Obesity is a major problem for public health due to weight gain from imbalance between energy intake and energy expenditure. According to published data by World Health Organization (WHO), obesity was increased rapidly from outset of last decades of 1900. Prevalence of obesity is accepted as a socioeconomic challenge in present decade. Based on this topic, in particular since 1980 decade, if this trend cannot be reversed or at least restrained, high levels of obesity will naturally lead to increases in the prevalence of chronic diseases, with enormous economic and personal costs. Epidemiological reports show, in 2008, approximately 35% of adults were overweight (body mass index [BMI] ≥25-29.9 kg/m²) (34% men and 35% of women). The worldwide obesity prevalence has increased meaningfully between 1980 and 2008. In 2008, 10% of men and 14% of women in the world were obese (BMI ≥30 kg/m²), compared with 5% for men and 8% for women in 1980. An estimated 205 million men and 297 million women over the age of 20 were obese a total of more than half a billion adults worldwide. Since physical activity rates over the past three decades are essentially unchanged or lower, it would seem that increased body mass has limited the weight gain due to increased energy output. As a result, obesity prevention has become an international priority. Changes in life habits and patterns, such as dietary behaviors, advancing in technology, relief, sedentary life, and decrease of lifestyle physical activities, results in an increase of obesity and weight gain among men and women. Obesity is related to increased morbidity and mortality rates due to coronary heart disease (CHD), osteoarthritis, infectious disease and cancers. Excessive body weight, in addition, increases the risk of hypertension, unhealthy lipid profile, menopause, gallbladder disease, diabetes, some cancers, psychosocial experiences, and many other causes of chronic morbidity. Obesity, in addition, involves major expenditure and therefore represent a socioeconomic health problem of the highest magnitude. It is clear that obesity as worldwide problem results in considerable morbidities and decrease individuals abilities for keep their good health for live. In this review we try that augment this history argument, epidemically and represent the relation between physical activities and weight control among men and women.

**Keywords:** Obesity prevalence; Fatness related-disease; Physical fitness; Weight control

### Obesity Definition and Measurement

To most non-professionals, obesity means very fat and overweight means either less fat. Whereas overweight implied to excess body weight compared to set standards, obesity refers specifically to having an abnormally high proportion of fat [1]. To health professionals and researchers, however, both these terms have definitions that specify the degree of excess fat [2]. Body fat exists in storage and essential forms. Essential fat found in all organs involving the central nervous system or intestines that is necessary for body normal functions. Storage fat as an efficient energy fuel is accumulated in the adipose tissue, specially under the skin and that is affected by diet or exercise, whereas the amount of essential fat remains constant [3]. World health organization, in addition, produced a definition of obesity based on Body Mass Index (BMI), as a criterion taking into particular consideration the correlation between this index and mortality and disability [4]. Indeed, body fatness assessed by BMI that is calculated by easily and quickly dividing an individual’s weight measured in kilograms by their height in meters squared (kg/m²); e.g., a man weighing 80 kg and measuring 1.7 m, BMI = 80/(1.7 × 1.7) = 27.7 kg/m². This index is independent of gender and age [2]. Table 1 shows accepted scale of BMI for degrees of overweight and obesity by WHO [5,6]. Defined objectively as a BMI of 30 or more, obesity is related with markedly increased health risks. Although, a BMI of 25 kg/m² is the commonly accepted threshold for recognizing bedridden identifying a patient at higher risk for obesity-related illnesses [7].

Individuals who have a BMI of ≥ have a 50-100% increased death hazard from all causes compared with individuals who have BMI 20–25 kg/m² [8]. Morbid obesity is defined by a BMI ≥40.0 kg/m². Body mass index calculation as a test for reorganization of overweight and obesity, although, is not a perfect measure, but it is the industry standard, as its formula makes it certainly accurate enough to determine presence of increased health...
hazard [9,10]. It, indeed, has replaced percentage ideal body weight as a criterion for assessing obesity for several reasons [7]. It is not proper index in individuals with a great muscle mass (such as bodybuilders) and falsely low in those that have lost muscle mass, such as the elderly [11]. The main assumption of BMI guidelines is that body mass, adjusted for stature squared, is closely associated with body fatness and consequent morbidity and mortality [12,13]. On base of BMI data, men have more BMI when compared with women, generally. However, more men are overweight than women, but in almost more women than men are obese through the world [14]. Same to BMI, Waist Circumference (WC) is a useful predictor; commonly for Coronary Heart Disease (CHD) risks and undesirable profile of blood fats (Table 1). It is reported that there is a clear relation between the accumulation intra-abdominal fat and WC and increased hazards [5]. On this base, WHO suggested WC measures for predict of hypertension and lipid disorders, particularly low density lipoprotein (HDL) cholesterol, added to crudely predicted whether people were overweight or obese [6]. Waist circumference, indeed, is an independent hazard for raised risk of backwash from obesity that increased. It can indeed be a marker for increased risk even in persons of normal weight [7].

