**CHAPTER 4**

# BULGARIA

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## 4.1. Introduction

### 4.1.1. General information

Since the great political changes in central and eastern Europe in 1989, Bulgaria has been in a period of transition with major transformations at all levels of society – political, economic, social, health care, etc.. The main national priorities during this period were the development of a democratic society, achieving political and economic stabilization, and joining the EU and NATO.

Bulgaria covers a territory of 111,000 sq. km. The population at 31/03/2001 was 7,932,984, of whom 51.3 % were female. The population peak was in 1985 when it reached 8,948,649. Since 1986 the population has consistently decreased with a mean of 0.8% decrease per year. This decrease is due mainly to emigration in the years of transition (more than 680,000) and to natural changes in the population related to a lower birth rate, a slow but constant increase in the mortality rate, and socio-economic and demographic factors.

The majority of the population is urban (68.4 %) with 31.6 % in the rural population. Mean duration of life was 70.5 years (67.1 for men and 74.3 for women) in 1998[1].

### 4.1.2. Cultural context related to alcohol: professional and public attitudes

Cultural and social beliefs and norms have traditionally strongly affected drinking patterns and tendencies in alcohol consumption in Bulgaria. Social beliefs and cultural stereotypes have formed the dominant public discourse about alcohol and drinking. Bulgarian culture has an extremely permissive attitude to alcohol consumption and, especially for men, it is considered socially expected behavior[2]. In addition to being a beverage, alcohol has culturally symbolic meanings as a part of life-style, rituals and celebrations. Young people view drinking alcohol as a symbol of adulthood and of independence from parents; some beverages are used as an expression of social well-being, personal life-style or masculinity; and serving alcohol is a part of hospitality. Alcohol consumption is considered an irreplaceable part of socializing and having a good time, as well as a means to relax and overcome negative moods. High levels of alcohol consumption are considered the social norm and beliefs about the *macho* drinker as an expression of strength, bravery and strong character are common. Ideas about alcoholic beverages and particular drinking patterns are a common part of national and local identity[3].

Bulgarian health professionals, including GPs and other primary health care workers, reflect this dominant public discourse. In the WHO Phase III, Strand I study, they were shown to be the most permissive in Europe to large amounts of alcohol consumption among their clients[4].

### 4.1.3. Alcohol consumption

Bulgaria has long-standing traditions in alcoholic beverage production and consumption, especially home production of wine and brandies, and a high level of consumption of mainly

wine, beer and brandies. Bulgaria is among the top six countries in spirit consumption in the world and among the top 15 in overall consumption.

Alcohol consumption in Bulgaria has traditionally been carried out in a hedonistic style, with a preference for wines and brandies. A clear tendency towards a change in that style has been observed over the past 20 years, with a substantial rise in the consumption of beer and imported liquor. Traditionally, home produced alcohol has been a significant part of consumption, especially in villages[5].

For the second half of the last century, per capita alcohol consumption substantially increased, the 1990 figure reaching a 3.4 times higher level than 1952. This increase had different rates for different kinds of beverages – 2.5-fold increase for wine and spirits and 12-fold for beer.

Recorded per capita consumption of pure alcohol was 7.8 litres in 1991. This represents a decrease over the figure of 8.7 litres in 1980 and is in fact the lowest consumption recorded for the period 1980-1991, during which the figure tended to be around 9 litres. The 1991 figure is considered to be an underestimate of real consumption since there is no information available on unrecorded consumption[6]. For the same reason, the recorded figure of 2.6 litres per capita of pure alcohol in 1999 is considered underestimated and unreliable.

The overall recorded per capita consumption of alcohol beverages for 2001 was 18.2 litres, of which 8.6 was beer, 6.9 wine and 2.7 liquors and brandies. This figure is also suspect since, for the last 12 years, unrecorded imports, untaxed sales and illegal sales substantially increased and became a significant part of total alcohol consumption[1].

For the last 25 years alcohol consumption has been constantly increasing. The increase seems to be slower among males 20-50 years of age but rapid for women of the same age-range and for adolescents and young people of 15-20 years. The mean age of first alcohol consumption is 12.8 years. Regular alcohol consumers over 15 years of age for the period 1986-1996 increased from 76.4 % to 81.5 % for men and 33.6 % to 49.9 % for women[4].

