大健康社群助力科学体重管理调研报告

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摘要

超重肥胖已成为中国面临的严峻公共卫生挑战，不仅导致严重的慢性病负担，还产生了个体行为与社会经济成本的外溢效应。尽管政策层面已通过“体重管理年”等行动确立了治理框架，但现实中的体重管理仍深陷“意志力与环境不对称”及“行为改变难以坚持”的结构性困境。本研究通过对八个城市 1771 名参与者的深度调研，验证了“健康社群”模式在破除这一困境中的核心价值。研究结果表明，社群不仅是互动的场所，更是通过同伴互助、监督机制与情感支持，有效提升依从性的关键外部变量。数据清晰地揭示了参与频率与减重成效之间的线性正相关：在 100 天的周期内，社群参与度越高，体重、体脂的改善越显著，例如“总是”参与活动的群体，其减重达标率（≥3%）高达 64.7%，而“从不”参与的群体仅为 7.9%。此外，这种模式有效推动了参与者生活方式的系统性优化，包括均衡营养摄入与改善久坐、熬夜等不良习惯，进而实现了“减脂不掉肌”的健康路径。在心理维度上，社群缓解了参与者的孤立感，提升了主观幸福感与社会支持感，良好的体重管理具有一定程度的心理、经济等外溢效应。综上所述，中国应进一步推动关口前移，将以社群为基础的体重管理模式纳入慢性病防控与健康促进的基础工程，通过数字化工具与社交平台的深度联动，构建全方位支持性微环境，

[1] 本报告仅代表企业相关研究观点，不代表论坛主办单位和承办单位立场和观点。

从单纯的治疗转向系统性的社会治理与预防转型，从而有效缓解老龄化背景下的公共卫生压力。

一、超重肥胖已经成为全球共同面临的重要公共卫生问题，亟需系统应对

超重肥胖是重要的公共健康风险因素。大量研究与国际组织共识指出，体重异常与心脑血管疾病、2 型糖尿病及部分癌症等慢性非传染性疾病风险显著相关，是推动疾病负担与医疗支出增长的重要因素，且体重问题具有明显的外部性，个体体重变化在宏观层面会通过慢性病发病、劳动生产率损失与医疗保障支出等渠道外溢成社会成本。

中国超重肥胖的增长具有“增速快、覆盖广、年龄下沉”等特点，已经成为严重的公共卫生问题。据国家卫健委援引的《中国居民营养与慢性病状况报告（2020 年）》数据，中国 18 岁及以上居民超重率为 34.3%、肥胖率为 16.4%，分别比 2012 年上升 4.2 和 4.5 个百分点，呈现出显著的上升趋势。此外，6～17 岁儿童青少年超重率和肥胖率则分别达到 11.1%和 7.9%，体重异常已经从成人群体广泛扩散到青少年阶段，且伴随城市化、饮食结构变化、体力活动不足等因素，可能形成从儿童到成年的风险累积路径。在中国正在经历快速老龄化的当下，这一趋势将会对未来的疾病负担带来很大压力，基于 GBD 2021 框架的系统分析，2021 年全球“高 BMI（BMI > 25）”可归因死亡约 370 万例、DALYs 约 1.285 亿，且主要归因疾病集中在糖尿病、缺血性心脏病、高血压性心脏病、慢性肾病与卒中等[2]。根据国际医学顶级期刊《柳叶刀》发布数据[3]，中国超重肥胖率处于中等水平，若采用 WHO/NCD-RisC 体

[2] Xie F, Xiong F, Yang B, et al. Global, regional, and national burden of mortality and DALYs attributable to high body mass index from 1990 to 2021 with projections to 2036. BMC Public Health. 2025;25:2053. doi:10.1186/s12889-025-23237-7.