**Table 1: Classification of obesity and Comorbidity risks.**

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
<th>Comorbidity Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.5</td>
<td>Low (But Risk of Other Clinical Problems Increased)</td>
</tr>
<tr>
<td>Normal range</td>
<td>18.5-24.9</td>
<td>Average</td>
</tr>
<tr>
<td>Overweight (Pre-obese)</td>
<td>25.0-29.9</td>
<td>Increased</td>
</tr>
<tr>
<td>Obesity</td>
<td>≥30.0</td>
<td></td>
</tr>
<tr>
<td>Obese class 1</td>
<td>30.0-34.9</td>
<td>Moderate</td>
</tr>
<tr>
<td>Obese class 2</td>
<td>35.0-39.9</td>
<td>Severe</td>
</tr>
<tr>
<td>Obese class 3</td>
<td>≥40.0</td>
<td>Very severe</td>
</tr>
<tr>
<td>Comorbidity risks</td>
<td>Waist Circumference (cm)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Above action level 1</td>
<td>≥80</td>
<td>≥94</td>
</tr>
<tr>
<td>Above action level 2</td>
<td>≥88</td>
<td>≥102</td>
</tr>
<tr>
<td>Data from reference: [6].</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Obesity and Diseases**

Obesity and overweight are considered the third most important hazard attributable to burden of disease. There was approximately 350 million obese people (BMI ≥30.0) and over 1 billion overweight people (BMI ≥25) in the world in the beginning of this century. Over all more than 2.5 million deaths are, in addition, attributed to overweight/obesity worldwide [6]. Since that time, the population of obese people has risen and is still rising in advanced countries. According to “Obesity Update 2017 Report” published by Organization for Economic Co-operation and Development (OECD), more than one in two adults and nearly one in six children are overweight or obese in 2015, across OECD countries, 19.5% of the adult population was obese. This rate ranges from less than 6% in Korea and Japan to more than 30% in Hungary, New Zealand, Mexico and the United States (US). More than one in four adults is obese in Australia, Canada, Chile, South Africa and the United Kingdom (UK). Overweight and obesity rates have grown rapidly in England, Mexico and the US since the 1990s, while the increase has been slower in the other seven OECD countries.

