MONICA Populations

#50 Introduction to Population Pages

Population name (7 character population name, 2 digit population name)

MCC Number: MCC Name

Number of Reporting Units

Population names are those previously agreed. See Appendix, MONICA Manual (1).

Map

The maps locate the MONICA populations for an international readership (but see the disclaimer on page ii). A red spot denotes a single location. A red star indicates scattered populations or a large territory in one RUA.

Administrative Centre

This is the institution of the MCC and the Principal Investigator. It may be situated at a distance from the population being studied. Institution names, telephone, FAX and e-mail addresses are all subject to change and are updated, when notified, on the MONICA public Website (2).

Population

Description of the target population for registration and population surveys. Population size is from the MONICA demographic assessment (3).

Funding

Local sources of funding. Activity within the MCCs was not funded by WHO which funded coordination work only.

Dates

Registration activity and surveys did not always correspond with data that were used in the collaborative analyses. The latter timings are shown in the introductory graphics pages of this Monograph and are also available from MONICA Quality assessment reports on the different activities such as coronary-event registration, coronary care, stroke-event registration and population surveys (4–7).
Additional description
Other activities linked to MONICA.

Local research interests and continuing activity
Self-explanatory.

Key personnel
As identified by the Principal Investigator.

Selected publications
Chosen locally, but verified on PUBMED wherever possible. Does not include
MONICA collaborative publications, see #85 and #86 MONICA Publication List
and Abstracts.

References
MONICA Web Publications are also accessible on the Monograph CD-ROM

Hugh Tunstall-Pedoe
#51  Australia-Newcastle (AUS-NEW, AN)

**MCC 11: Newcastle**

Five Reporting Units merged into one Reporting Unit Aggregate (RUA).

**Administrative centre**

Centre for Clinical Epidemiology and Biostatistics, University of Newcastle, New South Wales 2308, Australia

Current contact: Professor Annette Dobson, School of Population Health, University of Queensland, Herston, Brisbane Q 4006, Australia

T +61 7 3365 5346; F +61 7 3365 5442

E-mail: a.dobson@sph.uq.edu.au.

**Population**

Residents aged 25–69 of the Hunter Region of New South Wales, 120 km north of Sydney on Australia’s east coast; total population of 445 000 in 1991, many descended from British industrial immigrants. Closure of shipyards and steelworks in the last two decades caused economic depression. Coalmining, farming and viniculture occur inland. Health services improved with a new hospital, and specialist services, including cardiac surgery. Health services and the education sector are major employers in Newcastle.

**Funding**


**Dates**


**Additional description**

The three Australasian MONICA Centres collaborated. Nested case-control studies were conducted on active and passive smoking, alcohol consumption and diabetes. John Malcolm (PhD), Scott Kinlay (PhD), Anne Russell (M.Med Stat), Khaldoon Al Roomi (PhD), Kate (Boyle) D’Este (PhD) and Patrick McElduff (PhD) researched MONICA-related projects.

**Continuing activity**

Elements of MONICA continue in the hospital-based Hunter Heart and Stroke Register and the programme of the new Cardiovascular Monitoring Unit of the Australian Institute of Health and Welfare. This encompasses risk factors, acute events and treatment, using data from national health surveys, hospitals and death certificates, and use of pharmaceuticals.

**Key personnel**


**Selected publications**


### Annette Dobson

MCC 10: Perth
Two Reporting Units, inner and outer Perth. Main results and Monograph graphics use risk-factor data from the inner city only (PERa) but coronary-event and coronary care data from both areas (PERb), as the outer city was not included in the first population survey.

Administrative centre
Department of Public Health, University of Western Australia, Western Australia 6907, Australia
T +61 8 93801258; F +61 8 93801188
Website: http://www.publichealth.uwa.edu.au/research/
Site of MONICA Quality Control Centre for Health Services information.

Population
Perth is the capital of Western Australia with a population in 1991 of 1 189 000.

