoa because of the Black Plague pandemic. Contrary to the Republic of Venice, the Republic of Genoa took longer to set up a permanent Health Magistrate. It seems that in 1480, the relevant legislation was encoded, but the health offices exercised their power though provisional decrees. In 1501, a decree gave full authority to the health offices, however it was only in 1528, with the political reforms of Andrea Doria, the Health Magistrate, was established with full civil and criminal jurisdiction and the authority to inflict the death penalty to those who did not respect the rules (Pallavicino, 1846, p.240). The Health

Magistrate could also apply financial penalties, which was also a method of self-financing. The regulations of the time were focused on the protection of public health since already, the Republics understood that epidemics spread due to the mobility of people and goods (Pallavicino, 1846, pp.239,240). It seems that the Health Magistrate was made up of four nobles, a citizen and a senator as president. Additionally, in the port of Genoa there were Guardians located in a small house from which they could see the ships arriving and question the captain and the sailors about their place of origin and control the health passes. During the emergency of 1579, some extraordinary commissaries were adopted in order to grant the execution of the orders of the Health Magistrate. The pandemic of 1579 was very important because it facilitated the consolidation and maturation of the sanitary machine.

In 1590, Genoa became a free port. In 1613, a new figure was established, the mayor who was at the dependencies of the Health Magistrate. He was tasked with the examination of the ships, the health passes and the supervision of cargoes. During the 17th century the number of ministers working for the Health Magistrate grew and among them there were the Mayor, the Chancellor, the Under Chancellor, the *Sottocassiere*, the *traglietta* (that is to say a messenger), a Commissioner and the Chaplain of the Lazaret. There were also some agents displaced in all the territory. However, the real staff on which the Health Magistrate relied on, were the health offices which were expression of Genoa's communities and they controlled the territory daily.

From 1628, the Republic of Genoa required that all citizens follow new rules for a major responsibility "*per la comune salvezza dal morbo contagioso*" (for the common salvation from contagious disease) (Assereto, 2011, p.48). In the Orders of Health of 1628, the Health Magistrate affirmed that in every city of the Republic there should be a health office, with the election of the officials to whom is given the maximum jurisdiction for what concerned health. They also had to supervise the control of health passes and the correct procedure of ships and crews' control. It is also interesting that the ship's chief *could be "intimandoli in caso di bugia qualsivogli pena sì pecuniaria come corporale*" (Assereto, 2011, p.161), which means that the health officers could intimidate the crew with corporal or monetary punishment. There is also another interesting point, precisely order 12 of the Orders of Health of 1628, in which the Health Magistrate suggested that in case of ships arriving from infected countries the Chancellor had to "receive the health pass using scissors or clips, in order to not touch the health pass with hands and then they had to smoke the health pass, without burning

it. If the ship came from a banned or suspected place, the chancellor had to write "seen in that place without practice[15]"" (Assereto, 2011, pp.161-162). This specific statement is interesting because the idea of prevention and precaution is presented with the use of a pincer to take the health pass from the infected ship (State Archives of Genoa, Ufficio di Sanità, 1875, n. 324-361 in Assereto, 2011, pp.161-162).

In 1691 sea guard posts were institutionalised in the Republic. The example was soon followed by Livorno, Marseille and Venice. They were located all along the maritime coast and their function was controlling ships that entered together with the control of health passes. Those who worked in the sea guard posts were skilled residents that served in the militia ready to be mobilized in case of emergency (Assereto, 2011, pp.15-16,19-20,34-35,37,41-42,48,52,55).

The Republic of Genoa, following the example of Venice, created lazarets in order to quarantine all infected and suspected travellers. As regards Genoa, we do not know the exact date of the creation of the first lazaret since there could be some confusion with hospitals or the *Albergo dei Poveri* (Pesce, 1960, pp.110-145). It seems that the lazaret was financed by Ettore Vernazza (Accinelli, 1750, p.114) in 1522. Ettore Vernazza was a notary and he belonged to the Genoese aristocracy. He was an important figure of the time because he represented the aristocratic effort to create a public welfare system through charity. The lazaret was a building in which infected were welcomed. This building had several roles, among them the control and confinement of poor and marginal people. Precisely for this in Genoa the *Ufficio dei Poveri* (Office of the poor people) was created. It had the control of the lazaret in the *Foce* together with the Health Magistrate. Before the pandemic of 1579, this Office was characterized by home assistance, later the Office decided to use the Lazaret to conduct a census and to put poor people in an adequate place. Poor people were more likely to contract the disease and for this reason it was better to concentrate this part of the population in a side of the Lazaret under the control of the Office of poor people. This policy was named policy of poor peoples (Assereto, 2011, p.69-70,72).

However, a place only for poor people was advocated for especially by Emanuele Brignole, another protagonist of the Genoese organized charity. In 1650 he suggested to host these people somewhere else. Starting from 1651 the Lazaret was used only for

[15] The original italian version: "ma ricevendo la sua patente con forfici [tenaglie],molle o altra cosa acciò non si tocchi con le mani la carta la prefumeranno alla fiamma del fuoco, avvertendo però che non si abbruggi, e vedendo che procede da luogo bandito o sospetto doverà il cancelliere scriver sotto "vista nel tal luogo senza pratica"" (Assereto, 2011, pp.161-162).

infected people and in 1652 the construction of the "*Albergo dei Poveri di Carbonara*" started (Bonaventura, 1658, p.396).

The role of the Lazaret of the *Foce* was similar to the role of all the other lazarets in the Mediterranean. It was characterised by a part in which there were goods and a part for people. Further, the healthy and the infected were always divided. Among the staff of the lazaret there were porters, "*sciorinatori*" that means those who left the goods in the open air in order to sanitize them (Pallavicino, 1846, p.243) and purgatories (Assereto, 2011, p.69-70,72,75).

Around 1720, the Health Magistrate of Genoa decided to build another lazaret, the Lazaret of Varignano. Following the example of the Republic of Venice, also the lazarets of Genoa used the quarantine both for people and goods. (Pallavicino, 1846, pp.241,243).

4.2 PRACTICES OF CONTROL IN THE REPUBLIC OF GENOA

As was the case in Venice, in the Republic of Genoa control assumed an important role as well, which can be analysed in the context of Foucault's biopolitics. The Republic was able to use the Health Magistrate and all its ramifications to create an efficient sanitary police to control the territory. In order to improve the control in the *Genovasto*, new techniques were adopted, such as the census and the division of the Republic in districts that are used even nowadays (Calcagno, 2022).

The main institutional apparatus with direct control over the territory of Genoa was the Health Magistrate (Pedemonte, 2016, p.33) and as we have analysed for the case of Venice, different aspects of control implemented using the pretext of sanitary control will be outlined, such as the control of territory, economy, information and everyday aspects of the population. The Republic of Genoa is also an interesting example of enlargement of state power thanks to sanitary control. There is a parallelism between state and health which has led to a thickening of government functions. The "police" of health was important to create consensus on the government and to better institutionalise some practices (Calcagno, Palermo, 2017, p.11).

When the sanitary apparatus arose to face the spread of epidemics, it assumed a different role as an instrument to interact with local or periphery realities. From prevention and protection, this system started to use the orders and rules to control territories, regulate traffics and protect borders and markets. In this paragraph I will first

analyse the role of the Health Magistrate in the economic sphere, control of information and competition with rivals.

The territory of the Republic of Genoa was characterised by coasts overlooking the sea and the island of Corsica. It was easy to enter and to exit from the dominions. The permeability of the territory and the request for autonomy, especially from Corsica, were difficult to manage together with sanitary apparatus such the Health Magistrate which needed uniformity in order to create a centralised power. However, the concern for public health led the Republic to create an organic organisation and collaboration in health matters. The most important moment of this process was the emanation of the "*Ordini di Sanità*" (Health orders) in 1628, for which I gave some examples in the paragraph above, and the institutionalisation of guard posts in 1691 in all the territory (Pedemonte, 2016, pp. 34-37). The Republic was divided into 230 guard posts and mobilised 40,000 people (Assereto, 2011, p.56). The number of guard posts increased to 378 after the plague of Marseille as reported by Matteo Vinzoni in his chart *Pianta delle due Riviere della Serenissima Repubblica di Genova divise ne' Commissariati di Sanità* (Pedemonte, 2016, p.38) in which he represented the territory of the Republic at the time in which it was characterised by the guard posts (Ghelfi, 2017).

FIGURE 2: *Pianta delle due Riviere della Serenissima Repubblica di Genova divise ne' Commissariati di Sanità*, Vinzoni, M. Source: Il Corriere Apuano, Matteo Vinzoni cartografo, Ghelfi, R. 2017. Available on https://www.ilcorriereapuano.it/2017/02/matteo-vinzoni-cartografo/

Guard posts, grouped according to their area, refer to the Commissariats. It is really in the Commissariats that the real control is put in place through the inspection of the ship and the interrogation (Pedemonte, 2017, p.103). Exactly in this optic, the idea of Foucault can perfectly fit. The device of discipline used to control the territory and

events used against this invisible enemy, which is the plague, can bring order and be used as a term of analysis (Foucault, 1976, p.215).

As said before, the guard posts and the Commissariats were the main factor of control which constituted the power of the Republic. They could be considered as a sort of "intelligence" (Pedemonte, 2016, p.38) since they had to manage information first of all for health purposes but not only. When in 1767, Jesuits were expelled from Spain, they landed in Corse. Frome there, some of them, because of the difficult social and environmental situation in Corse, fled to Genoa, Rome and Livorno. On this occasion, the "*Conservatori di Sanità della Repubblica*" ordered the chancellors and health officials to not let the ships dock if there were Jesuits on board. To make sure of the Jesuits' presence, they had to be able to acquire the most meticulous information and question the ship's chief and at least two members of the crew in order to see if the statements coincided (Pedemonte, 2016, p.39). This is an interesting example to understand how the sanitary system could use the sanitary instruments for other purposes. In this specific case, the role of guard posts was intensified, with stricter interrogation in order to better control the maritime space from a non-sanitary danger.

Guard posts have been defined as "*Giano Bifronte*" since they were able to look inside and outside the territory and control the territory both from the sanitary dangers but also from "visible" stranger dangers (Pedemonte, 2017, pp.105-106).

As introduced above, the system of sanitary control has also been used as instruments to promote mercantile interests. As already seen in the case of Venice, health is at the base of commerce (Andreozzi, 2009, p.225) and public health can be guided by the logic of market. An interesting and practical case is the one of Genoa and Livorno because since they overlook the same sea, they were subject to the same dangers, however the two port cities wanted to achieve a major economic advantage using also the sanitary police as an instrument for economic strategy (Pedemonte, 2017, pp.112-113).

A practical example is when, between 1748 and 1749, Maria Theresa of Austria and Francis Stephen of Lorena signed a peace agreement with the Barbary states of Tripoli, Tunisi and Algeri. This peace agreement, in the perspective of Italian states, caused two major threats. The first one was the fact that the port city of Livorno could offer the right of asylum to the North Africa's corsairs and it could be a problem for the traffic-line from Genoa to the other ports of centre Italy. The second threat was the fact that the corsairs would not have damaged Tuscan boats, making the port of Livorno more attractive and safer compared to the ones from Venice, Genoa or Naples. It is important

to underline that in North Africa the plague was endemic and this offered to the Italian states the pretext to affirm that the port of Livorno, who signed agreements with North African states, was not safe from a health point of view. Using this pretext, that hid the previous economic motivations, almost all states of Italy decided to apply 14 days of quarantine to the ships which came from Livorno (Pedemonte, 2016, pp. 44-45).

Another area in which sanitary provisions were used to increase the power of the state and government apparatus, was the one of international relations. health offices were in charge of gathering and sharing information, keeping a constant correspondence with all the other health offices of Europe. This characteristic, defines the Health Magistrate as a real foreign ministry which needs to deal with sanitary, political and economic affairs (Assereto, 2013, p.177).

To conclude this first part, sanitary instruments have been used in an instrumental way as we have seen both for gathering information and for economic interests. Furthermore, the Health Magistrate was important in facing the epidemic risks by creating cooperation even among port cities which were in competition.

4.3 REORGANISATION OF URBAN SPACE AND CONTROL IN THE PRIVATE SPHERE

The Republic of Genoa is an interesting example to analyse because in order to better control the spread of epidemics, a change and reorganisation of urban space was implemented.

The plague of 1656 is a good starting point to better analyses this phenomenon. The decision to divide the territory and Genoa into smaller districts, ruled by the Commissariats as we have seen above, was taken in 1656 with the proposal by Filippo Fiesco, Carlo Impierale and Geronimo Garbarino. The document proposed the designation of forty districts in Genoa inside the old walls and six districts outside the walls. These four zones took the name from a church or a particular masterpiece that was inside its territory: Sant'Agostino, San Domenico, San Francesco e Fabbrica and each of these districts was divided into ten contrades (Calcagno, Ferrando, 2019, p.122). For instance, the district of San Agostino was composed of: "*Piazza di Sarzano sino alla strada di Ravecca, Carroggio di Dragone, Carroggio di Cazzareggio e Stella*", "*tutta Coccagna*", "*Strada del Melgranato sotto le mura e Campo Pisano*", "*Piazza della Marina, Corte della Marina sino a Santa Margherita e Rocchetta*", "*Borgo di*

Marina sino a Santa Maria dei Servi", "*Colla d'alto, case nuove della Colla*", "*Colla da basso sino al Caroggio de Pontelli*", "*Salita di Sant'Agostino, Carroggi annessi cioè di Sant'Agostino del Bagno*", "*Colla di mezzo e Fozze della Colla*" and finally "*Sotto le mura di Sarzano sino all'oratorio di Sant'Antonio*" (Appendice 1, Biblioteca Medica Mario Segale, Compendio de' decreti de Ser.mi Colleggi et Ill.mo Mag.to di Sanità con insertione di leggi de Consegli della Ser.ma Rep.ca per preservare, e liberare la città e dominio dalla peste negl'anni 1656 e 1657 raccolti da Gio. Bartolomeo Campasso, cc. 34 r- 36 r. in Calcagno, Ferrando, 2019). This division was also used by the poor office to distribute bread.

What is new in this configuration is the fact that the Commissariats had to divide their area in streets and nominate for each of them a responsible called *Capostrada* (chief of the road) which had to control the functioning of sinks, visit the homes were people were in quarantine and burn the personal effects that could be infected. All these information was later given to the Commissariats and to the Health Magistrate in order to have major control of what was the situation in their dominions. They also had to note all the people living along the streets creating a sort of modern census (Calcagno, Ferrando, 2019, p.123). For instance, here there is an example of the annotations of one of the chiefs of the road regarding the state of quarantine and disinfection:

***Megi**: dalli 2 novembre senza casi giorni 89, quarantene numero 0, le case profumate*

***Verzema**: dalli 3 settembre senza casi giorni 149, quarantene numero 0, non si è profumato*

***Testana**: dalli 22 genaro senza casi giorni 8, quarantene numero 12, restano da profumare alcune case*

***Avegno soprano**: dalli 30 ottobre senza casi giorni 92, quarantene numero 0, le case profumate*

***S. Pietro d'Avegno**: dalli 7 novembre senza casi giorni 84, quarantene numero 0, le case profumate*

***Salto**: dalli 26 dicembre senza casi giorni 35, quarantene numero 1, da profumarsi*

***Terrile**: dalli 17 agosto senza casi giorni 166, quarantene numero 0, le case profumate*

***Colodri**: dalli 23 dicembre senza casi giorni 38, quarantene numero 1, da profumarsi*

***Vexina**: dalli 7 genaro senza casi giorni 23, quarantene numero 5, restano alcune case da profumare*

***Cortesella**: dalli 19 genaro senza casi giorni 11, quarantene numero 4, restano due*

case da profumare

***Liceto e Coteglia**: dalli 19 decembre senza casi giorni 42, quarantene numero 2, le case profumate*

***Cazori**: dalli 13 dicembre senza casi giorni 48, quarantene numero 0, le case profumate*

***Cotù**: dalli 19 genaro senza casi giorni 11, quarantene numero 1, le case profumate*

***Ruta**: dalli 3 novembre senza casi giorni 88, quarantene numero 1, le case profumate*

*Dove non sono mai seguiti casi: **Polanesi**, **Banna** et il resto delli quartieri*[16] (ASG, Ufficio di Sanità, 45 in Calcagno, 2012, p.140).

The chief of the road noted for each street the number of people who were in quarantine, if there were new cases of infections or not. They also signed if houses were *profumate* which means smoked or not. The smoking procedure was based on the idea that by subjecting objects to fire they could be disinfected (Da Tolone, 1661). The procedure of tracking the number of people who died and who contracted the plague, can be similar to the one that we experimented in Italy during the COVID-19 pandemic. From the beginning of the COVID-19 pandemic, the Ministry of Health kept track of the number of people who tested positive to COVID-19 and of those who died after contracting COVID-19 with the help of the hospital network.

