
An Assessment of the Awareness of Screening Tests for Early Detection of Cardiovascular Disease (CVD) Risk by the Female Civil Servants in Uyo

BY

Hannatu C. EKONG
Department of Nursing Science
Faculty of Health Sciences and Technology
University of Nigeria, Enugu

ABSTRACT

The study sought to assess the awareness of screening tests for early detection of cardiovascular disease (CVD) risk by the female civil servants in Uyo. The descriptive design of a cross sectional type was used for the study. The study area was the entire Akwa Ibom State Secretariat Complex known as Idongesit Nkanga Secretariat. The population of this study consisted of 4803 female civil servants in the Akwa Ibom State secretariat complex, Uyo. Stratified random sampling techniques was used for the study. The main instrument used for the study was questionnaire. Split-half reliability test using Cronbach's statistical analysis to determine the consistency of the instrument. Reliability coefficient obtained was 0.91 and this was high enough to justify the use of the instrument. The data was analyzed using inferential and descriptive statistics with the help of SPSS version 20.0 at .05 level of significance. The study concluded that there is no significant relationship between the level of awareness of cardiovascular disease risk factors and the level of practice of screening tests to detect cardiovascular disease risk by the female civil servants in Uyo. It was therefore recommended that government should sponsor screening activities to be carried out at the place of work and all civil servants must be encouraged to avail themselves of the screening

KEYWORDS: Awareness, Screening Tests, Early Detection Cardiovascular Disease, Civil Servants

INTRODUCTION

Cardiovascular disease, also called 'heart disease' is the leading cause of death in the world for both women and men. Cardiovascular disease is the cause of worldwide preventable morbidity and mortality in developing countries and rates are expected to rise over the next few decades (Ejim, et al., 2011). World Heart Foundation (WHF, 2015) fact sheet, No. 317 reported that cardiovascular diseases (CVDs) are the number one cause of death globally; more people die annually from CVDs than from any other cause. An estimated 17.5 million people died from CVDs in 2012, representing 31% of all global deaths. The risk for men is more widely known with the result that CVD is often more primarily a threat to men. CVD claims women and men in nearly equal numbers. (Gurley & Tomasello 2013).

Oguanobi, Ejim, Onwubere, Ike, Anisiuba, Ikeh and Aneke (2014) quoted that Reports from the Global Burden of Disease study 2010 revealed that non – communicable disease account for 66.7% of death worldwide with cardiovascular disease contributing 43% to the

global mortality figure. Sowemimo (2015) stated that there are no reliable statistics about cardiovascular disease in Nigeria. Pockets of studies conducted in communities show that burden of heart related diseases in Nigeria are very high. According to him, CVD deaths worldwide is thought to be more than the ones caused by malaria, HIV and Tuberculosis put together. It does not have respect for status or social class as it kills both the rich and the poor, educated and none educated. The American Heart Association (AHA) (2014), stated that the key to preventing cardiovascular diseases is managing the risk factors such as high blood pressure, high cholesterol or high blood glucose. Cardiovascular disease risk factor awareness and knowledge are believed to be prerequisites for adopting healthy lifestyle behaviours both to prevent and detect these diseases to curb the morbidity and mortality associated with it.

Statement of the Problem

Cardiovascular diseases remain the major cause of deaths worldwide. Although cardiovascular mortality rates have declined in many high-income countries, over the last two decades it has increased at a fast rate in low and middle-income countries. Dr Biodun Ogungbo, a brain expert, as reported by Ogbebo (2014), said:

“We see more and more of people with this problem and heart attack is also on the increase... people are dying from stroke and heart attack and the major cause of that in our country is hypertension, diabetes and obesity...yet these condition could be prevented...”

These incessant cases of slumping and death due to causes that can be averted has motivated the researcher to go into this study to ascertain the level of awareness of screening tests for early detection of cardiovascular disease risk by the female civil servants in Uyo.

Research Questions

This study sought to answer the research question:

What is the level of awareness of screening tests for early detection of cardiovascular disease risk by the female civil servants in Uyo?

Hypotheses

There is no significant relationship between the level of awareness of cardiovascular disease risk factors and the level of practice of screening tests to detect cardiovascular disease risk by the female civil servants in Uyo.

Literature Review

Overview of Cardiovascular Disease

As the largest single cause of death on the planet, cardiovascular disease (CVD) in all its forms is an important and life or death matter. CVD is not a single disease, but a cluster of diseases and injuries that affect the cardiovascular system (the heart and blood vessels). These are most commonly diseases of the heart and of the blood vessels of the heart and brain. Individuals at risk of CVD may demonstrate raised blood pressure, glucose, and lipids as well as overweight and

obesity. These can all be easily measured in primary care facilities. Identifying those at highest risk of CVDs and ensuring they receive appropriate treatment can prevent premature deaths. (WHO, 2004).