Funding

Dates

Additional description
Perth and Newcastle, two Australian MCCs, have respectively the lowest and highest coronary heart disease mortality of major Australian cities. Perth is an administrative and service centre with little heavy industry. The only city in Western Australia with a population over 25 000, it is more than 2000 km from major specialist medical services elsewhere. Its population is growing rapidly from substantial inward, and little outward, migration. Highly centralized medical services with sophisticated statistical systems, including record linkage, make it ideal for epidemiology and health services research.

Local research interests

Continuing activity
Continuing cyclical registration of acute coronary events and stroke, and risk-factor surveys. Cohort studies of registered cases and survey participants. Application of record linkage to monitoring incidence, survival and treatment of selected cardiovascular conditions, particularly coronary artery revascularization.

Key personnel

Selected publications
Comprehensive list available on Vascular Epidemiology group page at: http://www.publichealth.uwa.edu.au/research/

Peter Thompson

Konrad Jamrozik
Belgium-Charleroi (BEL-CHA, BC)
Belgium-Ghent (BEL-GHE, BG)

- contrasting Belgian populations only 100 km apart
- coronary-event rates 50% higher in Charleroi
- different risk-factor levels
- event rates falling in Ghent, rising in Charleroi

MCC 12: Ghent/Charleroi
Two geographically separate Reporting Units, Ghent and Charleroi; used separately for many analyses, amalgamated into one Reporting Unit Aggregate (RUA) for coronary care.

Description
The MONICA Project recruited two Belgian populations that were geographically close but with different economies, cultural traditions and languages. Event rates and trends over time were different. There was close collaboration between the two Principal Investigators and they were considered as one MONICA Collaborating Centre (MCC). The two Reporting Units are described separately. A third distinct Belgian population, Luxembourge, was entered initially as a separate MCC but did not produce data over a sufficient number of years for an analysis of trends. (See #84.)

Belgium-Charleroi (BEL-CHA, BC)

Administrative centre
Unité cardiovasculaire, École de Santé Publique CP 597, Université Libre de Bruxelles, Route de Lennik, 808, B–1070 Bruxelles, Belgium
T +32 2 555 4087; F +32 2 555 4049

Population
Residents aged 25–69 of 15 municipalities, centred on the city of Charleroi. Charleroi was a major industrial centre in the nineteenth century. Its main industries were coal mining, iron and steel, and glass production. It became economically depressed in the 1930s, and remains so today, with many health problems and high unemployment, although it is slowly recovering. Since World War II, a significant Italian community has grown up. A cardiovascular prevention programme was launched in 1994. The total population in 1991 was 206 000.

Funding

Dates

Continuing activity
*Coronary-event registration is continuing. A fourth population survey is being planned.

Key personnel
PI: Marcel Kornitzer. Others: L Berghmans, R Desqueuve, M Lannoy, MP Vanderelst, P Legrand, M Candeur, P de Smet.

Belgium-Ghent (BEL-GHE, BG)

Administrative centre
Dept of Public Health, Ghent University, Ghent University Hospital, 2 Block A, De Pintelaan 185, B-9000 Gent, Belgium
T +32 92 403 627; F +32 92 404 994

Population
Once a major trading centre, in the 13th century Ghent was equal to Paris and larger than London. Its tradition of spinning and weaving reached a climax in the 19th century. It is now a relatively prosperous small city, with a total population in 1991 of 230 000. It is the capital of Eastern Flanders and is known for its financial services, iron and steel, and vehicle manufacture.

Funding
Belgian National Fund for Scientific Research.

Dates

Continuing activity
*Coronary-event registration continues. It has been extended to cover the 25–74 year age group, and to the region of Bruges. Further risk-factor surveys are planned.

Key personnel

Selected publications
Local research interests

Continuing activity
Event registration and population surveys have ceased. A cohort follow-up study (over a 5-year period) of hospital survivors of myocardial infarction.