Returning to the matter of division into forty districts, after a better analysis it was decided to halve the districts in order to make the procedure more functional. The instructions for Commissariats and chiefs of the roads were the same with the exception of the new order consisting of the renumbering of houses. The chiefs of the roads sometimes were subject of controversy because they usually abused their power and committed fraud (Calcagno, Ferrando, 2019, pp.132-133).

The Republic of Genoa, is an interesting example because it shows how sanitary

[16] English version: **Megi**: from 2 November 89 days without cases, quarantine number 0, smoked houses
Verzema: from 3 September 149 days without cases, quarantine number 0, has not smoked
Testana: from the 22nd of January 8 days without cases, quarantines number 12, some houses remain to be smoked
Avegno soprano: from 30 October 92 days without cases, quarantines number 0, smoked houses
S. Pietro d'Avegno: from 7 November days 84 without cases, quarantine number 0, smoked houses
Salto: from 26 December 35 days without cases, quarantine number 1, to be smoked
Terrile: from 17 August 166 days without cases, quarantine number 0, smoked houses
Colodri: from 23 December 38 days without cases, quarantine number 1, to be smoked
Vexina: from 7 January 23 days without cases, quarantines number 5, some houses remain to be smoked
Cortesella: from 19 January 11 days without cases, quarantine number 4, two houses left to smoked
Liceto and Coteglia: from 19 December 42 days without cases, quarantine number 2, smoked houses
Cazori: from 13 December 48 days without cases, quarantine number 0, smoked houses
Cotù: from 19 January 11 days without cases, quarantine number 1, smoked houses
Ruta: from 3 November 88 days without cases, quarantine number 1, smoked houses
Where cases never followed: **Polanesi**, **Banna** and the rest of the districts

policies and institutions were used to change and reorganise urban spaces and to survey inhabitants. It is at this point that the idea of disciplinary system and biopolitics presented by Foucault can be contextualised. Especially in emergency times, such as during an epidemic (Foucault, 1976, p.215), the government exerts its control even in the most intimate sphere of the population into their home and burning whatever is infected. During the 17th century, the Republic of Genoa, thanks to the disposition of the Health Magistrate, was reorganised with regards to town planning. The city was divided into districts and the house numbering system was put in place and it is still valid today.

To conclude this second focus on the epidemic management and role of control in the Early Modern Age with the specific case of the Republic of Genoa, some general findings on the case of Genoa will be given.

Analysing this case, it is interesting to notice how during emergencies, such as epidemics, the government put in place stricter control. Emergency sets in motion control mechanisms and new devices giving more power to the institutions, also permeating the intimate lives of people. This control prevented Genoa from suffering worse consequences from the plague. However, there is a clear correlation between plague and the growth of government functions. Health controls created a thickening of the functions of government and the Republic of Genoa acted like that, experimenting, deciding, controlling, organising a health apparatus and reorganising the urban space.

5. PORT CITY OF MARSEILLE

Together with the Republic of Venice and Genoa, the port city of Marseille played an important role in the context of epidemic management and control of information during and after the plague epidemic of 1720. The port city of Marseille was an important port of trade, especially between the 17th and 18th century.

In 1669 the city of Marseille became a free port, as designed by the politician and economist Jean Baptiste Colbert, in order to attract more goods from different countries and to improve the competition with Genoa and Livorno (Rambert, 1949). Colbert wanted to establish mandatory companions to protect French ships from corsairs, the regulation of exchange currency and a consulate reform (Takeda, 2011, p.24)

However, with an edict of 1703 there were few restrictions imposed: for instance, foreign wool fabrics, codfish and tanned skins were prohibited. There were also additional taxes to pay for the import of meat, fish and tobacco. From 1703, the tax on sugar and coffee was eliminated (Iodice, 2016, pp.20-23).

The important event that changed the asset of the port city was the plague of 1720-22 in which the management of epidemics through the health offices was more interested in controlling military movements and extracting information (Buti, 2017). This last aspect will be analysed in chapter 5.4.

5.1 THE "BUREAU DE LA SANTÉ DE MARSEILLE"

Following the example of the other port cities, Marseille established the "*Bureau de la Santé de Marseille*" (health office) in order to prevent the spread of diseases and to give instructions to face potential epidemics. There is not an exact date of establishment, but it seems that the first instances of health offices date back to the end of the 15th century. To reduce the possibility of contagion, only few ports were authorised to receive ships coming from countries considered infected. In 1622, Marseille became one of the authorised ports. In fact, Marseille was the port which received the majority of commercial traffic.

The health office was composed of elected members whose number changed according to place and time. The members were not people from the health sector; in fact, they were merchants, aristocrats and shop owners (Buti, 2017, pp.44-45).

After 1720, the health office of Marseille was composed of 16 commissioners of the merchant class together with two ship captains. The commissioners did not receive a

salary, only some presents for holiday, and they were appointed for two years.

Since the institution of free port in 1669, the health magistrate of Marseille was the main apparatus in the health system together with the local health offices that were dependent on it (Belmas, 2017, pp.41-42).

The health office of Marseille was part of a hierarchical system. At the state level, it depended on the royal administration of Versailles and on the Secretary of State of the navy. At the provincial level, it depended on the Commissariat of Provence and at the same time the health administration was influenced by the municipal administration of Marseille (Hildeshimer, 1996, pp.483-489).

The health control in Marseille was similar to the one applied in Genoa and Venice. The ships that arrived from infected countries had to stop at the Frioul islands before the entry of Marseille's port. At that point, there was the control of health passes and the ship's captain had to release a statement to the health office of Marseille and later store it. In the statement the captain wrote the name of the ship, the place where they came from, the eventual stopovers, details about their cargo, if there were other passengers and the state of the health pass.

The decision of the health commissioner depended on the statement and on the health pass and the quarantine could be applied. The person in charge of the health office had to inform the police in case of breach of regulations. The reputation of the health office of Marseille was questioned during the plague epidemic of 1720-22. In that period, the health office of Marseille became more dependent and instrumentalised by the central power since it was politically and economically interested in the captain statement enough to force the health offices to ask more details about captain's declarations (Buti, 2017, pp.45-46). This last idea will be better developed in chapter 5.4.

5.2 HEALTH REGULATIONS IN MARSEILLE

In 1622, the Parliament of Provence published a first set of rules establishing some important points: the ships that came from infected countries had to stop at Marseille; in the port of Marseille there was a sanitary administration that could check the health pass and establish quarantine for the ships and for the crews transported to the lazaret. Finally, there were penalties for those who did not respect the regulations.

All the following regulations can be collected in different sections. The first one collects all the regulations from 1622 to 1683, all centred on the protection of the state from the

spread of plague. An important document for the prevention of the spread of the epidemic, was the health pass as it was important for the other port cities as well.

The second group of regulations was the one regarding the functioning of health administration in Marseille, explaining the role of health offices, commissioners and the use of quarantine, lazarets and infirmaries.

The third group of regulations is the one concerning the temporary dispositions to face the plague epidemics. For instance, between 1712 and 1715 there were six regulations in order to protect the coasts from the Northern plague that started from the Balkans. In 1739 there were other regulations to prevent the spread of plague epidemics from Hungary. The last collections of documents about regulations are those regarding infractions that will be later outlined.

In the first regulations, the functions and the roles inside the health office of Marseille were explained. In the health office there was a secretary, physician, guards, assistant and captains.

The main breach to regulations were those regarding the administrative frauds such as the absence of the health pass or incidents inside the lazarets such as the escape of a sick person or cases of theft. The last and largest case of breach was the contact with the infected. After the breaches there were of course sanctions decided after a fast procedure. There could also be death penalty (Panzac, 1986, pp.39-71).

5.3 THE PLAGUE OF 1720-22

The first plague epidemic in Marseille of which there is a mention is the one of 1387. After the capture of Constantinople in 1453, which caused the end of the Eastern Roman Empire, Marseille was hit by numerous epidemics due to the ships coming from eastern countries that were always suspected of plague. For instance, in 1416, 1424, 1505, 1506, 1507, 1527, 1530, 1547, 1557 and 1558. It was really from this first crisis that the first healthcare structure, procedures of quarantine and lazarets were developed. In 1416, the Hospital of Rondeaux was transformed into a lazaret, but not a permanent one, to host all the infected from eastern countries, especially from the Ottoman Empire. Later, under the reign of Francis I of France, the decision to build a new lazaret was taken in 1526. This lazaret took the name of Hospital of infirmary or charity. The plague hit Marseille again in 1628, 1649 and 1650. During this period, the quarantines were strict and the sanitary system was almost perfect because Marseille was no longer

hit by the plague until 1720 (Bertulus, 1864, pp.17-25).

The east countries were always suspected of plague and for this reason all the vessels that came from there to Marseille, were stopped to the islands of Château-d'If where they were examined by the *intendants de la santé* (health commissioners) who decided the procedures of quarantines and controlled the health passes.

In March 1720 the plague erupted in Palestine and Syria. In May the ship of captain Chataud arrived in Château-d'If. The health passes were clean, however he declared that when they had stopped in Livorno, six members of the ships had died because of food poisoning as declared also by the Health Magistrate of Livorno. The cargos were subjected to quarantine. One day later, a member of the ship died and two days after the arrival of the ship, the guardian that was charged by the health commissioners to control the goods in quarantine died. However, the physician Guerard, declared that the cause of death was not the *mal contagieux* (plague). In the following days, a lot of people got sick or died but the idea that there could be plague was apparently not taken into consideration. Marseille started to inform all the European port cities to reassure them that in Marseille there was no plague epidemic but only few infected in infirmaries and the disease had not spread in the city. However, they had not officially and publicly declared that the cause of sickness was the plague so as not to worry the people.

Nevertheless, the epidemic started to spread in Marseille and as soon as the infected were discovered, they were transported to the lazaret and put in quarantine and their houses were smoked. Those who died were buried. The Magistrates did not listen to the advice of those physicians who wanted to adopt the strict measures used during epidemics. However, the Magistrates accepted the idea of Mr. Sicard who suggested turning on some fireplaces in order to “disinfect” the city. Mr. Sicard was a physician that refused to visit sick people at home and to face this lack of professionalism, he proposed that solution to put an end to plague. The proposal was such good news and in contrast with the bad and negative news reported by the other physicians, that it was immediately accepted by the magistrates. The idea of turning on some fireplaces was so easy and hopeful that the Magistrates had no doubts. Nevertheless, considering that the plague spreads faster with heat, this idea created better conditions for its spreading and did not work (Bertrand, 1721, pp.83-93). On August 2, the municipality of Marseille declared that since there was an increase in infected, a guardian was placed at the entrance of every street in order to control if there were people entering or going out. In addition to this, Marseille put fifty soldiers into service during the night in order to

transport all the infected and the corpses to infirmaries. The physicians that were willing to take care of the infected were provided with the necessary equipment such as tarpaulin clothes in order to protect from the plague.

At the end of the month of august, the epidemic was very strong and started to spread in the Provence region. Marseille was like a ghost city; everything was closed and people could not leave their houses. Some bakeries closed, others were charged to prepare with the remaining flour some bread for poor people that were hit by the plague and that did not have economic resources. The hospitals were full and they were not enough to host all the infected and for this reason it was decided to build a new one. The plague spread in all the region and it was one of the biggest epidemics of the time leading to the death of more than half the population in Provence (*Pièces historiques sur la peste de Marseille et d'une partie de la Provence en 1720, 1721 et 1722, 1820*, pp.32-126).

5.4 INFORMATION AND DISINFORMATION

Information played an important role in the context of disease epidemics as we also analysed in the example of Venice and Genoa, where news and information were used for commercial purposes and competition (Calafat, 2015, pp.101-103).

Information about political, military events and shipping incidents could be used for economic and strategic purposes by the government (Buti, Kaiser, 2007). Commercial information was made public in Marseille using commercial print, merchant guidebooks and circular letters (Bartolomei, 2007).

The main actor in this context was the health office of Marseille, which played an interesting role in gathering information that was useful for commercial purposes. Therefore, this is an example of the use of sanitary apparatus for political or commercial goals.

The documents that are most relevant for the analysis of this topic are the statements made by the ship captains at their arrival in Marseille at the health office. As explained before, they had to declare different details and it was really on these details that the state wanted to linger. In their statements, the captains, in addition to declaring health issues, also gave information about remarkable events that they noticed during their trip, for instance storms, damages or injured people. However, they also reported the presence of enemy ships during their trip or at the stopover. They also signalled the eventual presence of corsairs, English merchants or barbary pirates. The economic and

military information were abundant and full of details even if these statements should have been about sanitary issues.

Some of the secret statements which contained important political, military and diplomatic information were interesting for the central government. For this reason, the state charged the health office to exert pressure to acquire some details or on the captains that seemed to not give the full account of events.

Of course, the state had other important channels of information, but the health office seemed to be a new way to control and to have information. The state recognised the role of the health office but the latter had to quickly inform the state. Especially after the plague epidemic of 1720, the central government verified the resolutions of the office.

During the period of the French revolution, the passage of information was more regular since the statements of the captain were important to understand the movement of the fleet in the Mediterranean.

The health office of Marseille was also considered by the state as an informant about economic statistics but it could also be instrumentalised in order to serve the political aim of the state. The tensions between the state and the health office of Marseille lasted until the end of the 18th century since the control from the state was increasingly stricter. The state also started to control the municipal institutions that remained the only one to which the health office could freely relate. The employers of the health office of Marseille decided to resign in response to these changes but it did not work.

From the 19th century the health office of Marseille disappeared because new special agents under the directives of the state had been instructed to deal with health-related issues (Buti, 2017, pp.47-49, 53-57). It was for these reasons that sometimes the *Bureau de la Santé de Marseille* was called *Bureau des renseignements* (information office) (Buti, 2017, p.53)

From this analysis it is possible to understand the double role of health information in the Mediterranean. The first one was the real sanitary role: the control of health passes and the regulations in order to prevent possible epidemics. On the other hand, there is the role of information as a commercial weapon used by the state (Hildesheimer, 1980, p.203). Of course, as in the case of Genoa and Venice, there was a dense information network between the port cities, especially those who faced the Tyrrhenian Sea: Marseille, Livorno and Genoa. In the context of competition between these three port cities, the use of information or the creation of fake news were used for the purpose of

"jealousy of commerce" (Hume, 1758). For instance, in 1676, there was the rumour that the plague was in Marseille. The Republic of Genoa explained to the counsellors that the rumour came from Livorno. But in turn the consul of Livorno blamed Genoa for spreading this rumour. This episode can demonstrate the competition, the networking and the distrust that characterised these three competitive ports. The spread of rumours was reinforced by the competitiveness, the threat of the plague, the economic competition and the different trade routes that connected Marseille, Genoa and Livorno (Calafat, 2015, pp.99-119).

To conclude this third focus on the epidemic management and role of control in the Early Modern Age with the specific case of the port city of Marseille, some general findings on the case of Marseille will be outlined.

Marseille was chosen as the port that could receive ships from infected countries and for this reason an important sanitary machine and regulations were put in place. However, the state control on the operations of the health office of Marseille was huge. The health apparatus was used for economic, military and political purposes using the statements made by the ship captains at their arrival.

Marseille was also characterized by an important competition with Genoa and Livorno that brought to the creation of rumours to discredit the other ports.

5.5 GOVERNMENT CONTROL AND ECONOMIC INTEREST IN EARLY MODERN AGE EPIDEMIC MANAGEMENT

To conclude, this first part of my thesis regarding the epidemic management in the Republic of Venice, Genoa and in the port city of Marseille during the Early Modern Age and the different functions of health apparatus, I will briefly summarize my main findings.

The Republic of Venice was the leader in managing epidemics with the establishment of lazarets and sanitary cordons. However, as in the following cases, health and epidemics management was used for different purposes that deviated from the one of prevention. For instance, the pretext of health prevention and health institutions could be used as a way for the government to control population and to pursue economic and political goals, as exemplified by the use of quarantine to disadvantage the port of Livorno. Also, the role of information in the health field could have a double purpose. Sometimes the information was used to shape ideas and beliefs, for example to convince people to get

vaccinated in the case of Venice, or using fake news in order to disadvantage other port cities.

As regards the Republic of Genoa, it is interesting to underline how the government used a stricter control leading to the strengthening of the power of the state. Institutions were able to permeate the intimate lives of the people and a reorganisation of urban space was put in place (Calcagno, 2022).

The port city of Marseille was characterised by the health office of Marseille that after the plague of 1720 was more used as an information office. The state exercised an important influence and control on the health office because it used the captains' statements for economic, political and military goals (Buti, 2017). Also, rumours had a crucial role in the port city, since they were used to discredit the ports of Livorno and Genoa, which were the main competitors (Calafat, 2015).