### 4.1.4. Alcohol-related problems

Male mortality rates from cirrhosis had more than trebled over a period of 25 years (9.8/100,000 in 1970 to 33.6/100,000 in 1994) and have continued to rise. The standardised mortality rate (SMR) per 100,000 population (all ages) from chronic liver disease and cirrhosis was 23.8 in 2001. The number of people seeking treatment for alcohol dependence showed a steady increase during the period 1980-1992 and was relatively stable for the period 1992-2001.

The SMR from the external causes of injuries and poisoning per 100,000 population increased from 61.1 (93.9 for men and 29.7 for women) in 1980 to 67.2 in 2001 (107.5 and 30.1). The number of road traffic accidents involving alcohol was 13.8/100,000 in 2001. With some minor fluctuations, this figure has been relatively stable since 1989[1].

Alcohol abuse and intoxication are important factors in a major part of fatal road traffic accidents, domestic, recreational, work-related and fatal incidents, public order problems, crime, homicide and violence. Alcohol consumption takes second place (after tobacco smoking) among the behavioral risk factors contributing to morbidity, absenteeism and death due to external causes.

Alcohol-related diseases comprise a heavy problem for the health of the nation and the health care system. The estimated number of alcohol dependents is 350,000 and 30% of the male population are risky drinkers. Bulgaria is at number one in Europe for death rates due to brain stroke (277.6/100,000) and in the top 10 in Europe for death rates due to coronary heart disease (262.3/100,000), both related to alcohol and tobacco consumption. It is also at number two in Europe for death rates due to circulatory diseases and problems (737.1/100,000) in 2000[7].

### 4.1.5. Responses to alcohol-related problems

*Legislation*

Advertising of alcohol beverages was banned on television and radio, in newspapers, magazines and cinemas[8]. However, these bans were not at all enforced. Recently these limitations were practically removed by the introduction of regulations allowing advertising under some restrictive conditions, addressing mainly messages to young people. The result is a flooding of TV, magazines, billboards and public places with alcohol advertisings.

A license is required for production, trade and distribution of wine, beer and spirits. Restrictions on sale on hours, days and location of outlets and the age limit of 18 for buying alcohol are not effectively enforced. The use of alcohol is forbidden in specific places, such as institutions, public transport, clubs and discos for teenagers, etc.[9,10].

The BAC limit for driving is 20mg/100ml and is fairly effectively enforced. Conviction for driving above the BAC limit does not usually lead to suspension from driving or imprisonment. Random breath testing is carried out infrequently.

*Alcohol policy*

Prior to the political changes in 1989, alcohol policy was centralised and predominantly restrictive. It was mainly directed at limiting the production of alcoholic beverages and the prohibition of consumption. These activities were of a propaganda character relevant to the existing social structure, which substantially limited their impact and made them insufficient in terms of time and effectiveness.

Contemporary alcohol policy, relevant to the present situation of the country and the principles of the European Alcohol Action Plan, is in the process of creation. It is confronted by significant difficulties related to unfavourable conditions during the period of transition, the instability of the political, social and economic situation, political and public neglect of alcohol-related problems, and the strong political and economic position of the alcohol trade and alcohol producing industries.

The priorities of recent years have been reducing availability, mass media campaigns to encourage safer drinking, encouraging lighter drinking in particular settings, using price to reduce demand, and addressing specific problems (drinking and driving, alcohol and young people, alcohol and health, alcohol and the family)[5].

*Prevention*

Bulgaria applies a joint approach to issues related to alcohol, drugs and tobacco. Alcohol prevention programs are developed together with health education programs and drug misuse prevention programs. Such programs are developed at national, community and sectoral levels. Prevention programs are targeted mainly at school populations and much fewer prevention

programs address the workplace and the home. Alcohol prevention issues are now incorporated in the newly-developed health education school programs that are to be implemented at a national level[2].

*Treatment*
Treatment of alcohol-related problems is provided by various treatment facilities depending on locality, the nature of the problem and patient needs. Treatment of acute alcohol intoxication is provided at specialized toxicology services and emergency units. A significant number of patients with alcohol-related problems are treated in specialised medical units (neurology, gastroenterology, cardiology, etc.) relevant to the specific disease. Quite often the alcohol genesis of cases with cardiovascular disturbances is not acknowledged. Patients with alcohol dependence, dual diagnosis and marked behavioral changes are treated at specialised inpatient and outpatient units, generally incorporated in the psychiatric care system. At seven of the major psychiatric hospitals there are specialized wards for treatment of alcohol-related disturbances; 13 of the outpatient psychiatric units in some district centres have consulting rooms for outpatient treatment. In the remaining districts this activity is carried out together with the general psychiatric services offered to the population. The development of a specialized treatment network started in 1994, when the *National Centre for Addictions*, providing short-term and mid-term outpatient and inpatient programs, was established.