[3] Ng, Marie et al. Global, regional, and national prevalence of adult overweight and obesity, 1990–2021, with forecasts to 2050: a forecasting study for the Global Burden of Disease Study 2021. The Lancet, Volume 405, Issue 10481, 813 - 838

系的 BMI≥25（18 岁及以上、年龄标化）口径进行典型国家对比，2022 年中国超重肥胖率合计约 38%，明显高于日本 24%、越南 18%的水平，与韩国（36%）近似，略低于新加坡（41%）等国。主要问题体现在：一是绝对规模大，中国拥有全球最多的超重肥胖成年人，约 4.02 亿人。二是上升趋势明显，全球 BMI ≥ 25 的人数从 1990 年的约 7.31 亿上升到 2021 年的约 21.10 亿，2021 年为 1990 年的 2.89 倍，肥胖人数则为 4.20 倍，与此对比，2021 年中国 BMI≥25 和 30 的人数则分别提高到 1990 年的 4.40 倍和 10.02 倍，即使除外人口数增加带来的影响，患病率的快速提升也不容忽视。三是青少年肥胖率高，根据联合国儿童基金会数据[4]，2024 年中国儿童肥胖率为 11.1%，高出中等收入国家平均水平（5.5%）约 6 个百分点。

国际上，不少国家已经开始努力为解决超重肥胖问题提供系统方案：

1. 提供综合性支持环境，即通过财政与规制工具改变社会环境，使健康选择更容易、不健康选择更昂贵。典型工具包括：（1）通过含糖饮料税等相关财政政策促进健康饮食。WHO 2024 年发布《促进健康膳食的财政政策指南》，并指出截至 2024 年 2 月已有 115 个成员国在国家层面征收含糖饮料税，墨西哥的经验研究显示，实施含糖饮料消费税后，含税饮料购买量相对反事实情景平均下降约 6%。（2）要求提供前包装营养标识与警示，WHO 发布了前包装营养标识的指导原则与框架手册，强调政府主导、可监测评估的包装体系建设。（3）针对儿童青少年的广告宣传限制，WHO 2023 年建议加强对高盐高糖高脂食品与非酒精饮料营销的强制性监管，以减少儿童暴露并削弱营销诱导。（4）餐饮场景等提供菜单热量标注，美国 FDA 对连锁餐饮等覆盖场所提出菜单标注热量等要求，将干预延伸到外食环境与即时消费场景。

[4] United Nations Children's Fund (UNICEF). *CNR 2025: Feeding Profit Data Tables (English, FINAL)*[R/OL]. UNICEF Data, 2025.

2. 通过同伴支持等方式鼓励超重肥胖群体坚持体重管理。这也是国际常见做法，强调将体重管理嵌入医疗与社区服务，强调行为改变的长期性与社会支持的重要性，其核心并非单次科普，而是建立持续的、可跟踪的支持体系，其中同伴支持与社群机制被用于解决坚持率、成本与覆盖面问题。典型做法包括：（1）以“群体课程+教练”的形式提高坚持率与自我效能，如美国疾控中心的国家糖尿病预防项目生活方式干预明确包含“群体支持”，由训练有素的生活方式教练带领课程，通过目标设定、记录与障碍应对等机制支持参与者实现体重控制与行为改变。（2）引入同伴支持与同伴教练，即由同样在进行体重管理的同伴担任教练，提供长期支持，《国际肥胖杂志》的荟萃分析肯定了这一模式的效果[5]。（3）制度化筛查与个体化指导，如日本的“特定健康检查与特定保健指导”将内脏脂肪型肥胖/代谢综合征相关风险纳入保险方义务性检查与健康指导。

中国从倡导到行动化、制度化的超重肥胖管理政策链条也正在形成。《健康中国行动（2019—2030 年）》确立了健康生活方式相关行动，为体重管理提供了总体框架与治理方向。2024 年，国家卫生健康委等 16 部门印发《“体重管理年”活动实施方案》，提出通过三年左右时间建立支持性环境、提升全民意识与技能，并强调编制权威核心知识、指导原则、基层医务人员健康教育要点等。2025 年，全国爱卫会将“健康体重管理行动”纳入健康中国行动，并随文发布附件《健康体重管理行动》，明确到 2030 年“初步减缓人群超重肥胖上升趋势”等目标，并把体重管理科普宣教进家庭、社区、医疗机构、学校、机关企事业单位、餐馆食堂等作为关键任务。技术层面，中国发布《成人肥胖食养指南》，进一步将体重管理转化为可执行的膳食与生活方式干预建议，提升基层与公众的可操作性。

[5] Jensen MT, Nielsen SS, Jessen-Winge C, et al. The effectiveness of social-support-based weight-loss interventions—a systematic review and meta-analysis[J]. *International Journal of Obesity*, 2024, 48: 599–611. DOI: 10.1038/s41366-024-01468-9.

