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**REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND
THE COUNCIL**

**On the implementation of the Council Recommendation of 18 June 2003 on the
prevention and reduction of health-related harm associated with drug dependence**

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1. BACKGROUND

On 18 June 2003, the Council adopted a Recommendation on “the prevention and reduction of health-related harm associated with drug dependence”¹. The aim of the Recommendation is to reduce the number of drug-related deaths (DRDs) and drug-related health damage by encouraging Member States to set up and develop responses and strategies to prevent and reduce drug-related harm. This sense of urgency was reiterated in the EU Drugs Strategy 2005-2012 and the EU Drugs Action Plan 2005-2008.

The Recommendation includes three main points for Member States' action:

- (1) to set as a public health objective the prevention of drug dependence and the reduction of related risks and to develop and implement comprehensive strategies accordingly;
- (2) to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C, and tuberculosis) and the number of DRDs, through 13 sub-points relating to harm reduction services and facilities (e.g. distribution of injection materials, vaccination, treatment, information and training);
- (3) to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and to reduce drug-related health risks, through 9 sub-points covering quality assurance, monitoring and evaluation of programmes.

The Recommendation foresees that the Member States report back on the implementation of the above points within two years after its adoption and invites the Commission to prepare a report.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) publishes yearly a report on the state of the drugs problem in EU including information on DRDs and drug-related infectious diseases such as HIV/AIDS and hepatitis. **See figure 1.**

2. METHODOLOGY – DATA COLLECTION

This Report is based on two main sources.

First, in 2005, the Commission asked the 25 Member States to report on the state of affairs regarding the implementation of the Council Recommendation.

Moreover, the above information was subsequently processed by the Trimbos Institute, an independent research centre in the field of mental health and addiction, which had been commissioned to write a background document in preparation of this Report. The background document includes detailed information on existing policies and practices across Member States for the prevention and reduction of health-related harm associated with drug dependence, together with a review of the current situation regarding the effectiveness of harm reduction interventions².

¹ OJ L165, 03/07/2003, p. 0031 – 0033

² See Annex 2

3. MAIN OUTCOMES RELATED TO THE IMPLEMENTATION OF THE COUNCIL RECOMMENDATION

3.1. Recommendation point 1 - Harm reduction as a public health objective

In all Member States, the prevention and reduction of drug-related harm is a defined public health objective at national level. In this process, the Recommendation played an important role in particular in most of the countries joining the EU in 2004.

Member States have also included a reference to the Council Recommendation in the EU Drugs Strategy 2005-2012.

3.2. Recommendation point 2 – Harm reduction services and facilities in the Member States

All Member States have established harm reduction services and facilities, some to a lesser extent.

The data assembled for the background document provide a good overview of the availability of services and facilities in the Member States.

See Figure 2, Annex II.

- *Harm reduction facilities and services in the Member States*

All Member States have implemented the policy of providing information and counselling to drug users. Further measures of **information, education and communication (IEC)** are telephone help lines and a broad range of educational leaflets, which are available to drug users in all countries. Twenty-two countries use websites and some even have internet-based counselling tools. Training courses that address prevention of risks and harm are provided in 21 countries. In Malta, for example, such training is available for drug users on an individual basis for those who attend an outpatient unit.

The communities and families of drug users are widely involved in harm reduction activities in the Member States and specific information packages are available for them in the majority of countries. In the United Kingdom, for example, families are involved in overdose prevention training to reduce DRDs.

Outreach work is a common response strategy to prevent infectious diseases. Either street-based or in recreational settings such as dance parties/raves, it is well implemented across Member States though with geographical variations within countries. For example, outreach projects and low-threshold services exist throughout Italy and the variety of facilities has expanded over time. Moreover, mobile methadone treatment has recently been introduced in some areas of the country.

Peers and volunteers are systematically involved **in outreach work** in the majority of Member States (19). Information on the training of peers and volunteers is available, even though information on their concrete involvement in outreach work is limited. In Belgium, for example, (former) drug users are trained to disseminate HIV prevention and overdose prevention messages.

Networking and cooperation between outreach work agencies exists in the vast majority of Member States (20), even though the number of agencies is quite small in some of them. It is very encouraging that Lithuania and Latvia will soon implement this policy.

