**CMI QUESTIONNAIRE ON EPIDEMICS AND PANDEMICS**

# Q.1. Is your jurisdiction a member of the World Health Organisation?

**AUSTRALIA**

Australia is a member of the WHO.

**NEW ZEALAND**

New-Zealand is a member of the WHO.

**UNITED STATES OF AMERICA**

 The United States of America is a full member state of the World Health Organization (“WHO”). The United States of America is also a member of the Pan American Health Organization, the Regional Office for the Americas of the WHO.

The Commonwealth of Puerto Rico, an unincorporated territory of the United States is an associate member.

**MALTA**

Yes.

**UNITED KINGDOM**

Yes.

**NIGERIA**

Yes.

**KOREA**

Yes.

**IRELAND**

Yes.

**DENMARK**

Yes.

**FINLAND**

Yes.

**POLAND**

Yes, Poland is a member of the World Health Organisation since its foundation.

**VENEZUELA**

Yes, Venezuela is a member of the World Health Organisation.

**CANADA**

Yes, Canada is a member of the WHO.

**NORWAY**

Yes, Norway is a member of the WHO.

**THE NETHERLANDS**

*INTRODUCTORY NOTE:*

*The Kingdom of the Netherlands is made up of four separate countries.*

*The Netherlands.*

*Aruba*

*Curaçao*

*Sint Maarten*

*Within the country of the Netherlands there are two separate legal systems: the one applying in the Netherlands in Europe and the other in the Caribbean Netherlands on the islands of Bonaire, Sint Eustatius, and Saba. Consequently there are five different legal systems existing within the entire Kingdom.*

*With regard to the topic of this CMI questionnaire the differences between the separate jurisdictions will mainly arise from the fact that there may be inconsistencies in respect of ratification of international conventions: some of the conventions may not be ratified for each and every jurisdiction, and may therefore have not been incorporated in national law.*

The answer to Q.1. Is Yes. The Kingdom of the Netherlands (as a whole) has been a member of the WHO since 7 April 1948, thus being amongst the earlier members of the organisation.

**ITALY**

Yes. Italy is a member of WHO since 11 April 1947.

**GREECE**

Yes. Greece has been a member of the World Health Organisation since 1952.

**GERMANY**

Yes.

**HONG KONG**

Hong Kong is a member of the World Health Organisation as Hong Kong (China).

**BELGIUM**

Belgium is a member of the World Health Organisation following signature and acceptance of the Constitution of the World Health Organization, as entered into force on 7 April 1948.

Belgium acceded to the Convention on the Privileges and Immunities of the Specialized Agencies and its Annex VII on 14 March 1962.

# Q.2. Has your jurisdiction given effect under its domestic law to the International Health Regulations (2005)?

**AUSTRALIA**

Yes, the National Health Security Act 2007 gives effect to the requirements of the IHR 2005. More Specifically, Australia’s accession to the National Health Regulations required Australia to develop multi-level capacities in the health sector to effectively manage public health threats and develop, strengthen and maintain the the capacity to detect, report and respond to public health events. This was achieved by the Health Society Act 2007 and the National Health Security Agreement.

**NEW ZEALAND**

New-Zealand has ratified the International Health Regulations (2005). New-Zealand is compliant with the International Health Regulations (2005) and reports annually to the World Health Organisation on the measures it takes to achieve compliance.

**UNITED STATES OF AMERICA**

In 2005, the World Health Assembly of the World Health Organization (WHO), following almost 10 years of discussion and debate, unanimously adopted revisions to the International Health Regulations (IHR) (2005). These new regulations built upon previous international agreements, including the International Sanitary Regulations of 1951 and IHR 1969, which obligated member states of the WHO to report any cases of cholera, plague, or yellow fever that occurred within their boundaries.

The International Health Regulations (2005), entered into force in the United States in July, 2007. Under IHR (2005), the 194-member states are required to notify the WHO of any public health emergency of international concern (PHEIC), as defined through an algorithm included in Annex 2 of the regulations. Specifically, each country must have the capacity to notify the WHO within 24 hours of assessing a potential PHEIC. The regulations also revise rules for detecting and managing disease at national ports of entry; require the development of national capacity for surveillance, detection, and response to infectious diseases; and set expectations for developing public health response mechanisms to protect individual rights and avoid interference with international trade.

The International Health Regulations (IHR) (2005) require countries to report potential public health emergencies of international concern to the World Health Organization. Given that in the United States is a federal system, disease surveillance and reporting is a state, territory, or local-level responsibility.

Implementation of IHR (2005) with nations having a federal system of government, especially nations in which the majority of public health regulatory powers lie—by law, custom, or both—with regional governments, poses a particular challenge. Even so, the United States was the only nation explicitly to cite federalism as a reservation to IHR (2005). This reservation rested on the fact that in the United States, diseases are reported first to the local and state public health authorities and then, depending on the disease and threat, are reported voluntarily to the national level (i.e., the Department of Health and Human Services [HHS] through the Centers for Disease Control and Prevention [CDC]). In the United States system, reporting to the federal government is a matter of custom rather than overarching law; that is, the federal government does not claim the authority under its inherent plenary powers to collect or order the collection of pertinent disease surveillance data, but instead relies upon state governments to voluntarily report conditions or diseases to the national authorities. The completeness and timeliness of reporting by the states is highly variable.

This U.S. custom for surveillance stands in stark contrast to WHO regulations, which require reporting of a PHEIC within 24 hours to encourage rapid information sharing. Thus, the U.S. system for complying with the WHO standards rests on voluntary state action—with the advice of organizations such as the Council for State and Territorial Epidemiologists (CSTE)—regarding what is appropriate information to be passed to federal authorities. In practice, states normally share important disease information with their federal partners in a timely fashion, often consulting with experts at CDC, yet this custom is not codified into law.

**MALTA**

Yes. Malta adopted the Public Health (Ships) Regulations (Subsidiary Legislation 465.10) back in 2008. These aforementioned domestic regulations were promulgated to implement the International Health Regulations of 2005.

**UNITED KINGDOM**

Yes. The International Health Regulations are legally binding between members of the EU and have been implemented in England through the Public Health (Ships) (Amendment) (England) Regulations 2007.

**NIGERIA**

Yes. By virtue of the fact Nigeria and some other 190 States did not make reservations to it.

**KOREA**

The Major parts of the IHR 2005 were incorporated into the Infectious Disease Control Control and Prevention Act of Korea in 2009.

**IRELAND**

Ireland has, Statutory Instrument (SI) of 2008.

**DENMARK**

Yes.

**FINLAND**

Yes, under Act 254/2007. The rules of the Health Regulations have statutory force in the form for which Finland has bonded itself (Source: [Valvira.fi](https://protect-eu.mimecast.com/s/alcrCVOMrcqZ9NTAVsJ7?domain=valvira.fi)).

**POLAND**

According to information provided by the Polish Government, Poland has given effect under its domestic law to the International Health Regulations (2005) [IHR]. The Polish Government established the National IHR Focal Point within the structures of the International Institute of Public Health, which is designated to fulfil provisions of IHR. Moreover, part of the obligations stipulated in the IHR, especially referring to “Points of entry” - pursuant to Part IV of IHR - is executed by the State Sanitary Inspection.

**VENEZUELA**

Venezuela ratified the International Health Regulations in 2007. In Official Gazette of January 14 2013 was introduced the foundation of the National Center in connection to the International Health Regulations (2005) as “essential requirement in the exercise of the International Health Regulations (2005)”. Also, Venezuela is a member of the Pan American Health Organisation: this Organisation operates in Caracas and serves to 5 entities: Venezuela, Aruba, Curaçao, Saint Marteen and Island Territories of the Kingdom of Netherlands.

**CANADA**

Yes, Canada has confirmed its ability to meet the public health core capacities requirements needed to collaborate in IHR global efforts, including the ability to carry out: surveillance,reporting, notification,verification, response and collaboration activities across the country and at points of entry (designated airports, ports, and ground crossings with international traffic).

Canada has established an IHR National Focal Point (NFP) as required under the IHR (Art. 4) for rapid communication with Canadian public health authorities, the WHO and its regional office, the Pan-American Health Organization (PAHO), and other countries. The NFP is accessible at all times for communications with the WHO concerning global public health risks. The IHR NFP for Canada is located at the Public Health Agency of Canada (PHAC).

The IHR NFP is responsible for coordinating the implementation of the IHR (2005) on behalf of the Government of Canada. It provides dependable and timely monitoring, distributes information domestically and internationally on global public health risks, and notifies the WHO of potential PHEIC. It also develops guidance documents, communications protocols, and tools for stakeholder groups, to help build public health and inter-sectorial collaboration, so Canada can continue to meet its IHR obligations.

Canada continues to work towards strengthening and improving its public health core capacities through an IHR National Action Plan. This includes promoting the purpose and role of the IHR to all Canadian public health professionals.

Source: [http://www.phac-as](https://protect-eu.mimecast.com/s/-wHwCW6Nvhr4GRIPR_lI?domain=phac-as) [pc.qc.ca/ep=mu/ihr-rsi/index-eng.php](https://protect-eu.mimecast.com/s/MPqECXDOwuE90Vs89FMB?domain=pc.qc.ca)

**NORWAY**

Yes. Through our law of communicable diseases and through our new national IHR-regulation. The latest regulation within the health sector was given in 2007 and then later revised in accordance with requirements in IHR (2005).

**THE NETHERLANDS**

The Netherlands in Europe has given effect to the IHR 2005 by including the regulations in the *Wet Publieke Gezondheid* (Public Health Act) on 1 December 2008 (*Stb.* 2008, 482). This act also directly applies to the Caribbean Netherlands since 28 July 2012, while similar legislation applied to the Caribbean Netherlands since 10 October 2010 (*Wet Publieke Gezondheid BES*). The Countries Aruba, Curaçao and Sint Maarten have draft ordinances available implementing the IHR 2005 in their local laws. In both Curaçao and Sint Maarten this draft ordinance is called the *Landsverodeningen Publieke Gezondheid* (Public Health Ordinance) and in Aruba the *Landsverordeningen infectieziekten* (Infectious Diseases Ordinance). Yet, to date, it is uncertain when these Ordinances will enter into force. In the meantime, general rules on (infectious) disease control in these countries can be found in, amongst others, the *Landsverordeningen regelende de bestrijding van besmettelijke Ziegler* (Infectious Disease Control Ordinances) and the *Quarantaine verordeningen* (Quarantine Ordinances).

**ITALY**

Yes, the IHRs (2005) have been enforced by Italy on 15 June 2007 as amended version of IHRs (1969) previously enforced by Law No. 106 dated 9 February 1982.

**GREECE**

The International Health Regulations were ratified by virtue of law No. 399/2001.

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**GERMANY**

Yes.

**HONG KONG**

Yes, under the Prevention and Control of Disease Ordinance (Chapter 599) and its subsidiary regulations, which have been in force since July 2008.

**BELGIUM**

The 2005 International Health Regulations, as adopted by the Fifty-eighth World Health Assembly on 23 May 2005 were published in the *Official Journal* (*OJ*) of 18 June 2007, stipulating entry into force as of 16 June 2007.

# Q3. Has your jurisdiction ratified the IMO-MLC 2006 Convention?

**AUSTRALIA**

After signing an accord in Cairns on 5 May 2011, Australia has ratified the IMO MLC 2006 convention.

**NEW ZEALAND**

New-Zealand has ratified the ILO-MLC 2006 Convention on 9 March 2016. It will enter into force one year later on March 2017.

**UNITED STATES OF AMERICA**

The United States has not ratified MLC 2006, and as a result, the Coast Guard will not enforce compliance with MLC 2006 on U.S. vessels or foreign vessels while navigating within U.S. waters.

**MALTA**

Yes. Malta deposited the instrument of ratification with the ILO on the 18th January 2013.

**UNITED KINGDOM**

Yes.

**NIGERIA**

Yes.

**KOREA**

Yes. The Convention was ratified on January 9, 2014 and became effective from January 9, 2015.

**IRELAND**

Ireland ratified the IMLO-MLC 2006 Convention on the 21.07.2014.

**DENMARK**

Yes. On 20 August 2012.

**FINLAND**

Yes. Finland ratified MLC on 9 January 2013 and it entered into force on 9 January 2014.

**POLAND**

Yes, the Polish government has ratified the IMO-MLC 2006 Convention. The Convention has been in force under Polish jurisdiction since 20 August 2013.

**VENEZUELA**

Venezuela has not ratified the MLC 2006 Convention.

**CANADA**

Yes, Canada ratified the IMO-MLC 2006 on June 15, 2010.

**NORWAY**

Yes. Both law and regulations within maritime sector have been revised in accordance with requirements in MLC 2006.

**THE NETHERLANDS**

The Netherlands has ratified the MLC 2006 on 13 December 2011. The Convention entered into force on 20 August 2013 (*Trb.* 2013, 126) for the Netherlands in Europe. The Convention entered into force for Curaçao on 14 April 2015 (*Trb.* 2015, 133).

**ITALY**

Yes, Italy ratified ILO-MLC 2006 Convention on 19 November 2013 and the Convention entered into force in Italy a year later, namely on 19 November 2014.

**GREECE**

Yes. It was ratified by virtue of law No. 4078/2012 (published in the Government Gazette A’ 179 and entered into force for Greece on 4/1/2014.