但是，体重管理在现实实践中还面临三类结构性困境：一是环境与意志力的不对称。世界肥胖联盟的《世界肥胖地图（2025）》强调，肥胖与慢性病上升往往是多重系统失效的结果，单靠个体意志力很难长期对抗结构性诱因。二是行为改变的长期性与反复性。体重管理需要长期饮食、运动、睡眠、压力管理等多维度习惯改变，且常伴随反弹风险，很可能因缺乏持续反馈与情绪支持而难以转化为稳定行为。三是服务供给碎片化与可及性不足，专业体重管理往往涉及营养、运动、心理与慢病管理的多学科协作，工作场所、学校、社区等关键生活场景的服务存在不足。

面对上述困境，探索“社群支持”具有明确的政策价值。一是社群可通过共同目标、互相见证与轻量但持续的互动，提高坚持率，通过共同目标、群体规范与互相见证，把一部分自我控制成本“外部化”，还可以在工作场所、学校、社区等微观场景推动轻量的环境改善；二是针对行为改变的长期性与反复性，社群可通过持续但不高强度的互动、阶段性复盘、同伴教练的督促与共情，帮助个体把短期目标转化为可维持的生活节律，在反弹或中断出现时，社群还能提供情绪与认同，缓解羞耻与孤立感；三是针对服务供给碎片化与可及性不足，社群可作为专业服务的外延，用标准化工具包（简易评估、分层建议、风险提示）实现初筛与分流，以较低成本扩大覆盖面，并与宏观政策形成协同。因此，在中国“体重管理年”等政策框架已经明晰的背景下，进一步从社群与同伴支持角度探索可复制、可评估、可规模化的体重管理支持模式，不仅具有公共卫生意义，也具有社会治理与健康服务体系创新的现实价值。

二、健康社群助力体重管理专项研究结果洞察

（一）研究方法及研究对象简介

课题组设计研究方案，通过构建以减重为目的的健康社群，将社会支持、同伴互助与个体干预相结合，通过干预不同时期的问卷调查及身体指标，分析社群互动等对提升减重成效、改善心理状态及全面健康状况的具体作用，其中，问卷涵盖基本人口学与体重自评、减重意愿及既往方式/阻碍；随访记录近 30 天饮食、运动、作息、压力与情绪进食等行为及反弹、慢病管理和身体感受；同时评估活动参与频率、社群归属与同伴支持、心理体验、满意度及获得的健康与生活质量变化。课题组于 2025 年 6 月-12 月在北京、成都、广州、杭州、上海、武汉、沈阳、西安 8 个城市招募共计 1771 人，分别纳入不同的小组，由组长带领形成体重管理社群，各个社群设置有组长与组员，各组可采用线上的活动共同减重，鼓励并支持社群成员间的互助、鼓励、分享与结伴行动，组长发挥主要的监督与支持作用。同时，依托“我们行动啦”微信小程序[6]，开展问卷调查，并通过打卡记录追踪健康生活方式情况。研究分为四个关键评估点，基于通过问卷调查和 Inbody 体脂仪采集的数据，从主观和客观角度多方面追踪参与者的变化。（1）前测：评估原始生活习惯（饮食、运动、睡眠、心理、社交）及当前健康状况打分，并同步测量体重、体脂等数据。（2）干预 30 天后：观察初步成效及心理反馈，重点考察参与者在社群中的初步感受（如是否有成就感、是否感到被认可），同步测量体重、体脂等数据。（3）干预 60 天后：评估行为习惯是否养成，考察坚持的难度变化及身体状况的阶段性改善。（4）干预 100 天：最终成效评估，包括减重效果、

[6] “我们行动啦”微信小程序是本研究用于数字化实施与数据采集的工具载体：一方面用于向参与者推送并回收前测及 30/60/100 天随访问卷，统一记录关键自评信息；另一方面提供日常打卡入口，持续追踪饮食、运动、作息等健康生活方式执行情况，并形成可汇总的数据，用于分析社群参与与行为变化对减重成效、心理状态及整体健康的影响。此外，这一小程序还涉及健康课程模块，可供参与者学习有关健康生活方式的知识。