Key personnel

Selected publications

Halifax waterfront

Hermann Wolf, Ronald Gregor, Iqbal Bata
Population
Residents aged 25–74, of six separate urban and suburban districts and one rural county in the Beijing area, with a total population in 1991 of 686,000. Two-thirds of the population monitored between 1984 and 1993 were urban and one-third rural. Beijing, the capital of China, is a city with more than a thousand years of history. It has a population of 11 million. The lifestyle of the Beijing population has changed in the last 20 years, with dramatic economic developments. These have been accompanied by changes in cardiovascular risk factors and disease.

Funding

Dates

Additional description
While Beijing was the only Chinese population participating in the WHO MONICA project, a national collaboration (named Sino-MONICA) was organized and conducted from 1985 to 1993. It covered 16 Chinese provinces and used the same criteria and methods. This collaboration has provided valuable data for estimating the magnitude and trend of cardiovascular disease and risk factors in the different Chinese populations.

Local research interests
Stroke and risk factors. The discrepancy between the pathological studies of atherosclerosis in coronary arteries and the incidence rate of coronary events in China. The interaction between environmental risk factors and genetic characteristics for cardiovascular disease.

Continuing activity
Registration of coronary and stroke events in part of the Sino-MONICA populations. Cohort studies in those who participated in the risk-factor surveys.

Key personnel
Pt: Zhaosu Wu. Former Pt: Yingkai Wu. Co–Pis: Chonghua Yao, Dong Zhao.

Selected publications
#56 Czech Republic (CZE-CZE, CZ)

- a composite MONICA population from the Czech Republic
- coronary mortality rose and then fell in the MONICA decade
- home of one of MONICA's godfathers, Zbyněk Piša

MCC 18: Czech-MONICA

Six geographically separate Reporting Units merged into one Reporting Unit Aggregate (RUA).

Administrative centre

Department of Preventive Cardiology, Institute for Clinical and Experimental Medicine, Vídenská 1958/9, 140 21 Prague 4, Czech Republic

T: +420 2 4172 1574; F: +420 2 4172 1574

Site of MONICA Quality Control Centre for Lipid Measurements.

Populations

Residents aged 25–64 of the six districts (Benešov, Cheb, Chrudim, Jindrichuv Hradec, Parádek, Praha východ) representing the middle, south, east and west of Bohemia. Mixed rural and urban populations. High coronary mortality. Presented as one population. Total population in 1991 was 631 000.

Funding

1. Institute budget to 1989. 2. Czech Ministry of Health Internal Grant Agency 1990–

Dates


Additional description

The MONICA core study, and studies linked with Czech MONICA (nutrition, psychosocial factors, trace elements genetics) were used for monitoring, investigation and interpretation of the changes in total and cardiovascular mortality, which occurred after the revolution in 1989. The MONICA and MONICA-linked Projects are the only source of data on the prevalence of different cardiovascular risk factors in the population of this country.

Local research interests

Longitudinal monitoring of the cardiovascular risk of the population over the period of increase and decline in total and cardiovascular mortality (classic and newer risk factors). Investigation of the health consequences of the economic and social transition in the country after 1989. Genetic studies, nutrition, psychosocial factors.

Continuing activity


Key personnel


Selected publications


Zdenka Škodová, Zbyněk Piša
MONICA POPULATIONS

Danmark-Glostrup (DEN-GLO, DN)

- Denmark’s only MONICA population
- Earlier risk-factor surveys go back to 1964
- Danish women have very high all-cause mortality

MCC 19: DAN-MONICA
Single Reporting Unit.

Administrative centre
Copenhagen County Centre for Preventive Medicine, Glostrup Hospital, University of Copenhagen, DK2600 Denmark
T +45 4323 3254; F +45 4323 3977
Coronary Heart Disease and Stroke Registers: Danish Institute of Public Health.

Population
Residents aged 25–74 of 11 municipalities in the urban county (Glostrup) of Copenhagen city. This county has hosted population studies continuously since 1964 from an epidemiological unit situated in a clinical environment. Over 30,000 men and women, one in ten of the total 1991 population of 326,000, have participated up to seven times in surveys based on random sampling and their date of birth.

Funding
1. Danish Heart Foundation. 2. Danish Medical Research Council.