**GERMANY**

Yes.

**HONG KONG**

No, but the IMO-MLC 2006 Convention has been ratified by China and enters into force in China on 17 November 2016. The Convention will be extended to Hong Kong after China has notified the International Labour Organisation and the making of the relevant legislation. Such legislation has been made as amendments to the Merchant Shipping (Seafarers) Ordinance (Chapter 478) and its regulations in 2016 to implement the Convention in Hong Kong which amendments will come into force on a day to be appointed by the Secretary for Transport and Housing. In the meantime, since November 2013, pending the extension of the Convention to Hong Kong, Hong Kong has authorised recognised organisations to issue provisional compliance certificates to ships which meet the requirements stipulated in the Convention.

**BELGIUM**

 *Nota bene*, it is being assumed that reference is made to the Maritime Labour Convention as (ILO-MLC 2006 Convention) instead of the IMO-MLC 2006 Convention.

In view of the various competences at stake within the Belgian state structure, the MLC Convention is ratified by the federal State, as well as by the federated Regions (Flemish Region, Walloon Region, Brussels-Capital Region) and Communities (Flemish Community, French Community, German-speaking Community). This was done by means of the following legislation:

- Law of 17 August 2013 on approval of the Convention on Maritime Labour, done in Geneva on 23 February 2006 at the 94th Session of the International Labour Conference, *OJ* 8 August 2014;

- Ordonnance of the Brussels-Capital Region of 26 July 2013 on approval of the Convention on Maritime Labour, done in Geneva on 23 February 2006 at the 94th (maritime) Session of the International Labour Conference, *OJ* 3 September 2013;

- Decree of the Walloon Region of 10 July 2013 on approval of the Convention on Maritime Labour, done in Geneva on 23 February 2006 by the General Conference of the International Labour Organisation, *OJ* 31 July 2013, and – as far as it concerns matters within the competence of the French Community as transferred to the Walloon Region, Decree of the Walloon Region of 10 July 2013, *OJ* 1 August 2013;

- Decree of the French Community of 4 July 2013 on approval of the Convention on Maritime Labour, done in Geneva on 23 February 2006 by the General Conference of the International Labour Organisation, *OJ* 17 July 2013;

- Decree of the German-speaking Community of 24 February 2013 on approval of the Convention on Maritime Labour, done in Geneva on 23 February 2006; *OJ* 20 March 2013;

- Decree of the Flemish Region of 4 May 2012 on approval of the Convention on Maritime Labour, done in Geneva on 23 February 2006 at the 94th Session of the International Labour Conference, *OJ* 29 May 2012.

# Q.4. What steps have been taken within your jurisdiction to give effect to the IMO-MLC 2006 Convention?

**AUSTRALIA**

In Australia,the IOL-MLC 2006 Convention has been implemented primarily through the Navigation Act 2012 and associated delegation legislation, such as Marine Order 11 (Living and working conditions on vessels) 2015.

The annex of the questionnaire mentioned particular articles of the Convention. In Summary, Australia Australia has given effect to all the particular articles mentioned in the questionnaires.

*Regulation 4.1 Medical Care on Board Ship and Shore.*

*Regulation 4.1 requires each member state to ensure that adequate medical care can be provided,at no costs to the seafarers, on ships that fly its fla*g.

Division 12 of the Marine order 11 places various health related obligations for the owner of an Australian vessel. The owner of an Australian Vessel must put in place measures for the health protection, medical care and essential dental care for seafarers working of board. Further, expenses for all medicine , surgical and medical advice and attendance, and essential dental care, given to a seafarer while the seafarer is on board a vessel must be paid by the owner of the vessel. Also, the owner of the vessel must ensure that medical care and health protection services are provided at no charge to seafarers on board the vessel and in any port that the vessel visits.

*Guidline B4. 1.3*

*Guidline B4. 1.3 recommends the shore-based medical facilities for treating seafarers be adequate for the purposes. The doctors, dentists and other medical personnel should be properly qualified.*

The owner of an Australian Vessel must insurer that a seafarer in need of immediate care is transported to shore and given access without delay to medical facilities onshore including outpatient for sickness and injury,hospitalisation when necessary and facilities for essential dental treatment.

*Guideline B4.14*

*Guideline B4.14 recommends each member state to give due consideration to participate in international cooperation in the area of assistance by developing and coordinating search and rescue efforts and arranging prompt medical health and evacuation at sea for the seriously inn and injured a ship through such means as periodic ship position reporting systems, rescue coordination centres and emergency helicopter services, in conformity with the Internatioal Convention of Maritime Search and Rescue (IAMSAR) Manual.*

Australian Maritime Safety Authority (AMSA) Search and Rescue service is responsible for the national coordination of both maritime and aviation search and rescue. It coordinates medical evacuations, broadcasts maritime safety information and operates the Modernised Australian Ship Tracking and Reporting System (MASTREP).

The Australian National Search and Rescue Manual is the standard reference document for use by all Australian Search and Rescue Authorities and the manual is consistent with the IAMSAR.

**NEW ZEALAND**

New-Zealand’s Maritime Rules were amended in 2016 to implement the requirements of the Convention that we have not already ratified. Parts 31,34 and 51 have been amended to implement the requirements and Part 52 has been added to fill the remaining gap. (Maritime New-Zealand) (Maritime NZ) is the responsible government agency for implementing the Convention.

The annex of the questionnaire mentioned particular articles of the Convention. In summary, New-Zealand has given effect to all the articles mentioned in the Annex of the questionnaire.

*Regulation 4.1 - Medical Care on Board Ship and Shore.*

Regulation 4.1 requires each member state to ensure that adequate medical care can be provided, at no cost to the seafarers, on ships that fly its flag.

Section 23 of the Maritime Transport Act 1994 requires all New Zealand ships to ensure that any seafarer requiring medical attention while overseas receives all necessary medical attention at the employer’s expense. Other general health and safety requirements for work on board ships are covered by the new Health and Safety At Work Act 2015 since 4 April 2016.

*Standard A4.1*

Standard A4.1 also draws attention to require ships which do not carry a medical doctor to have at least one seafarer on board who is in charge of medical care and administering medicine as part of their regular duties that meets the requirements of the International Convention on Standards of Training, Certification and Watchkeeping for seafarers, as amended (STCW).

New Zealand has implemented requirements of the STCW for New Zealand ships.

Part 34 of the Maritime Rules was amended to align the law with the STCW, requiring foreign seafarers to hold a current certificate of medical fitness issued by or on behalf of a state that is a party to the STCW.

*Guideline B4. 1.3*

Guideline B4. 1.3. Recommends the shore-based medical facilities for treating seafarers be adequate for the purposes. The doctor,dentists and other medical personnel should be properly qualified.

In New Zealand, medical practitioners providing medical care must be registered medical practitioners registered under the Health Practitioner’s Competence Assurance Act 2003 with the Medical Council of New Zealand. The care must also be within the scope of their work.

*Guideline B4. 1.4.*

Guideline B4. 1.4. Recommends each member state to give due consideration to participate in international cooperation in the area of assistance by developing and coordinating search and rescue efforts and arranging prompt medical help and evacuation at sea for the seriously ill or injured on board a ship through such means as periodic ship position reporting systems, rescue coordination centres and emergency helicopter services, in conformity with the International Convention on Maritime Search and Rescue (IAMSAR) Manual.

The Rescue Coordination Centre New Zealand (RCCNZ) is a rescue coordination centre that provides search and rescue services, including emergency medical and helicopter services, covering one of the largest search and rescue areas in the world. The RCCNZ Procedure Manual, Search and Rescue incidents, SOP Vol 1 P01 is aligned to the principles laid out in the IAMSAR Manual.

**UNITED STATES OF AMERICA**

The Maritime Labour Convention, 2006 (“MLC 2006”) was adopted by the International Labor Organization (“ILO”) at the 94th Maritime Session of the International Labour Convention (“ILC”) on February 7, 2006, and will enter into force on August 20, 2013. The United States has not ratified MLC 2006; however, on February 11, 2013, the Coast Guard published a notice (“MLC Notice”) in the Federal Register announcing the availability of a draft Navigation and Vessel Inspection Circular (“NVIC”) setting forth proposed Coast Guard policies and procedures regarding the inspection of U.S. vessels for voluntary compliance with MLC 2006. http://www.gpo.gov/fdsys/pkg/FR-2013-02-11/pdf/2013-02956.pdf. The primary purpose of the NVIC is to assist U.S. vessels in avoiding port State control actions in foreign ports of countries that have become party to MLC 2006 by providing for a voluntary inspection program mechanism for U.S.-flag vessels resulting in the issuance of a Statement of Voluntary Compliance, Maritime Labour Convention (“SOVC-MLC”).

The United States has not ratified MLC 2006, and as a result, the Coast Guard will not enforce compliance with MLC 2006 on U.S. vessels or foreign vessels while navigating within U.S. waters. Despite the fact that the United States has not ratified MLC 2006, U.S.-flag vessels are exposed to potential port State action under the “no more favorable treatment clause” as discussed above under the background section. In light of this potential risk, which could include detention at a port in a country that is a party to MLC 2006, the Coast Guard encourages shipowner and operator compliance with MLC 2006. To that end, the U.S. Coast Guard published the MLC Notice.

The NVIC, titled “Guidance Implementing the Maritime Labour Convention, 2006,” clarifies that the NVIC is intended to provide guidance for Coast Guard marine inspectors, Recognized Class Societies (“RCS”), and U.S. vessel owners/operators for meeting the provisions of MLC 2006 and to establish a voluntary inspection program for vessel owners/operators who wish to document compliance with the requirements of MLC 2006. Consistent with MLC 2006, the Guidance applies to ships greater than 500 gross tons on international voyages as well as U.S. commercial vessels less than 500 gross tons, including uninspected commercial vessels, engaging in international voyages to ports of MLC 2006 party nations. Vessels that do not operate in ports of those countries that are a party to MLC 2006 are not required to be in compliance with MLC 2006. The MLC Notice and draft NVIC may be reviewed at http://www.regulations.gov/#!docketDetail;D=USCG-2012-1066.

Similar to the Maritime Labour Certificate and DMLC issued by parties to MLC 2006, the Coast Guard intends to issue a SOVC-MLC to vessels demonstrating compliance with MLC 2006. Shipowners and operators of vessels that fall within the scope of the NVIC are not obligated to obtain a SOVC-MLC certificate, but may voluntarily request inspection to obtain this certificate. The Coast Guard has authorized RCSs to conduct MLC 2006 compliance inspections and issue SOVCs at the request of vessel owners and operators.

Generally, MLC 2006 establishes fourteen areas that are subject to mandatory compliance for certification and the issuance of certificates. These areas that must be inspected for compliance include: minimum age; medical certification; qualifications of seafarers; use of any licensed or certified or regulated private recruitment and placement services; seafarers’ employment agreements; payment of wages; hours of work and rest; manning levels for the ship; accommodation; on-board recreation facilities; food and catering; on-board medical care; health and safety and accident prevention; and on-board complaint procedures. Similar to the MLC 2006 certificate, an inspection conducted by the RCS for the purposes of issuing a SOVC-MLC will confirm compliance with these fourteen points.

The format to the SOVC-MLC will be consistent with the MLC certificate provided in the MLC Code and will be supplemented with a SOVC Declaration of Maritime Labour Compliance, which will reference the applicable U.S. federal rule or regulation applicable to the relevant mandatory area of compliance. To the extent that there is no applicable U.S. rule or regulation, the Coast Guard will defer to the applicable MLC 2006 standard. In addition to stating the current U.S. laws and regulations for the relevant mandatory areas of compliance, the SOVC-MLC must also state the measures adopted by the shipowner or operator to ensure compliance with the laws and regulations.

Once the SOVC-MLC is issued, it must be posted on the vessel in a visible location accessible by the seafarers. The certificates will be valid for a period not exceeding five years or until there has been a material change in circumstance. Foreign country port State control authorities are not obligated to accept the Coast Guard SOVC-MLC, and unless the United States becomes a party MLC 2006, the Coast Guard has no enforcement authority to certify vessels as compliant with the MLC.

**MALTA**

The MLC Convention entered into force in Malta on the 20th August 2013 and the provisions therein were transposed into the Laws of Malta through the Merchant Shipping (Maritime Labour Convention) Rules of 2013.

On the 20th February 2013, the Merchant Shipping Directorate published *The Guidelines for the Implementation of the Maritime Labour Convention, 2006* (published as Merchant Shipping Notice 105) whereby it briefly outlined what changes will be brought about as a result of the MLC Convention when the said instrument came into force in Malta.

On the 10th of May 2013, our legislators adopted the Merchant Shipping (Maritime Labour Convention) Rules, which gave effect to the MLC 2006 Convention under Maltese law.