Provision for drug treatment exists in all Member States and they implement opioid substitution treatment (Cyprus is preparing such treatment programmes). There are maintenance and detoxification regimes to stabilise and reduce/terminate drug use, respectively. Opioid **substitution treatment** is a common response strategy to reduce DRDs, and substitution treatment with methadone and/or buprenorphine, supported by psychosocial care, is available in almost all countries (24). Sweden, for instance, was the first country to provide methadone maintenance treatment, and a strict high-threshold methadone maintenance programme is currently running.

Several studies show a relationship between maintenance treatment of opiate users and a reduction of drug-related deaths. Effectiveness may increase with higher doses and when psychosocial intervention supplements treatment programmes.

Regarding the **prevention of the diversion of substitution substances**, almost all Member States (22) reported that measures such as strict registration, supervised consumption, urine testing, and daily pick-up of doses are in place to prevent leakage to the black market. Estonia and Slovenia, for example, specifically reported that the implementation of policy to prevent diversion is the result of the Recommendation.

The testing/screening of infectious diseases is available nationwide to drug users in 19 Member States and in certain geographical areas in three countries. Prevention and education measures as well as specific treatment programmes for the prevention of infectious diseases targeted at drug users are available nationwide in 15 countries and for specific geographical areas in five countries. **Vaccination campaigns** for hepatitis B focusing specifically on drug users are available nationwide in 15 countries and for specific areas in five further countries. In Luxembourg for example, an action and research programme was initiated in 2005 by the National Focal Points (NFPs)³ to provide for on-site testing (hep. A, B, C, and HIV) and vaccination (hep. A, B) by specialised national non-governmental organisations (NGOs). **Vaccination programmes** exist throughout the EU, but do not always specifically target drug users.

Needle and syringe exchange programmes are available to drug users in 24 Member States, in 15 of which nationwide. **Condom distribution** is available from drug services throughout the EU with a few exceptions (2). Needle and syringe exchange programmes, combined with information or education strategies, which target drug users in their daily environment have been shown to be both effective and cost-effective in reducing risk behaviours among injecting drug users and are therefore likely to prevent the transmission of infectious diseases.

All countries have a policy ensuring that **emergency services** are trained and equipped to deal with overdoses and in most them (20), ambulances routinely carry the opiate antagonist naloxone. However, the medical staff working in emergency services does receive specific training in dealing with drug overdoses in 10 countries only.

The last sub-point under this point of the Recommendation calls for support for **training activities leading to a recognised qualification for professionals** responsible for the prevention and reduction of health-related risks associated with drug dependence. Such a policy exists in almost all Member States (22). Training for outreach workers and

³ <http://www.emcdda.europa.eu/?nnodeid=403>

professionals in maintenance treatment is available respectively in 21 and 20 countries. Training for professionals in low-threshold services is provided in 19 countries.

- ***Harm reduction services in prisons***

The EMCDDA reports that the lifetime prevalence of injecting drug use among prisoners in Europe is between 7% and 38%. A policy to provide drug users in prisons with services that are similar to those available to drug users outside prisons exists in 20 Member States and is about to be introduced in four countries.

The background document reports that needle and syringe exchange programmes in prison are probably effective in reducing needle sharing among injecting drug users and the transmission of drug-related infectious diseases. They may also reduce abscesses.

The distribution of drug paraphernalia⁴ is not a common practice in the prisons (11 countries only). Three countries provide needle and syringe exchange in prisons. In Spain, for example, a needle and syringe exchange programme is available in 38 prisons.

Substitution and detoxification treatments are available in prisons in, respectively, 17 and 19 countries although the coverage varies greatly. Condom distribution is available in prisons in 16 countries.

See Figure 3, Annex II.

- ***Integration of harm reduction with social and mental health care***

The Member States indicate that harm reduction is considered at policy level to be an integral part of (mental) health and social care, but according to the background document this integration has not always been put into practice: “Member States continue to struggle with drug users who have both a dependency problem and a mental health problem (co-morbidity or double diagnosis) and the reintegration of former drug users to a regular working life and housing is often still problematic”.

Twenty-three countries have a policy to promote appropriate integration between health services (including mental health services) and social care, on the one hand, and specialised approaches to risk reduction on the other. It is reported as implemented practice in four-fifths of the countries. In France, for example, the RMS programme (Réseau Micro-Structures) provides care for all kinds of addicted patients by physicians, social workers and psychologists.

Nevertheless, it seems that the implementation of this policy still needs development, since it appears that providing a fully integrated system of care for drug users remains a challenge.