Dates

Additional description
The Dan-MONICA population surveys used previous Glostrup Population Studies survey methods, employing Danish population registers to sample one year of birth for each 10-year age group. Participants have been resurveyed after five and 10 years using the MONICA protocol plus additional items.

Local research interests
Stroke, dietary intake, physical activity, social status, gallstones.

Continuing activity
The Copenhagen county Centre for Preventive Medicine uses MONICA results in local clinical trials on risk-factor intervention in the community and in hospital settings. The Nationwide Danish Hospitalisation Register uses MONICA criteria for its validation of myocardial infarction. Register results show that high Danish mortality rates are not primarily from coronary disease or stroke.

Key personnel

Selected publications

Marianne Schroll


Marianne Schroll

Danish Institute of Public Health.

Local research interests
Stroke, dietary intake, physical activity, social status, gallstones.

Continuing activity
The Copenhagen county Centre for Preventive Medicine uses MONICA results in local clinical trials on risk-factor intervention in the community and in hospital settings. The Nationwide Danish Hospitalisation Register uses MONICA criteria for its validation of myocardial infarction. Register results show that high Danish mortality rates are not primarily from coronary disease or stroke.

Key personnel

Selected publications

Marianne Schroll
very high coronary-event rates in men but major downward trends
FINMONICA incorporated into national prevention strategy and ongoing population surveys
base in National Public Health Institute (KTL) enabled observation to be combined with action
administrative centre adjoined the MONICA Data Centre in Helsinki
hosted 3rd Council of Principal Investigators in Porvoo, Finland, August 1985
hosted 2nd MONICA Congress in Helsinki, Finland, August 1987, (Acta Medica Scandinavica Supplementum, 1988, 728)

MCC 20: FINMONICA
Three Reporting Units, separate for most analyses, merged for coronary care.

Administrative centre
Department of Epidemiology and Health Promotion, National Public Health Institute (KTL), Mannerheimintie 166, 00300 Helsinki, Finland T +358 9 474441; F +358 9 4744 8338

Finland-North Karelia (FIN-NKA, FN)
Residents of the rural province of North Karelia in eastern Finland, bordering Russia. North Karelia has high rates of unemployment and emigration. Its economy is based on forestry, farming, timber, paper and steel industries. Known for its exceptionally high rates of cardiovascular diseases since the Seven Countries Study in the 1950s, North Karelia has been the site of a community-based prevention programme, the North Karelia Project, since the early 1970s. Community registrars for coronary and stroke events were set up, based in the main hospital at Joensuu, and risk-factor surveys were carried out. This experience was the background to the FINMONICA study, which therefore included North Karelia. The total population in 1991 was 174,000.

Finland-Kuopio Province (FIN-KUO, FK)
Residents of the rural province of Kuopio adjoining North Karelia to the west, in eastern Finland. Kuopio has the same economic base but with, in addition, a university and medical school established in Kuopio town in 1972. Kuopio province has similar disease problems and was the reference (control) community for the North Karelia Project in the 1970s, sharing the risk-factor surveys; but coronary and stroke registration were only set up with the FINMONICA study. The total population in 1991 was 257,000.

Finland-Turku/Loimaa area (FIN-TUL, FU)
Residents of Turku city and Loimaa town with neighbouring rural communities in southwestern Finland. Known to have the lowest cardiovascular mortality in Finland. Epidemiological studies of this area date back to the Seven Countries Study. A coronary-event register was set up in Turku in 1972. The area was included in FINMONICA to provide a contrast with the east. The local economy is relatively strong. The total population in 1991 was 200,000.

Funding
1. National Public Health Institute. 2. North Karelia Central Hospital, Kuopio University Hospital, City of Turku, Loimaa District Hospital. 3. Academy of Finland, Foundation for Cardiovascular Research.

Dates

Additional description
FINMONICA monitored the national action to reduce high rates of coronary heart disease and stroke in Finland. Five-yearly risk-factor surveys had previously been conducted in North Karelia and Kuopio in 1972 and 1977, and they are being continued, making the long-term analysis of risk-factor trends possible. The national personal identification number and computerised databases helped to ensure full coverage of event registration. Record linkage is used in prospective follow-up. Turku registered stroke at all ages, others registered stroke up to age 74.