Causes Cardiovascular Disease?

The main function of the cardiovascular system is to transport blood throughout the body. Cardiovascular disease occurs when blood flow becomes obstructed. This is primarily caused by Artherosclerosis – a build-up of deposits on the inside of arteries. Artherosclerosis is a gradual disease process. The inner layer of the arteries is normally smooth. During early adulthood fatty particles from the blood make their way into the inner layer of the arteries. They build up and form fatty streaks. Injuries to the internal lining from smoking, high blood pressure or diabetes, make it more likely that fatty particles will build up. As time goes on fat from low density lipoprotein (LDL_s) continues to build up. The lipids react with oxygen and are taken over by smooth muscle cells of the artery. The cells develop a foamy appearance. The foam cells attract platelet from the blood stream as well as calcium deposits and cell debris. The walls of the artery become inflamed as white blood cells try to heal the injured area. In the meantime, a fibre-like cap forms over the fatty mixture and create a hardened lesion called an “atherosclerotic plaque”. As the plaque continues to grow, it narrows the affected artery and slows the flow of blood through it. At times the fibrous cap covering atherosclerotic plaque may rupture. When this happens platelets become exposed to the content of the plaque. This causes them to collect and form a clot at the site of the rupture (thrombosis). The clot may grow very large leading to total obstruction of flow in the artery. Pieces of clots (emboli) may also break off and travel downstream (AHA, 2013).

Types of Cardiovascular Diseases

- 1) ***Peripheral vascular disease:*** Affects the circulation primarily in the (legs). Patients with this disease typically complain of pain in their calves especially when walking.
- 2) ***Heart failure*** occurs when the pumping action of the heart cannot provide enough blood to the rest of the body as it is needed. This can happen as a result of damage to the heart muscle, for example from a heart attack or from excessive consumption of alcohol, or because of a heart disease also called a cardiomyopathy. Patients with heart failure visually suffer from shortness of breath and swelling of the legs.
- 3) ***Rheumatic heart disease:*** Is a problem in many poor countries. This disease begins with a bacterial infection in childhood, affecting joints and heart valves. The heart problem appears many years later. Often the valves have to be replaced by an operation. Other infections can occur attacking the inner tissues of the heart including the valves (endocarditis) and the outer tissues overlying the heart (pericarditis).
- 4) ***Congenital heart disease:*** Is a problem with the structure of the heart arising because of a birth defect. These anatomical defects can be as simple as a small hole in one of the inside walls of the heart or they can be very complex, affecting the way blood flows through the heart and lungs. Some congenital heart problems result in death unless immediately corrected by surgical intervention. Other cause disability to

varying degrees and are treated by surgical later in life with correction of the problem sometimes requiring more than a single operation.

Screening for Cardiovascular Risk Detection

Cardiovascular screening is the practice of using tests or examination to see if a person is at risk of certain kinds of heart disease. Primary prevention of cardiovascular disease is aimed at risk factor identification and treatment as well as screen individual with vascular and cardiac test aimed at identifying early abnormalities likely to progress and to measure risk contributors susceptible to therapy. The screening tests are effective in uncovering unsuspected early cardiovascular disease in which targeted treatment could be effective in reducing the incidence of cardiovascular event in susceptible individuals. Cardiac disease which may lead to heart failure is commonly asymptomatic. Although atherosclerosis is a common cause of such disease left ventricular dysfunction frequently is idiopathic.

Types of Screening Tests

A comprehensive array of non-invasive testing, imaging and biochemical method have been developed using techniques that have either been established or advocated for early detection. Screening consist of 3 phases

- 1) Risk category assignment
- 2) Early disease assessment
- 3) Modifiable disease contributor assessment.

The extensiveness of the screening evaluation and its cost is based on risk category assignment. Certain tests are highly unlikely to be abnormal in low-risk individuals. Individuals are placed in low or high risk categories on the basis of information obtained on initial interview.

The criteria for high risk assessment are;

- 1) Age: women above 55years and men above 45years
- 2) Family history: Individuals with one primary relative (parent or sibling) or 2 secondary relatives (grand parent, cousin etc) with cardiovascular disease or diabetes before the age of 65 in women or before 55 in men
- 3) Personal history: Individuals who present with a history of an abnormal risk factor (blood pressure, cholesterol, blood sugar or a previous presumed cardiovascular event).
- 4) Smokers
- 5) Abnormal test results.