These three port cities were commercially important because they were fundamental commercial hubs that received vessels from all over the world. For this reason, they were all exposed to epidemics. This first part has underlined the instruments used to manage epidemics, the double role of health institutions and the role of state control. In all the three cases the pretext of health prevention and health institutions were used for other purposes even if the role of prevention of diseases and personal care was always maintained.

In the second part, from chapter 7, there will be an analysis of the pandemic of Covid - 19, that hit all the world in 2020, with a comparison to the managing of epidemics in the three port cities in the Early Modern Age.

Before starting this last section, a brief explanation on the origin of international sanitary systems and the first international regulations will be given.

6. THE ORIGINS OF THE INTERNATIONAL SANITARY SYSTEM AND REGULATIONS

Plague, during the Early Modern Age, was important because it gave rise to the development of public health. As we have analysed, the first form of public health policy was designed in that historical period to protect the population (Snowden, 2019, pp.29-31). Some port cities started to cooperate and to build health systems in order to protect from possible epidemics, through quarantine systems, control systems and vaccination.

The period of the Enlightenment was characterised by an increase in medicalization of Western societies. The 18th century saw the growth in the power of medical practitioners since bodies became the subject of political intervention, from responses to plague epidemics to inoculation programmes (Spray, 2012, pp.1-23).

In the early 19th century, European nations started to take the first steps towards an international sanitary cooperation that culminated with the International Sanitary Conferences and the first sanitary laws. The international context from which the idea of cooperation appeared was the Congress of Vienna in 1815, that was aimed at ending the fragmented system trying to find agreements, equilibrium and an international organization able to transcend all the different interests (Harrison, 2006, pp.197-198).

What gave the inspiration to the international cooperation and first international regulations, were the cholera epidemics that characterised the 19th century. There were six global cholera pandemics, which started in Asia and spread in all Europe through commerce, tourism, migration and sailors in the following years: 1816-1826, 1829-1851, 1852-1860, 1863-1875,1881-1896 and 1899-1923 (Markel, 2014).

The most important phase of international sanitary cooperation is the first International Sanitary Conference held in Paris in 1851. This conference was a meeting between twelve nations that ended with an agreement stating that quarantine procedure and similar sanitary measures had to be decided by an international agreement (Harrison, 2006, p.197). The International Sanitary Convention of Paris designed a code of quarantine trying to maintain the commercial interests of each nation but preventing the spread of diseases (Markel, 2014). During the Early Modern Age, quarantine was sometimes used and imposed for commercial interests or for competitivity reasons, for example in the Republic of Genoa and other port cities of Italy that decided to apply 14 days of quarantine to the ships that arrived from Livorno (Pedemonte, 2016, pp. 44-45).

Quarantine was also used as a form of commercial protection or useful for thickening the nation's borders using the pretext of health issues. An example was the sanitary cordon established by Austria with the Ottoman Empire. The cordon was controlled by soldiers with the task to shoot those who crossed the border without quarantine. From 1710, the sanitary cordon became a military border used to defend against Ottoman invasion (Harrison, 2006, p.202).

These international meetings, after the first one held in Paris in 1851, were later held in Paris in 1859, in Constantinople in 1866, in Vienna in 1874, in Washington in 1881, in Rome in 1885, in Venice in 1892, in Dresden in 1893, in Paris in 1894 and the last on in Venice in 1897. However, during these meetings it was difficult to find an agreement because there were competing theories and explanations especially about cholera and different economics and political interests.

Nevertheless, it is not possible to consider the International Sanitary Conventions as a failure. They are still the symbol of an important achievement: the creation of an international space to discuss health issues (Markel, 2014, p.125).

The International Convention of Paris 1903 represents a great step forward for international cooperation. The proceedings published after the international conference are divided into six parts. The first part is about the general provisions, the second one is about special provisions regarding countries outside Europe. The third part explains special provisions regarding pilgrimages; the fourth one is about administration and control. The fifth one is the smaller one about yellow fever and the last one explains the adhesions and ratification process.

The first part is interesting because it explains all the details and the instructions in case of a pandemic. For example, the government must immediately notify if there were cases of plague and cholera. The government should also give information about the location and the date of appearance. But also, the number of deaths, if there were rats with plague and the measures taken. These communications should be done once a week, especially explaining the preventive measures undertaken and the measures that the government wants to use not to spread the plague through the departure of vessels. In the second section the guidelines to state if a location is infected or not are outlined. If there were different cases of plague or cholera and the local area was a foyer, it should be considered as an infected. When a determinate zone was infected, any type of restrictive measures should be taken against people arriving from the infected zone they left five days before the start of epidemics. A local area ended up being considered as

infected when there were no more deaths after five days following the recovery of the last case of plague or cholera and if all the prevention and disinfection measures were undertaken.

In the second chapter of the first part the measures of defence against infected territories are described. First of all, the government had to make public the measures that it wanted to undertake towards the arrivals from the infected territories. It must communicate it to the consular agent of the infected territory and also to the International Sanitary Boards.

In the second section it is also underlined that merchandise can not itself convey plague or cholera. Merchandise was dangerous if contaminated by plague or cholera products and only this type of merchandise should be subjected to disinfection. In section three of the second chapter there are all the measures at ports and land frontiers.

A ship was considered infected if there is plague or cholera on board. It is considered suspected if there have been cases at the departure or during the voyage but no new cases within seven days. Finally, a ship was considered healthy if there have never been cases of plague or cholera.

In the case of plague, infected ships should follow some provisions: medical inspection, isolation of sick people, isolation and observation of the healthy people, and elimination of rats that were on board. As regards the measures at land frontiers, land quarantine was not to be used anymore.

In the second part, the measures at infected ports on the departure of vessels are listed. There are different sections that focus on different geographical areas, for instance the measures undertaken in Egyptian ports or at the entrance of Suez Canal, in the Red Sea or in the Persian Gulf.

The final resolutions are interesting because the creation of an International Health Office that periodically had to set out the results of the labours in official reports and shared with the contracting governments was suggested (*The International Sanitary Convention of Paris 1903*, 1904, pp.3-12,37).

The International Sanitary Convention of Paris was a huge step forward for international cooperation. The disposition of these common rules and guidelines were important to guarantee the same treatment for all countries. Some crucial concepts, such as the definition of an infected area or an infected ship, were designed and fixed. This also made possible the partial end of the use of quarantine or other prevention measures to

pursue the port cities' interests. The final provisions are also important because they underline the continuity of this "project", creating reports based on different projects and government contributions.

Also in the 20th century, three more international sanitary conventions were held, precisely in 1911-1912, 1928 and 1938. However, the two World Wars stopped international health cooperation. Anyway, during the International Convention of Paris 1903 different mechanisms of public health administration were elaborated. Some of these mechanisms are practiced even in our century (21st). For instance, systems of surveillance and reporting of modern disease, the sharing of scientific or therapeutic information and the universal regulations about quarantine and isolation.

In 1902, the Pan-American Sanitary Bureau was established and it is still existing today. It was initially created in relation to yellow fever epidemics coming from South America to North America (Markel, 2014, p.125). Nowadays, it is known as Pan American Health Organization (PAHO), and it operates in different fields and in five departments. For example, the Communicable Diseases and Environmental Determinants of Health Department (CDE) focuses on communicable diseases and on environmental threats to health. The Department of Evidence and Intelligence for Action in Health (EIH) is centred on the use of information for health and it also coordinate the monitoring for the SDGs about health. The Family, Health Promotion and Life Course Department focuses on the creation of technical cooperation in different fields from immunization to prenatal and Neonatal Health. The fourth department is dedicated to gender, equity and cultural diversity where the main goals to achieve is health equality, underlining gender and ethnic inequalities in health. The Department of Health Systems and Services has the task of strengthening and supporting the health system. It is also responsible for developing financial mechanisms to ensure public funding for health. The last department of PAHO is the Noncommunicable Diseases and Mental Health Department. It is responsible for promoting and implementing cooperation in the field of non-communicable diseases and mental-health. It also has the role of promoting awareness of this type of disease. Of course, the PAHO has a crucial role in Health Emergencies since it has to expand the health sector in case of emergencies such as in the case of COVID-19 pandemic (*Who we are*, https://www.paho.org/en/who-we-are).

As explained, the Pan American Sanitary Bureau which was created firstly to face the yellow fever disease, nowadays plays an important role also in the field of common

rights and equality. It is responsible for raising awareness about special diseases such as noncommunicable diseases.

In 1907, the *Office International d'Hygiène Publique* (OIHP), was founded in Paris. This Office had a crucial role in informing the international public health community about new quarantine methods that took into consideration new technologies. The Office also applied new methods of surveillance and disease reporting. During the First World War, the Office started to gather information about the mortality data during the battles. In the period between the First and the Second World War, it contributed to gathering data about infestations, tuberculosis and other diseases around the world (Markel, 2014, pp.125-126).

The Office was created following the Convention of 1903. The project of the creation of this Office was presented at the Conference in Rome in 1907, where it was approved. The Office of International public health had the following characteristics: its headquarter was in Paris; it could not interfere in the affairs of other states; the office was under the authority of an international committee composed of technical representatives chosen by the participating States; the annual expenditure was covered by the States' contributions. The main goal of the international Office was to gather data and inform the participating states about issues related to public health, especially those regarding infectious disease such as plague, cholera or yellow fever. The participating governments had to apply the international sanitary conventions. The committee met once per year. The Office was composed of one director, a general secretary and some agents. The first signatory countries in 1907 were: Belgium, Brazil, Egypt, Spain, United States, France, Great Britain, Italy, Netherlands, Portugal, Russia and Switzerland.

The main activities of the Office were the application of the International Sanitary Conventions and sanitary international agreements, gathering documentation of well-known diseases and collecting data about new infectious disease. The main international conventions to which the OIHP worked were the International Sanitary Convention of 1912 (the first chaired by the OIHP) and 1926. The Office also implemented the International Sanitary Convention for the air navigation of 1933 and the Convention for the diphtheria vaccine of 1930. The Office also designed some conventions against the drug and about the transport of corpses. It produced documentation about the plague, the cholera, the yellow fever, the typhus and smallpox. The work of the International Office of Public Hygiene was interesting because it went beyond the most common

diseases, evolving the concept of public health to a more global sphere that included any kind of disease that could undermine public health. For instance, research on tuberculosis, venereal disease, cancer, leprosy, goitre, fiver, drugs and care of poliomyelitis was undertaken (Abt.,G , 1933, pp. 4-5, 8, 136, 139-140). During the First World War the work of the International Office of Public Hygiene was continued in compatibility with world situations (The International Health Organization of The League of Nations, 1924, p.673). The Office emerged in the context of the League of Nations in 1919 where the leaders wanted to create an international committee composed of the OIHP, PAHO, the International Red Cross, labour groups and philanthropies. The idea of the League of Nations was to expand the research of the Health Committee beyond infectious epidemics, following the example of the OIHP, in order to include research about alcohol and drugs, nutrition and working conditions. However, the League of Nations focused on infectious diseases since they were common killers and antibiotics and vaccines were absent. The International Health Organization of the League of Nations was composed of an advisory council, an executive committee, and a secretariat (*The International Health Organization of The League of Nations*, 1924, p.673).

After the Second World War the League of Nations was replaced by the United Nations in 1945 and soon after the World Health Organization was born. After the end of the Second World War and the Holocaust perpetrated by Hitler, a major sense of humanitarianism and public health principles took hold (Markel, 2014, p.126).

The World Health Organization was founded in 1948 and it is the United Nations specific agency dedicated to sanitary issues. There are 194 Member States and Italy became a member state in 1947. The main goal of the WHO is the "achievement, by all populations of the highest possible level of health" defined as a "state of total physical, mental and social well-being" (*Constitution of the World Health Organization*, New York, 1946). The Governing Bodies of the WHO are the Secretariat, the World Assembly and the Executive Council. The main objectives of the WHO are the promotion of development and sanitary security by enhancing health systems and fostering research. The Constitution of the WHO was adopted in 1946 by the International Health Conference in New York. The main principles in the preamble of the Constitution are the following:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures (*Constitution of the World Health Organization*, New York, 1946).

The European Union works together with the international organization also in the health sector. There are specific agreements of cooperation with the WHO, the Council of Europe and the Organization for Economic Cooperation and Development. The cooperation between the European Commission and the WHO is based on the exchange of letters between them. An important passage of the exchange of letters between the World Health Organisation and the Commission of the European Communities concerning the consolidation and intensification of cooperation underlines the similar objectives that unites the two bodies:

"[…] The Commission and the WHO have roles and duties, which extend worldwide. Whilst their nature, means and procedures are different, they nevertheless have common interests in a large number of areas related to health. Above all they are both committed to striving for a high level of human health protection and health improvement. From their effective cooperation in this changed and changing world a lot of good can be derived not only for the Member States of the European Union which are all members of the WHO but also for the other countries which are represented at the WHO, Member States of the European Communities and those of the

WHO have repeatedly stressed the need for such cooperation and the desire to avoid any unnecessary duplication in effort while pursuing common objectives.[…]" (*Exchange of letters between the World Health Organisation and the Commission of the European Communities concerning the consolidation and intensification of cooperation*, 2001/C 1/04).

In the exchange of letters, the general principles and objectives are also defined and reinforced highlighting their importance.

In 2020 the European Commission and the WHO renewed their commitment to cooperation following the SDGs, especially the ones regarding health and well-being. The cooperation is in three levels: with the WHO, with the WHO regional office for Europe and in various countries of the world. The European Commission and the WHO are elaborating common steps to face emergency situations, transmissible diseases, vaccines and antimicrobial resistance.

The development of the international sanitary system is an ongoing process; however, its foundation dates back to the 19th and 20th century and especially after the Second World War, the system was further developed. During the Early Modern Age, cooperation already existed as we have seen with the example of the port cities, however the process improved and in later centuries when new diseases appeared, the antiplague measures were reactivated, such as in the case of HIV/AIDS but also in the most recent case of COVID-19.

In the next and final chapter, the management of the COVID-19 pandemic will be analysed, starting from the origin of the disease, the measures implemented to cope with the epidemic and the role of the Italian government, with an analysis of primary sources such as the Prime Minister's speeches and the Ministerial Decrees and the role of European institutions and the WHO in the management of pandemic. At the end there will be a comparison with the measures implemented in the port cities during the Early Modern Age.

7. THE COVID-19 PANDEMIC

The COVID-19 pandemic was a new phenomenon for our contemporary society: COVID-19 was a new virus for which we had no vaccine or medicine, and governments introduced new measures to protect public health to face this danger. In this last chapter of my thesis, we will understand the start of the pandemic thanks to materials and reports carried out by the international organizations and the Italian government. I will also analyse the measures implemented by the Italian government during the pandemic crisis, retracing primary sources such as the Ministerial decree-laws stored in the Parliamentary documentation of the Chamber of Deputies and the public speeches of the Italian Prime Minister. Later I will outline the main methods used to contrast and control the virus such as quarantine, green passes and vaccination. Of course, I will present the principal critiques made to these measures even though Italy was considered as a model in the organisation (Grossi, Zanus, Felice, 2021, pp. 236-237 and Nicola, 2021). Finally, I will provide a comparison with the techniques and the laws used during the epidemics in the Early Modern Age through a comparative analysis of the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* realised by Giovan Antonio Boncio in 1770 and the contemporary Ministerial decrees and public speeches. The pandemic created a major social division between different currents of thoughts and an increase in circulation of fake news about COVID-19 and vaccines.

The emergence of SARS-CoV-2 (COVID-19) started in the city of Wuhan in China after some unexplained pneumonia cases appeared. During the first weeks, an association between the cases and the Wuhan Huanan Seafood Wholesale market was noted. The market sold seafood and wild animal products. In fact, people affected by this new form of pneumonia were sellers that operated in the market. The market was disinfected and it was initially suspected to be the origin of the epidemic. However, later development underlined that the virus was present already in December 2019 and not only in Wuhan Market (Huang, Wang, Li, Ren, Zhao, Hu et al. 2020).

The SARS-CoV-2 was isolated and studied. It was found that the virus was a positive-stranded RNA belonging to the Coronaviridae family and it was new to humans, even though it was similar to the coronavirus that caused the SARS epidemic in 2002-2004. For this reason, it was called SARS-CoV-2 (Zhu, Zhang, Wang, Li, Yang, et al., 2020).

In February 2020, the WHO-China mission on COVID-19 was established to plan the next steps in response to COVID-19 both in China and in all the world. The main

objectives were to understand the evolution of the COVID-19 outbreak in China; to find some measures to face the COVID-19; to create recommendations for COVID-19 containment and to create a collaborative programme of research on COVID-19 (*WHO-convened Global Study of Origins of SARS-CoV-2: China Part Joint WHO-China*, 2021).