A process of establishing a network of specialised centres having broader treatment options is being carried out. The *National Centre for Addictions* is the main research and treatment centre, providing short-term, mid-term, inpatient and outpatient treatment programs, counselling, day-hospital, home detoxification and family counselling. Recently, qualified treatment for alcohol dependence and alcohol-related problems is provided by emerging medical centers and specialized private treatment centers.

There was some experience of early interventions for alcohol-related problems in the 1970s and 1980s, when research work in Bulgaria was carried out and specialists were trained in implementing screening methods for early detection of alcohol-related problems and early interventions. Since then, this approach has remained within the psychiatric institutions, was transformed and gradually lost its value. Attention to the importance and possibilities of applying early identification and brief intervention was increased recent years in the context of, and due to the activities of, the WHO Phase III and Phase IV projects.

### 4.1.6. The health care system

At the beginning of 2003 there were 1,423 outpatient health care services, mainly ambulatory services, group practices and medical centres, with 11,092 doctors. The number of GPs was 5,293 (19.1 % of all physicians in the country). Each GP was in charge of a mean of 1, 482 people. The number of hospitals is 251 with 46,929 beds, including 11 psychiatric hospitals with 2,780 beds and 49 dispensaries with 4,101 beds. In the hospitals and dispensaries there were 13,161 doctors, 83.1 % of them with a speciality. There was a mean 76 beds per 10,000 people.

The total number of physicians in the health care system was 27,688, the greater proportion of whom were GPs (6.7 per 10,000) and internists (5.3 per 10,000). There were 45,604 and a mean of 35.3 doctors per 10,000 people for the country as a whole[1].

*Organisation of primary health care*

Until 2000 the primary health care (PHC) system was based on a district principle (living place and workplace). The medical care system had three levels: national, regional and municipal. One primary care doctor was in charge of an average of 314 people.

There were no specialized GPs. Primary health care (PHC) was provided by district doctors, pediatricians and gynaecologists in cities and towns and general doctors in villages. Referrals to specialist consultations and hospitalization were the responsibility of PHC doctors but they did not act as health care gate-keepers to specialized services. Since 1996 there has been a possibility for patients to choose their permanent PHC doctor.

In June 2000 the National Health Reform had commenced, together with the introduction of the National Health Insurance Fund. That started a process of transformation from a centralized model to privatization and a GP-based system, with radical changes in the structure, organization, functioning, regulation and funding of the health care system, as well as a change in the nomenclature and status of health services. The main focus was on the reform of the PHC and outpatient services and a decrease of inpatient services. The GP system started working with 5,451 GPs. GPs act as gate-keepers to specialized services. Their work is regulated, funded and controlled by the National Health Insurance Fund (NHIF) according to the so-called National Frame Contract that defines and regulates the services, activities, obligations, financing, GP package of services and practically all aspects of GP work. GPs are overloaded, receive little additional payment for preventive medicine and are not motivated to become involved in preventive activities and practices[7].

## 4.2. Bulgarian Phase IV Project

Bulgaria is among the few countries to have participated in all four phases of the WHO Project. It joined Phase IV at its beginning. The activities carried out followed the study protocol and were planned, modified and developed taking into account the resources of the project team, the dynamics of health policy and the reform in the health care system, as well as other country-wide specifics related to and influencing the project implementation.

The developments and progress in implementation of the Phase IV Project were closely related to and strongly influenced by developments in the health care reform and the political situation in the country.

The central goal of Bulgarian Phase IV strategy was to influence decisions at the highest health care policy level and get Phase IV objectives and activities integrated in the policy of the Ministry of Health for PHC work and preventive medicine, as well as the policy of the National Health Insurance Fund (NHIF) and requirements of the National Frame Contract defining and regulating the package of GP work and services[2].

### 4.2.1. Customization

The main objectives in the customization component were to adjust the EIBI package to the country's particular needs and circumstances and to develop an appropriate EIBI dissemination strategy taking into account country-specific factors.

The brief intervention package that was selected was the Drink-less Programme. Validation of the AUDIT questionnaire, focus groups and a Delphi study were carried out under the auspices of the ECAToD Project.