3.3. Recommendation point 3 – Quality assurance, monitoring and evaluation

Not all Member States see quality assurance, monitoring and evaluation as the task of national government. However, they subscribe in general to the need for greater emphasis on and use of scientific evidence in harm reduction practice. In countries with a federal or decentralised structure, tasks are divided among the different levels of competence. In others, quality

⁴ Tools and equipment needed to prepare or administer drugs

assurance, monitoring and evaluation are seen as a task for independent scientific organisations.

See Figure 4, Annex II.

Assessment, monitoring and evaluation of harm reduction services and facilities in the Member States

The majority of Member States (19) report policy decisions to be specifically based on **scientific evidence of effectiveness**. Several have research and evaluation projects to examine harm reduction interventions (e.g. substitution programmes, outreach work, needle exchange). For example, Germany reports an evaluation of substitution treatment (methadone and heroin). Lithuania reports its “Blue Bus” needle exchange project, which is assessed on a monthly basis and also by performing client surveys. In Hungary, the National Institute for Drug Prevention has developed a database ‘SZIP’ to make scientific evidence of effectiveness broadly available, i.e. by combining programme information and scientific research. Slovakia reported that the results of international research are systematically being used for the development of interventions and policies.

In general, Member States do agree with the **need for assessments** at the initial stage of programmes but often do not make it a condition in the selection of programmes and interventions. In Ireland, however, a baseline assessment determined the hepatitis B vaccination coverage among drug users in order to design a pilot project to improve infectious disease preventive care for IDUs.

The **development of evaluation protocols** for the evaluation of interventions is a task often considered to be one for scientific institutions dealing with quality evaluation. However, some Member States such as the Czech Republic and Denmark have developed protocols and guidelines as part of their drugs policy. In Cyprus, for example, the Anti-Drug Council’s scientific committee has developed specific guidelines for drug treatment centres to ensure minimum quality standards. In Greece a policy includes evaluation in every programme. This part of the Recommendation is reported as being implemented in 12 countries.

Fourteen Member States have a policy in place that aims to **support the development of evaluation quality criteria**. Such policies are often at an early stage of development. In Finland, for example, the Drug Policy Action Programme 2004-2007 calls for the development of a quality framework for drug service providers. EMCDDA has produced several manuals and monographs on quality and evaluation⁵, but countries do not specifically refer to their use.

Twenty-three Member States report **compliance with the five key EMCDDA indicators**⁶. However, some do not yet implement all five. Every year, EMCDDA provides feedback to individual countries on the quality of their input and possible deficiencies in their information. National reports are usually published on national websites.

Nineteen Member States emphasise that the **results of evaluation contribute to the refining and development of drug prevention policies**. The countries report that the evaluation of national drug strategies and action plans is gaining increasing importance, but only a limited

⁵ Available at http://publications.eu.int/others/sales_agents_en.html

⁶ <http://www.emcdda.europa.eu/?nnodeid=1365>

number of them seem to carry out systematic evaluation to assess the effectiveness of specific interventions. Many evaluation schemes do not specifically target harm reduction interventions but rather the wider field of drug demand reduction. In Poland, for instance, an evaluation of drug therapy programmes for women in prisons to prevent relapses has resulted in the inclusion of new objectives within the National Programme for Drug Prevention. In Portugal, the National Drug Strategy 'Horizonte 2004' has been evaluated both internally and externally, leading to new recommendations such as the further development of existing initiatives to improve risk reduction and harm minimisation systems (e.g. substitution programmes, syringe exchange, campaigns for the use of condoms).

The **evaluation training programmes** for different levels and target groups have been implemented in 14 Member States. The NFPs are frequently mentioned as (co-)organisers of such training programmes, but these programmes are not reported to be part of the regular curricula for professionals in addiction care. However, in the Czech Republic, for example, quality standards for addiction treatment services have been developed and implemented within a training programme for professionals, and in Austria quality assurance and evaluation forms part of the curricula for drug-specific further education.

Fourteen Member States reported having a policy in place to enable **all actors and stakeholders to be involved in the evaluation process**, but very few present concrete examples of participation and involvement. In the Netherlands, for instance, a system of 'client councils' for patients in health care, including addiction care, has been created. In Spain, the involvement of stakeholders in evaluation is a priority in the National Action Plan on Drugs.