The screening tests employed are designed to separately assess early markers for arterial and left ventricular disease.

Arterial disease: Because endothelial dysfunction may be earliest manifestation of arterial disease likely to progress to symptomatic atherosclerosis, assessing the early markers for endothelial and vascular dysfunction becomes necessary in an attempt to identify disease that has not become symptomatic. The following tests are employed.

- 1) **Arterial elasticity:** Pulse contour analysis allows separate assessment of the elasticity of the large conduct arteries and small arteries that serve as sites of the reflected waves in the circulation. A pulse wave analysis methodology is utilized. This consists of applying a piezoelectric transducer to a radial artery with on-line computer analysis of the pulse wave with a rapid print out of the cardiovascular profile that include large artery elasticity (C1) and small artery elasticity (C2). Studies that have validated the methodology demonstrated the decline in C1 and C2 abnormally low C2 levels in patients with cardiovascular disease, and shown a correlation between risk factors for cardiovascular disease and a low C2
- 2) **Blood pressure at rest and during exercise:** Resting sitting blood pressure is recorded by standard sphygmomanometry. The patient then stands on a treadmill and exercises for 3 minutes or at 5 metabolic equivalents workload. The exercise induced change in blood pressure is recorded. A brisk rise has been shown to correlate with reduced arterial elasticity or compliance.
- 3) **Optic fundus photos:** A digital camera is used to image the optic fundus without the need for mydriasis. Fundus photos are analyzed for the A:V ratio and the presence of A:V crossing changes.
- 4) **Microalbuminuria:** A spot urine sample is analyzed for the albumin excretion per milligram creatinine, a marker for small artery disease in the kidney.
- 5) **Ankle/brachial index (high risk only):** Systolic blood pressure is measured in the arm and leg by Doppler detection. A ratio of leg/arm systolic pressure below 0.90 is taken as evidence for lower extremely occlusive disease.

Cardiac disease: Left ventricular disease precedes the onset of symptoms of cardiac dysfunction. Identification of early cardiac disease could allow intervention that may be effective in solving progression.

- 1) Electrocardiogram.
- 2) Left ventricular ultrasound: A hand held portable echocardiographic unit is used to screen the left ventricle (LV) for transverse diameter, wall thickness, and calculated LV mass.
- 3) Plasma B-type peptide (BNP) concentration. BNP levels are a sensitive guide to left ventricular dysfunction BNP is assayed using an on-line platform that utilizes a drop of venous blood placed on a slide device for immediate analysis.

Each of the tests employed can be categorized as normal, border line, or abnormal. An abnormal test is arbitrarily assigned a score of 2 and each borderline test a score of 1. The seven vascular and 3 cardiac tests can yield an overall score of 0 to 20, this score provide a continuum from “no

evidence for disease” to “strong evidence for disease”. The hypothesis is that the disease score will be a guide to the risk for a cardiovascular event (heart attack and stroke).

Simple First Line Screening

However, in the detection of risk factors for cardiovascular disease (heart attack and stroke) the following screening tests have become imperative as the first line tests.

- 1) **Blood pressure:** taken seated at rest.
- 2) **Fasting lipid levels:** Patients are instructed to come to the centre fasting and blood is drawn for analysis of cholesterol, low-density lipoproteins, high-density lipoproteins and in triglycerides.
- 3) Fasting blood sugar.
- 4) **C-reactive protein:** This inflammatory maker is associated with the risk for atherosclerotic events. Anti-inflammatory therapy may suppress the levels.
- 5) **Plasminogen Activator inhibitor (PAI-1):** This platelet aggregating factor may increase the risk of thrombotic events and may be suppressed by therapy.
- 6) **Homocystenie:** Elevated levels have been identified as a risk factor for atherosclerosis and may be suppressed by folic acid.

