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Policy Paper

Obesity in Egypt: Dangers, Consequences, and Government Action

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ABSTRACT

Obesity in Egypt has become a leading contributor to non-communicable diseases, placing significant strain on public health systems and the national economy. Its determinants are complex, arising from the interplay of individual behaviors, genetic predispositions, and broader food environments shaped by cultural, economic, and policy factors. This brief, based on the 2020–2022 study “Obesity in Egypt: Dietary and Health Risks,” employed national food balance sheets, the Household Income-Expenditure-Consumption Survey, and the National Nutrition Survey for women to benchmark consumption patterns against WHO dietary guidelines, while also reviewing school-feeding programs, policy frameworks, and health indicators such as breastfeeding practices, childhood stunting, and iron-deficiency anemia. The results highlight that Egyptian diets diverge substantially from recommended healthy patterns, with declining production of protective foods such as fruits, vegetables, and legumes, coupled with the rising availability of ultra-processed, energy-dense products. In addition, inadequate infant and child feeding practices, high rates of anemia and stunting, and overall poor dietary quality contribute to a double burden of malnutrition that amplifies obesity risks from early childhood onward. The findings underscore the urgent need for comprehensive food system transformation to foster healthier dietary behaviors, cultural and societal shifts in food practices, alignment with national economic development, reform of health services, and robust monitoring and evaluation mechanisms through sustained food and nutrition research.

Keyword: Obesity, Non-communicable diseases, Dietary risk factors, Food environment, Nutrition policy.

INTRODUCTION

The 100 Million Health initiative screened Egyptians for malnutrition (obesity, stunting, iron deficiency anemia) and noncommunicable diseases (NCD) and stressed the need to combat obesity through changing underlying causes and recommending programs and policies to support decisions makers to combat obesity. This builds on the fact that food is an important component of preventive medicine and malnutrition has serious health and economic consequences. Based on the answers to these questions, this brief summarizes key findings and presents policy options to address the serious obesity challenge facing Egypt with its health and economic consequences. Addressing the challenge of obesity in Egypt is of paramount importance due to its far-reaching implications on public health, social well-being, and economic sustainability. Egypt's adult overweight and obesity prevalence in women is 62.1% and 38.4% respectively while among men aged 15–49 years 46.3 % are overweight and 23.7 % are obese Egypt Demographic and Health Survey, 2023). In children under five years – overweight (weight-for-height > +2 SD) is 9.8%.

Obesity is not only a significant risk factor for various chronic diseases such as diabetes, cardiovascular diseases, and certain types of cancer (*World Health Organization, 2021; GBD, 2017*), but it also places a heavy burden on the healthcare system, leading to increased healthcare costs and decreased human productivity. Obesity-attributable deaths were quantified ($\approx 115000/\text{year}$) and DALYs (≈ 4 million in 2020) and the annual direct healthcare cost of obesity-related diseases was estimated at ~ 62 billion EGP (*Aboulghate et al., 2021*). Moreover, obesity can have detrimental effects on individuals' quality of life, affecting their physical and mental health, as well as their overall life expectancy (*CAPMAS, 2022; Mowa et al., 2014*). Therefore, tackling obesity in Egypt is crucial to safeguarding the health and well-being of the population, and to reduce health care costs ensuring a sustainable future for the country. The urgency of addressing the challenge of obesity in Egypt cannot be overstated, as the prevalence of obesity in the country has reached alarming levels in recent years.

The rapid urbanization, changes in dietary habits exasperated by tough economics, sedentary lifestyles, and lack of awareness about healthy living have contributed to the escalating rates of obesity among Egyptians, particularly among children and adolescents (*Galal, 2002; El-Sayed and Almarhomy, 2017; World Health Organization, 2021*).

If obesity is left unchecked, obesity can lead to a multitude of health problems and place an unsustainable strain on the healthcare system, exacerbating existing health disparities and inequalities as well as its costs. The World Bank estimated that cost-effective NCD interventions in low- and middle-income countries would yield around US \$350 billion in net economic benefits by 2030 and avert roughly 8 million premature deaths, implying a return of about US \$2–3 per US \$1 invested (*World Bank, 2018*). Therefore, immediate action is needed to implement effective policies and interventions that promote healthy lifestyles, improve access to nutritious food options, and encourage physical activity to combat the obesity epidemic in Egypt before it reaches irreversible levels.