The ratification and transposition process also entailed the replacement and/or revocation and/or amendment of a number of existing Maltese legislation. Upon the coming into force of the Merchant Shipping (Maritime Labour Convention) Rules, 2013, the following legislation was revoked automatically:

* The Merchant Shipping (Distressed Seaman) Regulations of 1973 [Subsidiary Legislation 234.02]
* The Merchant Shipping (Provisions and Water) Regulations of 2001 [Subsidiary Legislation 234.03]
* The Merchant Shipping (Medical Stores) Regulations of 2002 [Subsidiary Legislation 234.05]
* The Merchant Shipping (Medical Examination) Regulations of 2001 [Subsidiary Legislation 234.24]
* The Merchant Shipping (Minimum Wage) Regulations of 2002 [Subsidiary Legislation 234.26]
* The Merchant Shipping (Hours of Work) Regulations of 2002 [Subsidiary Legislation 234.27]
* The Merchant Shipping (Protection of Seamen) Regulations of 2003 [Subsidiary Legislation 234.28]
* The Merchant Shipping (Safe Manning and Watchkeeping) Regulations of 2003 [Subsidiary Legislation 234.31]
* The Merchant Shipping (Crew Accommodation) Regulations of 2004 [Subsidiary Legislation 234.39]

Furthermore, on the 25th November 2016, Malta adopted the *Merchant Shipping (Maritime Labour Convention) (Amendment) Rules 2016,* which incorporated the 2014 amendments to the Maritime Labour Convention (MLC), which predominantly relate to financial security of seafarers in cases of abandonment and contractual claims for compensation in the event of a seafarer’s death or long term disability due to an operational injury, illness or hazard.

**UNITED KINGDOM**

On 07 August 2014 the IMO-MLC 2006 Convention fully entered into force in the UK. It had slowly been implemented through various pieces of legislation, namely:

(a) The Merchant Shipping (Maritime Labour Convention) (Minimum Requirements for Seafarers etc.) Regulations 2014 (SI 2014/1613);

(b) The Merchant Shipping (Maritime Labour Convention) (Consequential and Minor Amendments) Regulations 2014 (SI 2014/1614);

(c) The Merchant Shipping (Maritime Labour Convention) (Recruitment and Placement) Regulations 2014 (SI 2014/1615); and

(d) The Merchant Shipping (Maritime Labour Convention) (Health and Safety) (Amendment) Regulations (SI 2014/1616).

**NIGERIA**

Regulations have been made awaiting Ministerial Approval.

**KOREA**

The contents of the Convention were incorporated into the Seafarers Act of Korea and became effective from February 6, 2015.

**IRELAND**

Ireland implemented the Convention on a formal footing through SI 376 of 2014.

**DENMARK**

Due to the ratification of the IMO-MLC Convention in April 2010 seven acts were amended in Denmark. The amendments were given effect when implemented by the Minister for Business and Growth 20 August 2013. These acts set the framework and contain the powers for the necessary amendments being made as ministerial Orders.

**FINLAND**

Changes in EU and national legislation as a consequence of the requirements imposed by MLC 2006. MLC inspections of Finnish ships are carried out by the Regional State Administrative Agencies and the Finnish Transport Safety Agency (Trafi) according to a mutually agreed division of Labour.

**POLAND**

On 5 August 2015, the Polish Parliament passed the Act on Labour at Sea. The Act implements to Polish system of law regulations stipulated in the IMO-MLC 2006 Convention, as well as other European Union directives referring to work of seafarers.

**VENEZUELA**

We are not aware of any steps taken to give effect to the IMO-MLC 2006 Convention.

**CANADA**

In accordance with Standard A4.5 (2) and (10), the Government has specified the following the following branches of social security coverage to apply to the Labour standards implemented by the MLC.

Medical care; sickness benefit; unemployment benefit; old-age benefit; employment injury benefit; family benefit; maternity benefit; invalidity benefit; and survivors’ benefit.

The Canadian Authority overseeing the implementation of these standards in the industry is Transport Canada, Safety and Security division.

Source: [http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:80021:0::NO::P80021\_COUNTRY\_ID:102582](https://protect-eu.mimecast.com/s/JeJzCYEPxcV9OEFW2IEn?domain=ilo.org)

**NORWAY**

Both law and regulations within maritime sector have been revised in accordance with requirements in MLC 2006.

**THE NETHERLANDS**

Implementation of the IMO-MLC 2006 in the Netherlands in Europe has taken place by amending existing legislation. The IMO-MLC 2006 has been implemented in the following legislation: the Dutch Civil Code, the Dutch Code of Civil Procedure, the *Wet Zeevarenden* (Seafarers’ Act), the *Wet Havenstaatcontrole* (Port State Control Act), *Arbeidsomstandighedenwet 1998* (Working Conditions Act 1998), the *Wet allocative arbeidskrachten door intermediaries* (Placement of Personnel by Intermediaries Act), the *Wet economies he delicten* (Economic Offenses Act) and the Dutch Criminal Code. (Legislative history to the Act on the Implementation of the Maritime Labour Convention 2006 (Trb. 2007, 93)(Stb. 2011, 394).

The legislator of Curaçao is currently working on a draft *Landsverordening Zeearbeid* (Ordinance Sea Labour), implementing the IMO-MLC 2006. On 24 June 2014, the temporary *Regeling Zeearbeid* (Regulation Sea Labour; PB 2014, no. 46) has been adopted to bridge the period until the Ordinance Sea Labour will enter into force.

**ITALY**

With the law ratifying the ILO-MLC 2006 (Law 113/2013) the Parliament abolished/amended the provisions of the Italian Code of Navigation that did not comply with the provisions of the Convention. So far there is no other intervention from the Government on this issue.

**GREECE**

The following Ministerial Decisions and Circulars have been issued to give effect to the IMO-MLC 2006 Convention:

a) Ministerial Decision No. 4113.305/01/213 (published in the Government Gazette B’ 1553/2013) <>.

By virtue of the above Ministerial Decision, three Regulations for the application of the Maritime Labour Convention, 2006 were approved and entered into force. Specifically: the Regulation “Maritime Labour Inspectors”, the Regulation “Audit and Compliance” and the Regulation “Authorisation of Recognised Organisations”.

b) Ministerial Decision No. 3522.2/08/213 (published in the Government Gazette B’ 1671/2013) <>.

By virtue of the above Ministerial Decision, one Regulation was approved and entered into force for the application of the requirements of Maritime Labour Convention, 2006. This regulation was divided into the following Chapters: Chapter 1 “Minimum requirements for seafarers to work on a ship”, Chapter 2 “Conditions of Employment”, Chapter 3 “Accommodation, recreational facilities, food and catering”, Chapter 4 “Health protection, medical care, welfare and social security protection”, Chapter 5 “Compliance and enforcement”.

c) Circular No. 3527.1.2/2013 <> by virtue of which the Ministry of Shipping and Island Policy intended to inform the shipowners, as well as any Recognised Organisation and/or Authority, for the basic structure and content of the Maritime Labour Convention, its implementation and requirements etc.

d) Circular No. 4451.2/01/213, code No: MLC/01/2013/02-08-13 <>.

By virtue of the above Circular, the Ministry of Shipping and Island Policy intended to inform the shipowners of ships under the Greek flag, as well as any Recognised Organisation and/or Authority, for the certification of the ships which are obligated for certification under the Maritime Labour Convention, 2006 and the relevant procedure for obtaining that certification.

e) Circular No. MLC/02/2013/11-12-13, code No. 4451.2/07/2013 << Certification of the Part II of the Declaration of Maritime Labour Compliance>> by virtue of which, the Ministry of Shipping and Island Policy gave instructions and directions for the issuance and certification of the Declaration of Maritime Labour Compliance.

f) Circular No. MLC/03/2014, code No. 4451.2/04/2014 <>, by virtue of which the shipowners were informed that at their request and upon a voluntary basis, they could achieve the certification of their non-obliged for certification ships under the Maritime Labour Convention, 2006.

**GERMANY**

MLC 2006 has been implemented into German law by the German Maritime Labour Act (Seearbeitsgesetz - SeeArbG) of 20 April, which has been published as Article 1 of the German *“Gesetz zur Umsetzung des Seearbeitsubereinkommens 2006 der Internationalen Arbeitsorganisation”* in the Federal Law Gazette (Bundesgesetzblatt, Teil I,2013, S.868). The German Maritime Labour Act entered into force on 1 August 2013 (together with several related regulations; a preliminary English version of the German Maritime Labour Act is published on the ILO Website).

**HONG KONG**

See above. (3).

**BELGIUM**

To date, effect to the 2006 MLC Convention is given through the following set of legislative and regulatory measures:

- Law of 15 May 2014 implementing the Pact for Competitiveness, Employment and Relance measures (esp. Title VII on seafarers’ employment agreement modifying the Law of 3 June 2007 on various employment provisions), *OJ* 22 May 2014;

- Law of 13 June 2014 on giving effect to and control of the application of the Convention on Maritime Labour 2006, *OJ* 11 July 2014;

- Royal Decree of 21 July 2014 modifying the Royal Decree of 22 December 2010 on Port State Control, *OJ* 12 August 2014;

- Royal Decree of 4 August 2014 establishing model of the Maritime Labour Certificate and model of the Declaration of Maritime Labour Compliance, as referred to in Title 2 of the Law of 13 June 2014 on giving effect to and control of the application of the Convention on Maritime Labour 2006, *OJ* 18 August 2014;

- Royal Decree of 4 August 2014 designating government officials having power to control compliance with the Law of 13 June 2014 on giving effect to and control of the application of the Convention on Maritime Labour 2006 and its executive orders, *OJ* 18 August 2014;

- Royal Decree of 4 August 2014 establishing complaint procedures on board ships under Belgian flag and establishing model of on-board complaint form, *OJ* 18 August 2014;

- Royal Decree of 30 September 2014 modifying various royal decrees giving effect to the Convention on Maritime Labour 2006 and implementing the Agreement of 19 May 2008, as concluded by the European Community Shipowners’ Associations (ECSA) and the European Transport Workers’ Federation (ETF) on the Maritime Labour Convention, 2006, 9 October 2014;

- Royal Decree of 7 May 2015 on transposition of Directive 2013/54/EU of the European Parliament and of the Council of 20 November 2013 concerning certain flag State responsibilities for compliance with and enforcement of the Maritime Labour Convention 2006, *OJ* 8 May 2015;

- Law of 25 December 2016 on the establishment of administrative fines applicable in case of infringements on shipping legislation [including infringements on the Law of 13 June 2014 on giving effect to and control of the application of the Convention on Maritime Labour 2006], *OJ* 19 January 2017;

- Law of 6 March 2017 modifying the Law of 3 June 2007 on various labour law provisions and modifying the Law of 13 June 2014 on giving effect to and control of the application of the Convention on Maritime Labour 2006, *OJ* 11 April 2017, aiming at the implementation of the 2014 amendments relating to the abandonment of seafarers (financial security) and to claims for compensation in the event of a seafarer’s death or long-term disability due to an occupational injury, illness or hazard (shipowners’ liability).

# Q.5. Has your jurisdiction ratified the IMO Facilitation of Marine Traffic Convention 1965 (FAL Convention)?

**AUSTRALIA**

Yes.

**NEW ZEALAND**

Yes, New Zealand has ratified the FAL Convention.

**UNITED STATES OF AMERICA**

The United States has ratified the FAL Convention.

**MALTA**

Malta acceded to the FAL Convention on the 24th of September 2002. The said Convention entered into force in Malta on the 23rd November 2002.

**UNITED KINGDOM**

Yes. The Convention was ratified on 5 March 1967.

**NIGERIA**

Yes - Came into force in Nigeria on 5th March, 1967.

**KOREA**

The Convention became effective in Korea from May 5, 2001.

**IRELAND**

Ireland has ratified the IMO FAL Convention of 1965.

**DENMARK**

Yes, Denmark has ratified the IMO Facilitation of Marine Traffic Convention 1965 (FAL Convention) (5 March 1967).

**FINLAND**

Yes.

**POLAND**

Yes, the Polish authority ratified the IMO Facilitation of Maritime Traffic Convention 1965 with its amendments till the amendment of 2002 [FAL.7(29)].

**VENEZUELA**

Yes, Venezuela ratified the IMO Facilitation of Maritime Traffic Convention on 2000.

**CANADA**

Yes, although as Canada’s constitution does not require the treaty to be ratified by the head of state, Canada has instead deposited an “Instrument of Acceptance” of the FAL. This was done in August of 1967.

The “Instrument of Acceptance” of the treaty has the same legal effect as ratification and consequently expresses Canada’s consent to be bound by the treaty.

Source: [https://imo.amsa.gov.au/public/circular-titles/FAL.html](https://protect-eu.mimecast.com/s/vB-FCZ6QyhKj2rTZTe5n?domain=imo.amsa.gov.au)

**NORWAY**

Yes.

**THE NETHERLANDS**

Yes.

**ITALY**

Yes, FAL Convention 1965 has been ratified by Italy with Law No. 831, 8 May 1971.

**GREECE**

Yes, it was ratified by virtue of legislative Decree No. 1028/1971 (published in the Government Gazette A’ 250) and was entered into force upon the fulfilment of the conditions of the article XI thereof.

The subsequent amendments were ratified by the following legislative acts:-

* Presidential Decree No. 1019/1977 <>.
* Joint Ministerial Decision No. 1141.16/01/04 << Acceptance of Modifications of the Year 2002 to Annex>>.
* Joint Ministerial Decision No. 3131.A.16/295/2012 <>.

**GERMANY**

Yes.

**HONG KONG**

Yes.

**BELGIUM**

The Convention on Facilitation of Maritime Travel and Transport, done in London on 9 April 1965 and entered into force on 5 March 1967 was signed by Belgium on 9 September 1965 and adopted on 4 January 1967 (*OJ* 24 February 1967).