The most common symptoms of COVID-19 are fever, cough, tiredness, loss of taste or smell. There are also some fewer common symptoms such as sore throat, headache, aches and pains, diarrhoea and a rash on skin. The severe symptoms that characterised COVID-19 are difficulty breathing or shortness of breath, loss of speech or mobility and chest pain (*Coronavirus disease (COVID-19) available on https://www.who.int/health-topics/coronavirus#tab=tab_3*).

With the outbreak of COVID-19 virus, the WHO started to give instructions to all the countries about the following steps. Of course, a period of collaboration among all countries started.

After the discovery of the new virus in Wuhan, in mid-January the WHO communicated that there was evidence of a possible human to human transmission of the disease, but that its extent should be verified. However, this communication led to the start of the alert phase. In the case of Italy, on January 22, 2020 a task force to face COVID-19 was created by the Italian Minister of Health, Roberto Speranza. The task force was managed by the Ministry of Health. The institutions included in the task force were the *Istituto Superiore di Sanità* (ISS, the National Institute of Health in Italy), the *Dipartimento della Protezione Civile* (DPC, the Italian Department of Civil Protection of the Presidency of the Council of Ministers), the *IRCSS Istituto Nazionale Malattie Infettive* (INMI, National Institute of Infectious Diseases) L. Spallanzani, the Network of the *Uffici di Sanità Marittima, Aerea e di Frontiera* (USMAF, the Maritime, Aviation and Border Health Offices), the NAS of the Armed Force Carabinieri (Unit responsible for food safety and health related issues), *the Agenzia nazionale per i servizi sanitari regionali* (AGENAS, the National Agency for Regional Healthcare Services), the *Agenzia Italiana del Farmaco* (AIFA, the Italian Medicines Agency) and Armed Forces and the Regions/Autonomous Provinces (APs).

The main goals of the task force were to alert the health structures; to provide airport controls; to repatriate compatriots from infected areas; to create guidelines for prevention and restrictions of people's mobility; to implement response actions following the international guidelines from WHO and ECDC and to manage positive

cases in Italy in collaboration with health services, Local Health Units, hospitals and IRCCSs.

On January 30, 2020 direct flights from China to Italy were suspended and the WHO declared COVID-19 as a Public Health Emergency of International Concern. On the 31st of January, Italy declared a state of national health emergency for six months, which was then extended through a resolution of the Council of Ministers (*Prevention and response to COVID-19: evolution of strategy and planning in the transition phase for the autumn-winter season*, 2020). In this resolution the Italian Prime Minister Giuseppe Conte, given the emergency declaration of WHO about public health due to COVID-19, the recommendations of the WHO about the necessity of adequate countermeasures, the actual emergency situation and considered the need of extraordinary and urgent initiatives to protect public health, he declared the beginning of a state of national health emergency for six months (GU Serie Generale n.26 del 01-02-2020).

Since this crisis was an emergency of international concern, some international actors came into play. The WHO for example, published on 3 February 2020 the Strategic Preparedness and Response Plan, to support countries with public health measures. On February 4, 2020 the UN Crisis Management Team was established with the role of coordinator in the UN. The COVID-19 crisis was the highest level of crisis in the UN system, and it was the first time that this mechanism was activated to protect public health. On February 12, 2020, the Operational Planning Guidelines were published and the COVID-19 Partners Platform was activated to help national authorities to plan resource needs.

On March 25, 2020, the OCHA published the COVID-19 Global Humanitarian Response Plan to mobilize the whole humanitarian system. Also, the World Bank Group, International Monetary Fund and other multilateral banks and financial institutions came into play to support countries in the economic response to COVD-19.

Organizations that represented aviation, maritime, trade, and tourism sectors have worked with WHO to control if the measures used by governments related to travel and trade were following the provisions of the International Health Regulations (2005).

The WHO established a focus on public health. Since COVID-19 transmission was advancing globally only two months after its discovery, the primary focus was a rapid identification, testing and treatment of patients with serious COVID-19 symptoms. Countries had to do whatever they could to stop cases in order to avoid the creation of clusters and outbreaks. The WHO suggested implementing methods for testing and

diagnosis, isolation, tracing and quarantine. The World Health Organization also underlined how COVID-19 is a threat to public health and human life. The only way to face this virus is through cooperation. The main guiding principles to protect public health were: speed, scale, and equity. The last principle is very important because everyone is at risk and for this reason COVID-19 was a real global crisis and solidarity and cooperation is the main way to overcome the crisis.

The global objectives issued by the WHO were to mobilize all sectors and communities to make sure that every sector participates in the response, to control cases and clusters and prevent transmission through isolation and quarantine, to suppress transmission through prevention and control measures, physical distancing measures, and proportionate restrictions on non-essential domestic and international travel, to provide clinical care for those affected by COVID-19 and to develop vaccines and therapeutics.

The WHO affirmed that everyone had a crucial role against COVID-19: individuals had to protect themselves and others by "washing hands, avoiding touching their face, individual level distancing, isolating if they are sick, identifying themselves as a contact of a confirmed case when appropriate, and cooperating with physical distancing measures and movement restrictions when called on to do so" (*COVID-19 strategy update*, 2020, p.6). Communities had to guarantee that services and aid were adapted at each local context. Governments had to coordinate the response implementing distancing measures and movement restrictions proportionate to the health risks and give support to the health system. Finally, private companies had to grant the continuity of essential services. In addition to this, they could also provide innovation to sustain the response to COVID-19 through the production of laboratory diagnostics, personal protective equipment, ventilators, and medical oxygen (*COVID-19 strategy update*, 2020).

After the Italian declaration of national health emergency, on February 3, 2020, the Technical Scientific Committee (Comitato Tecnico-Scientifico, CTS) was established with the role of advisor and supporter. In February 2020, some studies were carried out through a collaboration involving the Directorate General of Health Planning of the Ministry of Health, the ISS, the General Directorate of the Regional Emergency of Lombardy and INMI L. Spallanzani, representing the State-Regions Conference, with the involvement of the Bruno Kessler Foundation.

During this phase, activities were carried out to strengthen the ability to identify cases of COVID-19 in Italy. A network of 31 laboratories with capabilities to perform

laboratory analyses for cases of COVID-19 infection according to the WHO protocols, was established (*Prevention and response to COVID-19: evolution of strategy and planning in the transition phase for the autumn-winter season*, 2020).

The first case of COVID-19 in Italy was identified on February 20 in Codogno, the patient zero. In Northern Italy there were different outbreaks, especially at Vo' Euganeo and Bergamo. In 3 days, there were 325 positive cases confirmed (Banfi, 2020). On the February 20, 2020, Italy entered an epidemic response phase. Since the 27th of February, with Ordinance n. 640 of the Presidency of the Council of Ministers Department of Civil Protection, epidemiological and microbiological surveillance of the COVID-19 were defined with the establishment of a national system of surveillance of all confirmed cases of COVID-19 in Italy with a parallel surveillance system of collected by the Ministry of Health and published by the Civil Protection, that had to monitor the progress of the epidemic (*Prevention and response to COVID-19: evolution of strategy and planning in the transition phase for the autumn-winter season*, 2020).

After the discovery of the first patient, the Italian Prime Minister issued the first Prime Ministerial Decree (DPCM) of February 23. In the DPCM, the first measures to contain the COVID-19 epidemics are listed:

- Suspension of manifestations, initiatives, events, reunions and any form of meeting in public or private places, even if carried out in closed places open to the public;
- suspension of education services and schools as well as the frequency of the scholastic activities and higher education, including university, except for remote training activities;
- suspension of museum opening services to the public and places of culture;
- suspension of educational trips organized by educational institutions of the national education system, both on national territory and abroad;
- suspension of the competition procedures for the hiring of personnel;
- application of the measure of quarantine with active surveillance to individuals who have had close contact with positive cases;
- obligation for the individuals who have entered into Italy from areas at epidemiological risk, to communicate this circumstance to the Prevention Department of the competent health authority for the area;
- closure of all commercial activities, excluding shops for the purchase of basic

necessities;

- closure or limitation of the activity of public offices, public utilities and public essential services;
- access to essential public services and commercial establishments for the purchase of basic necessities is conditioned on the use of personal protective equipment or the adoption of particular precautionary measures identified by the competent authority;
- limitation of access or suspension of transport services of goods and people by land, air, rail, sea and in internal waters, on the national network, as well as on public transport local, even non-scheduled;
- suspension of work activities for companies, excluded those that provide essential and public services utility and those that can be carried out at home;
- suspension or limitation of working activities in the municipality or in the area concerned as well as the work activities of the inhabitants of said municipalities carried out outside of the municipality or from the indicated area (GU Serie Generale n.45 del 23-02-2020).

In this first Ministerial Decree, it is possible to read the first measures to prevent the diffusion of COVID-19, especially limiting mobility and gatherings.

With these dispositions, the Italian peninsula was divided into three different zones: yellow, orange and red depending on the number of positive cases and situation gravity.

On February 25 some more measures were implemented in the DPCM:

- in all the municipalities of the Emilia Romagna and Friuli Venezia Giulia, Lombardy, Veneto, Liguria and Piemonte regions, events and sporting competitions are suspended;
- educational trips, exchange or twinning initiatives, guided tours and educational outings are suspended until March 15, 2020;
- readmission to schools of all types and levels for absences due to illness lasting more than five days takes place, until March 15, 2020, upon presentation of medical certificate, even in derogation of current provisions;
- the school principals of the schools in which the activity teaching has been suspended due to the health emergency, they can activate, in agreement with the competent collegial bodies and for the duration of the suspension, distance

learning methods had also with regard to the specific needs of students with disability;

- on Sunday March 1st, 2020, throughout the territory national, there will be no free access to institutes and to places of culture;
- in relation to the activities carried out by the peripheral offices of the Ministry of Infrastructure and Transport, located in the provinces of Bergamo, Brescia, Cremona, Lodi, Milan, Padua, Parma, Pavia, Piacenza, Rovigo, Treviso, Venice, Verona and Vicenza are take the following measures: 1) suspension of the eligibility exams to be carried out at the peripheral offices of the Civil Motorization located in said provinces; 2) regulation of user access methods offices of the Civil Motorization established in these provinces, by predetermination by the manager in charge to the office of the maximum number of daily accesses;
- with a specific managerial provision is disposed in favour of candidates who were unable to take the exams the extension of terms;
- in artistic, music and dance universities and higher education institutions in which it is not permitted, for the needs related to the health emergency referred to in this decree, the participation of students in educational activities o curricula, the same activities can be carried out, where possible, with remote modalities;
- for the benefit of students to whom it is not permitted, for the needs related to the health emergency referred to in this decree, participation in educational or curricular activities Universities and Institutions of higher artistic and musical education and dance, these can be carried out, where possible, with distance modality;
- in the judicial offices included in the Corte d'Appello districts for services open to the public and in relation to activities not strictly connected to urgent acts and activities, the Head of the judicial office, having heard the administrative manager, may establish the reduction of opening hours to the public;
- taking into account the indications provided by the Ministry of Health, in agreement with the coordinator of interventions for the overcoming the coronavirus emergency, the territorial articulations of the National Health Service assure to the Ministry of Justice suitable support for the containment of the diffusion of contagion of COVID-19, also through adequate safeguards suitable to

guarantee, according to the health protocols drawn up by the Management of health prevention, new admissions to prisons and penal institutions for minors, with particular regard to subjects coming from the municipalities of Emilia Romagna and Friuli Venezia Giulia, Lombardy, Veneto, Liguria and Piemonte regions (GU Serie Generale n.47 del 25-02-2020).

On March 1st, the epidemic was advancing, hospitals in Lombardy were close to collapse and deaths were increasing exponentially. Emilia Romagna, Lombardy and Veneto and the provinces of Pesaro and Urbino and Savona became red zones. In the night between 7th and 8th March in Lombardy everything closed down and the same in 14 provinces of the Centre-North. The fear of being stuck led to an "*exodus"* from North to South with a rush to the train station (*Covid, un anno fa il primo lockdown: tutte le tappe*, 2021). March 11 was the first day of lockdown for Italy, following the DPCM that affirmed that in order to counter and contain the spread of the virus COVID-19, the following measures are adopted throughout the national territory:

- Retail commercial activities are suspended, except for the sale of food and raw materials, both in the context of neighbourhood businesses, both in the media and large-scale distribution, also included in shopping centres, provided that access to only the aforementioned activities is permitted. The newsstands, tobacconists, pharmacies and para-pharmacies remain open. In any case, the
  interpersonal safety of one meter. distance must be guaranteed;
- The activities of catering services are suspended (including bars, pubs, restaurants, ice cream parlours, pastry shops), with the exception of canteens and continuous catering on a contractual basis, which guarantee the interpersonal safety distance of one meter. Only catering with home delivery in compliance with the hygienic-sanitary standards both for the activity of packaging and transport. Food and drink administration establishments located in the areas service and refuelling stations located along the road network, motorway and inside railway stations, airports, lakes and in hospitals stay open.
- Activities relating to personal services are suspended (including hairdressers, barbers, beauticians);
- Banking, financial and insurance services, agricultural activities and activities related to the zootechnical and agro-food sectors stay open;
- The President of the Region with an order pursuant to art. 3, paragraph 2, of the decree-law of February 23, 2020 n. 6, can arrange the planning of the service

provided by the Transport Companies local public, including non-scheduled, aimed at reducing or suppressing services in relation to health interventions necessary to contain the coronavirus emergency on the basis of actual needs and for the sole purpose of ensuring the minimum services essential. The Minister of Infrastructure and Transport, of agreement with the Minister of Health, may arrange, in order to contain the coronavirus health emergency, programming with reduction and abolition of interregional car services, rail, air and sea transport, on the basis of actual needs and for the sole purpose of ensuring the minimum services essential;

- The public administrations ensure the ordinary performance of work services in the form of smart working;
- With regard to production activities and activities professionals it is recommended: a) the maximum use by companies of smart working for the activities that can be carried out at home or remotely; b) holidays and paid leave are encouraged for employees as well as the other instruments envisaged by the collective contract; c) the activities of non-essential departments are suspended; d) to adopt anti-contagion safety protocols and, where it is not possible to respect the interpersonal distance of one meter as the main containment measure, it is encouraged the adoption of tools of individual protection; e) site sanitization operations are encouraged;
- for productive activities only, it is also recommended that movements within the sites are limited as much as possible and limited access to common areas;
- For all non-suspended activities, the maximum use of smart working is encouraged (GU Serie Generale n.64 del 11-03-2020).

The Italian Prime Minister Giuseppe Conte announced the new measures and the lockdown on March 9 during the press conference with this speech: “Our habits must be changed now. We must all give up something for the good of Italy and when I speak of Italy I speak of our loved ones, our parents, our grandparents. We must do it immediately and we will succeed only if we all collaborate and adapt immediately to these more stringent rules. That's why I decided, in agreement with the other members of the government, to adopt even stronger, even more stringent measures to be able to contain the advance of the Coronavirus as much as possible and thus protect the health of all citizens whom I would like to mention is our primary objective while reconciling trying to reconcile as far as possible also other interests that deserve to be protected but

if the health of citizens, public health is an asset that is jeopardized. We are forced to choose to impose sacrifices with regard to other interests, while worthy of protection. This is why I am about to sign a provision that we can summarize with the expression: I stay at home. There will no longer be a red zone. There will no longer be zone 1 and zone 2 of the peninsula, there will be Italy, an Italy protected zone. Movements throughout the peninsula will therefore be avoided unless they are motivated by three specific circumstances: proven work reasons, from cases of necessity or even for health reasons[17]" (*Un anno fa Giuseppe Conte annunciava il lockdown: "Non c'è più tempo"*, 2021). It is possible to understand that through this speech, the Prime Minister Conte decided to focus on emotion and feelings emphasizing how all these measures are taken to protect our families and our health. He also defined Italy as the whole of our families, grandparents and beloved people. Giuseppe Conte referred to parents and grandparents because in the COVID-19 context they were considered at risk and as a fragile category, therefore it was a call to the younger ones to pay attention and use the mask. The use of family, grandparents and parents is not neutral but it is almost a "populist" choice because he tried to convince people precisely thinking of real people that they could endanger. One of the keywords in these few lines is the word "Italy" to accentuate the sense of community. By leveraging common values and emotion, the Prime Minister wanted to make less difficult the imposition of "sacrifices".