Local research interests
FINMONICA included additional risk factors and cardiovascular and non-cardiovascular outcomes. Special interests have been smoking, diet, vitamins, electrolytes, socioeconomic factors, diabetes and other metabolic disorders, haemostatic factors.

Continuing activity
Coronary and stroke-event registration continued until 1998 in some but not all of the FINMONICA communities. Since then, coronary-event registration has continued in some but not all of the FINMONICA communities. Another risk-factor survey was carried out in all FINMONICA areas in 1997. The next one was completed in 2002. The risk-factor surveys have also been extended to cover several other geographic areas of Finland.

Key personnel

Selected publications
A comprehensive list of all publications is available at: http://www.ktl.fi/eteo/publications


#59 France-Country Coordinating Centre

### Administrative centre

Unité 258-INSERM, Hopital Paul Brousse, 16 av Paul Vaillant-Couturier, 94807 Villejuif Cedex, France  
T +33 2 4559 5109; F +33 1 4726 9454  

### Description

The French Coordinating Centre, located in Unit 258 in Paris, initiated the national studies. It managed the French database and organized test case and ECG coding seminars. It also organized the 3rd International MONICA Congress in Nice (15–16 September 1989) and the publication of its proceedings in the Revue d’Épidémiologie et de Santé Publique. It initiated the ECTIM (case-control) Study and the PRIME (cohort) Study in cooperation with the three French Centres and the Belfast Centre. It currently coordinates the French simplified coronary heart disease registers.

### Key personnel


### Selected publications (and see French MCCs)


Pierre Ducimetière, Annie Bingham
#60 France-Lille (FRA-LIL, FL)

- the northernmost of the three French centres
- highest mortality rates in France
- north-south gradient challenges the so-called French Paradox

**MCC 59: MONICA Lille**
Single Reporting Unit.

**Administrative centre**
Department of Epidemiology and Public Health, INSERM U508, Institut Pasteur de Lille, 1 rue Albert Calmette, B.P. 245, 59019 Lille Cedex, France
Tel +33 3 2087 7710; F +33 3 2087 7894
E-mail: philippe.amouyel@pasteur-lille.fr

**Population**
Residents aged 25–64 of the urban community of Lille in the Département du Nord, containing 86 administrative areas. The population is predominantly urban and the socioeconomic level is rather low. Mortality rates are high for all causes of death, and the highest for coronary heart disease in France. There is a university cardiology hospital located in Lille and 11 acute hospitals in the area, half of which are privately funded. The total population in 1991 was 1 068 000.

**Funding**

**Dates**

**Additional description**
All data are standardized across the three French centres with quality control procedures organized by the French coordinating centre. This fostered specific French studies and facilitated the estimation of trends in French coronary heart disease. The Lille Centre participated in the EUROASPIRE I and II Study (European Society of Cardiology), in a case-control study (ECTIM); and an on-going prospective study (PRIME) together with the two other French centres, and the UK-Belfast Centre.

**Local research interests**

**Continuing activity**
Registration continues with an extended age range of 35–75, as with the two other French centres. Cohort study (PRIME) continues.

**Key personnel**

**Selected publications**

**Philippe Amouyel**

**Michèle Montaye**

**Lille**
Continuing activity
Registration of coronary events continues. Cohort study (PRIME) continues.

Key personnel

Selected publications


#61 France-Strasbourg (FRA-STR, FS)

- one of the three French MONICA centres, located in the north-east of the country
- high coronary-event and mortality rates for France
- studies of delays in hospitalization for patients suffering from an acute MI

**MCC 54: MONICA Strasbourg**

**Administrative centre**

Department of Epidemiology and Public Health, Faculty of Medicine
11, rue Humann, 67085 Strasbourg Cedex, France
+33 3 9024 3189, F +33 3 9024 3189
E-mail: monica@medecine.u-strasbg.fr

**Population**

Residents aged 25–64 of the Bas-Rhin district of north-eastern France, across the Rhine from Germany. While the west of the district is rural with agriculture and viticulture, 42% of the population live in Strasbourg, a university city with high technology industry, a young expanding population, and low unemployment rates. However, compared with the French average, there is excess mortality from all causes, and from coronary heart disease. The total population in 1991 was 960,000.