# Q.6. What steps have been taken within your jurisdiction to give effect to the FAL Convention?

**AUSTRALIA**

The annex of the questionnaire mentioned particular provisions of the Convention. In summary, Australia has given effect to these particular provisions.

*Provision 3.8 - Medical Examinations of Persians on board.*

*Provision 3.8 - of the FAL Convention recommends that medical examinations of pensions on board or of persons disembarking from ships normally be limited to those persons arriving from an area infected with quarantineable diseases within the incubation of the disease concerned (as stated in the International Health Regulations). Additionally medical examination may, however, be required in accordance with the International Health Regulations.*

Medical examination is only compulsory when a person is ordered into Quarantine. If Pratique has been granted to a ship, then a person will only be examined if the Quarantine officer suspects the person to be suffering, or at least exposed to infection, from the disease.

*Provision.3.20*

*Provision 3.20 requires public authorities to grant pratiqueby radio to a cruise ship when, on the basis of information received from it, prior to its arrival,the health authority for the intended port of arrival is of the opinion that its arrival will not result in the introduction or spread of a quarantinable disease.*

If a quarantine officer is satisfied that an overseas vessel at, or about to arrive at, a port that is free from infection, the quarantine officer will grant the vessel pratique. This can be done by giving the master particulars of the pratique by radio message or otherwise.

*Provision 3.30*

*Provision 3.30 recommends that the Maritime Declaration of Health should be the only health control necessary for cruise passengers.*

All overseas vessels intending to arrive in a place in Australia must send a pre-arrival report to the Quarantine Officer, in a form prepared by the Director of Quarantine. The details of a pre-arrival report are set out in Section 10 of the Quarantine Regulations 2000 and includes health information on the passengers.

*Provision 6.4*

*Provision 6.4 recommends that health authorities should as far as practicable be allowed to join a ship prior to the entry of a ship into port.*

A quarantine officer may board any vessel that is Australian water, bound for a port in Australia.

*Provision 6.4.1*

*Provision 6.4.1 requires authorities to seek the cooperation of ship owners to ensure compliance with any requirement that illness on a ship is to be reported promptly by radio to health authorities or the port for which the hip is destined.*

After the master of the ship has sent the pre-arrived report to the Quarantine Officer pursuant to 27A, If the master becomes aware that the information is complete or correct, the master must cause the additional or correct information to be given to a quarantine officer as soon as practicable.

*Provisions 6.10*

*Provisions 6.10 requires that except in the case of an emergency constituting a grave danger to public health, a ship which is not infected or suspected of being infected with a quarantinable disease shall not, on any account of of any other epidemic disease, be prevented from the health authorise for a port of discharging or loading of stores or taking on fuel or water.*

There is no legislation that places a positive duty of care to not prevent discharging or loading cargo or stores or taking along fuel or water. However, the quarantine officer may only order goods into quarantine when the goods are likely to be infected or comes from a ship that in infected.

**NEW ZEALAND**

The annex of the questionnaire mentioned particular provisions of the Convention. In summary, New Zealand has given effect to all of the provisions mentioned in the annex of the Convention.

*Provision 3.8*

Provision 3.8 of the FAL convention recommends that medical examination of persons on board or of persons disembarking from ships normally be limited to those persons arriving from an area infected with quarantinable diseases within the incubation of the disease concerned (as stated in the International Health Regulations). Additional medical examination, may, however, be required in accordance with the International Health Regulations.

A ship will face various quarantine restrictions - including isolation and medical examination of persons aboard the ship - when the radio pratique has been denied. However, even if a radio pratique has been granted for a ship, persons from the ship could face medical examinations as medical examinations are *not legally limited* to persons arriving from an area infected with quarantinable diseases. The medical officer of health, appointed under the Health Act 1956, may enter any premises - including boarding a ship or an aircraft - in which he or she has reason to believe that there is or recently has been any person suffering from a notifiable infectious disease or recently exposed to the infection of any such disease, and may medically examine any person on those premises. The medical officer of health may also require a person on an arriving ship that has a quarantinable disease or was exposed to such in last 14 days to be examined

*Provision 3.20*

Provision 3.20 requires public authorities to grant pratique by radio to a cruise ship when, on the basis of information received from it, prior to its arrival, the health authority for the intended port of arrival is of the opinion that its arrival will not result in the introduction or spread of a quarantinable disease.

New Zealand law requires the captain of every ship liable to quarantine (any ship arriving from a foreign port) to inform the medical officer of health by radio message of the last port of call, the date of departure therefrom, and the state of health on the ship. On receipt by the medical officer of health of such radio message to the effect that no infectious disease exists on board, the medical officer may grant pratique by radio.

*Provision 3.30*

Provision 3.30 recommends that the Maritime Declaration of Health should be the only health control necessary for cruise passengers.

New Zealand law requires the master of the ship to complete and deliver to the medical officer of health a Maritime Declaration of Health form. There are no other legal controls aside from requirements to provide additional information required by the medical officer of health and getting passengers and crews to fill out cards and forms.

*Provision 6.4*

Provision 6.4 recommends that health authorities should as far as practicable be allowed to join a ship prior to entry of a ship into port.

New Zealand law allows the medical officer of health, if the radio pratique has been denied, to board the ship and inspect it for the purpose of ascertaining whether any infectious disease exists on the ship.

*Provision 6.4.1.*

Provision 6.4.1 requires authorities to seek the co-operation of ship owners to ensure compliance with any requirement that illness on a ship is to be reported promptly by radio to health authorities or the port for which the ship is destined. Under New Zealand law, the master is liable on conviction to a fine not exceeding $1,000 if he does not comply with the requirements regarding declaration of health set out under section 102 of the Health Act 1956. Further, declaration of health is required for ships to be granted pratique. Any ships that are not granted pratique will be liable to restrictions under sections 99 to 101 of the Health Act 1956. This s a practical incentive to ensure compliance with illness reporting requirements.

*Provision 6.10.*

Provision 6.10 requires that except in the case of an emergency constituting a grave danger to public health, a ship which is not infected or suspected of being necked with a quarantinable disease shall not, on account of any other epidemic disease, be prevented by the health authority for a port from discharging or loading cargo or stores or taking on fuel or water.

Section 99 restricts discharging or loading goods to only ships that are liable to quarantine and have not been granted pratique. Therefore there is no legal basis to restrict loading or discharging goods from and to ships that are not infected or suspected of being infected with a a quarantinable disease in New Zealand, barring in the case of an emergency constituting a grave danger to public health.

**UNITED STATES OF AMERICA**

The United States requires seafarers to obtain transit and crew visas called individual C-1/d visas. The C-1 part of the visa allows the seafarer to remain in U.S. waters up to 29 days. This allows them to travel from port to port, and when necessary, to transit from the airport to the seaport and vice versa. The D part of the visa identifies the seafarer to U.S. immigration authorities as a crew member working on a vessel.

The United States has also adopted security measures on the identification of seafarers as part of the formalities on the arrival of ships. Section 402 of the Enhanced Border Security and Visa Entry Reform Act provides the requirement for commercial aircraft or vessels arriving at, or department from, the United States to provide border officers with specified passenger and crew manifest information 96 hours before arrival in the port.

**MALTA**

The requirements of the FAL Convention have been incorporated into our local legislation, by virtue of the Vessel Traffic Monitoring and Reporting Requirements Regulations of 2004 (Subsidiary Legislation 499.34), the provisions of which relate to the establishment of a maritime information management system, electronic transmissions and exchange of relevant data.

**UNITED KINGDOM**

The FAL Convention has effect throughout the EU, as amended, through EU Directive 2010/65/EU (the “Reporting Formalities Directive”). The UK is piloting the UK National Maritime Single Window reporting framework in summer 2016 in order to implement the Reporting Formalities Directive.

**NIGERIA**

Attempts to implement the Convention have been made. However the full implementation is slowed down by bureaucratic hiccups.

**KOREA**

No particular steps have been taken since it is believed that the current laws and regulations of Korea meet the standard and recommendations of the Convention.

**IRELAND**

Ireland implemented the IMO FAL Convention on a formal footing through SI 549 of 2003.

**DENMARK**

The FAL Convention was given effect with the implementation of Directive 2010/65/EU of the European Parliament and of the Council of 20 October 2010 on reporting formalities for ships arriving in and/or departing from ports of the Member States and repealing Directive 2002/6/EC.

**FINLAND**

N/A

**POLAND**

First of all, the FAL Convention, as a ratified international agreement, binds Poland and, as a consequence, applies directly. Thus regulations stipulated in the FAL Convention has effect on Polish jurisdiction without prior whatsoever implementation. According to Polish system of law, should there occur any conflict between regulations of ratified international and domestic statue, regulations of ratified international agreements would prevail.

Regardless to the above, the Polish authority establishes domestic statues in compliance with regulations of theFAL Convention. The FAL Convention regulations are followed by numerous domestic acts of law as well as numerous European Union acts of law, the latter either implemented or directly applying into Polish jurisdiction.

**VENEZUELA**

Venezuela integrated the FAL Convention into their legislation. On February 10 2001, the National Assembly dictate a “Law Approving the Convention to Facilitate International Maritime Traffic”.

**CANADA**

The provisions of the FAL Convention are enforced through the express inclusion of the Convention and its requirements under the Canada Shipping Act, 2001, (S.C.2001, c26), as well as through the enactment of the Quarantine Act (S.C. 2005, c20).

**NORWAY**

Both law and regulations within maritime sector have been revised in accordance with requirements in FAL.

**THE NETHERLANDS**

The Netherlands has ratified the FAL on 21 September 1967 and the Convention entered into force on 20 November 1967 (*Trb.* 1967, 174). The Convention applies to the entire Kingdom of the Netherlands. There is not a specific act by means of which the FAL Convention is incorporated into national law. However, depending on the particular topic (e.g. health, immigration), the particular legislation is intended to be compliant with the provisions of the FAL Convention where needed.

**ITALY**

First, by decree of 24 December 2004 No. 335 Italy enforced the Directive 2002/6/EC of the European Parliament and of the Council of 18 February 2002 on reporting formalities for ships arriving in and/or departing from ports of the Member States of the Community. As a result, Articles 179 and 180 of Italian Code of Navigation have been amended Accordingly.

Secondly, the Directive 2010/65/EU repealed the Directive 2002/6/CE in order to simplify and harmonise the administrative procedures applied to maritime transport by establishing a standard electronic transmission of information and by rationalising reporting formalities for ships arriving in and ships departing from European Union (EU) ports. EU countries are called to accept FAL forms for the fulfilment of reporting. As a result, section 179 of Italian Navigation Code has been amended again by decree of 18 October 2012 No. 179, expressly adopting FAL forms and setting up the Port Management Information System (PMIS) as a National Maritime Single Window.

**GREECE**

In view of, inter alia, the complexity of the provisions and obligations arising from the amendments to the FAL Convention, the Greek State, by virtue of related Ministerial Decisions, has constituted Committees of Experts in Legal, Shipping and Customs Regulations in order to incorporate into the national legal system the 2002, 2005 and 2009 amendments to the Annex of the FAL Convention, regarding the facilitation of the arrival, stay and departure of ships (e.g. by virtue of Ministerial Decision No. 3136.A.16/2010 a Committee was established for the incorporation into the national legal system of the 2005 and 2009 Amendments to the Annex of FAL Convention 1965). Indeed, as per previous question No. 5, such amendments have been duly incorporated into the national legal system.

The Directorate for Ocean-going Shipping of the Ministry of Shipping and Island Policy is the competent designated and national authority for all facilitation purposes under the FAL Convention. The Ministry is in close co-operation with the IMO Facilitation Committee in order to broaden the facilitation activities of IMO in Greece and place them on a permanent basis (e.g. in relation to the incorporation into the Greek administrative procedures of the Principals adopted by the Facilitation Committee on 22/01/2009 FAL.3/Cir. 194 relating to Administrative Procedures for Disembarking Persons Rescued at Sea). All developments and initiatives for the implementation of the requirements of the International Conventions by the Greek authorities are published on the website of the Hellenic Coast Guard, [www.heg.gr](https://protect-eu.mimecast.com/s/cZmkC1wAqiJZ52T5rC0Z?domain=heg.gr) and on [http://egos.yen.gr](https://protect-eu.mimecast.com/s/0Ie0C2kBru5mOPcNRHQE?domain=egos.yen.gr)

**GERMANY**

The FAL Convention has been given effect with the publication in the German Federal Law Gazette (Ubereinkommen zur Erleichterung des internationalen Seeverkehrs) (Bundesgesetzblatt, Teil II, 1967, S.2434). The amendments of the FAL Convention are regularly published and thereby given effect by the German authorities.

**HONG KONG**

Upon our enquiry, we have been informed that the Hong Kong SAR Government (through its Marine Department, Customs and Excise Department, Immigration Department and Department of Health) has been participating actively in the Facilitation Committee (FAL Committee) of the International Maritime Organisation (IMO) to keep abreast of the latest developments in the shipping industry and to ensure that Hong Kong is in compliance with the requirements of the Convention including its latest amendments. To facilitate the marine traffic, in addition to the conventional counter services, the Marine Department has implemented the Electronic Business System (eBS) to provide a new means for handling port formalities and other shipping related documents required by the Marine Department, the Department of Health and the Immigration Department. Registered Shipping Companies and ship agencies can apply for arrival and departure clearance permits around the clock via internet under the eBS, which includes features such as auto-approval of applications, self printing of permits and port clearances, auto-payment, and online application status enquiry. The Marine Department has maintained a system reporting any stowaway case that happened on Hong Kong registered ships to IMO as required.