*Validation of the AUDIT questionnaire*
Six GPs working in different practices participated in the validation of the questionnaire. The study included 600 patients who filled in the questionnaire. Patients seeking treatment or consultation for some health problem and over 18 years of age were chosen randomly from both sexes.

With regard to the needs of the study, one standard drink in Bulgarian conditions was defined as: 1 small bottle/box of light beer (330 ml) or 1 glass of wine (about 200 ml) or half a glass (25 ml) of liquor[5].

*Focus groups*
Six focus groups were carried out and the texts were processed and analysed:

- 2 with GPs - concerning alcohol and tobacco consumption;
- 2 with school doctors - concerning alcohol and tobacco consumption;
- 1 with Alcoholics Anonymous members - concerning alcohol consumption;
- 1 with specialized professionals - concerning alcohol consumption.

The main questions concerned which social institutions would have to participate in the development and realization of a community program for prevention of hazardous drinking, to whom such a community program would have to be addressed and what should be the possible elements of a community program for prevention of hazardous drinking.

Discussions within the six focus groups were very effective as a whole. Participants proved to be extremely active and they showed emotional involvement regarding both alcohol-related problems and their prevention.

A mini-report for each group and a Summary Report with analysis of the six focus groups was prepared. The focus groups suggested the following elements as advisable for a municipal program on prevention of hazardous alcohol consumption: health education, alternative activities, a media campaign, preventive messages, a change in public attitudes and understanding, amendments to legislation, and training for professionals. Such a program should address the general public, adults and adolescents, school curricula, journalists, specific risk groups, health care professionals (both PHC and specialists), and municipal administrations.

Institutions that should implement and realize municipal prevention programmes included local and central authorities, educational institutions, specialized health promotion centres, PHC and specialized services, religious institutions, volunteer organizations and funding bodies.

*Delphi study*
The aim of the Delphi study was to collect ideas for effective activities at the community level in order to assist the formulation of a strategy and a community action plan. The study was conducted in three successive rounds with separate questionnaires for each round. The institutional areas covered by the study included primary health care, specialized medical centres, public health institutions, state institutions and public organizations. A total of 63 specialists participated in the first round, 58 in the second and 60 in the third. All experts involved worked in areas concerned with alcohol-related problems – GPs, toxicologists,

neurologists, cardiologists, psychiatrists, medical administrators, sanitation experts, psychologists, sociologists, educationists and juridical experts. The analysis and conclusions of the study showed the method to be a useful means for reaching consensus among GPs on important aspects of their work: health policy regarding alcohol-related issues, the preparation of new documents, decrees, regulations in the field and, especially, defining the PHC role in the process.

*Field test of GP attitudes and recruitment procedure*
A small field test with the objective of investigating GP attitudes and the procedure for recruiting GPs to work with EIBI for alcohol-related problems was carried out. The main objectives were to test the recruitment procedure and willingness of GPs to be involved, to present the Drink-less package, to discuss the Phase IV strategy and ideas, and to form a stable group of interested GPs that would support the project activities.

A total of 100 GPs from Sofia were randomly chosen and contacted by telephone. They were offered materials on alcohol- and drug-related problems and were invited to attend a presentation and 3-hour workshop. Of the 100 GPs, 22 refused immediately while the remainder showed some interest. These were offered materials and were invited to the presentation and workshop, 28 showing interest in coming to the workshop and 12 actually attending. This group was given a presentation and workshop on drug and alcohol dependence issues, alcohol-related problems, brief interventions, and the Phase IV Project and Drink-less package, followed by discussion.

As a result of this, conclusions were drawn and a group of interested GPs was formed. A focus group to discuss Phase IV objectives and strategy and current GP problems and practices was carried out. The topics of the focus group were understanding of alcohol issues, the GP role, common PHC practices, incentives for GPs to work with EIBI for alcohol- and drug-related problems and suggestions for the Phase IV strategy[5].

### 4.2.2. Strategic Alliance

The institutions identified for the Strategic Alliance at the highest political level were the Ministry of Health, the National Health Insurance Fund (NHIF) and the Bulgarian Physicians' Union. These are the key players for negotiating the PHC and GP model and hence the most important organizations for introducing, influencing and supporting the project activities and the creation and implementation of a country-wide strategy for implementation of early identification and brief intervention for harmful and hazardous alcohol consumption in PHC. The strategy was effected by presenting official proposals, statements, recommendations and reports, as well as contacting and meeting the Minister of Health, Deputy Ministers of Health and high Ministry of Health experts, the senior management of the National Health Insurance Fund and key figures in the Bulgarian Physicians' Union.