Bi- and multi-lateral programmes involving several Member States have been developed, and 21 report that they have a policy to **encourage exchange and collaboration with others**. It appears that there is now more cooperation between them and even with third countries. They are also cooperating with the Commission, through e.g. the Community Programme on Public Health, to exchange skills and experiences within the EU. The EU Phare Twinning Programme⁷ has been an important tool for enhancing the collaboration between the old and the new countries joining EU in 2004. Seven countries indicate that the Recommendation has been an important tool in developing this kind of activity.

See Figure 5, Annex II.

4. CONCLUSIONS

- (1) All Member States have policies and actions in place that to a large extent reflect the measures recommended in the Recommendation and in most of the new countries the document is considered as an important support for policy development. It has also served as a benchmark for the implementation of harm reduction interventions. As the level of implementation is variable within and between countries, it is important to continue developing harm reduction measures and implementing harm reduction services/facilities as part of an integrated system of prevention and care.

⁷ http://ec.europa.eu/enlargement/key_documents/phare_legislation_and_publications_en.htm.

- (2) Almost all Member States have a policy in place to promote appropriate integration between health services (including mental health services and social care) and specialised harm reduction services. These efforts to integrate programmes within the general health care system need to be intensified and continued.
- (3) Methadone and buprenorphine substitution treatments supported by psychosocial care are available in all Member States, and availability has increased considerably over the past decade. However, the extent to which the provision meets the estimated need varies between countries. The accessibility, coverage and sustainability of these services should be ensured.
- (4) Data on the availability of harm reduction services/facilities collected by EMCDDA are comprehensive and of a high quality. However, information on the accessibility and the utilisation of such facilities, with a particular focus on at-risk populations, should be further improved in order to obtain an overview of the situation in the different countries with clear indications on coverage as a core-element in policy evaluation. In addition, the gap in compliance with the five key EMCDDA indicators needs to be addressed.
- (5) Almost all Member States have implemented measures to prevent infectious diseases among drug users in prisons. However, harm reduction interventions in prisons within the European Union are still not in accordance with the principle of equivalence adopted by UN General Assembly⁸, UNAIDS/ WHO⁹ and UNODC¹⁰, which calls for equivalence between health services and care (including harm reduction) inside prison and those available to society outside prison. Therefore, it is important for the countries to adapt prison-based harm reduction activities to meet the needs of drug users and staff in prisons and improve access to services. The continuity of these services, including quality and access, should be ensured after release from prison.
- (6) Among the Member States there is increasing awareness of the need to develop research-based, fact-driven policies and to implement evidence-based activities, including those to prevent and reduce health-related harm. To critically evaluate such measures, improved monitoring and in-depth research should become an integral part of overall policy to prevent and reduce drug-related harm, as reflected in the Recommendation, the EU Drugs Strategy 2005-2012 and the EU Drugs Action Plan 2005-2008.
- (7) A range of different methodologies to assess, monitor and evaluate harm reduction services and facilities are currently in use among Member States. It is therefore for them to discuss and exchange information on best practice with regard to such methods in order to develop standardised approaches and tools for the collection of objective, reliable and comparable information.
- (8) Finally, it is of utmost importance to ensure synergies between policies and initiatives with health-related aspects and possible links to drug use (e.g. mental

⁸ <http://www.pogar.org/publications/garesolutions/a45-111-90e.pdf>

⁹ http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf

¹⁰ http://data.unaids.org/pub/Report/2006/20060701_hiv-aids_prisons_en.pdf

health, alcohol, HIV/AIDS prevention, drug dependence at the workplace, drugs/medicines and driving).

5. FOLLOW-UP OF THE 2003 COUNCIL RECOMMENDATION

The reporting on the implementation of the Recommendation covers a period of 1.5 to 2 years at most. This period is still quite limited to produce a reliable picture of the influence of the Recommendation on national harm reduction policies, services and facilities. In addition, new countries have joined the EU during the reporting period (2004).

As a consequence this Report could be primarily seen as a baseline measurement for the implementation of the Council Recommendation. It can also function as a baseline overview on existing harm reduction measures in the EU for the evaluation of the EU Drugs Action Plan 2005-2008.

The Commission aims to repeat this exercise in the framework of the next EU Action Plan on Drugs 2009-2012, in order to examine if the implementation of policies, services and facilities regarding harm reduction has progressed. The Commission will then be in a position to consider, together with the Member States, if there is a need for further recommendations.