Burnak, Willaimson, Spitz and Edward (2013), conducted a study on Utilization of screening services for heart attack among women in Maleurdi. The population of the study was 344 patients (women) of which 48.3% of them were civil servants attending the out Patient clinic at the Bence State University Teaching Hospital, Maleurdi (BSUTH) between March and August 2012. Being a cross-sectional study, the researchers used interviewer administered questionnaire to 172 respondents. The data collected were analysed using EPI INFO statistical software version 322 and Chi-square was used as a test of statistic with P-value ≤ 0.05 considered statistically significant. The findings revealed that, the average age of respondents was 47 years, most (48.3%) were civil servants, married (89.0%) and had post-secondary education (64.5%); about 65% were aware of heart attack and 51% were aware of hypertension and high cholesterol as the risk factors. Main source of information was through the media (35.5%). About 34% were aware of the existence of screening tests to detect heart attack early. Among those who were aware of screening service, only 13.16% had utilized the services ($\chi^2 = 122$, $p = 0.0004$, $or = 3.7$). Overall, only 7% of the study population have ever screened for the disease. Education significantly affected awareness for heart attack ($p = 0.0001$) and screening services ($p = 0.0002$). According to the researchers, the reasons for non-utilization of services were; ignorance, absence of screening centres, perceived non necessity, faith in God, prohibitive cost, physician's non recommendation, among others. Based on the findings of the study, there existed a high degree of association between the level of awareness and utilization of screening services for heart attack amongst women. Also, from the researchers' assertion, most women were aware of heart attack and screening for the disease but utilization of screening services was very poor. Emphasis should be made towards the provision, accessibility and affordability of screening services to the women while sustaining campaigns.

According to Udofia, Akwaowo and Ekanem (2012) evidence exists that awareness and uptake of some preventive health examinations (CVD and cancer screening) remains low in Nigeria. Awareness was high in a study which involved well educated women in Accra, Ghana but only 39% of respondents had sufficient knowledge and 8.5% had previous screening tests. In their work, out of 367 women of childbearing age attending 3 public health facilities in Uyo 84.5% were aware of, and also carried out blood pressure screening and 74.4% were aware of, and also carried out blood sugar check. (Other screening modalities for CVD were not represented in their study). 66.7% had a blood pressure and blood sugar check. In this study health workers were the primary informants for all tests. Thus, the gaps in awareness of CVD screening test must be filled by the concerted effort of committed health care providers.

Methods

Research Design

The descriptive design of a cross sectional type was used for the study.

Area of Study

The study area was the entire Akwa Ibom State Secretariat Complex known as Idongesit Nkanga Secretariat.

Population of study

The population of 4803 female civil servants whose offices are located in the State secretariat complex, Uyo, was used for the study.

Sample and Sampling Technique

A total sample size of 406 respondents was selected for the study using stratified random sampling technique. Out of this number (406), 363 questionnaires were correctly filled in and returned.

Instrumentation

The main instrument used in this study was questionnaire.

Validity of the Instrument

The face and content validity of the instrument was ascertained by experts in test and measurements.

Reliability of the Instrument

In order to ensure the reliability of the instruments, split-half reliability test using Cronbach's statistical analysis to determine the consistency of the instrument. A reliability coefficient of 0.91 was obtained.

Method of Data Analysis

Analysis of the data was carried out using computer software programme called Statistical Package for Social Sciences (SPSS) version 20.0. The data was analyzed using inferential and descriptive statistics.

Result and Discussion

Result

Research Question One

What is the level of awareness of screening tests for early detection of cardiovascular disease risk by the female civil servants in Uyo?

Table 1: Awareness of Screening Test to Detect Cardiovascular Disease Risk Factors. n=363

		Frequency	Percent
Awareness of some screening tests that detects the risk for heart attack and stroke	Yes	356	98.1
	No	7	1.9
Awareness that regular blood pressure check helps to detect risk for heart attack and stroke	Yes	333	91.7
	No	30	8.3
Awareness that regular blood sugar check helps to detect risk for heart attack and stroke	Yes	304	83.7
	No	59	16.3
Awareness that regular weight check helps to detect risk for heart attack and stroke	Yes	304	83.7
	No	59	16.3
Awareness that checking blood cholesterol helps to detect risk for heart attack and stroke	Yes	315	86.8
	No	48	13.2
Perception that heart attack and stroke are cause by evil spirits hence cannot be detected easily	*Yes	54	14.9
	No	309	85.1
Overall awareness of screening tests: High (awareness score >50%)		343	94.5
	Low (awareness score ≤ 50%)	20	5.5

***implies wrong perception**

Table 1 displayed the women's awareness of screening tests to detect cardiovascular disease risk factors. Almost all the women (98.1%) were aware of some tests that detect the risk for heart attack and stroke. Awareness of regular blood pressure check (91.7%), blood cholesterol check (86.8%) and regular weight check (83.7%) were high as screenings to detect risk of heart attack and stroke. Wrong perception that heart attack and stroke are caused by evil spirits and hence cannot be easily detected was low (14.9%). In general, the women had very high level of awareness of screening tests for early detection of cardiovascular disease risk (94.5%).

Research Hypothesis

There is no significant relationship between the level of awareness of cardiovascular disease risk factors and the level of practice of screening tests to detect cardiovascular disease risk by the female civil servants in Uyo.