This policy brief builds on a study entitled “Obesity in Egypt: Dietary and health risks” (*Zaghloul, 2024*) that addressed the following questions:

- Are Egyptians consuming the type and amount of food required for healthy life?
- Does current food consumption explain the poor nutritional status of children and adults?
- Does the current food supply provide the needed amount of healthy food? What percentage of people is eating a healthy diet?
- How far is the amount of food currently consumed from the recommended amount?
- Is there a link between different malnutrition problems e.g. do iron deficiency and stunting induce obesity and NCD?

METHODOLOGY

This paper draws on three national data sources: Food Balance Sheets (2004–2018), Household Income and Expenditure Surveys (2015, 2017/18) (*CAPMAS, 2021*), and the National Nutrition Survey (2013–2015). Foods were grouped into healthy, harmful, and moderation categories based on cardiometabolic risk. Household consumption was estimated from representative surveys, while individual diets were assessed through 24-hour recalls. Data were consolidated into 22 food groups and expressed as grams per capita per day. Actual intake was compared with WHO (*World Health Organization, 2019; Afshin et al. (2015)*) recommended values to highlight dietary gaps. Indicators measured included average consumption, percent of recommended intake, and adherence levels. Trends and gaps were analyzed to inform nutrition policy priorities.

The Stakeholders, Actors and Influencers of Food and Nutrition Policies

It is essential to engage a wide range of stakeholders and government departments to ensure a comprehensive and coordinated approach including:

1. Ministry of Health and Population (MOHP): the primary government department responsible for public health policies, healthcare services, and disease prevention programs.
2. Ministry of Supply and Internal Trade (MSIT) to reshape food subsidy program to more healthier food options.
3. Ministry of Education: (MOE) responsible for integrating health education and promoting physical activity in schools, as well as implementing nutrition guidelines for school meals.
4. Ministry of Social Solidarity: (MOSS) engaged in social welfare programs, including initiatives targeting vulnerable populations affected by obesity and related health issues.
5. Ministry of Youth and Sports (MOYS): involved in promoting physical activity and sports participation among youth and the general population.
6. Ministry of Agriculture and Land Reclamation (MOALR): responsible for agricultural policies, food production, and ensuring availability to nutritious and affordable food options.
7. Ministry of Local Development (MOLD): involved in urban planning, infrastructure development, and creating environments that support physical activity and healthy living.
8. Ministry of Trade and Industry (MOTI): engaged in regulating food imports, food labeling, and promoting the availability of healthy food choices in the market.

9. National Nutrition Institute (NNI): a key stakeholder in developing nutrition guidelines, conducting research on dietary habits, and providing expertise on nutrition-related policies.
10. New Urban Communities Authority (NUCA) is the regulator of new urban communities and real estate project developer for healthier cities.
11. Healthcare providers and hospitals: engage healthcare professionals to provide input on clinical guidelines, treatment options, and preventive care strategies for obesity-related conditions.
12. Non-Governmental Organizations (NGOs) and civil society groups: collaborate with organizations working on public health advocacy, community outreach, providing food assistance and raising awareness about the impact of obesity.
13. Food Industry representatives: engage with food manufacturers, retailers, and restaurant associations to promote healthier food options, reformulate products, and implement responsible marketing practices.
14. Ministry of Transportation (MOT)
15. Academic and Research Institutions: collaborate with experts in public health, nutrition, epidemiology, and behavioral science to inform evidence-based policies and interventions.
16. Supreme Council for Media (SCM) Media outlets: work with media organizations to raise public awareness, promote healthy lifestyles, and combat misleading information about diet and nutrition.
17. Community leaders and advocacy groups: engage local leaders, community organizations, and grassroots advocates to promote health education, physical activity initiatives, and access to healthy foods at the local level.
18. Ministry of Defense (MOD) that contributes directly to food supply through its food security program (Rolling stores).
19. Ministry of Internal Affairs (MOIA) which contributes to food security and food prices control.