As seen in the DPCM of March 9 and in the following speech of the Prime Minister Conte, the measures implemented were even stronger and immobilized the entire peninsula. On March 11, 2020, the WHO declared COVID-19 a pandemic. All countries began to activate measures to contain, delay and mitigate COVID-19. An institutional collaboration was also established between the WHO and the Italian Government through the presence of a WHO expert in the CTS (Prevention and response to COVID-

[17] Italian original version: "Le nostre abitudini quindi vanno cambiate. Vanno cambiate ora. Dobbiamo rinunciare tutti a qualcosa per il bene dell'Italia e quando parlo dell'Italia parlo dei nostri cari, dei nostri genitori, dei nostri nonni. Lo dobbiamo fare subito e ci riusciremo solo se tutti collaboreremo e ci adatteremo subito a queste norme più stringenti. È per questo che ho deciso d'accordo con gli altri componenti del governo, di adottare misure ancora più forti ancora più stringenti per riuscire a contenere il più possibile l'avanzata del Coronavirus e tutelare così la salute di tutti i cittadini che vorrei ricordare è il nostro obiettivo primario, pur contemperando, cercando di contemperare fin quanto possibile anche altri interessi che meritano di essere tutelati ma se la salute dei cittadini, la salute pubblica un bene che è messo a repentaglio, noi siamo costretti a scegliere a imporre dei sacrifici per quanto riguarda gli altri interessi pur meritevoli di tutela. È per questo che sto per firmare un provvedimento che possiamo sintetizzare con l'espressione "io resto a casa". Non ci sarà più una zona rossa, non ci sarà più la zona 1 e la zona 2 della penisola, ci sarà l'Italia, un'Italia zona protetta. Saranno quindi da evitare su tutto il territorio della penisola gli spostamenti a meno che non siano motivati da tre specifiche circostanze: comprovate ragioni di lavoro, da casi di necessità o anche per motivi di salute" (Un anno fa Giuseppe Conte annunciava il lockdown: "Non c'è più tempo", 2021)

19: evolution of strategy and planning in the transition phase for the autumn-winter season, 2020). This one will be the so-called "first wave" from the end of February 2020 to October 2020. The first wave was characterised by three main phases: phase 1 of lockdown from March 9 to May 3, phase 2 of relaxation of the containment measures from May 4 to June 14 and the 3rd phase of cohabitation with the COVID-19 from June 15 to October 7 (*Misure sanitarie per fronteggiare l'emergenza coronavirus*, Camera dei deputati, 2022).

In the first phase, March 18 will be unforgettable for the province of Bergamo in Northern Italy, which saw military trucks with corpses of people who have died from COVID-19. Victims were hundreds per day (Birolini M., 2020).

FIGURE 3: *I camion allineati a Bergamo,* Birolini, M. Source: Coronavirus. Le bare sui camion militari, Bergamo sotto choc, Avvenire.it.

The lockdown was extended to May 3. From the April 10, positive cases and deaths started to decrease. We spent Easter at home in lockdown with enhanced law enforcement controls. From April 14, bookstores, stationery and children's clothing stores were opened again. In the DPCM of April 26, the Prime Minister defined the opening of some activities for the 2nd phase of COVID emergency (*Covid, un anno fa il primo lockdown: tutte le tappe*, 2021).

The 2nd phase was characterised for the first two weeks by the possibility to visit relatives (*congiunti*) inside the region of residence, always using mask and gloves and maintaining the interpersonal distance of one meter. The DPCM granted the opening of public parks, the service of take away for restaurants and bar, the opening of various productive activities, the reopening of bathing establishments and the performance of work out activities regardless of the distance from one's home (Ciriaco, T., Rubino, M., Ziniti, A.,2020). From May 18 people could go out freely. Only travel between regions

is limited. All shops, bars, restaurants and even churches reopened (*Covid, un anno fa il primo lockdown: tutte le tappe*, 2021).

On June 11, a new DPCM was signed by the Prime Minister Conte, with further easing of containment measures. The access of minors to indoor and outdoor places intended for recreational activities with the presence of operators was allowed; the activities of game rooms, betting rooms and bingo halls, shows opened to the public in theatres, cinemas and concert halls, with a maximum of two hundred spectators indoors and a thousand outdoors, with pre-assigned seats and spaced out by at least one metre. Bathing establishments, wellness and spa centres, cultural and social centres were reopened. Air transport was allowed with a self-declaration certifying that you have not had close contact with people affected by COVID-19. The new DPCM also allowed universities to reopen libraries and to carry out exams, internships, seminars, research and laboratories, always keeping the possibility of attending these activities also remotely (GU Serie Generale n.147 del 11-06-2020).

However, the DPCM left the Regions free to manage these last measures taking into consideration the epidemiological situation of their territories. For instance, the opening of discos and dance halls was allowed only in some regions: from June 12 in Campania; from June 13 in Tuscany but outdoors only; from June 15 in Puglia and Sicily; from June 19 in Veneto, Emilia-Romagna but outdoors only, Liguria, Friuli-Venezia Giulia and Calabria; from July 1st in Lazio. Fairs, congresses and ceremonies were prohibited, except for the regulations of the individual regions, until July 14; they could take place in Tuscany from June 13; in Lazio, Puglia, Umbria, Friuli-Venezia Giulia and Sicily from June 15; in Liguria from June 16; in Veneto, Emilia-Romagna and Calabria from June 19 (*Coronavirus fase 3, dalle discoteche ai matrimoni: le ordinanze delle regioni. In Lombardia mascherine fino al 30 giugno*, 2020).

During this phase also hotel and farmhouses reopened and started their activities again. However, as for the case of the farmhouse where I work, Corte Carezzabella, some rules had to always be respected such as the interpersonal distance of one metre, the use of the mask, sanitizing gel and the correct way to wash hands. As you can see in figure 4, *Agriturist,* which is the National Association for Farmhouse, Environnement and Territory, sent us these rules to show to guests.

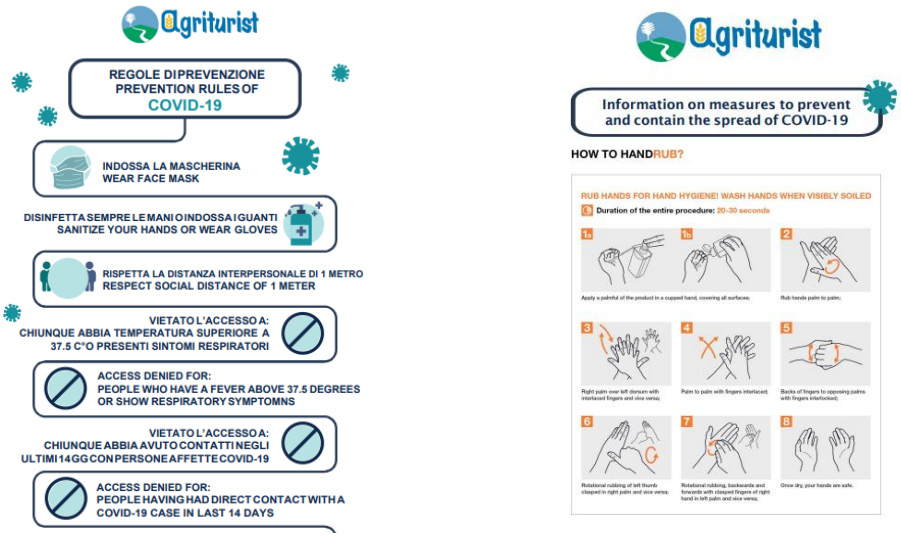


FIGURE 4: *Materiali informativi utili per la riapertura delle strutture agrituristiche sia con alloggio che con ristorazione.,* Agriturist (Associazione Nazionale per l'Agriturismo, l'Ambiente e il Territorio) sent by e-mail on the 20th of May 2020

From October 2020 the situation started to get worse and strict measures were adopted again through other DPCM. The Prime Minister Conte confirmed, through the DPCM of October 8, the previous containment measures and he also extended the state of emergency until January 31, 2021. The use of masks was mandatory both in outdoor and indoor places, with the exception of private homes and for circumstances in which continuous isolation is guaranteed. The Regions can only adopt more restrictive measures than the national ones and not ease them (GU Serie Generale n.248 del 07-10-2020).

A new DPCM was published on October 13 and it recommended the application of the safety measures even in private homes in the presence of non-cohabiting people, and it also strongly recommended avoiding parties and not hosting more than 6 non-cohabiting people in one's home. This decree introduced more restrictive measures: it reiterated the ban on outdoor and indoor parties; allowed public demonstrations to took place only in static form; fixed the number of spectators at 1 000 outdoors and 200 indoors for nationally and internationally recognized sporting events and competitions, and for theatre performances, concerts and film screenings; prohibited contact sports; set the maximum number of participants at 30 for parties following civil or religious ceremonies; suspended educational trips, exchanges and twinning, guided tours and school trips; it limited the access of relatives and visitors to hospitality structures such as nursing homes; allowed attendance of the catering services only until 9 pm without

consumption at the table, and until midnight with consumption at the table; it encouraged smart working, holidays and paid leave (GU Serie Generale n.253 del 13-10-2020).

On October 18, 2020, Prime Minister Conte signed a Prime Minister's Decree which allowed mayors to order the closure of streets after 9.00 pm and squares in urban centres, where situations of gathering may arise; conference or congress activities, community festivals and fairs were prohibited; high schools were allowed to organize distance learning activities, complementary to those in presence, and universities were allowed to organize their activities based on the epidemiological situation of the territory (GU Serie Generale n.258 del 18-10-2020).

Starting from October 22, 2020, the Lombardy Region imposed a curfew from 11.00 pm to 5.00 am the following morning, by which it was forbidden to move except for situations of necessity, work or health reasons; the same measures are also adopted, starting from October 23, by the Campania Region and by the Lazio Region, starting from October 25 from the Sicily Region, starting from October 26 for the Piemonte Region.

In the DPCM of October 24, the Prime Minister Conte added to the measures already adopted the closure of gyms, swimming pools, swimming centres, wellness and spa centres; the closing at 6.00 pm of the catering activities; the closure of theatres, concert halls and cinemas, including outdoors; the closure of arcades, betting rooms, bingo halls and casinos; the prohibition of celebrations, also consequent to civil and religious ceremonies; the increase in integrated digital teaching for high schools and entry to high schools not before 9.00 in the morning. The decree then strongly recommended not to travel, except for work or study needs, for health reasons or for situations of necessity (GU Serie Generale n.265 del 25-10-2020).

A new DPCM was signed on November 3. The ministerial decree, in force from November 6 to December 3, 2020, established a curfew throughout the national territory from 10.00 pm to 5.00 am the following morning, with travelling allowed in this time slot only for work needs, for proven health reasons and for necessity. The closure to the public of exhibitions, museums and other places of culture was also ordered, as well as the use of distance learning for secondary schools, the suspension of public and private competitions, the closure of shopping centres and medium and large sales structures on holidays and days before holidays, the reduction to 50% of the capacity of public transport (excluding school transport), in addition to the suspension of all other

activities already provided for in the previous decrees (GU Serie Generale n.275 del 04-11-2020 - Suppl. Ordinario n. 41).

Four types of territorial areas were identified which integrated the previous classification:

- white area, i.e. the regions in whose territories the weekly incidence of COVID-19 infections was less than 50 cases per 100,000 inhabitants for three consecutive weeks and with a low level of risk. For these regions, the application of the restrictive measures' ceases;
- orange zone, i.e. the regions in whose territories the weekly incidence of the COVID-19 infections was higher to 50 cases per 100,000 inhabitants and with a risk level of at least moderate;
- red zone, i.e. the regions in whose territories the weekly incidence of the aforementioned infections was higher than 50 cases per 100,000 inhabitants and with a risk level of at least moderate;
- yellow zone, i.e. the regions that did not fall under any of the above definitions and in which they find application of the restrictive measures, relating to the epidemiological emergency from COVID-19, valid on the whole National territory (*Misure sanitarie per fronteggiare l'emergenza coronavirus*, Camera dei deputati, 2022).

The DPCM established that in the Regions considered as orange zones, the curfew from 10.00 pm to 5.00 am was valid, any movement outside the Municipality of residence was prohibited, except for work needs or proven health reasons or necessity, and catering services were suspended (only take-away was allowed until 10.00 pm, and home delivery). All the other activities not mentioned remained active.

On the other hand, in the Regions considered red zones, the ban on unauthorized travel also within the Municipality of residence was valid, the suspension of catering services, the closure of retail trade activities and markets was established, distance learning starting from the seventh grade applied. Personal services remained active, such as hairdressers and laundries, with the exception of beauticians (GU Serie Generale n.275 del 04-11-2020 - Suppl. Ordinario n. 41).

On December 18, 2020, the decree-law n. 172 applied to all the National territory the containment measures envisaged for the red zone on public holidays and days before public holidays (December 24, 25, 26, 27, 31, January 1, 2, 3, 5, 6) and the measures of the orange zone on December 28, 29. 30 and January 4. During public holidays and

before public holidays, travel to private homes was permitted, but only once a day, within the limits of two people and between 5.00 am and 22.00 pm. The only exceptions, during the orange zone, were provided for municipalities with a population of less than 5,000 inhabitants, from which people could move within a radius of 30 km without reaching the provincial capitals (GU Serie Generale n.313 del 18-12-2020).

With the DPCM of March 2, 2021, the new Prime Minister Mario Draghi confirmed the previous containment measures and once again extended the ban on travel between regions. The DPCM also introduced, in the territories in the red zone, the closure of hairdressers and the ban on travel for visits to private homes and to reach second homes. From March 27, 2021, the reopening of cinemas and theatres in the white area and in the yellow area was ordered. It also provides for the closure of schools of all levels in the red areas and in the territories where more than 250 infections per 100,000 inhabitants were recorded for at least one week (GU Serie Generale n.79 del 01-04-2021).

From April 26, the situation started to get better and we faced an easing of containment measures. The government introduced vaccination and the Green Pass; however, these two measures will be explained in the next chapter together with the description of other measures. Summer of 2021 was characterised by a lot of reopening even if during autumn-winter of 2021 other restrictions were envisaged due to the worsening of the situation (Misure sanitarie per fronteggiare l'emergenza coronavirus, Camera dei deputati, 2022, pp.18-22).

On March 31st, 2022, the state of emergency ended in Italy and the decree-law of March 24, 2022, n. 24, regulated the gradual exit from the health emergency.

The decree provided that ordinances could be adopted until December 31, 2022 in line with the "progressive return to the ordinary". Also, from April 1st to December 31st, a "Unit for the completion of the vaccination campaign and for the adoption of other measures to combat the pandemic" was established, which assume the previous functions of the Extraordinary Commissioner for implementation and coordination of the health measures for the containment and contrast of the COVID-19 epidemiological emergency, a position that had been held by General Francesco Paolo Figliuolo.

The same decree provided that close contacts to positive people no longer isolated themselves in quarantine, even if not vaccinated, but placed themselves under self-surveillance for ten days, with the obligation to wear an FFP2 mask in the presence of other people; the quarantine obligation remains for positive people.

FFP2 masks remained mandatory until April 30, 2022 to access theatres, cinemas and means of transport (planes, ships and ferries, trains, buses, local and school public transport), and the obligation to wear a mask, even a surgical one, in all other indoor places open to the public remained until April 30.

The basic green pass obligation remained until April 30 for access to bars, restaurants, outdoor sporting events, planes, trains and ships; the enhanced green pass, on the other hand, remained mandatory, until April 30, for parties in bars and restaurants, for cinemas, theatres and concerts, gyms and swimming pools, dance halls, indoor sporting events, and, until December 31, to access as visitors in hospitals and nursing homes. On the other hand, the green certification obligation for shops and public offices, museums, archaeological parks, exhibitions, libraries, hotels and accommodation facilities, local public transport, no longer applied. Also from April 1st, the capacity limits for the structures lapsed.

On the July 22, 2021, the Italian Prime Minister Draghi gave an interesting speech during a press conference in which he underlined the importance of vaccination and the purpose of Green Pass: "[…] so the first thing I have to say is that I invite all Italians to get vaccinated and do it immediately. They have to protect themselves and their families. A brief consideration on green certification. The green pass is not an arbitrary act, it is a condition for keeping economic activities open [...][18]" (*Mario Draghi: "Invito tutti gli italiani a vaccinarsi, il Green pass è una condizione per tenere aperte le attività economiche"*, 22/07/2021). In his speech, the Prime Minister Mario Draghi underlined the importance of vaccination using also emotional reasons such as the protection of our families like Giuseppe Conte did before. He also highlighted how the use of Green Pass is important for the economy of our country. Indeed, he underlined how the use of the Green Pass could help the economy of the country to rise again allowing the access to restaurants, bars, beaches, accommodation facilities, museums, theatres and cinemas. Prime Minister Draghi used simple and clear words in order to be understood by all the population.

Until December 31st, 2022, the vaccination obligation remained for healthcare workers and employees in residential, social-welfare and social-health facilities, as well as for school and university staff, and for the security and defence forces. Furthermore, until

[18] Original italian version: "[…] quindi la prima cosa che devo dire è che invito tutti gli italiani a vaccinarsi e a farlo subito. Devono proteggere sé stessi e le proprie famiglie. Una breve considerazione sulla certificazione verde. Il green pass non è un arbitrio è una condizione per tenere aperte le attività economiche […]"

April 30, 2022, the basic green pass remained mandatory for workers; the obligation of a strengthened green pass for workers over 50 expired. Vaccination remained mandatory for people aged 50 or over until 15 June. The possibility of using smart working in the private sector was extended to June 30, 2022.