**BELGIUM**

Nowadays, further effect to the FAL Convention is mainly been given through transposition of Directive 2010/65/EU of the European Parliament and of the Council of 20 October 2010 on reporting formalities for ships arriving in and/or departing from ports of the Member States and repealing Directive 2002/6/EC.

Under Directive 2002/6/EC of 18 February 2002 on reporting formalities for ships arriving in and/or departing from ports of the Member States of the Community Member States were already required to accept certain standardised forms (FAL forms) in order to facilitate traffic, as defined by the IMO Convention on Facilitation of International Maritime Traffic (FAL Convention), adopted on 9 April 1965, as amended.

Based on Directive 2010/65/EU, the formalities to be reported electronically through the *Maritime Single Window* are divided into:

(i) Reporting formalities resulting from legal acts of the Union, including Notification for ships arriving in and departing from ports of the Member States; Border checks on persons; Notification of dangerous or polluting goods carried on board; Notification of waste and residues; Notification of security information, and Entry summary declaration (Customs code);

(ii) FAL forms and formalities resulting from international legal instruments, including FAL form 1: General Declaration; FAL form 2: Cargo Declaration; FAL form 3: Ship’s Stores Declaration; FAL form 4: Crew’s Effects Declaration; FAL form 5: Crew List; FAL form 6: Passenger List; FAL form 7: Dangerous Goods, and the Maritime Declaration of Health;

(iii) Any relevant information provided in accordance with national legislation of the Member State.

# Q.7. Are you aware if your jurisdiction has denied free pratique to a vessel during any of the following pandemics: Avian Flu; SARS; Chikungunya or MERS?

**AUSTRALIA**

Australia has never denied free pratique to a vessel during any of the following pandemics.

**NEW ZEALAND**

No vessel was denied pratique because of suspected quarantinable diseases on board the vessel. Some vessels may not have received radio pratique (ie health clearance before berthing) but instead received pratique on arrival because they reported illness on board or did not meet New Zealand’s statutory requirements for reporting the state of health on board the vessel prior to arrival.

**UNITED STATES OF AMERICA**

Under United States federal regulations found at 42 C.F.R. §71.31, the Centers for Disease Control and Prevention’s (“CDC”) grants controlled free pratique to vessels entering U.S. ports of entry. Port authorities, public agencies, and private organizations are prohibited from requiring SSCECs/SSCCs for seafaring vessels at U.S. ports of entry.

**MALTA**

We are not aware of any incidents relating to the Avian flu, SARS, Chikungunya or MERS. That said, in September of 2014, Malta refused entry to the vessel M.V. Western Copenhagen, a Hong Kong registered bulk carrier which was enroute from Guinea to Ukraine, on the grounds that one of the crew members, a Filipino national, was showing symptoms which were similar to those attributed to the Ebola virus.The decision taken was a direct consequence of the fact that the Maltese authorities felt that at the time it lacked the adequate facilities to treat an Ebola patient locally.The vessel then proceeded to Sicily where the patient was disembarked and treated. The vessel eventually resumed her journey to Ukraine. It later transpired that the respected seafarer was actually suffering from severe malaria.

**PANAMA**

**UNITED KINGDOM**

We are not aware.

**NIGERIA**

Yes. In the wake of the outbreak of Ebola, mild checks were put in place at entry points before grant of entrance, especially for people from the Countries that had outbreak of Ebola.

**KOREA**

A foreigner having any of the above 4 diseases may be prohibited from entering Korea pursuant to Article 12 of the Immigration Control Act of Korea. However, there are no laws and regulations regarding the denial of free pratique to a vessel related to any of the above 4 diseases.

**IRELAND**

Ireland did not/has not denied free pratique to any vessel.

**DENMARK**

Denmark has not denied free pratique to a vessel during any of the above-mentioned Pandemics.

**FINLAND**

N/A

**POLAND**

According to information provided by the Chief Sanitary Inspectorate, the Polish authority did not deny free pratique to any vessel during any of the above mentioned pandemics.

**VENEZUELA**

No, we are not aware if Venezuela has denied free pratique to a vessel during any of those pandemics.

**CANADA**

Not that we are aware of.

**NORWAY**

No ships/vessels have been denied free pratique during any of the pandemics mentioned.

**THE NETHERLANDS**

We are not aware of any ship being denied free pratique during any of the mentioned pandemics. However, during the recent Ebola outbreak the Port Health Authorities have been actively requesting a Maritime Health Declaration from ships from the affected areas.

**ITALY**

Yes, Harbour Master Offices denied the free pratique to some vessels that called one of the ports interested by a pandemic event.

**GREECE**

The question was addressed to the Hellenic Coast Guard at the Ministry of Shipping and Island Policy and accordingly it has been certified by virtue of their official response with Reg. No. 2132.6/39336/2015, that until 20.11.2015 no vessel has been denied free pratique, in the context of prevention of diseases and in particular in relation to the Avian flu or Ebola virus. Furthermore, it has been confirmed to us that all Port Authorities in Greece have been duly provided with all of the Circulars and Directions of the Ministry of Health and the other ministries which have further been responsible for addressing the bola virus outbreak, in order to be prepared to act in the context of their duties.

**GERMANY**

No, we are not aware of any such cases/incidents in Germany.

**HONG KONG**

No.

**BELGIUM**

Information not freely available

# Q.8. Are you aware if your jurisdiction has taken any steps to establish the care capacities identified in Sections A or B of Annex 1 of the International Health Regulations, and in particular a “national public health emergency health plan” in compliance with the International Health Regulations?

**AUSTRALIA**

Australian National Health Emergency Response Arrangements outline the strategic authorities, responsibilities, arrangements and the mechanisms that enable a coordinated national health sector response to emergencies of national consequence. The arrangements are used to inform and guide a coordinated Australian health sector response to, and recovery from, emergencies of national consequences including public emergency such as Pandemic influenza.

**NEW ZEALAND**

New Zealand’s implementation status of the core capacities is 100% according to the WHO database. New Zealand has a “national public health emergency response plan”: *New Zealand Influenza Pandemic Plan: A framework for action.* This framework/plan seems to establish the core capacities outlined in Annex 1 of the IHR. As well as a national public health emergency response plan, there are also regional and local pandemic plans.

**UNITED STATES OF AMERICA**

In the United States, a public health emergency declaration releases resources meant to handle an actual or potential public health crisis. Recent examples include incidents of flooding, severe weather.15 and the 2009 H1N1 influenza outbreak. Homeland Security Secretary Janet Napolitano described it as a "declaration of emergency preparedness.”16

The National Disaster Medical System Federal Partners Memorandum of Agreement defines a public health emergency as "an emergency need for health care [medical] services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack or other significant or catastrophic event. For purposes of NDMS activation, a public health emergency may include but is not limited to, public health emergencies declared by the Secretary of HHS [Health and Human Services] under 42 U.S.C. 247d, or a declaration of a major disaster or emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), 42 U.S.C. 5121-5206*)."*

**MALTA**

Unfortunately, this information could not be disclosed. However following its accession to the International Health Regulations (2005) on 15th June 2007, Malta has introduced National IHR Focal Points. National IHR Focal Points maintains continuous communication between Malta and WHO and ensures the analysis of public health risks, the implementation of WHO recommendations, advise health and government officials amongst other functions. Malta is also part of the EpiSouth Plus project, which was founded to increase health security in the Mediterranean area and South-East Europe by strengthening the preparedness for common health threats and bio-security risks at national as well as at regional levels in the countries forming part of the EpiSouth Network, and within the context of the International Health Regulations.

**UNITED KINGDOM**

Steps taken by the UK to establish the care capacities include:

Syndromic Surveillance, a tool created by Public Health England (“PHE”) to detect the onset of a pandemic and to gain timely information on the spatial and temporal development. The UK has local and national surveillance’s including:

- NHS Direct Surveillance

- School Surveillance

- UK Retail Sales Surveillance

PHE also focus on meeting responsibilities under the International Health Regulations. Within the UK, PHE have provided guidance to professional groups, including medical practitioners, requesting they remain vigilant for unexplained illness in those who have visited the affected areas, and has advised on actions to take in the event of a possible case.

The health protection (ships and aircraft)regulations 2013, further implement the International Health Regulations by updating the health protection powers and duties for use at England’s ports and airports.

Legislations are also in place to allow all UK administrations to issue sanitation control/exemption certificates. Ship Sanitation Certificates are designed to prevent international vessels from causing a public health risk and cover all areas of the ship-borne public health risks including vector control, potable and ballast water and food safety controls.

The UK Department of Health has a “government policy: health emergency planning” in place to deal with a wide range of events which can cause health emergencies.

**NIGERIA**

Yes.

**KOREA**

The Minister of Health and Welfare shall formulate and implement a master plan for the prevention and control of infectious diseases every five years and an Infectious Disease Control Committee shall be established under the Ministry of Health and Welfare to deliberate on major policies on the prevention and control of infectious diseases in accordance with the Infectious Disease Control and Prevention Act of Korea.

**IRELAND**

Ireland has not. Ireland did not experience any infected persons and focused on being prepared to deal with any eventuality. Ireland took many practical steps which have been integrated into the general strategy for any and all health alerts.

**DENMARK**

The Danish Health and Medicines Authority has established emergency response plans for Pandemics in compliance with the International Health Regulations, e.g. the authorities have issued an emergency response plan for pandemic influenza and an emergency response plan for Ebola.

According to national law, the foundation of the statutory national monitoring is the National Board of Health Order on doctors’ notification of infectious diseases. The regulatory reporting system includes a number of serious infectious diseases. Doctors are subject to a notification obligation for these diseases. The table (attached) shows a list of the infectious diseases that are reportable.

**FINLAND**

On the part of Finland, Valvira names the harbors as required by the Health Regulations that are authorized to issue certificates on sanitation control and on exemption from sanitation control for ships: [https://www.valvira.fi/web/en/environmental-health/health](https://protect-eu.mimecast.com/s/LGq-C31DviD406I7HHQh?domain=valvira.fi) protection/who health regulation

Regarding Finland’s Social Welfare and Health Care preparedness, please see: [https://julkari.fi/bitstream/handle/10024/114809/Es200605eng.pdf?sequence=2](https://protect-eu.mimecast.com/s/WeB5C4x0wT483MCPjcwt?domain=julkari.fi)

**POLAND**

According to information provided by the Chief Sanitary Inspectorate, each vessel arriving to any port in Poland is being controlled in accordance with the International Health Regulations.

Moreover, in the term of duration of any pandemics, the State Border Sanitary Inspectors evaluates risks related to onset of any pandemics on the territory of Poland in case of arrival of each vessel from the territory recognised by the WHO as affected with the pandemic. Subsequently, if necessary, the State Border Sanitary Inspectors undertake proper actions described in recommendations of the National IHR Focal Point and the Chief Sanitary Inspectorate, which complies with the schemes of crisis response system in the scope of public health established in the International Health Regulations.

**VENEZUELA**

No. Venezuela has not established the care capacities identified in Sections A and B of Annex 1 of the International Health Regulations. The last Epidemiological Bulletin was published in 2016 but it only includes information up to 2015, this violates the recommendations of the World Health Organisation and has influenced in the development of contagions.

Venezuela has suffered in the last two years different epidemics such as: Zika, Malaria, Chikungunya and Dengue. Nevertheless, the Health Ministry has not published any official data or statistics on the development and influence of these epidemics in Venezuela.

**CANADA**

Yes. On an annual basis, Canada re-assesses its core capacities and reports to the WHO. Canada continues to meet all of its State Party obligations under the IHR.

In addition, the Government of Canada has a Federal Emergency Response Plan (FERP), established to address an all hazards approach. The FERP is supported by the Health Portfolio Emergency Response Plan, the Federal Health Portfolio’s departmental emergency response plan.

**NORWAY**

Yes, according to the International Health Regulations Norway through our organisation has pointed out points of entries, as for the ports which are - Oslo, Bergen and Tromso - they all have focused on and are obliged to have the capacities as described in Annex 1. As far as we can see they more or less have fulfilled the obligations required. We have received the response plans from all these three cities (in Norwegian).

**THE NETHERLANDS**

According to the *Rijksinstituut voor Volksgezondheid en Milieu* (National Institute for Public Health and the Environment), which is a part of the Ministry of Health, Welfare and Sport, the Netherlands acts in compliance with the Public Health Act and the executive implementation, the Public Health Decree. Annex 1 is incorporated in the latter.

The National Institute for Public Health and the Environment has indicated that there are different emergency response plans, depending on the health emergency in question. The primary level of observation and assessment lies with the ‘Gemeentelijke Gezondheidsdienst’ (Municipal Health Institute) as well as general practitioners. Duties and level of operations scale in accordance with Annex 1. The National Institute for Public Health and the Environment indicated that response plans and the established care capacities can be reviewed on their website.

**ITALY**

Yes, since 2010 Italy has got a national public health emergency response plan that complies with the WHO International Health Regulations of 2005.