Engaging these stakeholders and government departments in a collaborative effort will be crucial for developing a comprehensive policy framework to address the challenge of obesity in Egypt effectively. By involving diverse perspectives and expertise, the policy can be tailored to address the unique social, cultural, and economic factors contributing to obesity in the country.

POLICY/ACTION RECOMMENDATIONS FOR ACTIONS TO COMBAT OBESITY

Food system transformation to promote healthy diets

It is critical to encourage protective and healthy food production and consumption while discouraging production and consumption of unhealthy foods. This requires a nutrition strategy (subsidies, taxation regulations, etc.) to incentivize healthy foods (for adults: Vegetables, legumes, fish, fruits and eggs, milk and fruits for children), create demand for them ensuring their availability, affordability, and accessibility as well as control of iron deficiency (with or without anemia to control obesity). At the same time, it is necessary to have strategies to de-incentivize unhealthy foods (trans fat, sugar, sugar sweetened beverages, salt, processed meats).

Incentivization of healthy food:

- a. Increase nutritious, nutrient dense food supply through adopting nutrition security rather than food security (MOALR).
- b. Increase availability of endogenous and traditional types of healthy food e.g, nuts/seeds, whole grains, and olives (agriculture sector). (MOALR, Research centers, MOSIT, NGO's (*Food bank, Misr EL Kheir, El Orman, etc.*)).
- c. Promote food production in homes, schools and community gardens to increase healthy food availability, generate income in low-income areas. Establish farm-to-school initiatives to help schools procure local foods for school meals. Vegetables, fruits, eggs and chicken farming should be targeted through collaborative effort (*MOALR, MOE, MOSS and NGOs*)
- d. Incentivize food manufacturers to produce healthy food e.g. low salt food products, healthy snacks, to ensure its availability and affordability through agriculture, trade and food industry (*MOALR, Research Centers, MOTI, MOSIT*).
- e. Align food and nutrition policies in targeted food programs, trading, manufacturing to follow dietary guidelines particularly to be nutrition rigorous (*Ministerial Committee for Food and Nutrition*).
- f. Review subsidy food programs and NGO programs with major procurement to provide healthy food needs and to substitute sugar and fat with healthy foods like fruits, vegetables, beans and fish. For children, provide eggs, milk, vegetables and fruits (*Ministerial Committee for Food and Nutrition, MOSIT, NGOs*).
- g. Ensure subsidy bread points are exchanged only for healthy foods while allowing their use at supermarket, military and police rolling stores (*MOSIT, MOD, MOIA*).
- h. Expand women-infant food program for pregnant women and their children under 2 years age to prevent malnutrition/stunting. This program should provide cash transfer to be used for healthy food (milk, egg, tuna, fruits and vegetables, beans), encourage mothers to breastfeed by giving free complementary foods till two years of age to children over six months with optimal growth rates, and include health services, supplements for pregnant women in addition to antenatal care to promote breastfeeding and proper complementary feeding in accredited baby friendly facilities (*MOSS, NGO's, MOHP*).
- i. Create consumer demand for healthy foods through using taxation of unhealthy food to incentivize individuals to consume healthy food through coupons, price control and gift certificates and through expansion of unsweetened drinks production (*MOSIT, MOSS, MOHP, MOTI, MOIA, Health committee of Egyptian Parliament, Egyptian Organization of Standards (EOS)*).
- j. Develop and implement dietary guidelines to day -care establishments (*MOSS*).
- k. Establish standards, specifications and easily readable and understandable food labeling, food based dietary guidelines to be implemented in trade and industry and Egyptian organization of standards to restrict unhealthy food (*EOS, NNI, MOTI, Food Safety Authority FSA*).

De-incentivization of unhealthy foods:

- a. Immediate government intervention through taxation, legislation, standards and specifications and food labelling to discourage sugar sweetened beverages, processed meat, and trans-fat (*MOTI, Health committee of Egyptian Parliament, EOS, NNI*).
- b. Resume the pre-existing "low sodium initiative" aiming at reducing the current intake levels of salt through lowering the amount of added salt in bread and cheese (*NNI, MOSIT, EOS, Agriculture research center*)
- c. Put in place trade policies to restrict unhealthy food through applying dietary standards and legal instruments to improve local food supply and require food labels (*MOTI, EOS, (FSA)*).