Special attention was also paid to involving middle-level managers and experts in the relevant institutions because they seemed to have relatively more consistent attitudes, were interested in practical activities and issues rather than politics, and were more stable in their positions and replaced less often.

In addition to working with these high-level institutions, efforts were made to broaden the alliance by involving NGOs working in the field of preventive activities, healthy lifestyle and drug use, such as the *Civil Alliance Against Drugs Foundation* and partners at the regional,

local and municipal levels. This was done in parallel with activities within the framework of the National Drugs Strategy for establishing multidisciplinary Municipal Drug Councils. These structures were involved in wider co-operation at local, municipal and regional levels in order to extend and combine their activities to work also with alcohol-related issues.

We also used opportunities to integrate Phase IV activities into existing prevention projects and campaigns, health promotion projects, healthy lifestyle activities, as well as in professional education and training for GPs, medical professionals, school health education and university curricula. This was carried out by the *National Centre for Addictions* and other educational, professional and non-governmental partner organizations.

An important achievement in the attempt to involve PHC professionals in working with alcohol problems was placing alcohol and drugs among the priorities of the NHIF. Another major step in this direction was developing Guidelines for dealing with alcohol problems at PHC level that were agreed and accepted by the NHIF[7].

### 4.2.3. Reframing

Reframing policy-makers', professionals' and public understanding of alcohol issues was one of the main components and a central activity in the project implementation. The focus here was on introducing the concepts of "safe limits" and "risky drinking", extending the view of alcohol-related problems beyond the notion of alcohol dependence, encouraging members of the general public to ask their GPs about drinking, as well as encouraging GPs to raise alcohol-related issues, and promoting the need for health care initiatives on a large scale. Some good results were achieved in this area.

In general, for the last 20 years alcohol-related issues have been largely neglected in the public, policy, professional and mass media spheres. This phenomenon was closely related to tradition, culture and the dominant public discourse on alcohol, and since 1989 to the emphasis on the epidemic spread of illicit drug use among young people.

In the area of reframing we targeted several levels. At the level of policy and decision-making we worked through personal contacts and meetings with key figures at the Ministry of Health - the Minister of Health, Deputy Ministers, NHIF senior management, Chiefs of Directories and Departments and the Parliamentary Health Commission, as well as other stake-holders and key persons, experts, policy-makers and decision-makers, regional and municipal administrators and Drug Councils.

The second target was at the level of health care professionals. The goal here was to reframe their understandings and attitudes through professional contacts and events, like participation and presentations at conferences of the Bulgarian Psychiatric Association, GP conferences, the conference of the NCA, and also through education and training events.

The third level actively and widely involved was the general public and mass media. Media advocacy was used to assist a Communications Strategy. A media lobby of journalists interested in the topic and willing to support our activities was established and sustained throughout the project. A mass-media strategy was developed with consultancy from media specialists. Two focused campaigns and three press conferences were organized on the topics of safe limits and risky drinking. Professionals from the Project Team participated in 8

specialized radio and 9 TV broadcasts, interviews and specialized programs. Popular journals and national newspapers printed 15 articles and published materials[7].

A whole specialized issue of the official monthly journal of the NHIF was devoted to the problems of alcohol and drugs. It reached all GPs, health care managers and officials.
The concept of risky drinking, safe limits, screening methods, the PHC role in early identification and brief intervention, and the rationale and need for a health policy concerning alcohol-related problems were the main themes.

The consultancy visit of Professor Heather (Phase IV Technical Focal Point) to Sofia in September 2001 was used to raise awareness and to achieve a focused influence on policy-makers, together with an impact on professionals and the general public. Practically it was influential at all levels, beginning with the senior management of the Ministry of Health and NHIF, experts at Ministry of Health and professional staff of the National Centre for Addictions. The main aspects of the concept of risky drinking and the policy towards alcohol-related problems were conveyed through the mass media with a large impact on the general public. The message reached an estimated number of 2.5 million of the population through two prime-time interviews on the leading TV channels and an article in a national newspaper that reached more than one million people. The impact was intensive and manifested in personal and professional contacts with intellectuals, health care professionals and even high officials. It resulted in increased media interest and openness to discussion of alcohol-related problems and issues[5].