心态变化（自信、焦虑缓解）、生活质量提升以及对社群模式的整体满意度，同步测量体重、体脂等数据。

本次客观指标有效样本量共计 1771 人，其中既有客观指标又有问卷调查指标的调查对象 1295 人，其中女性占比 81.9%，男性占比 18.9%，年龄中位数为 54 岁，平均年龄 48.4 岁，年龄分布主要集中在 40-49 岁、50-59 岁和 60 岁及以上年龄段，分别占比为 25.3%、33.6%和 21.2%，本科及以上文化程度的占比达到 28.9%，78.2%为轻体力劳动者。在干预到 100 天时，问卷调查数据和客观体测数据分别留存达到 947 人和 1447 人。

表 1：样本留存情况

时间点	**留存样本**	**时间点**	**有效测量样本**
前测(基线)问卷	1294	第一次 InBody(基线)	1778
30 日问卷	1051	第二次 InBody	1545
60 日问卷	957		
100 日问卷	947	第三次 InBody	1447

（二）体重管理现状及面临的问题挑战

1. 约四成参与者处于超重肥胖状态，超过一半的超重者体型自评存在问题，处于肥胖状态的参与者困扰与意愿较高。根据参与者基线时的身高及体重数据，32.7%处于超重状态，10.4%处于肥胖状态。超重者中仅 51.3%能够正确认识到自身存在超重问题。肥胖者中为体重管理困扰的比例高达 95.5%，其中 50.0%的达到非常困扰的水平，超重者中为体重管理困扰的比例达到 83.3%。体重正常、超重及肥胖的参与者参与意愿均很高，非常愿意的比例均超过 60%。

表 2：不同体型状态参与者的困扰程度及相应体重管理情况（单位：%）

	偏瘦	正常	超重	肥胖	合计
人数占比	3.1	53.9	32.7	10.4	100.0
体型自评					
合适	20.7	50.3	10.8	4.5	32.6

有点发福，适度控制一下即可	6.9	33.6	37.4	12.4	32.1
存在超重或肥胖的问题	3.4	9.5	51.3	83.1	30.2
偏瘦	69.0	6.6	0.6	0.0	5.1
为体重问题困扰					
非常困扰	3.6	4.0	20.4	50.0	13.0
有点困扰	64.3	49.9	62.9	45.5	53.5
没有困扰	32.1	46.1	16.7	4.5	33.5
体重管理意愿					
非常愿意	39.3	61.5	67.2	65.9	64.2
比较愿意	46.4	29.1	27.6	27.3	28.3
一般愿意	10.7	8.7	4.9	4.5	6.8
不愿意	3.6	0.7	0.3	2.3	0.8
既往体重管理尝试					
从来没有控制过体重	28.6	9.4	9.8	10.2	9.9
坚持运动	60.7	66.4	63.8	50.0	68.7
控制饮食热量	39.3	67.2	69.5	76.1	64.2
选择全营养代餐	39.3	46.1	45.4	39.8	45.6
严格节食（不吃晚饭/主食或轻断食）	10.7	10.6	14.4	27.3	12.8
抽脂/针灸/按摩等	0.0	2.4	2.6	6.8	2.6
吃减肥药/注射司美格鲁肽等	0.0	0.5	2.0	6.8	1.6
既往体重管理成效					
效果很好	39.3	51.3	32.2	17.0	42.9
效果一般	28.6	43.7	57.5	68.2	48.5
没有效果	32.1	5.0	10.3	14.8	8.6
阻碍体重管理的主要原因					
顺其自然，不需要刻意改善	21.4	29.6	25.6	18.2	27.2
不知道怎样做/无从下手	14.3	16.6	21.3	25.0	18.4
拖延症，不想采取行动	21.4	29.9	35.3	39.8	32.3
尝试过但很难坚持	35.7	36.5	48.9	65.9	43.5
没有人监督	21.4	25.4	28.2	31.8	26.6
心理压力过大	0.0	5.5	8.9	12.5	6.8
没有时间和精力	25.0	24.4	25.0	34.1	25.3
不想投入太多钱	21.4	19.8	19.8	26.1	19.7
不具备改善条件（设施等）	10.7	8.9	7.8	12.5	8.3
不知道/说不清	21.4	7.7	6.3	4.5	7.5
饮食习惯问题					
饮食不规律/不吃早餐	24.1	11.4	15.3	23.6	13.5
经常吃撑/口味偏重	13.8	17.1	25.1	42.7	21.2
膳食纤维摄入不足	55.2	42.7	46.0	52.8	43.5
蛋白质摄入不足	62.1	39.7	35.1	36.0	36.4