Society Awareness/Education

Changing the social culture of food is critical to combat obesity and is a critical role for the government. This requires a coordinated awareness campaign alongside policy/regulatory actions.

- a. Regulate exposure to unhealthy food through advertisement and social media (*SCM, MOSS, Health committee of Egyptian Parliament.*)
- b. Set up food based dietary guidelines to be used effectively in public awareness campaigns to modify and enhance better dietary choices for a healthy population and ensure its update through evidence-based research (*NNI, SCM, MOHP*).
- c. Assign NNI to standardize nutrition messages, train health providers and community workers (*NNI, MOHP*).
- d. Conduct an awareness campaign to substitute the habitual dietary use of salt by herbs as well as salty processed products at consumer and household level (*MOHP, NNI, SCM*).
- e. Focus awareness/education campaigns on the importance of nutrition of women and youth specifically about anemia, obesity and healthy lifestyle (*NNI, EOS, SCM, MOSS, MOYS*)
- f. Conduct comprehensive public campaigns to promote physically active lifestyles, make them easier to adopt and more socially acceptable (*SCM, MOYS, MOE, MOHE*).
- g. Document and promote traditional food consumption through new recipes and demonstrations, and through food labelling, social marketing or online advertisement (*NNI, Universities, Research centers*).
- h. Strengthen nutrition in medical school curricula (*NNI, MOHE*).
- i. Incorporate nutrition in In service training offered to medical school and nurses graduates and establish a degree in human nutrition (*NNI, MOHP, MOHE*).
- j. Re-activate the role of NNI training center to conduct courses of nutrition management programs (planning, communication skills and evaluation) and nutrition training of health providers (training of trainers) and the development of nutrition educational materials for health providers and community workers.

11. Identify mechanisms of providing support and on- going training for local NGOs. Improve the mother's ability to make healthy food choices through nutritional education, to improve child feeding behaviors.
12. Raising health professionals' awareness to teach mothers and Kindergarten teachers how to feed children.
13. Integrate nutrition education into all maternal and childhood programs to cover breastfeeding and complementary feeding.
14. Encourage the role of community to support BF through training of community volunteers and Raedat and provide them with educational materials.
15. Train health care providers for early detection of stunting using growth curve and with management protocol.
16. Map all different training activities in BF and complementary feeding in terms of who is training on what and producing what type of cadres. This will allow for identification of the quality of training (materials, methods, messages, etc.).
17. Update the vaccination notebook of ministry of health including complementary healthy food recipes according to a scheduled introduction of food types.
18. Regularly review and update available educational materials concerning breastfeeding and complementary feeding in health facilities and used by community health workers.

National Economic Development Programs

- a. Focus on employment generating programs and social protection programs to increase the purchasing power of the poor and vulnerable (*MOPED*), Social Fund for development (*SFD, NGO*).
- b. Direct small and very small projects to food production to produce nutritious food products and implement dietary guidelines and food safety measures (*SFD, AFS, MOP, MOIT*)
- c. Reduce inequality in food access through programs to reduce income inequality, wealth, and poverty (*MOPED, SFD, NGOs*).
- d. Increase the purchasing power of the poor and vulnerable through employment generating programs and social protection programs (*MOPED, MOSS, MOP*).
- e. Ensure regional balance in development programs to reduce disparities in access to food. (*MOPED, SFD, MOP*).
- f. Incorporate health aspects in new governmental housing project to ensure better planning of public parks and playground, sidewalks, safety and lightened roads as well as good transportation systems to encourage more physical activity (*NUCA, MOLD, MOT, MOALR*)
- g. Promote home stead production in villages and chicken farming (Haya Kareema) and in metropolitan areas increase top building planting and community gardening (*MOALR, NGOs*)
- h. Egyptian mega projects, public and private, must include a food security dimension to provide direct measurable return to the citizen with regards to food availability and affordability (*Ministerial Committee for Food and Nutrition, MOTI, MOSIT*)

Health Services Reform

- a. Health services must include nutrition clinics (preventive and referral) integrated into hospitals and PHC and activities (*MOHP, NNI*).
- b. Develop a referral system from health clinics for treatment of stunting, obesity and iron deficiency anemia (*MOHP*).
- c. Provide education kitchens with educational materials facilities (*MOHP, MOALR*).
- d. Strengthen the antenatal iron supplementation programs (*MOHP*).
- e. Design and promote effective weight loss programs and protocol (*NNI, MOHP, MOYS, Research centers*).
- f. Establish baby friendly accreditation for governmental hospital to implement 10 steps and international code of breastmilk substitution (*NNI, MOHP, Health committee of Egyptian Parliament*).
- g. Screen population at risk at school entry, issuing identification card, premarital exam (*MOHP*).