For schools, face-to-face teaching was guaranteed, with the obligation to wear a mask, including a surgical one; in the event of four or more cases of positivity within the class, the obligation to wear an FFP2 mask for ten days and to carry out a rapid or molecular test in case of symptoms took over.

Finally, with the cessation of the state of emergency, starting from April 1st, the classification of the Italian regions in different risk scenarios, commonly known as "white", "yellow", "orange" and "red" zones was no longer applied.

Starting from May 1st, 2022, the obligation to wear FFP2 masks expired. It is extended until June 15 only for local public transport, for indoor performances in theatres, cinemas and concert halls, and for indoor sporting events, as well as for health, social-health and socio-medical facilities. assistance. The use of the mask, even surgical, remained mandatory in schools until the end of the school year. For workers in the private sector, the use of the mask was regulated by individual protocols between trade unions and companies, while in the public sector the simple recommendation remained, and not the obligation, to protect yourself in the event of spaces shared with other workers or in contact with the public. Starting from June 16 and until September 30, the obligation to wear a mask remained in force only for means of transport and for health, social-health and social-welfare facilities.

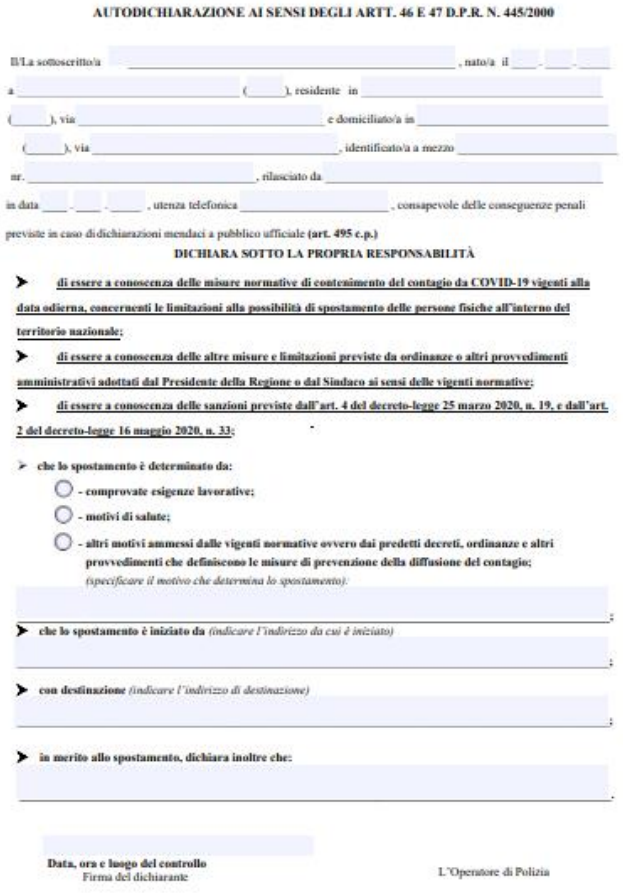
After September 30, the obligation to wear a mask in means of transport was no longer in force and remained only for health, social-health and social-welfare facilities; with the exception of this rule, and the obligation to vaccinate doctors, teachers and the police (until December 31), all other restrictive measures against contagion have now lapsed.

The only anti-contagion measures still in force in the first months of 2023 are the five-day isolation for infected subjects, at the end of which they will be allowed to leave isolation even without the obligation of a negative molecular or antigenic swab as long as they are symptom-free for two days and subject to the use of FFP2 masks and the obligation to wear masks in all health facilities until April 30, 2023 (GU Serie Generale n.70 del 24-03-2022). On May 5, 2023 the WHO declared the end of the emergency due to COVID-19 pandemic.

This is an overview of the evolution of COVID-19 pandemic in Italy. The managing of this situation was characterised by the use of the Ministerial Decree giving instructions and rules to the population. This situation of course was controlled also by the international institutions that have helped Italy and gave some general line of actions that should be implemented by the single states. In the next sections we will analyse the main methods and tools used to control the pandemic and to incentive vaccination: the self-declaration, quarantine, vaccination, Green Pass and Immuni App.

7.1 MAIN METHODS USED TO MANAGE THE PANDEMIC

In this chapter I will outline the main methods used to manage and control the pandemic. The first one to be shown is the self-declaration used during the first phase of COVID-19.



AUTODICHIARAZIONE AI SENSI DEGLI ARTT. 46 E 47 D.P.R. N. 445/2000

Il/La sottoscritto/a _____, nato/a il ___/___/____

a _____ (_____), residente in _____

(_____), via _____ e domiciliato/a in _____

(_____), via _____, identificato/a a mezzo _____

nr. _____, rilasciato da _____

in data ___/___/____, utenza telefonica _____, consapevole delle conseguenze penali previste in caso di dichiarazioni mendaci a pubblico ufficiale **(art. 495 c.p.)**

DICHIARA SOTTO LA PROPRIA RESPONSABILITÀ

- **di essere a conoscenza delle misure normative di contenimento del contagio da COVID-19 vigenti alla data odierna, concernenti le limitazioni alla possibilità di spostamento delle persone fisiche all'interno del territorio nazionale;**
- **di essere a conoscenza delle altre misure e limitazioni previste da ordinanze o altri provvedimenti amministrativi adottati dal Presidente della Regione o dal Sindaco ai sensi delle vigenti normative;**
- **di essere a conoscenza delle sanzioni previste dall'art. 4 del decreto-legge 25 marzo 2020, n. 19, e dall'art. 2 del decreto-legge 16 maggio 2020, n. 33;**
- **che lo spostamento è determinato da:**
  - ○ **- comprovate esigenze lavorative;**
  - ○ **- motivi di salute;**
  - ○ **- altri motivi ammessi dalle vigenti normative ovvero dai predetti decreti, ordinanze e altri provvedimenti che definiscono le misure di prevenzione della diffusione del contagio;**

  (specificare il motivo che determina lo spostamento);

_____;

- **che lo spostamento è iniziato da** *(indicare l'indirizzo da cui è iniziato)*

_____;

- **con destinazione** *(indicare l'indirizzo di destinazione)*

_____;

- **in merito allo spostamento, dichiara inoltre che:**

_____.

Data, ora e luogo del controllo

Firma del dichiarante

L'Operatore di Polizia

FIGURE 5: *Modello dichiarazione editabile ottobre 2020,* Ministero dell'Interno, available on https://www.interno.gov.it/sites/default/files/2020-10/modello_autodichiarazione_editabile_ottobre_2020.pdf

In Figure 5 we can see how the declaration was designed. First of all, it was available in the official site of the Minister of the Interior but it became viral in other websites such as those of newspapers as well in social networks. As we can see in the self-declaration, we had to declare our general specification and the to declare under our responsibility to be aware of the regulatory measures to contain the contagion from COVID-19 in force at that date, concerning the limitations on the possibility of moving natural persons within the national territory; to be aware of the other measures and limitations provided for by ordinances or other provisions administrative measures adopted by the President of the Region or by the Mayor in accordance with current regulations and finally to be aware of the penalties provided for by art. 4 of the decree-law of March 25, 2020, n. 19, and by art.2 of the decree-law of May 16, 2020, n. 33.

Subsequently, we had to specify the reason for the displacement, which could happen under three circumstances: proven work needs; health reasons or other reasons allowed by current regulations or by the aforementioned decrees, ordinances and other provisions that define the measures to prevent the spread of the infection. We had to specify where the movement started and what was the destination.

This method was used to better control the displacements during the pandemic period and the lockdown in order to contain the contagion. Of course, people had to follow hygiene measures such as the use of masks, gloves, disinfection gel and one-meter interpersonal distance.

7.1.2 QUARANTINE

Another instrument used as soon as the pandemic began was the quarantine, which was a technique used also during the Early Modern Age to contain and to control the propagation of the Black Plague.

Immediately after the first case, the measure of quarantine with active surveillance was punctually defined by the Ordinance of the Ministry of Health of February 21, 2020, as a measure applied in the event of: close contacts with confirmed cases of diffusive infectious disease COVID-19; returning to Italy from areas of China affected by the epidemic, dating back to the previous fourteen days. Active surveillance provided for daily information contacts between the public health operator and the person under surveillance, aimed at monitoring the health of the latter, who, for his part, had to: maintain the state of isolation for fourteen days since the last exposure; have no social

contacts; submit to the ban on travel and travel; remain reachable for surveillance activities.

Subsequently, this measure was also extended to anyone coming from the red areas located within the national territory and to those who entered Italy.

New scientific evidence and indications from WHO and ECDC, circular 32850 of October 12, 2020 updated the indications regarding the duration and term of isolation and quarantine, clarifying that:

- the isolation of cases of documented SARS-CoV-2 infection refers to the separation of infected persons from the rest of the community for the duration of the contagious period, in an environment and conditions such as to prevent the transmission of the infection;

- quarantine refers to the restriction of the movements of people who are healthy for the duration of the incubation period, but who may have been exposed to an infectious agent or contagious disease, with the aim of monitoring for any symptoms and timely identifying new cases.

Next, circular no. 36254 of August 11, 2021 "Update on quarantine measures and isolation recommended in light of the circulation of the new SARS-CoV-2 variants in Italy and in detail of the diffusion of the Delta variant (lineage B.1.617.2)" which distinguishes the subjects that have completed the vaccination cycle for at least 14 days with the other subjects, setting a deadline for the return to the community with 7 days instead of 10 with a negative molecular or antigenic test (*Misure sanitarie per fronteggiare l'emergenza coronavirus,* 2022, pp. 44-45).

With the progress of the pandemic, the rules about quarantine have changed through time. For instance, nowadays the rules for quarantine are different and they have been updated with Circular dated December 31st, 2022. People who have tested positive for a molecular or antigen diagnostic test for SARS-CoV-2 are subjected to isolation measurements, in the following ways:

- for cases that have always been asymptomatic and for those who have not shown symptoms for at least 2 days, isolation may end 5 days after the first positive test or the appearance of symptoms, regardless of whether the antigen or molecular test is performed; for cases that have always been asymptomatic, isolation may end even before 5 days if an antigen or molecular test carried out at a health facility/pharmacy is negative;

- for cases in immunosuppressed subjects, isolation may end after a minimum period of 5 days, but always necessarily following an antigen or molecular test with a negative result;
- for healthcare workers, if asymptomatic for at least 2 days, isolation may end as soon as an antigen or molecular test is negative.
- Citizens who entered Italy from the People's Republic of China in the 7 days preceding the first positive test, will be able to end isolation after a minimum period of 5 days from the first positive test, if asymptomatic for at least 2 days and negative for an antigen or molecular test.

At the end of isolation, the use of FFP2 type respiratory protective devices is mandatory up to the tenth day from the onset of symptoms or from the first positive test (in the case of asymptomatic), and it is in any case recommended to avoid high-risk people and/or crowded environments. These precautions can be discontinued in the event of a negative antigen or molecular test.

For those who have had close contact with confirmed SARS-CoV-2 positive subjects, the self-surveillance regime is applied, during which it is mandatory to wear FFP2-type respiratory protective devices, indoors or in the presence of large gatherings, until the fifth day following the date of the last close contact. If during the self-monitoring period symptoms suggestive of possible Sars-Cov-2 infection occur, immediate execution of an antigen or molecular test for the detection of SARS-CoV-2 is recommended. Healthcare workers must perform an antigen or molecular test on a daily basis until the fifth day after the last contact with a confirmed case (*Test diagnostici, contact tracing, isolamento e autosorveglianza*, 2023).

As we can see, quarantine was used with the scope of prevention and the rules regarding quarantine changed as quickly as the pandemic emergency developed.

7.1.3 VACCINATION

A great turning point in the management of COVID-19 pandemic was the discovery of a vaccine. On December 2, 2020, the Minister of Health Roberto Speranza presented in Parliament, Italy's strategic plan for vaccination against COVID-19. Following the recommendation of the European Medicines Agency (EMA), on December 21st, 2020 the European Commission authorized the first vaccine against COVID-19, mRNA BNT162b2 (Comirnaty), produced by Pfizer and BioNTech. On December 22, 2020,

the Italian Medicines Agency authorized the selling of the Pfizer/BioNTech Comirnaty anti COVID-19 vaccine in Italy for people aged 16 and over. On December 31st, 2020, the World Health Organization approved the Pfizer/BioNTech vaccine for emergency use, thus allowing countries that do not have their own regulatory bodies or the means to rigorously evaluate vaccine efficacy and safety, to start vaccination programs anyway.

The BNT162b2 mRNA vaccine (Comirnaty) is based on messenger RNA (mRNA) technology which, instead of inoculating the antigen to which you want to induce an immune response, inoculates the genetic sequence with the instructions for producing the antigen. The antigen produced is then expressed in the cells of the vaccinated individual. The Comirnaty vaccine contains messenger RNA that encodes the spike protein of SARS-CoV-2, a protein found on the outer surface of the virus, used to enter cells and replicate. The mRNA does not enter the cell nucleus and does not interact with or modify our DNA. Furthermore, mRNA naturally degrades after a few days once it has done its job. The BNT162b2 (Comirnaty) can be kept for 6 months at a temperature between -90°C and -60°C. Once removed from the freezer, the unopened vaccine can be stored before use for up to 5 days at a temperature between 2 and 8°C, and up to 2 hours at a temperature not exceeding 30°C. It is given in two doses, 21 days apart. The duration of protection is not yet defined with certainty: the observation period was a few months, but knowledge on other types of human coronaviruses indicate that it should be at least 9-12 months (*Comirnaty (BNT162b2), il primo vaccino contro il COVID-19 approvato in Europa e in Italia*, 2021).

The December 27, 2020, was the so-called "Vaccine Day" because it was the date that marked the official start of the vaccination campaign against COVID-19 throughout Europe. In Italy, the actual distribution of the vaccine began on December 31st.

Vaccination is offered to the population in consideration of the values and principles of equity, reciprocity, legitimacy, protection, promotion of health and well-being within the framework of the general strategy developed by the European Commission (*Piano nazionale di vaccinazione COVID-19*, 2021).

In June 2020 the European Commission coordinated a strategy for COVID-19 vaccines underling that vaccine development usually takes more than 10 years because developing a safe and effective vaccine is a difficult process. The strategy followed by the European Commission had the objective of ensuring the quality, safety and efficacy of vaccines; securing timely access to vaccines for Member States and their population

while leading the global solidarity effort and finally ensuring equitable access for all in the EU to an affordable vaccine as early as possible. The two pillars of the strategy were securing sufficient production of vaccines in the EU and thereby sufficient supplies for its Member States through Advance Purchase Agreements with vaccine producers via the Emergency Support Instrument. Additional financing and other forms of support could be made available on top of such agreements. Finally, adapting the EU's regulatory framework to the current urgency and making use of existing regulatory flexibility to accelerate the development, authorisation and availability of vaccines. Vaccines were chosen according to certain criteria: speed of delivery at scale, cost, especially the amount of financing requested, the schedule, the conditions of the related payments, the risk sharing and liability, the coverage of different technologies because and the capacity to supply through development of production capacity within the EU. Then the European Commissions elaborated a commitment to make future doses of vaccines available for partner countries to end the global pandemic and an engagement at an early stage with EU regulators with the intention to apply for an EU marketing authorisation for the candidate vaccine (*Communication from the Commission to the European Parliament, the European Council, the Council and the European Investment Bank, EU Strategy for COVID-19 vaccines*, 2020).

With the Decree of March 12, 2021, Italy adopted the new strategic plan for the execution of the national vaccination campaign, drawn up by the Ministry of Health, the Extraordinary Commissioner for the Emergency, the *Istituto Superiore di Sanità*, AGENAS and AIFA.

Age and the presence of pathologies represented the main variables correlating with mortality from COVID-19 and for this reason, an order of priority to vaccinate the population was decided.

The first category was made up of highly fragile people, i.e. extremely vulnerable or with serious disabilities of a physical, sensory, intellectual or psychic nature. The second category 2 consisted of people between 70 and 79 years of age. The third category was people between 60 and 69 years of age. The fourth category consisted of people under the age of 60. The last category was the rest of the population under the age of 60.

In addition, the categories of school and university personnel, teaching and non-teaching, armed forces, police and public aid such as the Armed Forces, State Police, *Guardia di Finanza*, Port Authority, Fire Brigade, Local Police, Civil Protection, prison

police, prison staff, prisoners and other social-health, civil and religious residential communities were prioritised.