维生素摄入不足	55.2	29.4	33.9	32.6	30.6
饮水量不足（未达约 1500-1700ml）	55.2	38.0	36.0	38.2	37.0
以上都没有	6.9	31.6	29.8	22.5	31.5
日常不良习惯					
经常久坐，很少起来活动	75.9	40.7	47.6	60.9	44.7
很少户外活动/很少晒太阳	41.4	32.4	29.9	48.3	33.0
熬夜	48.3	43.1	38.2	52.9	41.8
经常喝酒	6.9	2.2	5.0	6.9	3.2
吸烟（含电子烟）	0.0	3.2	5.6	8.0	3.8
日常压力大	31.0	25.3	29.0	29.9	26.1
经常独自一人/有孤独感	17.2	14.6	14.5	12.6	13.6
以上都没有	6.9	29.2	26.6	18.4	27.9
运动习惯					
平均每小时起来活动一下	24.1	28.2	26.0	26.4	27.6
平均每天达 6000 步	48.3	62.5	60.1	55.2	60.5
每周≥3 次且每次≥30 分钟中等强度	24.1	38.5	38.2	28.7	36.9
每周力量训练	6.9	10.9	10.1	5.7	10.3
以上均不符合	31.0	18.3	22.2	31.0	21.1

2. 参与者既往有较多体重管理尝试，坚持运动和控制饮食热量的尝试比例更高，但“尝试过却很难坚持”成为最大的结构性阻碍因素。仅 9.9%的参与者从来没有尝试过控制体重，其中分别有 68.7%和 64.2%尝试过控制饮食热量和坚持运动。但与此同时，“尝试过却很难坚持”成为最突出的结构性阻碍，总体占 43.5%，并且随客观体型状态显著上升：正常组 36.5%、超重组 48.9%、肥胖组高达 65.9%。与之相伴的是“拖延症，不想采取行动”，总体 32.3%（超重 35.3%，肥胖 39.8%）以及“没有人监督”总体 26.6%（超重 28.2%，肥胖 31.8%）。显示体重管理中主要痛点并非“缺知识、缺方法”，而是“缺持续性、缺外部约束与反馈”。因此，社群干预的潜在价值更可能体现在提供可持续的同伴监督、即时反馈与情绪支持，把个体的意愿与零散尝试转化为更稳定的坚持系统，对超重与肥胖人群的潜在支持作用更强。

3. 膳食结构与摄入习惯不佳，力量训练普遍不足，久坐与熬夜高发，共同影响体重管理效果。在饮食方面，突出问题是营养结构与摄入习惯问题，

如 43.5%的参与者表示膳食纤维摄入不足，随着体型从正常到肥胖，“吃撑/口味偏重”的比例明显升高（正常 17.1%、超重 25.1%、肥胖 42.7%）。日常不良习惯中，“久坐”是最普遍的风险，比例达到 44.7%），且在肥胖组明显更高（60.9%），熬夜也较常见，总体 41.8%，肥胖组为 52.9%。运动方面，虽然多数人能达到“每天 6000 步”，但“高质量运动结构”不足，每周中等强度运动达标仅 36.9%，力量训练更只有 10.3%。为此，体重管理需高度关注科学方法的普及和系统化的行为支持与社会机制，以推动结构性改变。

（三）社群支持下的体重管理具有明显成效

1. 干预参与者体重、体脂、BMI 均有所下降，体成分明显改善，且坚持时间越长，体重管理成效越好。干预人群整体体重、体脂与 BMI 均有所下降：30 天体重平均降低 0.74 kg、BMI 降低 0.28、体脂肪降低 0.33 kg；骨骼肌均值小幅上升，呈现体成分优化趋势。坚持到 100 天的人群改善幅度更大，体重平均下降 1.36 kg、体脂肪下降 0.51 kg，InBody 评分提升 0.97 分。若以相对减重≥3%或≥5%为达标指标，“≥ 3%减重”从 30 天 15.6%提升到 100 天 35.5%；“≥ 5%减重”从 5.6%提升到 15.3%。体成分质量上，“减脂不掉肌”在 100 天达到 45.2%，接近一半的参与者实现了更健康的体重管理路径。