**GREECE**

In compliance with the International Health Regulations (IHR), the Greek Ministry of Health has drafted the National Response Plan for Public Health in 2008. Furthermore, in order to respond to the need for a co-ordinated plan for the prevention of and response to the Ebola virus outbreak, especially with regard to emergencies arising from the spreading of the virus to the local society, the Ministry of Health has drafted the National Response Plan for Ebola Virus in December 2014 (published on the internet on 07.01.2015).

**GERMANY**

Yes. There are specific recommendations issued by the German institute (Robert Koch Institut - RKI) for implementing the core capacities at airports and ports. The RKI also co-ordinates the national public health emergency response plan and the national communication between different levels of authorities involved. The RKI Department of Infectious Disease Epidemiology is responsible for the collection, analysis and epidemiological assessment of data communicated to the RKI according to infection protection act (Infektionsschutzgesetz, IfSG). It further conducts research in infectious diseases Epidemiology as well as sentinel surveillance projects and supports the German Federal States in the investigation and management of outbreaks. The Department of Infectious Disease Epidemiology also represents the RKI in networks of the EU and WHO and maintains an information exchange with international partners (e.g. public health institutions within the EU, CDC).

**HONG KONG**

Yes, by enactment and enforcement of the Prevention and Control of Disease Ordinance (Chapter 599) and its subsidiary regulations.

**BELGIUM**

A "national public health emergency response plan" in compliance with the International Health Regulations was developed at the occasion of various pandemic outbreaks, such as the SARS and the H1N1 influenza epidemics.

The governmental service Saniport Seaports (a corollary to Saniport Airports) is responsible of for the Ship Sanitation Certificate (SSC).

In case of events with possible impact for public health (such as SARS or the H1N1 influenza epidemics), Sanitation Police – acting in continuous collaboration with European and international actors – is one of the main actors within the Public Health Emergency Response Plans, as established by the Federal Public Service Health, Food Chain Safety and Environment. Saniport will coordinate the hosting of travellers and animals, based on agreements with medical and veterinary services so as to separate them (or put them in quarantine), to give them treatment or to taking other necessary measures. They equally apply necessary measures for disinsection, deratification, disinfection of luggage, cargo, transport means, goods and postal packages.

Saniport is competent for controlling travellers at arrival and departure1.

# Q9 - The recent Ebola Outbreak:

# (A). What measures were taken by your jurisdiction during the recent Ebola Outbreak?

**AUSTRALIA**

The Department of Health, in partnership with the Department of Agriculture and Water Resources and the Department of Immigration and Border Protection, implemented measures at the Australian Border, including electronic sine age and banners to raise awareness of the Ebola Outbreak. Travel history cards were introduced for all incoming travellers, including cruise ship travellers, to assist with identifying anyone who may have been in an Ebola affected country The Department worked closely with Non-Government Organisations and the Australian Government contracted organisation (Aspen Medical) to identify health workers returning from relevant West African Countries. All identified travellers from Ebola-affected countries were assessed on their return for Ebola symptoms and given information about the disease. Their health and wellbeing was also monitored by state and territory health authorities for up to 21 days after leaving an Ebola affected country. Australia had no cases of Ebola during the outbreak.

**NEW ZEALAND**

The Ministry of Health’s *Risk Assessment Framework for managing III Travellers with suspected symptoms of Ebola Virus Disease and Contacts arriving in New Zealand: Guidelines for DHB Public Health Units* is an operational guideline for managing the Ebola virus and the guideline has been used during the recent Ebola outbreak to inform the border health protection officers on measures to take during the outbreak.

**UNITED STATES OF AMERICA**

In the United States:

* o Reducing the likelihood of spread of Ebola through travel, including working with federal and state health officials to establish entry risk assessment procedures
* o Establishing entry screening and monitoring of all travellers entering the U.S. from Ebola-affected areas
* o Assisting state health departments in responding to domestic Ebola concerns
* o Establishing trained and ready hospitals in the United States capable of safely caring for possible Ebola patients
* o Forming CDC Rapid Ebola Preparedness (REP) response teams that could provide assistance within 24 hours to a health care facility managing a patient with Ebola.
* o Identifying and distributing to state and local public health laboratories a laboratory assay that could reliably detect infection with the Ebola virus strain circulating in West Africa, and working with the Food and Drug Administration, the U.S. Department of Defense, and the Association of Public Health Laboratories to rapidly introduce and validate the assay in public health laboratories across the United States.

**MALTA**

At the beginning of the Ebola outbreak (back in 2014), a special monitoring committee was set up to aid with the coordination of the disease control sector in Malta. Various authorities and bodies are responsible for the different aspects of the implementation of the Ebola action plan – these include the health authorities, the Civil Protection Department, the Armed Forces as well as the Ministry of Health.

A set of guidelines was circulated to all healthcare professionals, civil protection police and armed forces personnel. Particular focus was placed on the education and training in various areas of the health care system in order to ensure awareness and familiarization with the Ebola virus and the relevant symptoms. This included the distribution of educational posters in clinics, airports, ports and pharmacies.

The monitoring committee also evaluated various possible threat scenarios in order to develop a plan of action in case of a local outbreak of Ebola.

All local health care centres were provided with necessary materials such as infrared thermometers and protective clothing and isolation rooms were set up in most hospitals in the Maltese Islands.

In light of the above, the Maltese authorities took a number of precautionary measures to minimize the risk of an Ebola outbreak. These measures included the screening of persons travelling to Malta from affected countries. With regards to migrants, those arriving from affected countries, namely West African countries, were kept in quarantine for a number of days and those working in detention centres were given training on how to spot and deal with the Ebola virus.

**UNITED KINGDOM**

The measures taken were:

(1) Screening at ports; and

(2) £427 million package of direct support to help fight and contain Ebola which included:

i. Medical help on the ground;

ii. NHS staff volunteered to travel to west Africa;

iii. Supporting 1,400 treatment and isolation beds and building 6 Ebola treatment centres;

iv. Rolling out community care centres;

v. £10 million to boost capacity of safe burial teams;

vi. Sending emergency supplies;

vii.Emergency research into how it spreads and how to stop it;

viii. Vaccine trials;

ix. 750 military troops to help;

x. Advised against all non-essential travel to Liberia, Sierra Leone and Guinea;

xi. Provided clinical management advice and guidance for medics; and

[xii.UK](https://protect-eu.mimecast.com/s/vJk4C5yGxckl45cWj8c8?domain=xii.uk) Aid matched first £5 million of public donations.

**NIGERIA**

Nigeria adopted four major steps which had great impact in curtailing the spread of the Ebola pandemic. They were:-

**Trace, Isolate, and Treat:**

Since it was confirmed that Ebola patients are not contagious until they exhibit symptoms such as fever, it was possible to adopt these strategies. Because the source of Ebola into Nigeria was quickly traced to a Liberian American, Patrick Sawyer, who came to Nigeria in July 2014, Nigerian government/health workers in charge could trace all the people that had contact, one way or the other, to Patrick Sawyer and the health personnel that had treated him or his contacts. In this way, the victim’s close contacts were identified, isolated, and they were educated about the symptoms. After a few lapses, proper medical protocol kept healthcare workers from getting sick.

**Early Detection before many people could be exposed:**

It is generally believed that anyone with Ebola, typically, will infect about two more people, unless something is done to intervene.

In Nigeria the virus passed from Patrick Sawyer through the hospital that treated him. A scared patient who fled to Port-Harcourt seeking better medical care spread the virus to a well-known medical doctor. But, after tracking down hundreds of contacts in Lagos, and in Port-Harcourt, officials brought the outbreak under control. The WHO confirmed that the few contacts who attempted to escape the monitoring system were all diligently tracked, using special intervention teams, and returned to medical observation to complete the requisite monitoring period of 21 days.

The medical doctor who initially diagnosed Sawyer, Stella Ameyo Adadevoh, prevented Sawyer from leaving the hospital to attend a popular Pentecostal Church for cleansing/cure. Not even the pressure from the Liberian ambassador to Nigeria could get Adadevoh to yield. She later died of Ebola.

Notably, Ebola is really hard to cover up.

**Strong Leadership.**

In the wake of the Ebola outbreak, Nigeria showed strong leadership with a top national priority.

In the summary report of the World Health Organisation (WHO), it was said about NIgeria that “the most critical factor is leadership and engagement from from the head of state and Minister of Health”. Standing tall in the leadership position was the Lagos State Government under Babatunde Raji Fashola, SAN.

The Nigerian Government also received donations from state partners, international groups and non-governmental organisations to successfully launch an attack on the Ebola outbreak.

**Public Awareness:**

Gaining public trust was key to the control of Ebola in Nigeria.

The Government embarked on information campaigns, house-by-house leafleting, messages on local radio stations, and enlisting entertainers, Nollywood actors/actresses and social mobilisers to deliver the health messages. Everyone in Nigeria became an ardent user of hand sanitisers, and they became hand washing compliant. Schools, hospitals, churches, mosques, restaurants, bars and such other public places installed hand sanitising machines and basins/taps for hand washing.

In particular, the Nigerian Ports Authority issued guidelines for prevention of the spread in all ports locations and terminals. The NPA put measures in place such as an enlightenment campaign about the origins, symptoms, mode of spread, identifying people at high risk, diagnosis, containment and prevention of infection. The Authority also issued guidelines to all its personnel on protection and prevention measures to be adopted in the discharge of their duties.

**KOREA**

The Ebola Control Committee was established in April 2014 and reinforced the quarantine procedure.

**IRELAND**

During the recent Ebola outbreak Ireland established a steering group which was led by the Health Service Executive but had participants from the Department of Transport and Customs and Immigration. That group took several steps, and identified any and all travel routes and vessels coming from affected areas. There was one such route coming from Liberia to the Port of Aghinah in the Shannon Estuary.

Firstly, they ensured that any vessel coming from an infected area filled out the IHR medical forms for all crew members even if they were not sick.

Secondly, at Port level, it was agreed with all parties that the Sailors would stay on the vessel whilst it was being unloaded and loaded. This was overseen by Medical Health Officers.

Thirdly, the Steering group set up protocols for those people such as navigation Pilots, Marine Inspectors and Custom and Immigration officers on what to look for and what steps to take if they came into contact with an infected party.

**DENMARK**

In order to prevent the spread of Ebola disease, the Danish Health and Medicines Authority issued guidelines to national doctors and hospitals.

**FINLAND**

Please see: [http://stm.fi/en/ebola-virus-disease](https://protect-eu.mimecast.com/s/mdupC68JyILW8jSg8EWQ?domain=stm.fi)

**POLAND**

The Polish MLA does not possess information about any actions taken by Polish jurisdiction in reference to recent Ebola outbreak.

**VENEZUELA**

In Venezuela, during the recent Ebola outbreak the General Director of Epidemiology, Edgar Rivera, declared that Venezuela has placed in practice the temporary recommendations of the World Health Organisation.

In order to ensure the safety of travellers, Venezuela issued a red alert level 3 to avoid the unnecessary trips to Sierra Leone, Guinea and Liberia, and yellow alert level 2 to Nigeria travellers. Following this outbreak, Epidemiological Surveillance was set in practice to detect possible cases in hospitals, airports, ports and other entry points with high probable contamination risks.

**CANADA**

See below.

**NORWAY**

Local level: going through and updating existing plans, giving necessary general information to passengers arriving from the three countries in West-Africa.

National level: Making Ebola guidelines and later on Ebola plan in cooperation with the Norwegian Institute of Public Health. Contributing into the British initiative with health personal to affected country. Giving advice and interpretations and support asked for and also pro-active to relevant institutions and the public and authorities. The Norwegian Institute of Public Health gave lots of information on their web pages and the Norwegian Directorate of Health also gave information besides and we linked info on our web pages into their pages. Posters how to behave according to the International Health Regulations were put up at main airports about precautions and recommendations for passengers coming from out-break area. No particular actions were taken by the Norwegian Public Health Institute or by the Norwegian Directorate of Health aimed particularly towards ship to my knowledge.

However, Norway has been a collaborating partner of the EU Ship San Act Joint Action and thereby has distributed relevant received information from this project to our designated ports and to ports issuing Ship Sanitation Certificate (SSC).

Norway is also part of and has implemented the SafeSeaNet system, though not fully complied with the Maritime declaration of Health in the International Health Regulations so far. The Coastal Authority also on their own initiative through the SafeSeaNet system collected ISPS information about ships arriving Norway and the ten latest ports that the ships had been into. They also got a report regularly over ships that had left West-Africa from EMSA. SafeSeaNet is a vessel traffic monitoring and information system operating under EMSA, and dealing with maritime safety, security and environment protection ( [http://www.emsa.europa.eu/ssn-main.html](https://protect-eu.mimecast.com/s/cGfTC73KziGRo4c6XQNN?domain=emsa.europa.eu) ). EMSA has also created the National Single Window (NSW) prototype under the Integrated Maritime Policy work programme, where 6 countries including Norway participate. ( [http://www.emsa.europa.eu/related-projects/nsw.html](https://protect-eu.mimecast.com/s/ilNNC82LAhNkLDuGkL-G?domain=emsa.europa.eu) ).

**THE NETHERLANDS**

One of the measures taken during the Ebola outbreak consisted of informing the public. The Netherlands does not have strong (historic) ties with the affected area, which makes it hard to define the group at risk. There are no direct flights from The Netherlands to the affected areas.