Over the past decade, the prevalence rate of overweight and obesity has increased in Canada, France, Mexico, Switzerland and the US [15]. Different studies have been showed an association between obesity and mortality factors such as diabetes, hypertension, CHD, and some cancers. Namely it is estimated that for every 1 kg increase in weight, the prevalence of diabetes rises by 9% [16-18]. It has indeed been known that obesity is a marked determinant of high levels total cholesterol and triglycerides, and low levels of HDL cholesterol [10]. BMI, WC and waist-to-hip ratio (WHR) have also been reported that as strong risk factors for colon cancer [19]. WHR is a useful method for assessment of central obesity [20]. It have been reported that obesity may decrease the ability of insulin to widen blood vessels. It indeed changes function of kidney and sodium balance that lead to hypertension [6]. Furthermore, obesity has more psychological and social effects, involving low self esteem and discrimination [11]. In general, obesity increases the risk of many diseases and health conditions that exhibited in Tables 2 & 3. With increase of BMI from 23 kg/m², compared with the lowest hazard category, risk of mortality rises progressively. Death hazards, indeed, increases with rising of BMI from 25 kg/m², through 1, 2, and 3 obesity classes [7,21], defined in Table 1. It is evident that sedentary lifestyle is an independent risk factor for heart related deaths [22]. According to estimates, more than half of disease is lifestyle related. Indeed, the scientific literature shows that adverse modifiable health risks such as physical inactivity and obesity are related to morbidities [23]. One of the sedentary life related hazards is accumulation of fat in trunk that increased WC and WHR [24]. This condition is related with hypertrophic obesity. Enlarged fat cells is symptoms of hypertrophic obesity (often begins in adulthood), that result in production of proteins and metabolites such as lipoprotein lipase (LPL), which communion to hydrolysis of the triglycerides of very low density lipoproteins (VLDL) and chylomicrons, and cytokines (tumor necrosis factor-α, and interleukin-6), leptin (a hormone involved in animal models of obesity), as well as angiotensinogen [1,2]. The hypertrophic fatness is correlates to obesity metabolic disorders such as damaged glucose tolerance and adverse lipid profile [7]. Whereas, in patients with a BMI ≥40 kg/m² occurred hypercellular obesity (often begins in childhood) that is a lower hazard type of illnesses [22]. It seems aging is an effectiveness variable in identification of hypertrophic obesity that occurred in adults. Therefore, age is important factor in investigation of side effects of hypertrophic obesity. Of note, individuals who have a BMI equal or more than 30 kg/m² must lessen their weight irrespective of WC rate or its hazards. Indeed, loss weight should be lionized for normal weight women who have WC ≥88 cm or men who have ≥102 cm, as well as two or more of the tabled hazards [7].
Sleep apnea and respiratory problems
Hypertension (17%)
Neoplasias
Mental and nervous disorders,
Insulin resistance syndrome
Coronary Heart Disease (17%)
Colon Cancer (11%)
Gynecological problems (abnormal
and Women. MOJ Womens Health 7(1): 00161. DOI:
perform physical activity, obesity and its side effects [4,29-31].
lots of studies have showed overt inverse relation between
activity if they have a positive attitude towards its benefits [3]. A
mored variables. Individuals are more likely to do physical
involvement of physical activities and restriction of
dedentary lifestyle as a negative social
paradigm lead to prevalence of obesity and side effects that its
extreme will be an unhealthy and bedridden society [24-26]. For
this aim should promote people attitude about physical activity
and exercise benefits [27]. It seems for improve of health and
disease prevention, physical fitness is more important than a
reduction in body fat. Many scientists have expressed a new
perception on relation between obesity and physical activity. They
have believed that obesity as result of “fat” accumulation is versus
“fit” as output of physical activity. They believe that fitness level
is premier to health than body fatness, and fit obese individuals are
at less risk than unfit normal weight individuals [18]. For
example, in a cross-sectional study, we investigate the prevalence
of obesity, overweight and lifestyle physical activities in Public
Transport Drivers in Tehran. We observed a significant negative
relationship between body mass index and with spending work
and behaviors improvement therapy that set by National Heart,
and researchers. A study on women who had successfully lost
their weight, show obese individuals needs 60-90 min physical
activity with moderate intensity or lesser amounts of vigorous
exercise [39,40]. For example, the women who did more than
activity with moderate intensity or lesser amounts of vigorous
For this aim, have been developed and published guidelines by
many institutes and organizations such as the National Institutes
of Health (NIH) [32], the North American Association for the
Study of Obesity (NAASO), American College of Sports Medicine
(ACSM), and WHO. In that guidelines, there is recommendations
on optimum levels of physical activities involves intensity,
duration, frequency, and type of them. It seems follow a suitable
exercise program can lead to decrease of fatness and treatment of
obesity and increase of fitness [33,34]. Weight loss in overweight
and obese individuals can reduce the risk of heart disease [14]. A
lot of studies show that weight loss, even if 5-10%, meaningfully
improves lipoproteins, high blood pressure, insulin resistance, risk
for osteoarthritis, cancers, and other hazards for chronic illnesses
[35,36]. Diet is of paramount importance in the management of
weight and obesity depended complications. It is accepted that
a composition of dietary changes (diet with less calories and
fat) and increased regular physical activities is the proficiency
method to promote weight loss and to maintain the weight loss
[14,28,37]. Diet and regular physical activity as behavior habits
are associated with strong beliefs that influence one's own health,
too [38]. Above sentence show a relation between daily behaviors
and psychological outcomes.

Indeed, choice of suitable diet with doing regular physical
activities on recommended guideline lead to qualified life. This
question “How much physical activity is sufficient to avoid
weight gain” always set as a major challenge among scientists
and researchers. A study on women who had successfully lost
their weight, show obese individuals needs 60-90 min physical
activity with moderate intensity or lesser amounts of vigorous
exercise [39,40]. For example, the women who did more than
2 hours vigorous physical activity per week show an inverse
relation with increased weight and obesity [10]. It seems there
are not acceptable evidences on requirement physical activity
for prevent of weight gain. It is not known. However, on basis
of different recommendations 45-60 min activity per day
with moderate intensity is needed to avoid excess weight gain
[2,39,40]. Perhaps, most recommended successful treatment
strategy involves an interaction of physical activity, diet therapy,
and behaviors improvement therapy that set by National Heart,
and Lung and Blood Institute [33]. Same to inactivity, age is strongly
associated with obesity [41]. It seems with aging reduce physical

Table 2: Health complications of obesity

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyslipidemia (for example, high total cholesterol or high levels of triglycerides)</td>
<td>Sleep apnea and respiratory problems</td>
</tr>
<tr>
<td>Fatty infiltration of liver</td>
<td></td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td></td>
</tr>
<tr>
<td>Immune disorders</td>
<td></td>
</tr>
<tr>
<td>Digestive diseases</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
</tr>
</tbody>
</table>

* Data from references: [6,7,25,26].