Furthermore, the Commission will continue to develop initiatives on areas that are closely related to the Council Recommendation and that take actively into account policies and practices that might be of significant influence to the achievement of its main activities. Two specific health actions relating to drug prevention are included in the EU Action Plan 2005-2008 (actions 12 & 13.2):

- a proposal for a Council Recommendation on drugs and prisons; the prison population has a high proportion of drug users, and prison settings are an urgent issue with regard to drug use and especially IDUs;
- a report on the situation regarding drug treatment and the exchange of good practice across the EU; more than half a million persons are receiving substitution treatment in Europe.

The Public Health Programme

The Community Public Health Programme includes actions on drug prevention aiming at tackling health determinants, which are multi-dimensional issues linked to a number of major health problems.

The Drugs Prevention and Information Programme 2007-2013

Activities will support the implementation of the EU Drugs Strategy by funding projects and activities in the field of drug demand reduction, including harm reduction.

Work on drug demand reduction should be linked to the following areas:

- HIV/AIDS prevention

Drug injection is a major vehicle for HIV/AIDS transmission. The Communication from the Commission to the Council and the European Parliament *on combating HIV/AIDS within the*

*European Union and in the neighbouring countries, 2006-2009*¹¹, sets out an action plan for work on HIV prevention and recognises the need for synergies with key prevention activities. One key point is the development of tailor-made training curricula for professionals involved in services (prevention, treatment, and care) for people living with HIV/AIDS and populations particularly vulnerable to HIV/AIDS (including intravenous drug users and migrants). In addition, the HIV/AIDS Think Tank has become a fruitful forum for exchanging experiences and information among partners.

- Alcohol prevention

In the context of polydrug use, alcohol-related harm and drug-related harm also need to be seen in conjunction. The Commission Communication for an EU strategy to support Member States in reducing alcohol-related harm¹² includes the promotion of effective behaviour change among children and adolescents in schools and families and other appropriate settings as well as the reduction of road accidents related to alcohol and polydrug use.

- Mental health promotion

Drug use often coincides with mental illness. Improving access to medical and psychiatric treatment for drug users remains an important challenge for public health policy. The Green Paper on Mental Health published in October 2005 by the Commission¹³ proposed the development of a strategy on mental health at EU level. This is now being prepared and should coordinate with other initiatives under different Community policies such as the EU Drugs Strategy 2005-2012.

- Civil society involvement

Efforts must also be made to reduce the indirect damage that drug users can cause to others. Drug users need to be actively involved in these efforts. The Green Paper on Drugs Policy and Civil Society in the European Union adopted by the Commission in June 2006¹⁴ explored opportunities to improve the involvement of civil society.

- Drugs/medicines and driving¹⁵

In the context of transport policy the issue of polydrug use and driving is being addressed. The Commission is also co-funding a project called DRUID (DRiving Under the Influence of Drugs, alcohol and medicines) under the framework of the Sixth Framework Programme for research and technological development (FP6).

- Drug dependence at the workplace

The Commission is currently preparing its Strategy on Safety and Health at Work 2007-2012. Concrete initiatives in support of specific public health actions addressing drug dependence at the workplace should be developed.

¹¹ http://eur-lex.europa.eu/LexUriServ/site/en/com/2005/com2005_0654en01.pdf

¹² http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0625en01.pdf

¹³ http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

¹⁴ http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0316en01.pdf

¹⁵ Council Resolution of 27 November 2003 on combating the impact of psychoactive substances use on road accidents: *Official Journal* n° C 097 of 22/04/2004 p. 0001-0003

