Background To investigate myocardial infarction (MI) morbidity, mortality and death rates between 1977 and 2006, and their determinants in a high-risk population in Russia.

Materials and Methods The WHO programs “Register of Acute Myocardial Infarction,” “MONICA”.

Results During 30 years (1977–2006), 23,137 MI cases were registered, of which 7,630 were fatal. The 30-year MI morbidity rates were relatively stable, with the exception of increases in 1988, 1994, 1998 and decreases in 2002–2004 and 2006. Mortality rates were also stable with the exception of increases in 1988, 1994, 1998, and 2002–2005 and decreases in 1977–1978 and 2006. Increases in anxiety levels were recorded by three screening studies in 1983, 1988, 1994 which roughly correspond with increases in MI morbidity and mortality rates.

Conclusions Our results have shown the MI morbidity in population (Novosibirsk) in Russia to be among the highest in the world. They may be markers of the increasing social and economic instability in the country.

Materials and Methods A random representative sample of males (a total of 2149 individuals) aged 25–64 years from the city Novosibirsk was examined (screening of the WHO “MONICA-psychosocial” program (“MOPSY”), 1984, 1988, 1994 yr.). Depression (D), vital exhaustion (VE), hostility (H), sleep disturbance; test Berkman-Syme (social support—index of close contacts (ICC), index of social connections (SNI)); Spilberger’s test for estimation personal anxiety (PA) were used. For AH accepted the arterial pressure >140/90 mm Hg.

Results Determined, that persons with AH have tendencies: (1) in higher parameters of “average”, “bad” sleep; (2) in lower values of indexes of social support—(a low ICC with AH—65.1%, p < 0.01) and SNI (low SNI with AH—45.1%, p < 0.05) (5) in increase of a parameter of PA (with AH—52.3%, p < 0.05). Authentic connection AH is precisely determined with: (1) education, achieving a maximum of distinctions at an initial education (initial: with AH—25.1%, p < 0.05) (2) an professional level (working trades—10.7% p < 0.001) (3) with VE (a high level of VE: with AH—16.6%, p < 0.05) (4) with D (with AH—55.3%, p < 0.05). In too time at hostility of distinctions between groups it is not determined.

Conclusion Received results testify to interrelation AH in a population with psychosocial factors and once again emphasis importance of their correction.

Objectives To know the range of services provided by the various health providers, to study their criteria for determining fees for the services provided, to understand their barriers in providing the services and to study the factors responsible for their job satisfaction and dissatisfaction in rural areas of Udupi taluk, Karnataka state, India.

Materials and Methods A cross-sectional study was conducted in rural areas of Udupi taluk between September 2007 and October 2008 among 150 rural practitioners. Data were collected by interviewing the practitioners using pre-tested, semi-structured questionnaire. The quantitative data were analysed using SPSS 14.0. The qualitative data were collected using In-depth interview technique.

Results and Conclusion Provision of preventive health services and participation in national programmes by the private practitioners was found to be inadequate. Practitioners determine their fees based on the economic status of the patient and the cost of medicines dispensed. Inadequate and irregular income is the major barrier for both government and private sector doctors and most of them were moderately satisfied with their job.