Table 3: Relation between obesity and many diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type-2 diabetes</td>
<td>(61%)</td>
</tr>
<tr>
<td>Endometrial Cancer</td>
<td>(34%)</td>
</tr>
<tr>
<td>GallBladder Disease</td>
<td>(30%)</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>(24%)</td>
</tr>
</tbody>
</table>

*Data from reference: [19].

Physical Activity and Weight Management

One of the reactions of health associations to rise of obesity
epidemic and the necessity for physicians to diagnose and
treat obesity as a worldwide problem is to be active physically.
Modification concentrated on increasing physical activity must
involve improvement of physical activities and restriction of
dedentary hours. It seems sedentary lifestyle as a negative social
paradigm lead to prevalence of obesity and side effects that its
extreme will be an unhealthy and bedridden society [24-26]. For
this aim should promote people attitude about physical activity
and exercise benefits [27]. It seems for improve of health and
disease prevention, physical fitness is more important than a
reduction in body fat. Many scientists have expressed a new
perception on relation between obesity and physical activity. They
have believed that obesity as result of “fat” accumulation is versus
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at less risk than unfit normal weight individuals [18]. For
example, in a cross-sectional study, we investigate the prevalence
of obesity, overweight and lifestyle physical activities in Public
Transport Drivers in Tehran. We observed a significant negative
relationship between body mass index and with spending work
and leisure time physical activities and being careful about what
and how much is eaten [23].

Whereas, some researchers believe that obesity has multiple
possible determinants [28], physical activity level and diet are
majored variables. Individuals are more likely to do physical
activity if they have a positive attitude towards its benefits [3]. A
lot of studies have been showed overt inverse relation between
perform physical activity, obesity and its side effects [4,29-31].

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activity level that lead to an imbalance in input and expenditure of energy. Indeed, disuse of energy intake and decrease of energy expenditure results in fat accumulation in subcutaneous area and obesity occurred gradually.

**Worldwide Epidemic**

It has been show that prevalence of obesity and overweight is high in countries that have an established economy [42,43], as well as developing countries [4,26,42]. Added with economy conditions, there is a clear inverse relation in most countries between the prevalence of obesity and different society variables included culture, ecology, and level of education [23,39,42-44]. According to new WHO analyses of global burdens in the different subregions of the world, there is a remarkable variation in the prevalence of both overweight and obesity. Obesity is clearly more prevalent in women than men worldwide [5,45]. Prevalence of overweight and obesity, indeed, is higher in industrial countries than developing and undeveloped countries (Figure 1). Besides, it is in addition a major health concern in developing nations and other regions of the world [38,42]. This increased prevalence maybe reflects a change in lifestyle patterns influenced by an overabundance of food choices and fatty foods, industrialization, technology [4], and convenience, with decrease opportunities and motivation for regular physical activity. Prevalence of obesity varies in different countries in worldwide [42,44,46].

The causes of this epidemic are influenced by many social, cultural, and economic variables that determine the quantity and quality of energy intake and energy expenditure [47-49] such as food patterns and physical activities. This value for Europe as well as other developed countries is estimated to average 15-20% of the population. In 1995, 10-20% of European men and 15-25% of women were obese [39], having increased 10-40% in the last decade [11]. Recently a comprehensive and detailed report on the obesity epidemiology show that, more than 50% of the 693 million obese persons in the world live in 10 countries including USA, China, India, Russia, Brazil, Mexico, Egypt, Pakistan, Indonesia, and Germany [50]. In Europe, it has been estimated 22% of children, 26% of men and 31% of women to be obese. In the UK (a developed European country) the increase of obesity prevalence between 1993 and 2003 was 43% for women and 74% for men [39]. Whereas, paradoxically, between 1997 and 2003 number of individuals achieved a physical activity for >30 min moderate intensity activity on a minimum of 5 days per week were increased [39,40]. In Ireland (neighbor of UK) prevalence of obesity was 18% and overweight 39% [37]. The Europe PMC Funders Group recently released a report that showed an increase in the prevalence of obesity over the past years in both developed and developing countries. Globally, the proportion of adults with a BMI of 25 or greater increased from 28.8% in 1980 to 36.9% in 2013 for men and from 29.8% to 38.0% for women [50]. Prevalence of obesity and its side effects such as type 2 diabetes have also been increasing in the Asia-Pacific region of the world [3].