Monitoring and Evaluation Programs

Having data is important to improve quality services and redirect food and nutrition programs and health. Equally important is sharing national data for better utilization of collected information and reduce cost of duplication.

1. Ensure regular evaluation and monitoring of the Egyptian School feeding program. (*MOHP, MOE, NNI*)
2. Create a system for school children monitoring and evaluation. Results must be analyzed to produce reports with performance indicators to guide policies and launch school-based interventions that target excess body weight and poor iron status (*MOHP, MOE, NNI*).
3. Establish a children surveillance system at Maternal Health Centers to make data during pregnancy and children's data available for monitoring and evaluation and policy guidance (*MOHP, NNI*).
4. Screen overweight and obese people regularly for iron deficiency. (*MOHP*).
5. Implement a nutrition assessment survey to be conducted every five years. (*NNI, MOHP, ASRT*).
6. Strengthen nutrition monitoring capacity and data validation in the first 1000 days after birth (*MOSS, NNI, ASRT*).
7. Prevent the intergenerational transfer of obesity through interventions across the early life stages, from preconception to prenatal to infancy (*MOHP, NNI*).
8. Activate and monitor the application of the international Code of Breast Milk Substitutes (BMS code) aimed at eliminating inappropriate and harmful marketing of breast milk substitutes (*MOHP, NNI*).
9. Assess child growth since birth and during the period of growth for early detection of stunting and to reduce its consequences (*MOSS, NNI*).

10. Strengthening the Baby Friendly Hospital Initiative (BFHI) through assessment of hospitals both public and private and include the neonatal units for preterm care units for supporting BF and in MOH hospitals, university hospitals, health insurance hospitals, teaching hospitals and private hospitals. Also, include BFHI centric as part of hospital accreditation criteria MOHP, NNI, Health committee of Egyptian Parliament

Food and Nutrition Research

- a. Create a long-term research agenda to identify causes of child malnutrition in Egypt (causal analysis) and to support programs for prevention and control of malnutrition (*NNI, MOHP, ASRT*).
- b. Conduct institutional review of research priorities to ensure they are aligned to the identified nutritional challenges. (*NNI, MOHP, ASRT*).
- c. Promote nutrition research to make nutrition policy more effective and efficient through identifying and bridging data gaps, disseminating data among all stakeholders, developing an evidence-based monitoring and evaluation platform for food and nutrition programs, building interdisciplinary food and nutrition research capacity to bridge the gap between research and public policies. (*ASRT, UN, NNI, MOHP*)
- d. Encourage applied research and product development among agriculture and industrial sectors that help increase productivity, reduce waste, and introduce new food products (*ASRT, Research centers.*)
- e. Monitor food consumption, nutritional status assessment, food composition and food security through research to support food and nutrition policies (*NNI, ASRT*).
- f. Support intervention research by robust, well-designed randomized clinical trials, adjustment for important confounders, use of various markers related to the iron status, inflammation, and hepcidin to allow examining the putative causal relationship between obesity and iron deficiency as well as longitudinal (cohort/experimental) studies to better show the direction and causality of association between overweight and/or obesity and IDA (*NNI, research centers, ASRT*).
- g. Develop dietary assessment methods research to collect food intake data and conduct research for iron assessment with better biomarkers (ferritin, sTfR and AGP tests) as well as short dietary assessment tools for quick screening of iron status. (*NNI, research centers, ASRT*).
- h. Conduct comprehensive nutrition mapping to provide an up to-date picture specifically around maternal and child nutrition (*MOHP, ASRT, NNI, research centers*).
- i. Review and update the Egyptian food basket based on a national study of what Egyptian eat (*NNI*).