In light of the updated recommendations on the Vaxzevria vaccine (previously called COVID-19 Vaccine AstraZeneca) the government decided that from April 2021 vaccination should continue respecting the following order of priority: people over 80 years of age, people with high frailty, people aged between 70 and 79 and, subsequently, those aged between 60 and 69, mainly using Vaxzevria vaccines (previously called COVID-19 Vaccine AstraZeneca) as per AIFA indications.

In parallel with the aforementioned categories, the vaccination of all health and social-health personnel on the front line in the diagnosis, treatment and care of COVID-19 and of all those who worked in the presence of public and private health and social-health facilities was completed. Finally, the other categories considered as priorities by the national plan were vaccinated. People who had already received a first administration would be able to complete the vaccination cycle with the same vaccine.

The operational plan of the extraordinary commissioner aimed to reach 500,000 administrations per day on a national basis when fully operational, with coverage of at least 80% of the population by September 2021 and the main three operational lines were procurement and distribution, the constant monitoring of needs and the capillarisation of the administration, in fact the audience of vaccinators was extended to general practitioners (up to 44 thousand), dentists (up to 60 thousand), medical specialists (up to 23 thousand) and possibly also doctors of the Italian Sports Medicine Federation, outpatient doctors and pharmacists (*Piano nazionale di vaccinazione COVID-19*, 2021).

The vaccines that were used against COVID-19 were Pfizer / BioNTech's Tozinameran which was the first to be approved, on December 23, 2020, by EMA and AIFA. The second vaccine to obtain approval was Moderna's mRNA-1273, on January 6, 2021 by the EMA and on January 7 by AIFA. The third vaccine to obtain approval was Vaxzevria by AstraZeneca, on January 29 by the EMA and on January 30 by Aifa. The fourth vaccine to be approved was Ad26.COV2. S by Janssen (Johnson & Johnson) on March 11 by the EMA and on March 12 by AIFA (*Via libera dell'Aifa al vaccino monodose Johnson & Johnson. È il quarto contro il Covid in Italia*, 2021). On December 22, 2021, AIFA authorized the Novavax COVID-19 vaccine (*Covid, via libera dall'Aifa al vaccino Novavax*, 2021). Before vaccination, the patient was required to sign an informed consent form, which explains the mechanisms of the vaccine and

the methods of inoculation, and where the signatory confirms that he has clearly understood the benefits and risks of vaccination, the methods and therapeutic alternatives (GU Serie Generale n.3 del 05-01-2021). With the decree-law n. 172 of November 26, 2021 starting from December 15, 2021, the obligation for a booster dose for health, school, law enforcement and other categories of workers, to be carried out five months after the primary vaccination cycle was established (GU Serie Generale n.282 del 26-11-2021). With the decree-law n. 1 of January 7, 2022 the vaccination obligation was applied, until June 15, for citizens aged 50 or more (GU Serie Generale n.4 del 07-01-2022).

7.1.4 THE EU DIGITAL COVID CERTIFICATE

The most contested item used to prevent and to regulate the COVID-19 pandemic was the so -called Green Pass.

In June 2021, the European Parliament and the Council adopted a Regulation establishing the EU Digital COVID. In this Regulation some common guidelines about issuance, verification and acceptance for interoperable certificates for COVID-19 vaccination, test or recovery were set out. The EU Digital COVID Certificate was a simple and secure way to demonstrate a person's COVID-19 status and it allowed European citizens to move freely and safely and the European tourism sector to open during summer 2021 (*Report from the Commission to the European Parliament and the Council*, 2021).

The EU digital COVID certificate was digital proof that a person has been vaccinated against COVID-19 or has had a negative test result or recovered from the disease. The Certificate could be in digital or paper format, with a QR code, free of charge, written in the national language and in English, safe and secure and valid in all EU countries. The EU digital COVID certificate could be obtained by all EU citizens and their family members and by third-country nationals who were legally staying or residing in a Member State. To obtain the certificate, each national authority was responsible for issuing the certificate. Vaccination certificates were issued by the Member State where the vaccination was administered. Test certificates were issued by the Member State where the test was carried out. Certificates of recovery are issued by the Member State where the person who was recovered was located. Both the digital version and the paper version contained a QR code containing the essential information and a digital signature

to guarantee the authenticity of the certificate.

The EU's digital COVID certificate has ensured that the implemented restrictions were lifted in a coordinated way. Furthermore, in case of travel, the certificate holder was exempt from restrictions on free movement (*Certificato COVID digitale dell'UE*, 2022).

As regards the Italian case, the EU's digital COVID certification was issued after vaccination or a negative test or recovery from COVID-19 and was automatically issued in digital and printable format by the National Platform. When the Certification was available, people received a message via SMS or email to the contacts communicated. The message contained an authentication code (AUTHCODE) to be used to recover the Certification.

The Certification could be obtained independently from various channels: on the Italian government website (https://www.dgc.gov.it/web/) by accessing via digital identity (Spid/Cie) or with a Health Card (or with the Identity document if you were not registered with the SSN) in combination with the unique code received via email or SMS; in the electronic health record; via the IO App.

The verification of the authenticity of the COVID-19 Green Certification was carried out by authorized operators in Italy via the VerifyC19 app. The verifier could only see a graphic sign on his mobile device and personal data. Anyone who cannot use a computer or smartphone could contact their general practitioner to recover the COVID-19 Green Certification (*Certificazione verde COVID-19, EU digital COVID certificate*).

In Italy, the EU digital COVID certificate has been made mandatory to use certain services. For example, the decree-law n. 105 of July 23, 2021 established that from August 6, 2021 it was mandatory to have the COVID-19 green certification to use the restaurant services with consumption at the table indoors; to participate in cultural performances; sporting events and competitions; museums and other places of culture; swimming pools, gyms, wellness centres, spas, theme and amusement parks; fairs, festivals, conventions and congresses; cultural centres, social centres and recreation centres; gaming halls, betting halls, bingo halls and casinos (GU Serie Generale n.175 del 23-07-2021).

With the decree-law n. 111 of August 6, 2021, green certification also became mandatory for school staff, university staff and students and for the use of long-distance means of transport (GU Serie Generale n.187 del 06-08-2021). With the decree-law n. 127 of September 21 certification was also mandatory for public or private workers (GU

Serie Generale n.226 del 21-09-2021).

The decree-law n. 172 of November 26, 2021, for the period between 6 December 2021 and January 15, 2022, differentiated the green certification issued to vaccinated or recovered people (nicknamed "strengthened green pass" or "super green pass") that was valid for access to shows, sporting events, indoor catering, parties, discos and public ceremonies , from the following green certification to molecular or rapid swab ("green pass base") that was sufficient only to attend the remaining activities (GU Serie Generale n.282 del 26-11-2021).

With the decree-law n. 229 of December 30, 2021, from January 10 to March 31st, 2022, the use of the Super Green Pass was also established for outdoor restaurant services; festivals, fairs, conventions and congresses; festivities resulting from civil or religious ceremonies (GU Serie Generale n.309 del 30-12-2021).

With the decree-law n. 1 of January 7, 2022 the use of the *Green Pass Base* was also extended to access personal services (such as beauticians and hairdressers), public offices, postal, banking and financial services, and commercial activities, with the exception of services essential to person (such as supermarkets) (GU Serie Generale n.4 del 07-01-2022).

FIGURE 6: *Certificazione verde COVID-19*, available on https://www.dgc.gov.it/web/comeFunziona.html

7.1.5 IMMUNI APP

Immuni was a free Italian mobile application, promoted by the Italian Ministry of Health and created by Bending Spoons. It was used to help monitor and contain the COVID-19 pandemic in Italy through contact tracing. The application was available from June 1st, 2020, with a trial that began on June 8 in four regions (Abruzzo, Liguria, Marche and

Puglia) and extended to the rest of Italy from June 15.

The app used the technology to warn users that they have had a risky exposure to COVID-19, even if they were asymptomatic.

Users were warned by the app of a possible contagion so they could isolate themselves to avoid infecting others in order to contain the epidemic and promote a rapid return to normality. The app sent a notification warning them of the potential risk of being infected to those who were in close contact with a user who tested positive for the COVID-19 virus. All this happened thanks to Bluetooth Low Energy technology (*Immuni, funzionamento*).

The app was decommissioned on December 31, 2022, after being a failure due to the lack of trust placed by citizens regarding privacy (Alongi, 2021).

As we have seen, these were the main instruments used to contain and control the pandemic together with the initial lockdown. However, not all the population was in favour of these methods. In fact, some movements such as the No Green Pass or No Vax were born. In the next section we will outline the main complaints about these instruments.

7.2 COMPLAINTS ABOUT THE INSTRUMENTS USED TO CONTROL THE PANDEMIC

Before analysing the complaints about the instrument used to control the pandemic, an explanation about the right to health will be given. The right to health is present in the Universal Declaration of Human Rights in article 25.1: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (*Universal Declaration of Human Rights*, 1948). Also, in the Italian Constitution the right to health is mentioned in article 32: "The Republic protects health as a fundamental right of the individual and in the interest of the community, and guarantees free healthcare to the poor. No one can be forced to undergo a certain medical treatment except by law. The law cannot under any circumstances violate the limits imposed by respect for the human person[19]." (*Italian Constitution, Title II, Ethical-social relations*). As we can see the

[19] Original Italian version: "La Repubblica tutela la salute come fondamentale diritto dell'individuo e

right to health is not just an individual right, but the protection of this right has become a public goal of the State. The protection of health is guaranteed by institutions at different levels, for these reasons the right to health must be understood as a collective right by the political community and by the people within it. In the United Nations Millennium Declaration of 2000, there was an attempt to introduce the idea that the real health protection takes place with prevention and the concept of health right protection as international and not only of national interest. For instance, during the COVID-19 pandemic we internationalised the risk by trying to collaborate to find vaccines but also sharing information (*United Nations Millennium Declaration*, 2000).

As we can see the right to health is interconnected with other rights and themes such as people's security, freedom of movement, freedom of opinion, freedom of thought and freedom of reunion. However, in certain occasions, for example during an emergency state or for matters of public health, the government can decide that some rights prevail and which rights can be limited and at what cost. According to the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, some limitations of rights can occur invoking public health. Articles 25 and 26 affirmed that "Public health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured.","" Due regard shall be had to the international health regulations of the World Health Organization." (*Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 1985). This was the solution put into practice by Italy but also by other states during the pandemic crisis. This type of decision of course created complaints from a part of society that also arrived to define the Italian state as a nazi state. The complaints started from the spread of fake news to the creation of real movements such as No Vax and No Green Pass.

The COVID-19 pandemic created and awakened the "hard core" of conspiracy theorists and deniers. The spread of fake news was favoured especially by social networks, mass media and messaging apps. The main conspiracy theories were the following: the idea that COVID-19 was a biological weapon in the sense that it was created to weaken the

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interesse della collettività, e garantisce cure gratuite agli indigenti.
Nessuno può essere obbligato a un determinato trattamento sanitario se non per disposizione di legge. La legge non può in nessun caso violare i limiti imposti dal rispetto della persona umana."

economy of some countries and favour that of others. In particular, the idea that the Americans had created the virus has spread in China and Iran (Kaszeta, 2020).

Another conspiracy theory linked the spread of SARS-CoV-2 with the presence of antennas for data transmission for the 5G mobile network. According to these theories, the frequencies used by 5G technology would make people's immune systems weaker; other theories argued that the virus could be transmitted directly through 5G antennas (Satariano, Davey, 2020).

Some argued that COVID-19 is an invention to create a "health dictatorship", with the aim of repressing the individual freedoms of populations by forcing people to stay at home and imposing social distancing and the use of the mask. In the Italian case, the creation of the Immuni app would consist of a ploy by the Italian government to have control over individuals and their movements (Paciello, 2020).

Also, the so-called “Green Pass” was labelled as a form of control and instrument of dictatorship as well as unconstitutional because it limited the access to some services only to those who possessed it as we have seen.

FIGURE 7: Ansa/Matteo Corner, *Corteo No Green pass*, Milano, 2 Ottobre 2021.

However, in our Constitution, health is not only protected as a fundamental right of the individual but also as a collective right. This allows for the imposition of a health treatment if directed "not only to improve or preserve the state of health of those subject to it, but also to preserve the state of health of others", as established by the Constitutional Court in 2018. On the other hand, the Constitution itself allows for the introduction of limits on freedom of movement precisely for health reasons. The

exercise of professions that require contact with many people could be subordinated to vaccination, especially when it comes to fragile people. Participation in events in which the contagion risks spreading rapidly, such as concerts, stadiums, discos and even restaurants or public transport, could be subjected to the same conditions. We would not see difficulties in extending similar restrictions to the attendance of schools or places of worship, if it were shown that these are precisely contexts where the virus circulates faster. And this not only to avoid the spread of outbreaks, but also to allow people who cannot take advantage of the vaccine for health reasons to exercise those rights that would otherwise be denied them for elementary reasons of prudence (Melzi d'Eril, Vigevani, 2021).

Vaccines were also objects of fake news; in fact, the Italian National Institute of Health created a dedicated page on its website listing all the fake news about vaccines. The main reason for insecurity about COVID-19 vaccine was the fact that it was created too quickly, but in reality, vaccines are approved by the competent authorities only after having verified the quality and safety requirements and after the EMA has approved them. Some other fake news was about the idea that the vaccine was useless because immunity last only a few weeks but in reality, the protection induced by the vaccines, on the basis of the data that emerged during the trials, lasted a few months and only when the vaccine is administered to large sections of the population will it be possible to verify whether the immunity will last one year. Another idea was that the RNA vaccine was dangerous because it modifies the genetic code, in reality the mRNA's job is only to carry the instructions for the production of proteins from one part of the cell to another, which is why it is called "messenger" (Vaccini, Fake news).

As we can see, the management and the instruments used by the government have been contested by a portion of the population that was pushed by the idea of a “super state” that could control them. However, the measures implanted were necessary and constitutional in order to protect the community from an unseen virus. In the next paragraph we will see how Italy was perceived as a model in the management of the pandemic especially during the first phase since it was the first Western country hit by the pandemic.

7.3 ITALY AS A MODEL IN THE MANAGEMENT OF COVID-19?

The COVID-19 pandemic was a real crisis that has been faced by all the world. The

term crisis can be understood as a challenge and a turning point in which the difference between the reality that precedes that moment and the reality that follows that moment is more marked than in other moments.

The ways that nations use to face crises can be similar to the ones adopted by humans. Therapists envisaged some factors that can be used to face personal crisis in eight phases: the recognition of the state of crisis, the acceptance of personal responsibility, the delimitation of the problem, ask help, the use of others as a model, the self-confidence, the capacity of self-criticism and finally the comparison with past crisis experiences.

As regards nations, just like individuals, they can recognize or deny being in a state of crisis. To solve a problem, nations have to accept their responsibility. Nations make selective changes tracking a delimitation to distinguish the institutions that need change or not. Nations can use other nations as a model trying to use the same policies and the fact that Nations use past national crises as a model to face new crises (Diamond, 2021, pp. 9, 17-31, 405-425).

In the context of this view about nations facing crisis, Italy was one of the first nations that had to face the crisis of COVID-19 and it was taken as a model by other states. The Italian model to fight COVID-19 was a series of governmental measures undertaken to reduce the contagion of COVID-19 ravaging the northern regions of Italy especially Lombardy, Veneto, and Piedmont. These measures were quarantine and lockdown, expansion of health services and economic recovery packages to address the standstill of the national economy. Even if other nations initially viewed the Italian model with suspicion, it has become an effective model, especially in the field of subnational cooperation between regions, cities, and the central government (Nicola, 2021).

The model used by the Veneto region was interesting for other nations because it adopted a large-scale population screening model allowing home isolation for a larger number of mild and asymptomatic cases. This strategy avoided overwhelming the health system. At a time when Italy was facing its biggest challenge since World War II, the 'Veneto model' indicates that early mass screening for SARS-CoV-2 can make a positive difference, and it should be recommended to other countries (Grossi, Zanus, Felice, 2021).

As we can see, in the process of facing a crisis the use of other nations as a model is important and Italy was a model for some countries even if some aspects were criticised and contested especially by the local citizens such as the use of DPCM and the

obligation of vaccines. In the next paragraph I will underline the contemporary link between public health and port cities that is still important.

7.4 PORT CITIES AND COVID-19

Port cities and public health are still current issues as they were in the Early Modern Age. The COVID-19 pandemic emphasized the relation between the two issues since the mobility of people, migrants and goods could be a risk for the spread of the virus.