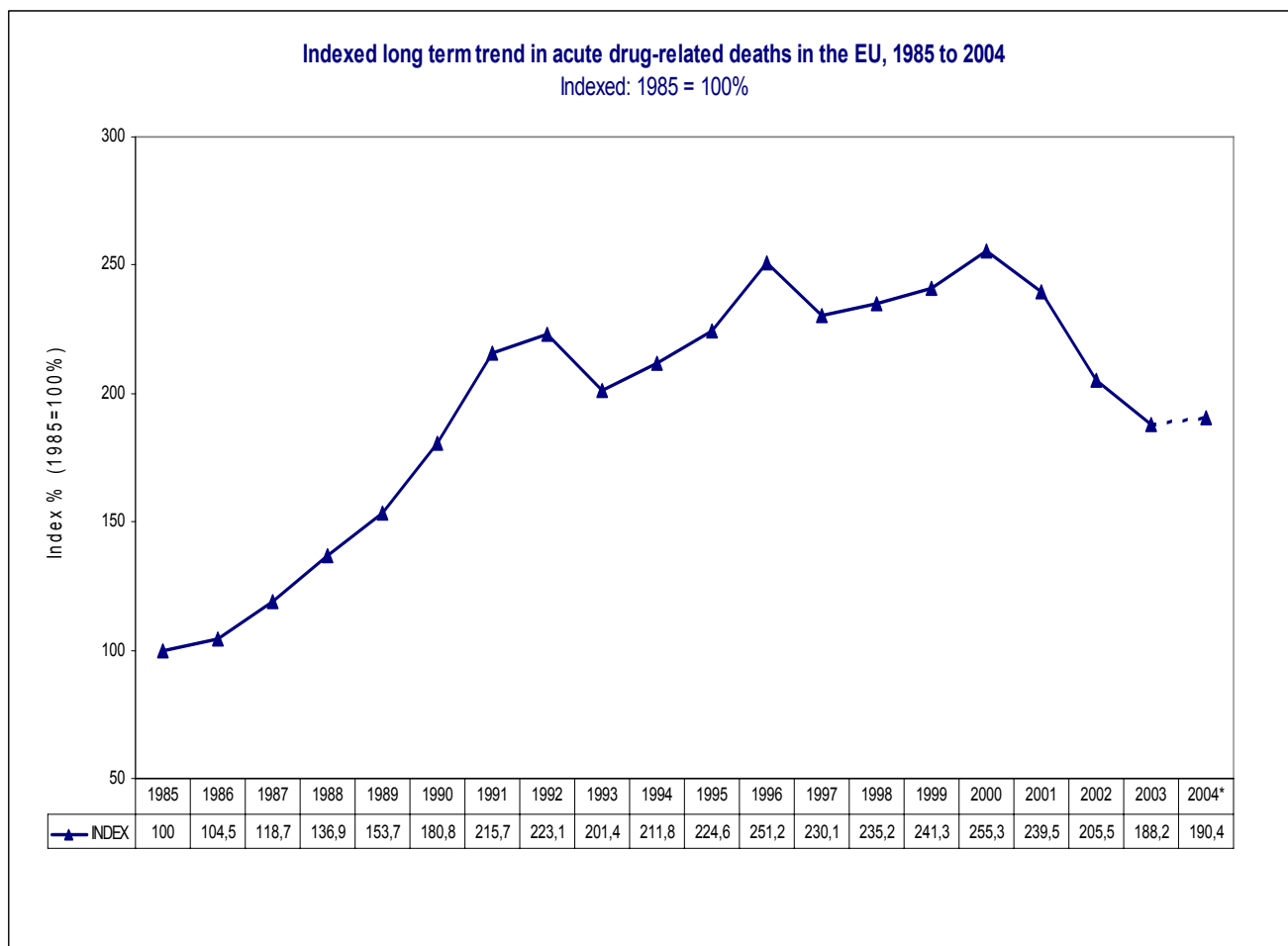
TECHNICAL ANNEXES

5.1. ANNEX I – Abbreviations and technical terms used

DRD	Drug-Related Death
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
IDU	Injecting Drug User
IEC	Information, Education, Communication
NFPs	National Focal Points
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
UNODC	United Nations Office on Drugs and Crime

5.2. ANNEX II – Figures

Figure 1



EMCDDA annual report 2006

Notes:

The new Member States and Candidate Countries are not included in this graphic due to the lack of retrospective data in most of them.

Index: 1985=100%.

A few countries did not provide data for some years (see Statistical Bulletin 2006 [Table DRD-2]). To correct this situation, it has been used the computation method defined in the report "European Monitoring Centre for Drugs and Drug Addiction (2001). Co-ordination of the implementation of the EMCDDA standard guidelines on the drug-related deaths in the EU Member States, and the collection and analysis of information on drug-related deaths. Project CT.99.RTX.04, Co-ordinated by the Trimbos Institute. Lisbon: EMCDDA.

Ten countries provided information for 2004 and six did not. Therefore, the figure for 2004 is provisional, based in comparing 2003 and 2004 only for those countries with data for both years. The trends for those countries that provided information can be seen in the figures with

trends by country. Number of cases per country per year are presented in Statistical Bulletin 2006 [Table DRD-2].