**Dates**


**Funding**

1. INSERM (Institut National de la Santé et de la Recherche Médicale). 2.InVS (Institut National de Veille Sanitaire).

**Additional description**


**Local research interests**

Jean Ferrières

G

lowest proportion of deaths from cardiovascular disease in MONICA

low all-cause mortality

average smoking and cholesterol levels, low blood pressure

MCC 55: MONICA Toulouse
Single Reporting Unit (Haute Garonne).

Administrative centre
Cardiovascular Epidemiology Unit, INSERM 558, Department of Epidemiology, 37 Allées Jules Guesde, 31073 Toulouse Cedex, France
T +33 5 6152 1870; F +33 5 6226 4240
E-mail: ferriere@cict.fr

Population
Residents aged 25–64 of the Haute-Garonne department, north of the Pyrénées, south-western France. Haute-Garonne is a rural department with a total population in 1991 of 939 000, 71% of whom live in the city of Toulouse. Toulouse is known for aeronautical, aerospace and other high technology industries. It is located in a sunny, hot, rural area. The region has low all-cause mortality rates.

Funding
1. InVS (Institut de Veille Sanitaire). 2. INSERM (Institut National de la Santé et de la Recherche Médicale).

Dates

Additional description
The three French centres carried out the only cardiovascular epidemiological studies in France and facilitated the detailed analysis of the reported low mortality from coronary heart disease in France, called the French Paradox. (See French collaborative and WHO MONICA Project publications). Several hypotheses, genetic and/or environmental, have been put forward to explain low CHD rates in southern Europe. Research teams have been created exploiting advances in molecular biology, and improved standardization in the recording of environmental factors, such as nutrition and physical activity.

Local research interests
Public health: comprehension, application and dissemination of guidelines for cardiovascular disease-prevention in the population. Underly-

ing causes of low coronary disease rates in the region. Studies of management of myocardial infarction management, specifically the role of invasive cardiology.

Continuing activity
Registration continues.

Key personnel

Selected publications

Jean Ferrières

Jean Bernard Ruidavets

Toulouse
Germany-Augsburg (GER-AUG, GA)

MCC 26: Augsburg
Two Reporting Units, separate for most analyses, merged for coronary care.

Administrative centres
Institute of Epidemiology and Social Medicine, University of Münster, Domagkstrasse 3, D-48129 Münster, Germany
E-mail: keilu@uni-muenster.de
and
Institute of Epidemiology, GSF-Research Centre for Environment and Health, D-85758 Neuherberg, Germany

Population
Augsburg MONICA, Bavaria, south Germany, with a total population in 1991 of 575,000, is in almost equal halves: city of Augsburg (Reporting Unit 1) and the less urban Landkreis Augsburg and Landkreis Aichach-Friedberg (Reporting Unit 2). Manufacturing and services support the economy. Coronary-event registration of residents aged 25–74, used hot pursuit in 26 hospitals in and around the study area; but 70% of admissions were to Augsburg’s central hospital. Each population survey recruited 5000 participants by random cluster-sampling; initial survey age 25–64, middle and final surveys, 25–74. Response rates were 75–80%.

Funding
1. GSF Forschungszentrum für Umwelt und Gesundheit, München. 2. Bundesministerium für Bildung und Wissenschaft, Bonn. 3. Pharmazeutische Industrie. 4. Stifterverband für die Deutsche Wissenschaft, Essen.

Dates

Additional description
Founded by the Romans, Augsburg has been prominent in Germany since medieval times. It is the third largest city in Bavaria. The MONICA-Augsburg Project stimulated awareness of cardiovascular disease, and additional health research in the area. The local medical community were supportive of MONICA, but were worried initially by the high community case-fatality from myocardial infarction (found in all populations) and subsequently by the failure of hospital case-fatality to decline.