The current regulatory instruments are different and among them it is interesting to cite the Regio Decree of September 29, 1895, n. 636 which approved the regulation on Maritime Health where the first article reads as follow: "*Il servizio di sanità marittima ha per oggetto di vigilare, per quanto riguarda l'igiene e la sanità pubblica, sui porti e sulle navi ancorate non che sugli arrivi e sulle partenze per la via di mare, e di eseguire e fare osservare quanto relativi, le ordinanze e i decreti delle autorità competenti*[20]*"* (Regio Decreto 29 settembre 1895, n. 636, Approvazione del regolamento sulla sanità marittima). Another important regulatory instrument is the International Health Regulation (IHR) released in 2005 that defines countries' rights and obligations about public health events and emergencies that may become of international interest. The IHR are legally-binding on 196 countries (International Health Regulations (2005) – Third edition, 2016). Particular attention to the *Dichiarazione marittima di Sanità* (Maritime Declaration of Health) was given especially during the COVID-19 pandemic. The captain of a ship before arrival to the first port of a State Party, shall ascertain the state of health of the crew and passengers. The Declaration must be presented before arrival or on arrival according to state regulations; the captain or doctor if present must provide the requested information by the health authority. A State Party can decide not to require that all ships provide the declaration (Regolamento Sanitario Internazionale - RSI 2005). This declaration can be similar to the health pass that was requested to the vessels in the Early Modern Age. However, it is an important instrument to regulate and prevent health diseases.

[20] English version: The purpose of the maritime health service is to supervise, as regards hygiene and public health, ports and anchored ships as well as arrivals and departures by sea, and to execute and enforce the related the ordinances and decrees of the competent authorities

Ministero della Salute

DICHIARAZIONE MARITTIMA DI SANITÀ

Da completare e trasmettere alle autorità competenti da parte dei comandanti delle navi provenienti dai porti stranieri

Maritime Declaration of Health

To be completed and submitted to the competent authorities by the masters of ships arriving from foreign ports

Declaration Maritime de Santé

A remplir par les capitaines des navires en provenance de ports étrangers et à présenter aux autorités compétentes

Presentato al porto di (*Submitted at the port of/Présenté au port de*) _____ Data (*Date*) : ___/___/_____

Nome della nave o del mezzo di navigazione interna _____ N. immatricolazione/IMO _____

(*Name of ship or inland navigation vessel*) (*Registration/IMO No*)

(*Nom du navire ou de bateau de navigation intérieure*) (*Numéro d'immatriculation/OMI*)

Proveniente da (*Arriving from/Ile provenance de*) _____ In viaggio verso (*sailing to/a destination de*) _____

Nazionalità-Bandiera del mezzo di navigazione _____ Nome del comandante _____

(*Nationality-Flag of vessel/Nationalité- Pavillon du navire*) (*Master's name/Nom du capitaine*)

Stazza lorda nave (*Gross tonnage ship/Jauge brute navire*) _____

Stazza mezzo di navigazione interno (*Tonnage inland navigation vessel /Jauge batteau de navigation intérieure*) _____

Certificato di Controllo/ Esenzione dalla Sanificazione valido eseguito a bordo? Sì☐ (*Yes*) (*Oui*) No☐ (*No*) (*Non*)

(*Valid Sanitation Control Exemption/Control Certificate carried on board?*) /

(*Certificat valuable de contrôle/d'exemption de contrôle sanitaire à bord?*)

Emesso a (*Issue at/délivré à*) _____ data (*date*) ___/___/_____

Richiesta nuova ispezione? (*Re-inspection required? Nouvelle inspection requise?*) Sì☐ (*Yes*) (*Oui*) No☐ (*No*) (*Non*)

La nave/il mezzo di navigazione hanno viaggiato in un'area affetta identificata dall'OMS Sì☐ (*Yes*) (*Oui*) No☐ (*No*) (*Non*)

(*Has ship/vessel visited an affected area identified by the World Health Organization?*) /

(*Le navire/bateau a-t-il/-elle visité dans une zone affectée telle que définie par l'OMS?*)

Porto e data del passaggio (*Port and date of visit/ Nom du ports et date de la visite*) _____ data (*date*) ___/___/_____

Elenco dei porti di scalo dall'inizio del viaggio, indicando la data di partenza, o comunque negli ultimi trenta giorni:

(*List ports of call from commencement of voyage, with dates of departure, or within past thirty days, whichever is shorter*)

(*Liste des escales depuis le début du voyage (avec indication des dates de départ) ou au cours des 30 derniers jours, à moins que le voyage n'ait duré moins de 30 jours*)

Su richiesta dell'autorità competente del porto di arrivo, compilare un elenco dei membri dell'equipaggio, dei passeggeri e delle altre persone che sono saliti a bordo della nave/del mezzo di navigazione dall'inizio del viaggio internazionale o comunque negli ultimi trenta giorni, includendo tutti i porti/gli stati visitati in tale periodo (aggiungere i nomi al modulo allegato):

(*Upon request of the competent authority at the port of arrival, list crew members, passengers or other persons who have joined ship/vessel since international voyage began or within past thirty days, whichever is shorter, including all ports/countries visited in this period (add additional names to the attached schedule)*)

(*Si l'autorité compétente du port d'arrivée en fait la demande, liste des membres de l'équipage, passagers ou autres personnes qui ont embarqué sur le navire/bateau depuis le début du voyage international ou au cours des 30 derniers jours, à moins que le voyage n'ait duré moins de 30 jours, et nom de tous les ports/pays visités au cours de cette période (ajouter les noms dans le tableau ci-après)*).

(1) Nome/*name/nom* ..... a bordo da/*joined from/embarqué à*: (1)_____(2) _____(3)_____

(2) Nome/*name/nom* ..... a bordo da/*joined from/embarqué à*: (1)_____(2)_____(3)_____

Nome/*name/nom* ..... a bordo da/*joined from/embarqué à*: (1)_____(2) _____(3)_____

Numero dei membri dell'equipaggio a bordo _____ Numero dei passeggeri a bordo _____

(*Number of crew members on board*) (*Number of passengers on board*)

(*Effectif de l'équipage*) (*Nombre de passagers à bord*)

FIGURE 8: *Dichiarazione Marittima di Sanità*, salute.gov.it

The spread of diseases and the correlation between port cities and public health is also due to the presence of migrants that through their mobility can bring new diseases in Italy. For this reason, some measures were implemented: during rescue operations at sea, migrants receive an initial health assessment by the health teams working on board. The Ministry of Health, in implementation of its functions of international prophylaxis and in application of the WHO International Health Regulations, through its "Maritime,

Air and Frontier Health Offices", is responsible for issuing ships carrying migrants upon arrival, for releasing a certificate of Free Health practice which signals the absence of risks to collective health and for allowing the migrants to disembark. On the docks, medical assistance is provided which consists of an initial assessment. This first health assessment may also be carried out in closed structures, for example in the so-called Hotspots. The first reception system is structured in government-level Hubs, regional and/or interregional, within which migrants can stay for a period which can vary from one week to one month. The health care offered at this stage should include a full medical examination.

In the second reception phase, applicants for international protection are, by law, compulsorily registered with the National Health Service and enjoy all guaranteed welfare rights (*I controlli alla frontiera, La frontiera dei controlli. Controlli sanitari all'arrivo e percorsi di tutela per i migranti ospiti nei centri di accoglienza*, 2017).

The relationship between port cities and public health is still strong since port cities are places of change and encounter between different cultures and the COVID-19 pandemic emphasized even more this correlation.

In the last part of this thesis, I will try to give a comparison with the management of epidemics during the Early Modern Age. Some instruments that we used to face COVID-19 pandemic can be similar to the ones used in the Early Modern Age but it is important to not neglect the differences: in the Early Modern Age offenders were punished with death penalty.

7.4 THE MANAGEMENT OF EPIDEMIC DURING THE EARLY MODERN AND THE CONTEMPORARY AGE: SOME REFLECTIONS

The COVID-19 pandemic arrived as a destabiliser in our modern society. We were no longer used to face a virus, without vaccines and without scientific preparation at least since the time of AIDS/HIV infection.

This pandemic has highlighted the vulnerability of our lives and our routine. With COVID-19 the scientific paradigm has fallen since science was not prepared for this infection.

This last characteristic can be similar to what happened in the Early Modern Age because the populations were not ready for epidemics and the type of method that they put into place was the control of the population. The COVID-19 pointed out the possibility for States and Institutions to limit some fundamental rights to give

precedence to health right and public health, that as I underlined is a collective fundamental right. The first steps put in place by national governments and international institutions were the isolation of infected people, as it happened in the port cities during the Early Modern Age through lazarets, and the quarantine with a resulting slowdown of economic activities and movement. Also, the instruments used during the COVID-19 pandemic can be similar to some of those used during the Early Modern Age such as the Eu Digital Covid certificate or the self-declaration that can be compared to the health passes used in the port cities to move between the different ports so the authorities could understand form where the vessels came from and their state of health. However, in the Early Modern Age offenders were punished with death penalty or corporal punishments as we have seen in the laws collected in the work of Boncio.

Also, the role of information and fake news had a specific role in COVID-19 pandemic even if different from the role that it had for example in Genoa and in Venice during the Early Modern Age. In the Republic of Venice, fake news was spread with the aim of damaging the reputation of other ports. Governments, led by the "jalousie du commerce" defined by Hume, started to spread fake news about other ports (Hume, 1758).

The example of the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* released by Boncio in 1770 is an important primary source to highlight differences and comparison with the COVID-19 Ministerial Decrees.

First of all, it is important to highlight that the health legislation of the Republic of Venice did not cover only the epidemics and pestilences matters, in fact the Venetian legislation was an example of precision and pervasiveness which incorporated very different and distant aspects forming the notion of what public health was, which was not only related to the management of epidemics, but also to aspects of everyday life such as the condition of pigs, dogs, public wells and the sale of cheese.

What I also underlined on the analysis of some laws used in the Republic of Venice during the Early Modern Age, is the force and the cruelty of the corporal punishments against the transgression of laws. People could be *ammazzati impunemente* (killed) (*Le leggi di sanità della Repubblica di Venezia*, 1995, vol.3, p.178) if they left the houses while infected. On the other hand, if we look at the first Ministerial Decree (GU Serie Generale n.45 del 23-02-2020) released in February 2020, of course there is no mention of corporal punishment or death penalty. The penalty in Italy follows the article 650 of Italian penal code that reads: "*Chiunque non osserva un provvedimento legalmente dato*

dall'Autorità per ragione di giustizia o di sicurezza pubblica, o d'ordine pubblico o d'igiene, è punito, se il fatto non costituisce un più grave reato [337, 338, 389, 509], con l'arresto fino a tre mesi o con l'ammenda fino a euro 206." (Codice Penale, Libro Terzo, art.650). The article 650 indicates that the penalty for those who did not respect the indications in the Ministerial Decrees during COVID-19 pandemic could be sanctioned with 3 months of detention or fined with 206€, that is an important difference compared to death penalty in the Early Modern Age. However, it is possible to see that some laws have the same purpose, that is the prevention of gathering of people in order to stop the spread of diseases.

Another important similarity that can be pointed out especially through the speeches of Prime Minister Conte and Draghi, are the emotional words and parallelism done by the two Prime Ministers to make people understand the gravity of the situation. They tried to enlarge the sense of community and underlined that we had to make some sacrifices to protect our parents, relatives and the beloved ones. They also emphasize the idea of homeland repeating the word Italy. Also, in the Early Modern Age emotional speech was used especially in sermons. For example, San Giovanni Leonardi wrote a sermon in 1580 describing the suffering during the plague "*Che spettacolo doveva essere il vedere quelle spaventevoli processioni di carette piene di morti andar per la città. Oh che orrore dovea essere il veder' che il padre portava il figliolo, o il figlio il padre, o il fratello il fratello a seppellire."* (Cardilli, 2020) remembering all the dead people and the suffering of a father in seeing his son dead and giving then a spiritual response to the tragic situation: "*Non doviamo però restare dalle orationi, anzi con maggior affetto frequentarle perché forse ne haverrà che, fatte con efficacia, ne verrà Dio placato, o che si ritarderà, o che serà minore, o che ci renderemo più atti a riceverlo e, morendo, si verrà, lassando il peccato, a morire in gratia di Sua Divina Maestà*." (Cardilli, 2020) saying that in order to stop the spread of the plague people had to pray to God to calm down. The description of the suffering and the emotional consequences of the Black plague were described emotionally in the sermons, convincing people that prayers to God were the solution to the illness.

As in the case of the Republic of Genoa during the Early Modern Age, the epidemic and the creation of an emergency state led to a strengthening of government functions, also the COVID-19 pandemic gave more power and control to the state but always in a constitutional way following the Siracusa Principles (*Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and*

Political Rights, 1985). As we have seen, the state decided to limit some fundamental rights such as the freedom of movement or the freedom of aggregate to protect the collective right to health. This decision also led to a major control of the territory through the deployment of police controls and through instruments such as the self-declaration, nevertheless in the Western democracies these measures were temporary and therefore constitutional during a state of emergency.

In addition to this, what is also different from the management of epidemics in the Early Modern Age are the sanctions to rules and the progress in scientific research. As we have seen in the case of the Republic of Venice through the analysis of the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* some violations to rules were sanctioned with the death penalty, which is not in force in Italy and in the European Union. The capacity to cooperate with other States and the international institutions led our society to the discovery of a vaccine for COVID-19 in record time, and this was also made possible by scientific progress.

8.CONCLUSION

This dissertation had the object to critically reflect on possible similarities and differences of the management of epidemics in two different historical periods: the Early Modern Age and the contemporary COVID-19 pandemic. I focused the comparison on the methods and legislation used to control and manage the epidemics.

Through the explanation of the epidemics management in the Republic of Venice, Genoa and in the port of Marseille, some final conclusions and results can be drawn.

First of all, as in the case of the port cities during the Early Modern Age, globalization played an important role in the spread of diseases not only in the past but also in the contemporary case of COVID-19 pandemic that started in Wuhan and quickly expanded all over the world becoming a pandemic.

The aspect of control was crucial in the port cities through which the government could use the pretext of health control to carry out other economic or political interests damaging other ports, as we have seen in the case of Genoa and Livorno. The aspect of control by the State in the recent case of COVID-19, could be intended as a "positive" control through which the State improved health prevention according to International Institutions promoting countermeasures, such as the total lockdown depriving people the right to move freely, and instruments such as the Green Pass. However, some movements such as No Green Pass or No Vax were against these types of instruments and countermeasures declaring them as a way from the State to control the society and as unconstitutional measures.

In the case of Genoa, it has been underlined the fact that in order to better control and manage the epidemics during the Early Modern Age, the territory was divided into commissariats. This particular practice can remind us of the division of Italy in different zones depending on the contagion risk during the COVID-19. Of course, there is a huge difference between the two methods, however the theoretical division of territory into different risk zones during the COVID-19 pandemic was made in order to implement the right countermeasures for each case.

During the Early Modern Age, the Health Pass was used as an instrument to certify the origin of the vessels in order to understand if they came from an infected country or not. A similarity to the case of COVID-19 can be found with the use of the Eu Digital Covid Certificate and the Maritime Declaration of Health employed to declare the state of health of the crew at their arrival to the port.

The most interesting example of comparison between the two historical epochs has been carried out through the comparability between an important primary source that is the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* with the contemporary Ministerial Decrees. Thanks to this comparison, it has been possible to underline similarities but especially differences.

If some rules adopted during epidemics looked similar to those adopted during the COVID-19 such as the impossibility for infected people to go out or the prohibition of gathering and doing celebration, the difference is in the penalty. During the Early Modern Age, transgressors were punished with the death penalty. In our contemporary case, those who did not respect the rules were subject to a fine. What is also relevant and underlined by both Prime Ministers speeches, is the real preoccupation for the population highlighting how these measures were difficult but necessary to protect all the population from infection and death. However, the *Rubrica delle leggi del Magistrato Eccellentissimo alla Sanità* is the first example towards public health protection since it covered not only the epidemics and pestilences matters, but also very different and distant aspects forming the notion of what public health was, which was not only related to the management of epidemics, but also to aspects of everyday life.

Therefore, the Early Modern Age could be intended as the period in which the first steps towards Public Health were made especially in the case of port cities. Venice, Genoa and Marseille implemented measures and instruments to face the problem of epidemics that especially in that period went to undermine the economy and trade in the port cities and for this reason these measures had second goals such as the protection of commerce disadvantaging the other port cities. The concept of Public Health changed over the years and now there are international institutions such as the WHO that works to protect this important human right. However, as we have seen with the case of COVID-19 pandemic, in certain cases and according to the Siracusa Principles some other important Human Rights can be suspended in order to protect and preserve the Public Health.

Finally, this thesis underlined the differences and similarities between the management of epidemics in the port cities in the Early Modern Age and the COVID-19 pandemic analysing different examples and concepts.

This comparison and the final conclusions have been made possible by the comparison between primary sources and analysis of secondary sources.

A limitation for my study was the fact that the materials about COVID-19 were

restricted since the phenomenon is contemporary and it is an ongoing process.

For future studies it would be interesting to carry out direct interviews with citizens to understand if public opinion has changed and how the period of COVID-19 is perceived.

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