One of methods for assessment of obesity is BMI values that currently used underestimates risk in Asians. Rates of absolute BMI values in Asia-Pacific individuals are more intense when compared to their European descendant counterparts [3,51]. Prevalence of obesity has doubled among Japanese men and young women in the last two decades [11]. Island nations in the Pacific and the Caribbean, and countries in the Middle-East and Central America, have already reached particularly high rates of overweight and obesity [50]. In Iran, as well as other developing countries, prevalence of overweight and obesity is ongoing. Based on data from first survey of the non-communicable disease risk factor surveillance system of Iran, 19.2% of Iranian women and 9.1% of men aged 15-64 years are obese. A 48.5% of women and 37% of men, indeed, have BMI ≥25.0 kg/m². In general, 42.8% of Iranian adults aged 15-64 years was overweight and 14.2% are obese in 2005 [51]. In a cross-sectional study, we investigate the prevalence of obesity, overweight and lifestyle physical activities in Public Transport Drivers in Tehran. Rate of obesity, overweight and both of them were 26.6%, 40.6%, and 67.2%, respectively. Furthermore, a significant relationship was observed between body mass index and much food consumption habits, for example using high-fat foods, candies, snacks, desserts [23]. Indeed, a global systemic review analysis (2015) show the 21.6% overweight and 5.9% obesity vs. 26.2% and 7.2% for Iranian male and female under 20 years old age, respectively. In addition, above 20 years old age, the statistics show that a 49.4% overweight and 13.6% obesity vs. 63.3% and 29.3%, respectively [51]. In Africa continent, higher rates have been reported in black men and women 10% and 44%, respectively. It is reported, whereas, that a
low rates of obesity prevalence (0.6-3.6%) in blacks from East and West Africa [52]. In Ghana (a country in West Africa continent) the prevalence of overweight was 23.4% and obesity was 14.1%. The prevalence of overweight and obesity were higher in females than males (27.1 vs. 17.5% and 20.2 vs. 4.6%), respectively [53]. This evidence is confirmed by the Non-communicable Disease Risk Factor Collaboration (NCD-RisC) network. This worldwide network has shown that between 1975 and 2014, the BMI of women and men has increased [54]. They reported that global age-standardized mean BMI increased from 21·7 kg/m² in 1975 to 24·2 kg/m² in 2014 in men, and from 22·1 kg/m² in 1975 to 24·4 kg/m² in 2014 in women.

In the US, prevalence of obesity -BMI- continues to be a health problem for adults, children and adolescents. In this country the prevalence of obesity raised by 74% from 1991 to 2001 [39]. It is reported that from recent National Health and Nutrition Examination Survey (NHANES) survey [39] among adult men the prevalence of obesity was 31.1% in 2003-2004, and 33.3% in 2005-2006. This rate in 2003-2004 for women was 33.2%, and in 2005-2006 was 35.3%. It is clear that intake of fast foods and nutrition with high fat are effective factors for increased obesity prevalence in the US [55]. Notable, in a study on different strains have conducted by Gallagher (2000), BMI rate was highest in African American women and lowest in Asian women and men [12]. More surveys on obesity epidemic show that transcend of obesity among women than men [5]. Based on above sentences, it is clear that obesity is increasing in different countries, rapidly. OECD projections show a steady increase in obesity rates until at least 2030. Obesity levels are expected to be particularly high in the US, Mexico and England, where 47%, 39% and 35% of the population respectively are projected to be obese in 2030 [56]. Therefore, treatment of obesity and avoid from excess weight gain is necessary for decrease of obesity related diseases. Naturally, for this intention modification of many lifestyle behaviors such as food patterns and level of physical activities have priority. It is vivid to overtake this aim need to a global standpoint.

**Conclusion**

The prevalence of obesity increased rapidly in last decades worldwide. For this modification, many variables such as change in lifestyle induced westernize, industrialization, relief, diets and decrease of physical activity are considerable. Thus, for maintenance of optimum weight it is necessary that reform nutrition behaviors and increase level physical activities. In addition, it is consideration to both fatness and fitness in interventions is very important.

**Acknowledgement**

None.

**Conflict of Interest**

None.

**References**

9. Center for Disease Control and Prevention (CDC).

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