The measures taken were mainly aimed at preparing the medical staff for possible Ebola infected patients, such as raising awareness for the symptoms of Ebola and obliging practitioners to report any possible case of Ebola to the Municipal Health Institute. Any patient possibly infected with Ebola is to be isolated and to be treated by a limited group of medical staff. All the patients’ contacts are to be tracked and their health to be monitored for three weeks.

Procedures for the Port of Rotterdam are available from the Port Health Authority Rotterdam pages on the Port of Rotterdam Website.

**ITALY**

As far as the port activity is concerned, the Italian Ministry of Health gave specific instructions to the Harbour Master Offices recalling a circular of 8.4.2014 in which the Ministry ordered to release the free pratique to ships that called a port interested by Ebola Outbreak in the previous 21 days only after a sanitary inspection on board. The ships that called one of those ports have been informed by the Harbour Master on UHF/VHF of the suspension of the free pratique once in the Italian national waters.

**GREECE**

In the context of harmonisation of Greek law with IHR, the FAL Convention and MLC 2006 Convention, as well as in compliance with the requirements of the national legislation with regard to Public Health, the Greek State has taken legislative initiatives as of the. End of 2014 for the purpose of preparing to respond to the Ebola virus outbreak and the possibility of its spreading to the local society, including but not limited to the following:

1. Ministerial Decision No. (Greek characters)-96894/05.11.2014 on the “Designation of Hospital Units for the hospitalisation of suspicious or confirmed cases of Ebola”.

2. Ministerial Decision No. (Greek characters)-95509/03.11.2014 on the “Establishment of a National Committee on Virus Hemorrhagic Fever” and its supplements.

3. Ministerial Decision No. (Greek characters)-1088 on the “Plan to respond to Ebola Hemorrhagic Fever “ATHENA”” (Ebola National Response Plan). This was issued and published on the main page of the website of the Ministry of Health as well as of the Hellenic Centre for Disease Control & Prevention (KEELPNO).

Further to and in the context of the above, a great number of Circulars, Directives and Guidelines have been issued by the relevant authorities, through which all the local authorities down the chain were informed and guided accordingly so as to ensure preparedness. Indicitavively, it is worth mentioning the following Circulars issued by the Ministry of Health: (a) No. (Greek characters)- 69893/08.08.2014 on “Ebola Hemorrhagic Fever - Directions, (b) No. (Greek characters) - 92962/23.10.2014 on “General Directions - Instructions for the Hemorrhagic Fever Ebola to the Health Units (private and public) of the country” and (c) No. (Greek characters) - 95662/03.11.2014 on the “Increase of levels of preparedness of the ports of the country for the Hemorrhagic Fever Ebola”. Additionally, public awareness was raised through the circulation and distribution of informative material by the relevant authorities as well as the media. Other measures include: (a) Training of the personnel of the authorities responsible for the implementation of the measures taken by the state to respond to the Ebola outbreak, (b) Activation of a 24/7 telephone line for recording Ebola incidents, (c) Creation of a dedicated Ebola portal on the internet intended to train the Public Health personnel participating in the Ebola National Response Plan, and (d) Supporting the infrastructure at the country’s entry points, such as the port authorities and airports, passenger and immigrants reception centres etc.

**GERMANY**

Special inspections of ships arriving from Ebola affected areas/ports. Good information policy about measures to implement for vessels trading in Ebola affected areas. The Maritime Medical Service of the German Social Accident Insurance Institution for Commercial Transport, Postal Logistics and Telecommunication (BG Verkehr) has published a leaflet for seafarers and shipowners with information about prevention and the symptoms of the Ebola Virus Disease.

**HONG KONG**

The Department of Health issued a Preparedness and Response Plan for Ebola virus disease in 2014.

**BELGIUM**

Cfr. infra, sub b).

# (B). Which Department of State or Organisation in your jurisdiction was responsible for implementing those measures during the recent Ebola outbreak?

**AUSTRALIA**

Yes, The Department of Health develops policies and plans to respond to public health events. The department works closely with border agency partners and state and territory health authorities to implement measures to respond to the Ebola outbreak

**NEW ZEALAND**

The Ministry of Health was responsible for implementing the measures, as outlined in the *Risk Assessment Framework for Managing III Travellers with Suspected Symptoms of Ebola Virus Disease and Contacts Arriving in New Zealand: Guidelines for DHB Public Health Units.*

**UNITED STATES OF AMERICA**

The Centers for Disease Control (“CDC”).

**MALTA**

The Health Department and the Infectious Disease Prevention and Control Unit are the main two departments responsible for implementing the relevant measures related to this matter. A special monitoring committee was also set up by the CEO of the Primary Health Care Department in 2014, which was responsible for the implementation of all measures concerned with the Ebola disease action plan. One of the main actors throughout the implementation of the necessary procedures and measures is the Minister of Health. Also in 2014, the Chief Medical Officer was appointed as the National Ebola Coordinator.

**UNITED KINGDOM**

Public Health England took steps to prevent disease spreading to the UK, the Department for International Development, with assistance from the Ministry of Defence, the Department of Health and the Department for Transport.

**NIGERIA**

The Ministries of Health (Federal and States) led the campaign.

**KOREA**

The Ministry of Health and Welfare was responsible for it.

**IRELAND**

The aforementioned Steering Group under the Department of Health.

**DENMARK**

Danish Health and Medicines Authority. The work was carried out in collaboration with the public health medical officer institutions, which have a number of Authority functions and coordinate the local response to epidemics. Statens Serum Institut is a specialist advisor to the Authority.

**FINLAND**

The Ministry of Social Affairs and health.

**POLAND**

Although the Polish MLA does not possess information about any actions taken by Polish jurisdiction in reference to recent Ebola outbreak, we indicate that the authority, which most likely would be responsible for implementing measures related to Ebola outbreak, is the State Sanitary Inspection.

**VENEZUELA**

The Ministry of Popular Power for Health was responsible.

**CANADA**

With respect to (A) and (B) above: For more information on Canada’s Ebola response, please refer to the “Health Portfolio; Framework for Action on the 2014 Ebola Virus Disease Outbreak”: [http://healthy](https://protect-eu.mimecast.com/s/ey1SC9rMBI4O9LCAkZ50?domain=healthy) Canadians [gc.ca/diseases-conditions-maladies-affections/disease-maladie-ebola/response-response/cadre-ebola-framework-eng.php](https://protect-eu.mimecast.com/s/k_nSC0RzpsNyZquMSyiG?domain=gc.ca)

**NORWAY**

On local level: The competent authority - it means the municipalities.

On the National level - the Norwegian Institute of Public Health and the Norwegian Directorate of Health.

**THE NETHERLANDS**

The National Institute for Public Health and the Environment indicated that in the case of Ebola or other infectious diseases the *Centrum Infectieziektebestrijding* (Centre for Infectious Disease Control) is put in charge of the national coordination and response. Local response is managed by the Municipal Health Institutes in conjunction with general practitioners.

The Centre for Infectious Disease Control also tends to the cooperation and sharing of information with international partners such as the WHO and the Centres for Disease Control and Prevention.

**ITALY**

The competent offices responsible for implementing the measures were the local Harbour Master Offices and the USMAF (ports and borders sanitary offices).

**GREECE**

Except for the Ministry of Health and its various Directorates, the KEELPNO, the National Health Operation Centre (E.K.EP.Y), the National Committee for Virus Hemorrhagic Fevers, the First Aid National Centre (EKAB), various regional Directorates etc. were set, inter alia, as the designated authorities for the purposes of implementation.

Furthermore, the Ministry of Shipping and its various Directorates, acting as Flag State authorities, the Hellenic Coast Guard and all the Port Authorities of the country (in their capacity as the authorities of the Flag State and/or the Port State), undertook the implementation of the measures on board the vessels as well as at the entry points of the country and sea passengers’ and immigrants’ reception centres.

It is also worth pointing out that, pursuant to the Ebola National Response Plan, the University of Thessaly (Faculty of Hygene and Epidemiology) was set to co-operate with the WHO in relation to the IHR and the country entry points. Furthermore, the Microbiology Laboratory of the Aristotle University of Thessaloniki (Faculty of Medicine) was set as the component laboratory for the investigation of any suspicious clinical specimen.

**GERMANY**

The responsible German Federal Port Health Authorities/Services which are part of the German Federal Health Authorities.

**HONG KONG**

The Department of Health.

**BELGIUM**

**National coordination**

The Federal Council of Ministers has appointed Dr. Erika Vlieghe as **national Ebola coordinator**. Her assistant coordinator is Dr. Daniel Reynders of the federal public service (FPS) Health, Food chain safety and Environment. They are both in charge of the global management of actions on Ebola in Belgium and of the coordination of the information flow to professionals and the general public.

When a threat for public health such as Ebola arises, health authorities must take measures enabling to keep the risk for the Belgian population as low as possible. This is the task of the **Risk Management Group**. This group is composed of all health authorities deciding together what measures need to be taken in order to protect public health in Belgium. Decisions are taken on the basis of the advice of the **Risk Assessment Group**. The Risk Assessment Group analyses the riskof Ebola for the Belgian population on the basis of epidemiologic and scientific data. The Risk Assessment Group consists of:

- physician epidemiologists from the Scientific Institute for Public Health (known as “WIV-ISP”)

- the federal and regional authorities competent for health

- experts with specialized knowledge of Ebola

Within the FPS Health, Food chain safety and Environment, a **departmental crisis cell** has been created. The crisis cell is responsible for all operational aspects relating to the preparation to a possible Ebola case in Belgium. Working groups are active within this crisis cell, in which actors of public health, government partners from other fields and experts collaborate on the development of procedures, forms and the communication to citizens and professionals.

**Saniport**

Saniport is the sanitary police of international traffic. The Saniport agents ensure the health of passengers and crew of aircraft and ships. Saniport is based at Brussels National Airport and in the ports of Antwerp, Ghent, Ostend and Zeebrugge. If a pilot or a captain reports a possible case of Ebola on board, Saniport is present 24/7 in order to take the necessary measures.

The health authorities of the Belgian communities and regions

Infectious diseases that (can) form a threat to public health, like Ebola, have to be reported to the physician responsible for infectious disease control of the health authority of the Belgian community or region in question. The health authorities are:

- *Agentschap Zorg en Gezondheid* (the Agency for Care and Health of the Flemish Community)

- the Common Community Commission of the Region of Brussels-Capital

- the Walloon Region

- the German-speaking Community

All general practitioners and other physicians, clinical laboratories, hospital physicians, care facilities, prevention services and the medical service of the airport have to report suspected Ebola infections immediately to the physician responsible for infectious disease control. The aim of this reporting obligation is to be able to take the necessary measures in time in order to prevent Ebola from spreading.

Any reported case of Ebola will be assessed by the physician responsible for infectious disease control, in consultation with several colleague physicians, like the treating physician, the infectiologist and the Ebola coordinator. In the event of a possible Ebola infection, the national Ebola procedure will be started. This implies that:

- the other Belgian health authorities will be informed.

- the transport of the patient to a referral hospital for Ebola will be organised.

- the patient’s diagnosis and treatment will be followed up.

- the patient’s contacts will be mapped out and followed up if the patient is found to have Ebola*.*

Reference hospitals for Ebola in Belgium

Every hospital in Belgium is equipped to detect Ebola infection and to place the patient in quarantine. In Belgium, a patient suspected or proven to have been infected with the Ebola virus is treated in one of three reference hospitals:

- the Saint-Peter’s Hospital in Brussels

- the Antwerp University Hospital

- the Leuven University Hospital

All three hospitals closely cooperate with the Belgian health authorities to ensure the safe treatment of the patient.

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Any reported case of Ebola will be assessed by the physician responsible for infectious disease control, in consultation with several colleague physicians, like the treating physician, the infectiologist and the Ebola coordinator. In the event of a possible Ebola infection, the national Ebola procedure will be started. This implies that:

- the other Belgian health authorities will be informed.

- the transport of the patient to a referral hospital for Ebola will be organised.

- the patient’s diagnosis and treatment will be followed up.

- the patient’s contacts will be mapped out and followed up if the patient is found to have Ebola*.*

Reference hospitals for Ebola in Belgium

Every hospital in Belgium is equipped to detect Ebola infection and to place the patient in quarantine. In Belgium, a patient suspected or proven to have been infected with the Ebola virus is treated in one of three reference hospitals:

- the Saint-Peter’s Hospital in Brussels

- the Antwerp University Hospital

- the Leuven University Hospital

All three hospitals closely cooperate with the Belgian health authorities to ensure the safe treatment of the patient.

See further information on www.info-ebola.be.

# (C). Were maritime administrations within your jurisdiction consulted in relation decisions taken within your jurisdiction during the Ebola outbreak?

**AUSTRALIA**

With the assistance of border agency partners, the Department monitored the movements of all vessels which had visited Ebola effected countries and were headed to Australia, for a 21 day period. During the period of the response, no vessel was identified as having berthed at an Australian port within the 21 day Ebola window.