The EMCDDA estimates the yearly number of acute DRDs (overdoses) in the EU since 1990 to be from 6500 to over 9000.

Recently published estimates show that a substantial proportion of mortality among young adults in some EU urban areas can be attributed to opioid use. In addition, HIV transmission is continuing to be a concern in specific injecting groups across Europe, although most countries report low rates of newly diagnosed HIV infection attributable to drug injecting and estimate the HIV infection rates among injectors to be below 5%. A far more negative picture presents itself for rates of infection with the hepatitis C virus (HCV), which remain almost universally high among drug injectors.

Since 2000, many EU countries have reported decreases in DRD numbers. In 2004, however, there was an increase. While the number of DRDs is still far too high from a longer-term public health perspective, a better availability of drug treatments and increased coverage of harm reduction services in recent years seem to have had an impact.

Figures from the background document on "prevention and reduction of health-related harm associated with drug dependence - an inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003".

The document is available in print (EN) and can be downloaded (EN, FR, DE) at the following web address: http://ec.europa.eu/health/ph_determinants/life_style/drug_en.htm

The Trimbos Institute extracted and analysed relevant data, in particular from the EMCDDA sources (the NFPs coordinated by the EMCDDA confirmed and updated the information provided for the Recommendation point 2), the projects funded under the ‘Programme of Community action on the prevention of drug dependence’ and the ongoing Public Health Programme, the projects funded under the 4th, 5th and 6th Framework Programmes for Research and Technological Development as well as from some field organisations, the World Health Organization (WHO), the Pompidou Group (PG), and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Finally, a literature review was conducted to identify, assess and summarise scientific evidence on harm reduction interventions and approaches.