Table 2: Awareness of Screening Test to Detect Cardiovascular Disease Risk Factors. n=363

		Practice		Total	p-value
		Poor	Good		
Awareness level of risk factors	Low	7(77.8)	2(22.2)	9(100.0)	.724
	High	231(65.3)	123(34.7)	354(100.0)	
	Total	238(65.6)	115(34.4)	363(100.0)	

Fishers Exact Test was computed as Chi-Square Assumption (more than 20% of the frequency <5) was violated

Table 2 displayed the relationship between awareness level of cardiovascular disease risk factors and the practice level of screening tests. Although, good practice (34.7%) was associated more to women with high awareness than those with low awareness (22.2%), the difference was not significant ($p = .724$). A p-value of .724 is enough evidence to accept the null hypothesis. Therefore, there was no significant relationship between respondents' level of awareness of risk factors and their level of practice of the screening tests.

Discussion of the Findings

Findings as displayed in Table 1 showed that almost all the women (98%) were aware of some tests that detect the risk for CVD. The screening test with the highest frequency is blood pressure check (91.7%) followed by cholesterol check (86.8%), blood sugar and weight check (83.7% each). Primary prevention of cardiovascular disease is aimed at risk factor identification and treatment as well as screening individuals with vascular and cardiac test aimed at identifying early abnormalities likely to progress and to measure risk contributors susceptible to therapy. The screening tests were effective in uncovering unsuspected early CVD in which targeted treatment could be effective in reducing the incidence of cardiovascular event in susceptible individuals. Therefore, the respondents' overall high level of awareness of screening tests (94.5%) for early detection of CVD risk is a very welcome and hope inspiring discovery as it is hoped that they will translate knowledge to action according to Knowledge, Attitude and Practice (KAP) principle.

The findings contradict that of Udofia, Akwaowo and Ekanem (2012) evidence exist that awareness and uptake of some preventive health examinations (CVD and cancer screening) remains low in Nigeria. Awareness was high in a study which involved well educated women in Accra, Ghana but only 39% of respondents had sufficient knowledge. However, in their work, out of 367 women of child bearing age attending 3 public health facilities in Uyo (84.5%) were aware of, and also carried out blood pressure screening and (74.4%) were aware of, and also carried out blood sugar check. Other screening modalities for CVD were not represented in their study. The respondent who had a combination of blood pressure and blood sugar check were (66.7%). In this study health workers were the primary informants for all tests. Thus, the gaps in awareness of screening test for CVD risk factors must be filled by the concerted effort of committed health care providers.

Findings as displayed in Table 2 showed the assessment of the relationship between respondents' awareness of cardiovascular disease risk factors and the level of practice of screening test to detect CVD risk factors, Fishers Exact Test was computed with a p-value of .724. The Fishers p-value of .724 is greater than 0.05 (5%). Therefore, the null hypothesis was accepted. This indicated that there was no significant statistical relationship between the level of awareness of CVD risk factors and the level of practice of screening tests to detect the CVD by female civil servants in Uyo. This finding is contrasted by many other findings by different authors in the field as Burnak, Willaimson, Spitz and Edward (2013) in their study found that there exists a high degree of influence between the level of awareness and utilization of screening services for heart attack among women. Most women were aware of heart attack and screening for the disease, but utilization of screening services was very poor.

Conclusion

Good knowledge of CVD risk factors and fair knowledge of the screening tests to detect CVD risk but the level of practice of screening is low the poor level of practice may be attributed to their lack of perception of personal risk or susceptibility to the disease. This therefore calls for concerted and targeted effort by medical personnel to deliver information that will highlight the danger of CVD and the women's personal susceptibility to the disease and the need for screening. Also the medical personnel must be well informed on the CVD risk factors and personally undergo the screening test so as to counsel based on experience. Therefore, the study reveals that there is no significant relationship between respondents' level of awareness of risk factors and their level of practice of the screening tests.

Recommendation

Based on the findings of the study, following recommendations are made:

1. Government should sponsor screening activities to be carried out at the place of work and all civil servants must be encouraged to avail themselves of the screening.
2. Non-governmental and other charitable organizations can also make significant contributions by sponsoring or staging health talks, symposia, and workshops targeted at relevant segments of the population.
3. Church leaders and leaders of other faith based organizations must be educated on the risk factors of CVD so that they would counsel their members to seek medical care or go for screening to detect these risk factors rather than encourage them to stay back in their "churches" and "prayer houses" and fast. As the saying goes, that "faith without work is dead, being alone".

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