表 3：从不同指标看干预参与者的体重管理成效

	样本量	30 天变化	100 天变化
客观指标			
体重 (kg)	1426	-0.74	-1.36
BMI	1426	-0.28	-0.51
体脂肪 (kg)	1324	-0.33	-0.51
骨骼肌 (kg)	1283	0.08	0.17
InBody 评分	1274	0.53	0.97
关键达标率			
≥ 3% 减重达标率	1426	15.60	35.50
≥ 5% 减重达标率	1426	5.60	15.30
减脂不掉肌（体脂↓且骨骼肌 ≥ 0）	1247	40.90	45.20

2. 干预前体型肥胖和超重组的干预对象效果更好，体现更优的健康价值。本次研究中，超重与肥胖人群通过科学干预实现了相对更加显著的健康改善。在 100 天的周期内，肥胖组体重平均下降 3.51%，平均减轻 2.82 kg，体脂肪减少 1.57 kg，其次为超重组，体重平均下降 2.79%。且干预有效促进了超重肥胖群体“减脂增肌”的理想体成分优化，肥胖群体中超过 51.6%的参与者成功实现了减脂同时保护肌肉的健康状态，超重人群中这一比例也达到 45.5%。

表 4：不同体型干预参与者的体重管理成效

分组	偏瘦	正常	超重	肥胖
100 天体重变化率	0.24	-1.56	-2.79	-3.51
100 天体重变化 kg	0.02	-0.92	-1.94	-2.82
100 天体脂变化 kg	0.61	-0.14	-0.9	-1.57
100 天骨骼肌变化 kg	0.04	0.2	0.07	0.11
100 天 InBody 评分变化	0.82	0.69	1.04	1.32
≥3%达标率%	6.67	31.2	43.16	45.03
≥5%达标率%	4.44	11.88	18.59	25.83
减脂不掉肌%	20	42.56	45.51	51.66

3. 参加社群人群的减重效果明显优于不参加的群体，且活动参与频率越高，减重效果越好，呈现清晰的线性关系。在 100 天的观察周期内，加入小组的群体其管理效果全面优于未参与者，100 天后，参与小组的成员体重平均下降 1.93kg（下降幅度平均达到 2.81%），且在减脂（-0.65kg）与增肌（+0.25kg）上的表现均显著好于未参与组（减脂-0.38kg，增肌+0.16kg），其“≥3%减重率”达到了 45.1%，较未参与组的 34.5%优势明显。参加活动的群体中，频率也与效果高度相关，保持“总是”参与社群活动的群体平均减重幅度达到了 4.14%，高达 64.7%的参与者实现了 3%以上的体重减重，45.5%实现减脂且不掉肌肉；相比之下，“从不”参与的群体减重幅度仅为 0.61%，减重达标率仅为 7.9%，减脂不掉肌的比例仅为 20.0%。强烈的对比充分证明，社群不仅是互动的场所，更是提升行为依从性、保障体重管理目标高效达成的核心外部变量。

表 5：是否参与小组的参与者的体重管理成效

	参与小组	未参与小组
干预 30 天后		
体重均值变化 kg	-1.06	-0.62
体重均值变化率%	-1.58	-1
体脂均值变化 kg	-0.5	-0.23
骨骼肌均值变化 kg	0.08	0.03
InBody 评分均值变化	0.65	0.16
≥3%减重率%	29.9	20.5
≥5%减重率%	9.6	5.7
干预 100 天后		
体重均值变化 kg	-1.93	-1.33
体重均值变化率%	-2.81	-2.09
体脂均值变化 kg	-0.65	-0.38
骨骼肌均值变化 kg	0.25	0.16
InBody 评分均值变化	1.2	0.61
≥3%减重率%	45.1	34.5
≥5%减重率%	21.2	14.5