Figure 2

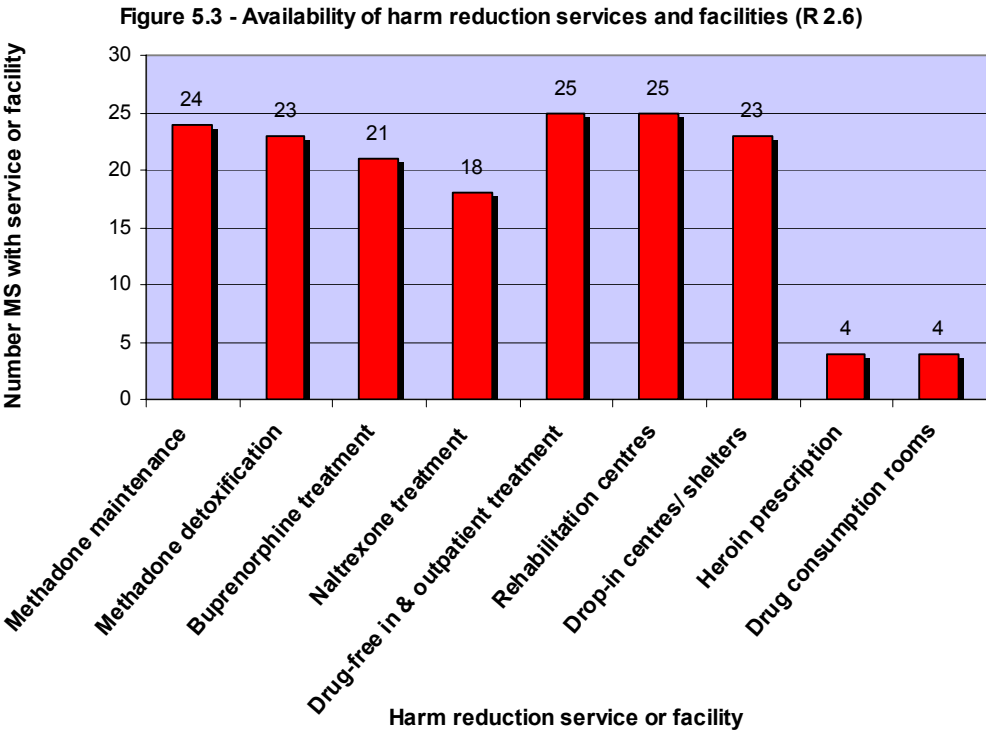


Figure 3

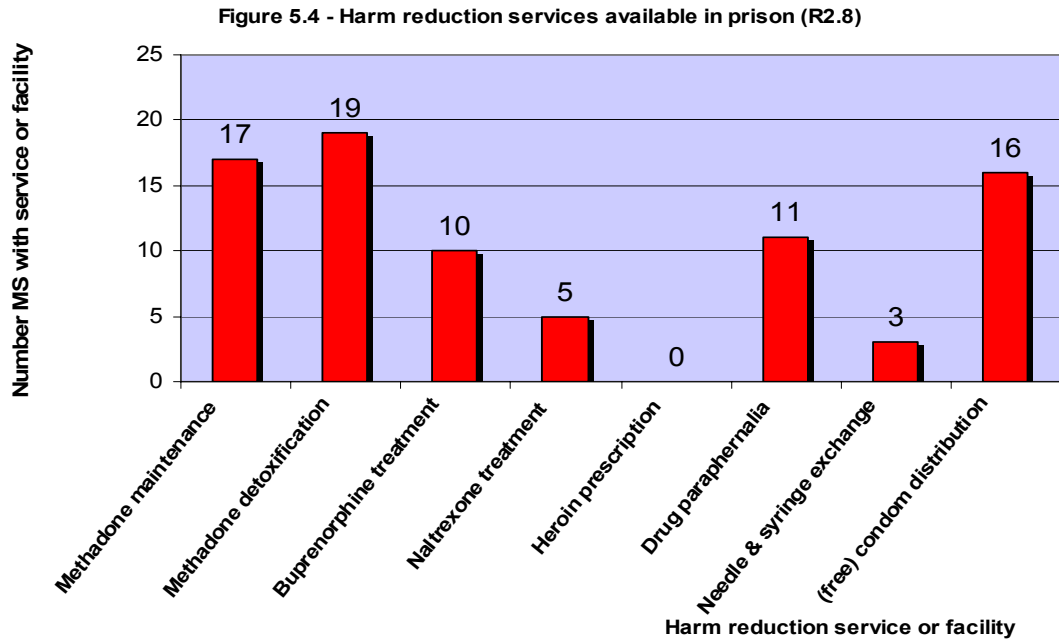


Figure 4

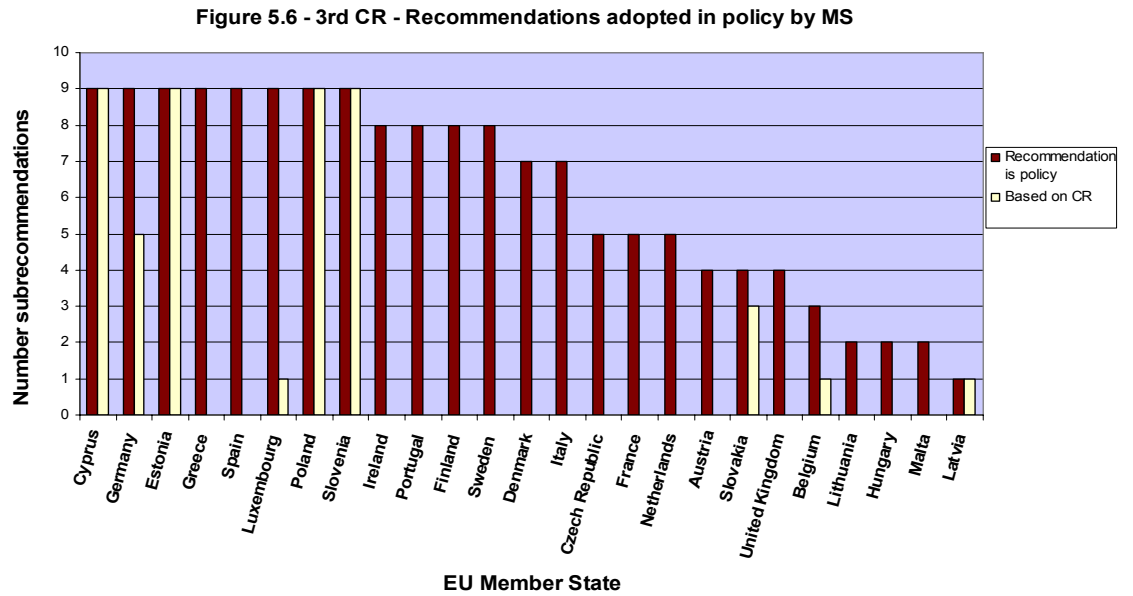


Figure 5