**NEW ZEALAND**

Maritime New Zealand was one of a large number of border stakeholders the Ministry of Health worked with during its preparedness for responding to suspected cases of Ebola. There were in excess of fourteen updates sent to border stakeholders, including Maritime New Zealand, with updated information from the World Health Organisation and others on the progress with the Ebola response in affected countries. These updates also included revised versions of the *Risk Assessment Framework for Managing III Travellers with Suspected Symptoms of Ebola Virus Disease and Contacts arriving in New Zealand: Guidelines for DHB Public Health Units.*

**UNITED STATES OF AMERICA**

Yes. The United States Coast Guard (“USCG”) continues to monitor the threat and work to prevent the possible waterborne entry or spread of the virus via U.S. ports. An Ebola Crisis Action Team has been stood up at USCG Headquarters and is conducting a comprehensive review of USCG policy to provide clarifying guidance to port stakeholders, and they will release additional guidance as necessary. Also, guidance from the CDC continues to evolve and updates will be available at: http://www.cdc.gov/vhf/ebola.

33 C.F.R. § 160.215 requires the owner, agent, master, operator, or person in charge of a vessel to immediately notify the nearest Coast Guard Sector whenever there is a hazardous condition aboard the vessel. An ill person on board, especially one displaying the symptoms listed above, may constitute a hazardous condition and should be reported. Facilities that encounter similar conditions are strongly recommended to report this to the Coast Guard.

**MALTA**

The responsible departments also worked in close collaboration with the maritime authorities in regard to communication between vessels and the Valletta Port Control.

**UNITED KINGDOM**

The UK maritime administrations were fully consulted throughout the outbreak and were kept fully informed of all decisions made by the UK government.

**NIGERIA**

No. Maritime Administrators were not specifically included. However, all the health related departments of the maritime administrators ensured the prevention strategies of hand washing and sanitising.

The relevant departments, particularly at Nigerian Ports Authority held a series of Seminars with Ports Health, Terminal Operators, Port Managers and stakeholders in the various ports to brief them on measures to take in curbing the spread of the Ebola virus. They also provided palliative measures such as health kits.

Port Officers also went on board vessels to check the crew before issuing berthing certificates and where necessary drastic measures were taken to prevent ships from major Ebola countries or those that traverse such countries from calling at Nigerian Ports.

**KOREA**

As far as we know, No.

**IRELAND**

Yes. Maritime administrations were consulted during the outbreak. They were consulted through the steering group and from Port level through to Departmental officials.

**DENMARK**

N/A

**FINLAND**

Yes, probably.

**POLAND**

According to information provided by the Chief Sanitary Inspectorate, the State Sanitary Inspection permanently cooperates with maritime administrations to comply with the International Health Regulations and other regulations. However, the Polish MLA does not possess information about any decisions taken in reference to recent Ebola outbreak.

**VENEZUELA**

We believe not.

**CANADA**

Yes, other relevant Federal governmental departments, including Transport Canada, were consulted.

**NORWAY**

Only in the way that two of our points of entry has both the function as being pointed out as harbour and airport points. The information from us (The Health Directorate) and the Public Health Institute was mainly focused on airplanes, but could also to some extent be applied on ports. However, this was not followed up in any particular way on national level towards the ports to my knowledge.

**THE NETHERLANDS**

The National Institute for Public Health and the Environment indicated that in the case of a medical emergency there is continuous consultation and cooperation with all related parties in the country, including the maritime administrations.

More in depth involvement occurs on a case by case basis. In the recent Ebola outbreak there were no specific cases in the Netherlands within the scope of the maritime administration that required consultation of the maritime authorities. The only case where there was a need to discuss specifics was regarding a potential case of infection entering the Netherlands through Schiphol Airport. The airport authorities were involved in the response to this specific case.

**ITALY**

Yes. The Italian Ministry of Health consulted the Maritime Authority for the enforcement of the rules stated in the Circular of 8.4.2014.

**GREECE**

The State Flag authorities, the Union of Greek Shipowners, the Hellenic Chamber of Shipping and other maritime authorities have been consulted, inter alia, by KEELPNO and have addressed numerous circulars and directions to crew, passengers, port authorities, shipping companies and vessels. Such circulars also advise on all the initiatives, actions and publications of the WHO on the outbreak of the virus as well as on the need for disease preparedness, co-ordination, public awareness, infection prevention, control and response plans.

KEELPNO was also very actively reporting and following up on any indication of Ebola infection. Pursuant to IHR, a Written Emergency Response Plan must be drafted for every port in the country, which would specifically provide for the appointment of a Co-ordination and for the duties of the relevant health and port authorities. KEELPNO provided instructions for the preparation of such Emergency Response Plan.

**GERMANY**

Yes, the German Federal Port Health Authorities/Services which were involved as well as the relevant department of the German Flag State Authority (Maritime Medical Service, Ship Safety Division, BG Verkehr) were aware of the relevant legal instruments (see below) and took action swiftly.

**HONG KONG**

The Department of Health has established the Port Health Office to enforce the Prevention and Control of Disease Ordinance (Chapter 599) and the International Health Regulations.

**BELGIUM**

Yes, all maritime administrations represented in the Coast Guard Agency were consulted and established a specific procedure, in close collaboration with the National Ebola Coordinator and Saniport (*see above*).

More specifically, the Coast Guard secretariat, in close cooperation with the Health & Safety Officer of the Maritime and Coastal Services Agency (MDK), organised a meeting on the Ebola subject on November, 28th 2014 in order to tackle concerns of a number of Belgian coast guard partners on the possible danger of contamination when boarding ships coming from countries affected by ebola. To minimise the danger of contamination as much as possible, a specific procedure was adopted and clarified. The Belgian national ebola coordinator assisted at this meeting to address any specific concerns2.

# (D)

# .

# Were those who took decisions in your jurisdiction during the Ebola outbreak aware of the requirements of:

(I) International Health Regulations 2005; and

(II) The FAL Convention 1965 (As Amended); and

(III) The ILO MLC Convention?

**AUSTRALIA**

The Department of Health is responsible for Australia’s implementation of the International Health Regulations 2005 (IHR). Decisions around the Ebola response were taken within the framework of the IHR.

**NEW ZEALAND**

Health officials were aware of the IHR 2005, but not of the two conventions.

**UNITED STATES OF AMERICA**

The United States Coast Guard (“USCG”) is aware of these requirements.

**MALTA**

Given the numerous governmental divisions, entities and bodies involved, we are not able to reply to this question. That said, as the above international instruments have all been incorporated into our domestic legislation, one can assume that the local authorities concerned were aware of the requirements laid out therein.

**UNITED KINGDOM**

The decisions that were taken complied fully with the requirements of existing UK legislation which included the requirements of the above three conventions/regulations.

**NIGERIA**

No. They were mainly concerned with the World Health Organisation as the umbrella body.

**KOREA**

Since maritime administration did not participate in or consult with the Ebola Control Committee, we believe that only the IHR 2005 was noted by the decision makers.

**IRELAND**

(i) IHR 2005 Regulations were considered in conjunction with the EU decisions on cross border health decisions from the EU Health Security committee.

(ii) The provisions of the FAL Convention of 1965 were considered and the people involved were aware of the requirements. Ireland sought to take a co-operative approach between Health Officials, Department of Transport officials, Customs and Immigration and Private shipping companies. It stayed very local and was ‘very much on the ground’.

(iii) In relation to the 2006 ILO MLC Convention it was identical to the FAL Convention. People were aware of it but opted to operate in a different manner.

**DENMARK**

N/A

**FINLAND**

N/A

**POLAND**

According to information provided by the Chief Sanitary Inspectorate, the State Sanitary Inspection is aware of each of the above mentioned regulations, however in practice, performing its statutory obligations, the State Sanitary Inspection mainly applies the International Health Regulations 2005. The FAL Convention 1965 and the ILO MLC 2006 Convention are being applied only supplementary.

**VENEZUELA**

Yes, we believe authorities were aware of all of the above.

**CANADA**

Canada is aware of these international instruments and they were taken into account.

**NORWAY**

(International Health Regulations) - Yes, absolutely - all authorities mentioned - The Norwegian Directorate of Health, the Norwegian Public Institute of Health, and the two mentioned harbours. They are well aware of the requirements in the IHR. It is also implemented into Norwegian regulations. Concerning Oslo harbour as the third harbour, we do not have much and contact directly in order to answer properly, but the municipality medical doctor in this city is well informed, so I assume that they are.

(The FAL Convention 1965 as amended) - Yes.

(THE ILO MLC 2006 Convention) - It is a part of the WHO Inspection Ship Sanitation, but only as recommended. In our (Norwegian Directorate of Health) learning of the handbook we focus primarily on the column “Required” as it deals with “public health risk” which is essential in the International Health Regulations. WHO handbook [http://www.who.int/ihr/publications/handbook](https://protect-eu.mimecast.com/s/HsEuCgJ4KuEBpOs9vRbZ?domain=who.int) ships inspection/en/

**THE NETHERLANDS**

The National Institute for Public Health and the Environment indicated they have a legal department that checks whether its policy is in accordance with the applicable international regulations and conventions. However, in the case of infectious diseases, it stated that it primarily operates in line with the Public Health Act.

**ITALY**

In the different circulars issued by Italian Ministry of Health during the Ebola outbreak there were specific references to IHRs 2005 and FAL Convention 1965 requirements. However, no reference to ILO-MLC 2006 Convention requirements has been noted.

**GREECE**

Yes they were, as the Greek State has ratified and incorporated into national law all of the above conventions and regulations as well as the amendments thereto. As above, most of the circulars and directions were based on the guidelines of the above Regulations and Conventions.

**GERMANY**

(I) In Germany the Federal Port Health Services are responsible for the execution of ship sanitation inspections and infection protection. The coastal states of the port health service work together as “Arbeitskreis der Kustenlander fur Schiffshygiene” (AkKu, working group of the coastal states for ship sanitation) to co-ordinate their work.

(II) Yes.

(III) Yes.

**HONG KONG**

The Department of Health was aware of the International Health Regulations 2005 as it is the authority responsible for their enforcement. We have no information as to whether it was familiar with the FAL Convention 1965 (as amended) or the ILO-MLC Convention.

**BELGIUM**

Information not freely available.

# (E). Were those making the decisions in your jurisdiction in relation to the Ebola outbreak aware of the potential conflict in the requirements between those Regulations and Conventions?

**AUSTRALIA**

The Department of Health administers compliance with the IHR, which have been in effect since 2007. We have not, to date, been notified of any potential conflict between the IHR and other international maritime conventions.

**NEW ZEALAND**

In response to the question, the Ministry stated:

No: Health officials were not aware of the two conventions. However, we note that our response was not fully consistent with the WHO’s advice and recommendations and was used as an example of good practice by the WHO. We also note the FAL Convention 1965 predates the IHR 2005, and the ILO MLC 2006 Convention is drafted around the same time as the IHR 2005 so we would assume the various drafting groups and those consulted during development would have taken these into account. We would not assume member states need to do this

I am also not sure what the potential conflict would be as the IHR 2005 are intended to address public health risks of international concern, to exclude occupational health and safety matters, and to avoid unnecessary interference with travel and trade. This is stated specially in Article 2: *“The purpose and scope of the Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks and which avoid unnecessary interference with international travel and trade.”*

**UNITED STATES OF AMERICA**

There is a presumption the government officials are familiar and aware with the domestic law and international commitments of the United States.

**MALTA**

Similar to the above question, due to the different authorities involved, it was not possible to confirm whether all entities involved were aware of the potential conflict which could exist between the provisions of the Regulations and those under the Conventions.

**UNITED KINGDOM**

The UK has robust health screening regulations in place to ensure the spread of pandemics is kept to a minimum. These regulations comply with all the UK’s international obligations.

**NIGERIA**

No.

**KOREA**

We believe that they did not know of such potential conflict.

**IRELAND**

The relevant authorities were aware of the conflict between the Regulations and Conventions. As previously indicated, they took a very practical approach. There were no cases or incidents in Ireland and so the emphasis at all times was on cooperation amongst all stakeholders and to ensure that the correct protocols were in place. Preparation was the main theme for the steering group.

In talking to the relevant authorities in Ireland, they found the co-operative approach to have been extremely refreshing. All parties took the threat, and concerns of each other on board.

In fact, this approach is planned to be put on a formal basis at the annual review. It is currently still in place because of the ongoing Ebola threat, and the new and emerging Zika threat.

**DENMARK**

N/A

**FINLAND**

N/A

**POLAND**

The Polish MLA has no information about the awareness of the State Sanitary Inspection of the potential conflict in requirements between the above mentioned Regulations and Conventions.

**VENEZUELA**

No, we do not have any information about the potential conflict in requirements between those Regulations and Conventions.

**CANADA**

The specified international instruments were taken into account. (Should you have specific concerns about the above requirements, please elaborate.

**NORWAY**

The Norwegian Directorate of Health answers that they do not know, but they do not think so.

**THE NETHERLANDS**

Upon inquiry we have no information about the awareness of the National Institute for Public Health and the Environment about potential conflicts between the above mentioned regulations.

**ITALY**

It is rather doubtful that Italian Ministry of Health and Italian Coast Guard were duly aware of the potential conflict in the requirements regarding seafarers’ health between those Regulations and Conventions. Anyway, no specific reference and/or mention have been noted in occasion of the issuing of the different circulars concerning the Ebola outbreak.

**GREECE**

From the perusal of the relevant regulations, conventions, circulars and directions, we did not notice any potential conflict of which the relevant public authorities were aware.

**GERMANY**

Which potential conflicts?

**HONG KONG**

The information cannot be ascertained.

**BELGIUM**

Information not freely available.

*Further replies will be incorporated (as they arrive) into the above.*