### 4.2.4. Demonstration Project

Our plan was to carry out the demonstration project in a district in the country with a population of 50,000-100,000 and 30-50 actively working GPs. The design included the obtaining of administrative and political support at the regional level, training of GPs prior to starting the project and providing them with support throughout. This was intended to start with a press conference and a local media campaign, including TV news reports, live discussion and program participation, newspaper interviews and publications, with an intention to repeat the campaign at the finish of the demonstration project together with presenting the results and producing a publication for further dissemination of project results, conclusions and recommendations to the key institutions, key figures, policy- and decision-makers, experts and health care professionals. For a number of reasons, however, it was not possible to obtain the necessary funding to carry out the Demonstration Project.

### 4.2.5. Major problems

A number of major problems affected the Phase IV project in Bulgaria.

*Instability of the political and economic situation*
The political situation in the country for the period of the project remained unstable, together with a deep crisis at the economic and social levels. This resulted in limited financial resources and attention to social issues and preventive medicine, hence no possibility to obtain funds for the project.

*Lack of funding*
Despite sustained efforts to find funding for the project implementation, this was not obtained from any funding body. All the work for the project was fulfilled by the project team on a

voluntary basis. Project activities were logistically supported by the *National Centre for Addictions*.

*Constant changes in MH and NHIF management*
Another negative impact was due to the frequent and radical changes in the senior management of the Ministry of Health (3 changes of Minister and the cabinet) and, especially, the National Health Insurance Fund (5 changes of director and senior management staff), i.e. the key figures that we activated to collaborate and support the Phase IV project were removed. Practically this wasted all our previous achievements and contacts, and we had to start negotiating from the very beginning again and again.

*Strong alcohol industry lobby*
Developments at an international level opened up new possibilities for wine exports and also increased alcohol production and the activity of alcohol industry. A tendency over the last two years was the widespread advertising of alcohol products in the mass media, TV and billboards in the streets. The alcohol lobby became very strong and influential in political circles.

*PHC reform*
The PHC reform was slow and generally unsatisfactory, both for patients and GPs. The NHIF was in a period of restructuring and the directors and senior management were often renewed. The National Frame Contract was the subject of sharp debates and the main priorities were scarcely defined as result of disagreement among the key partners at national policy level. This had a negative influence on the GP system and PHC work, bringing new tensions, dissatisfaction and uncertainty about the GP model, the role of GPs, their position and the package of their services, and destabilization and lowering of motivation among GPs to do preventive medicine and be involved in extra work and new activities[7].

### 4.2.6. Consequences for Phase IV

These changes in the MH and NHIF policy were the most important factor related to our Phase IV project development. The consequences were definitely unfavorable.

The debate on the main concepts of the PHC system was constantly renewed, resulting in the emergence of contexts and attitudes totally unfavorable to promoting and raising awareness, and understanding and acceptance of new preventive issues. This blocked our achievements and the possibility of negotiating Phase IV activities that we previously reached by contacting the key figures in the NHIF and MH.

## 4.3. Conclusions

The above analysis of the overall situation during the period of the project shows that effective changes in the alcohol policy in the country were unlikely to happen.

GPs were overloaded with documentation and had little time for the patient. They were not interested in working with preventive medicine in general. GPs felt they had a role in preventive medicine and preventing alcohol-related problems and diseases but were not willing to take on this role and not prepared for it.

In the current situation, the best and probably only way to include alcohol EIBI on a large scale in PHC work is to introduce this as obligation for the GPs imposed by the NHIF through

the National Frame Contract. On the other hand, a significant proportion of GPs are willing to incorporate advanced methods and strategies in their professional practices. This would depend on taking the time and effort to practice preventive medicine for the benefit of their patients but these could potentially form the pioneer group that would introduce and sustain EIBI in PHC practice.

The main conclusion is that the Phase IV activities have established a solid ground for future efforts to introduce a PHC-based system for EIBI for harmful and hazardous alcohol consumption in Bulgaria. Additional sensitization, energizing and support is needed for GPs in terms of education, training, diagnostic and intervention technology, and appropriate payment of PHC preventive work in order to enhance primary care-based EIBI and for GPs to accept their future role in preventive medicine and working with alcohol problems.
The future steps needed are to continue with strategic meetings with key figures at health policy level, to present new reports to the MH and NHIF, to sustain the debate on including EIBI in the National Frame Contract and to submit proposals to that end. Also we need to extend alliances and networking at regional, local and municipal and GP levels, keep good contacts with key administrators at these levels and with Drug Councils, join and integrate activities into a wide spectrum of existing projects, activities and campaigns.

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