tries, which develop national programs for the prevention of tuberculosis. The focus in such programs is shifted towards public rather than individual health, thus achieving better prophylaxis. In countries where TB prevalence is low – below 10 new cases per 100,000 people each year – specific immunoprophylaxis (BCG vaccine) may be avoided. In Bulgaria however, where prevalence is medium to high, it is indispensable. That is why the introduction of a totally new organization, i.e. transferring the responsibility for applying BCG vaccines to the general practitioners, is risky. Vaccines should be applied by special teams because this would help avoid mistakes and omissions. In the same time the professional TB diagnostics would contribute to identifying infected people and refering them to the special healthcare establishments where their condition could be monitored. The National Framework Contract should therefore provide that these functions are performed solely by the TB diagnostics and prevention centers (Z. Yankova, 2001).

In the last few years TB therapy involved quick measures to overcome the bacteriologic stage and a short course of treatment. In countries with high TB prevalence the directly observed treatment, short course, or DOTS, is very popular. According to the World Health Organization the efficiency of this method in such countries reaches 85%. Can this approach be introduced in Bulgaria? Associated Prof. Yankova notes that in this country:

1. More than half of the patients suffer from recurrent tuberculosis. These are mostly elderly people with many other diseases. The intensive course of treatment is carried out with 4 tuberculostatics and has serious side effects. For these patients individual therapy remains the only solution.

2. Among young people with deviant behavior continuing supervision and treatment is impossible. Therapy is often discontinued, which results in polyresistance. The identification and forced treatment of TB patients is frustrated by the adverse interpretation of existing legislation and this makes the work of TB specialists extremely difficult. The living conditions in the sanatoria are humiliating, the material prerequisites for diagnosing patients are poor, which means that these healthcare establishments are not suitable for TB patients with deviant behavior.

Everything noted above implies that most of the problems are organizational. In spite of the economic crisis in the last few years, the state has been allocating funds for the development of a National Program for Fighting Tuberculosis, but unfortunately they are not always being spent properly.

According to data collected by the City Phthisiatric Hospital in Sofia 30% of the TB patients who have received treatment in the hospital are Roma.

Our research in Kyustendil, Senovo and Tulovo also indicated that tuberculosis is quite common among Roma: it affects 0.6% of the Roma population in Kyustendil, 1.8% in Senovo, and 1.6% in Tulovo. Approximately 25% of the cases involve children. Almost all of the patients are impoverished people who suffer from malnutrition. Some of them are unable to cover the cost of transportation to the regional TB center to which they have to travel each month in order to receive the free medication they are entitled to. Among Roma tuberculosis is often accompanied by other chronic diseases, which makes the situation even more complicated. The cases of extrapulmonary tuberculosis, which are often difficult to diagnose, are also relatively common.

According to data submitted by Dr. M. Dimitrova from the Specialized Hospital for Active Treatment of Pulmonary Diseases in Sliven, 60% of the TB patients are Roma. Prevalence has increased from 49.34 per 100,000 people in 1997 to 67.92 per 100,000 in 2000 (from 38.61 per 100,000 to 56.16 per 100,000 for pulmonary tuberculosis and from 10.73 per 100 000 to 11.75 per 100,000 for extrapulmonary tuberculosis). Incidence has also increased from 182.75 per 100,000 people in 1997 to 251.21 per 100,000 in 2000. TB-related mortality was 5.66 per 100,000