CONCLUSION AND KEY FINDINGS

- a. Current consumption pattern in Egypt shows low consumption of healthy food and high consumption of unhealthy food associated with malnutrition and NCDs.
 1. The largest gap was observed in fruits, nuts/seeds, whole grains, milk/dairy products.
 2. Moderate gap was observed for vegetables, cheese, beans, PUFA oil, and fish.
 3. Alarmingly high intake of refined grains, sugar, salt, sweets, sugar sweetened beverages, and processed meat.

- b. Percentage of healthy food supply decreased while percentage of unhealthy food supply increased between 2004 and 2018.
- c. Inequality in healthy food consumption exists between rural and upper Egypt residency versus urban areas.
- d. The ratio between actual and optimal recommended consumption of healthy food consumption shows two patterns: i) Food available and unequal distribution (poultry, beans, and poly unsaturated fatty acids oil) ii) Low food availability and unequal distribution (milk, fruits, fish, vegetables, eggs, yogurt, cheese, whole grains, and nuts/seeds).
- e. Marked inflation in 2017 caused decreased consumption of eggs, milk, fish and meat.
- f. Consumption of healthy food was higher among non-obese compared to obese individuals (fruits, vegetables, and whole grains).
- g. Children of non-obese mothers and infants who were breastfed for one year were less obese.
- h. Stunting during childhood is associated with the increased risk of obesity during adulthood. Obesity, iron deficiency (ID) and iron deficiency anemia (IDA) are linked.
- i. Complementary feeding in Egypt is high in sugary drinks and snacks, lack diversity and micronutrients while rich in calories.
- j. Poverty is a cornerstone of malnutrition.

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الملخص العربي

ورقة سياسة حول السمنة في مصر: المخاطر والعواقب

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أصبحت السمنة في مصر عاملاً رئيسياً مساهماً في الأمراض غير السارية، مما يفرض عبئاً كبيراً على النظم الصحية العامة والاقتصاد الوطني. وتتسم محدداتها بالتعقيد، إذ تنشأ من تفاعل السلوكيات الفردية، والاستعدادات الجينية، والبيئات الغذائية الأوسع التي تشكلها العوامل الثقافية والاقتصادية والسياساتية. وتستند ورقة السياسات على دراسة الفترة ٢٠٢٠-٢٠٢٢ بعنوان "السمنة في مصر: المخاطر الغذائية والصحية"، إلى ميزانيات الأغذية القومية، ومسح الدخل والإنفاق والاستهلاك الأسري، والمسح القومي للتغذية للنساء، وذلك لمقارنة أنماط الاستهلاك بالتوجيهات الغذائية الصادرة عن منظمة الصحة العالمية، مع مراجعة برامج التغذية المدرسية، والاطر السياساتية، ومؤشرات الصحة مثل ممارسات الرضاعة الطبيعية، والتقرم لدى الأطفال، وفقر الدم الناجم عن نقص الحديد.

وتبرز النتائج أن النمط الغذائي المصري يختلف بشكل كبير عن الأنماط الصحية الموصى بها، حيث تراجعت مستويات إنتاج الأغذية الوقائية مثل الفواكه والخضروات والبقوليات، بالتزامن مع زيادة توافر المنتجات فائقة المعالجة عالية الطاقة. إضافة إلى ذلك، تسهم ممارسات الرضاعة الطبيعية والإطعام غير الملائمة للرضع والأطفال، وارتفاع معدلات فقر الدم والتقرم، وضعف الجودة الغذائية بشكل عام، في نشوء عبء مزدوج من سوء التغذية يعزز مخاطر السمنة منذ مرحلة الطفولة المبكرة.

وتؤكد النتائج على الحاجة الملحة إلى تحول شامل في نظام الأغذية بهدف تعزيز السلوكيات الغذائية الصحية، وإجراء تحولات ثقافية ومجتمعية في ممارسات الغذاء، وتحقيق التناغم مع مسار التنمية الاقتصادية الوطنية، وإصلاح الخدمات الصحية، وتطوير آليات قوية للمتابعة والتقييم من خلال بحوث مستمرة في مجالي الغذاء والتغذية.

الكلمات المفتاحية: السمنة، الأمراض غير السارية، عوامل الخطر الغذائية، البيئة الغذائية، سياسات التغذية.