Local research interests

Continuing activity
Registration and population surveys continue. Cohort studies have been developed from the three surveys and are the only population-based cardiovascular cohort studies in Germany.

Key personnel

Selected publications
Comprehensive list and abstracts available at http://medweb.uni-muenster.de/institute/epi/forschung/index.html

Ulrich Keil
MCC 24: Bremen

Two Reporting Units, merged for coronary-event registration, (GER-BREb). Risk-factor results in the Monograph and collaborative papers are from one only: North and West Bremen (BREA).

Administrative centre

Bremen Institute for Prevention Research and Social Medicine (BIPS), Linzer Straße 8-10, D-28359 Bremen, Germany T +49 421 59596 0; F +49 421 59596 65

Collaborating Centre and Reference Centre for Drug Epidemiology.

Population

Residents aged 25–69 of the city of Bremen in two sub-populations: Bremen North and West (Reporting Unit 1), and Bremen City, South and East (Reporting Unit 2). The area of Bremen North and West, predominantly of blue-collar workers, was contemporaneously one of the intervention regions in the German Cardiovascular Prevention Study. The total population of GER-BREb in 1991 was 552 000.

Funding

1. Bundesanstalt für Arbeit.

Dates


Local research interests

Drug epidemiology. Primary prevention of cardiovascular diseases. Interventions on nutrition and smoking.

Continuing activity

Registration and population surveys have ceased. Analyses with focus on drug utilization continue.

Key personnel


Selected publications

Comprehensive list and abstracts available at: http://www.bips.uni-bremen.de


#65  Germany-East Germany (GER-EGE, GE)

**MCC 23: MONICA East Germany (previously known as DDR MONICA)**

Thirty nine Reporting Units in 1982 became 17 for the MONICA Manual (1990) and fell to three for the main MONICA trends papers and for this Monograph: Erfurt, Chemnitz and Zwickau (EGEa) for coronary-event registration; Chemnitz and Zwickau (EGEb) for risk-factor surveys; Zwickau (EGEd) alone for coronary care. Other Reporting Units contributed to early MONICA Publications through Reporting Unit Aggregates (RUs) of variable composition named Berlin-Lichtenberg, Cottbus, Halle County, Karl-Marx-Stadt and Rest of DDR MONICA. Detailed analysis of the permutations is beyond the scope of this Monograph but will be available on the MONICA Website.

**Administrative centre**

Department of Preventive Medicine, Academy of Sciences, Berlin (1982–1990) after 1990: ZEG—Centre for Epidemiology & Health Research Berlin, Invalidenstrasse 115, D-10115 Berlin, Germany

T +49 30 9451 0124; F +49 30 9451 0126

Website: www.zeg-berlin.de

**Population**

Residents aged 25–74. Of 39 districts in 1982, 22 were excluded before the 1987–89 population survey because of data quality and completeness. After German unification in 1989/90 three Reporting Units (RUs) and the administrative centre continued. The total population of these three in 1991 was 612 000.

**Funding**


**Dates**


**Local research interests**

Coronary disease and risk-factor differences, social differences and impact of these on life expectancy in East and West Germany.

**Key personnel**


Surviving RUs: H Holtz, S Brasche (Erfurt), S Böttig (Zwickau), G Voigt, D Quietsch (Chemnitz).

**Selected publications**


**Additional description**

Health service administrators across East Germany volunteered but found complying with MONICA beyond their resources. Most withdrew, leaving the north unrepresented. German unification involved privatizing health-care, so East German physicians gave lower priority to MONICA while building their private practices. Funding of MONICA and CINDI (another WHO project) stopped.
Continuing activity
Coronary-event registration continued from 1995 up to 1998. An additional population survey was carried out in 2001 as well as coronary-care monitoring.

Key personnel

Selected publications

Nikulás Sigfusson

Inga Ingibjörg Guðmundsdóttir

Ingibjörg Stefánssdóttir

Reykjavik