表 6：不同社群参与频率的参与者的体重管理成效

不同社群活动参与频率	总是	经常	有时	很少	从不
干预 30 天后					
体重均值变化 kg	-1.46	-0.72	-0.58	-0.29	-0.26
体重均值变化率%	-2.25	-1.12	-0.87	-0.36	-0.45
体脂均值变化 kg	-0.71	-0.34	-0.24	-0.02	-0.27
骨骼肌均值变化 kg	0.11	0.06	0.06	0.07	-0.02
InBody 评分均值变化	1.11	0.5	0.26	-0.22	0.2
≥3%减重率%	39.4	14.7	14.8	8.5	4.8
≥5%减重率%	12.1	5.1	4.7	1.7	0
减脂不掉肌%	39.8	43.1	34.6	36.7	39.1
干预 100 天后					
体重均值变化 kg	-2.74	-1.29	-1.16	-0.72	-0.37
体重均值变化率%	-4.14	-1.98	-1.72	-1.04	-0.61
体脂均值变化 kg	-1.11	-0.39	-0.4	-0.16	-0.06
骨骼肌均值变化 kg	0.08	0.25	0.18	0.06	0.24
InBody 评分均值变化	1.19	1.12	0.71	0.76	0.18
≥3%减重率%	64.7	29.8	24.3	17.6	7.9
≥5%减重率%	34.1	12.1	11.1	7.4	2.6
减脂不掉肌%	45.5	40.5	43.0	44.1	20.0

4.社群支持健康生活方式优化，成为成功体重管理的重要支撑。社群活跃度能够支持参与者建立并维持健康生活方式。以基线调查时养成率较低的 6 个习惯为例，社群参与频率与生活方式的改善程度呈现高度同步的增长曲线。以 100 天的观察期为例，自评为高频的参与者（“总是”与“经常”）在营养均衡方面展现了极高的自律性，膳食纤维与蛋白质的达标率稳定维持在 75%-80%的高位，而低频参与群体在同一周期内的达标率则仅为 30%左右，且比 30 天时回落了 23 个百分点。在身体活动方面，高频组在“拒绝久坐”上保持了 80%以上的极高依从性，且在“坚持力量训练”这一最难落地的指标上，高频组依然维持着 35%-40%的执行力，而“从不”参与组仅有不足 5%的人能坚持完成。这种由高频参与建立的营养规律与运动习惯，能够为身体带来更稳定的能量平衡与代谢适应，从而形成可持续的健康改善。

表 7：不同社群参与频率的参与者的生活方式改善情况

	总是	经常	有时	很少	从不
30 天时					
膳食纤维充足	80.2	74.2	60.3	41.6	51.6
蛋白质充足	81.9	81.6	68.6	54.7	58.1
饮水达标	80.2	79.5	66.7	55.5	58.1
拒绝久坐	84.2	72.1	62.5	51.8	54.8
尽量早睡	80.8	79.5	70.2	63.5	45.2
坚持力量训练	36.7	30.2	16.7	7.3	9.7
60 天时					
膳食纤维充足	80.0	79.3	62.4	47.0	37.9
蛋白质充足	84.6	83.3	74.1	52.1	44.8
饮水达标	81.1	82.3	67.5	56.4	55.2
拒绝久坐	90.3	78.0	67.8	64.1	48.3
尽量早睡	84.6	81.2	75.3	64.1	44.8
坚持力量训练	46.9	33.6	11.4	14.5	13.8
100 天时					
膳食纤维充足	77.8	72.9	59.9	46.9	28.6
蛋白质充足	75.5	80.4	66.8	53.1	33.3
饮水达标	72.7	75.9	60.8	53.1	33.3
拒绝久坐	81.5	76.4	68.5	65.3	42.9
尽量早睡	74.1	79.3	66.8	60.2	52.4

坚持力量训练	41.2	34.7	17.2	11.2	4.8

（四）社群支持下的体重管理具有较好的溢出效应

5. 社群参与能够推动参与者个体心理与社会归属感的提升，成为推动高质量生活的价值放大器。数据表明，随着社群参与频率的增加，参与者不仅在慢性病控制上表现出绝对优势（“总是”参与者控制良好率高达 75.6%），更在主观幸福感与社会支持维度上实现了提升——高频参与者中，有 70%明确感到幸福感提升，近 69%收获了更强的社会支持与人际连接，这种心理与情感的富足，让 94.2%的人对整体干预效果感到满意。此外，从主观评价上看，这种社会性投入与生活方式的系统性改善，直接构成了“经济减支”的底层逻辑：当科学的体重管理与规律运动成为常态，参与者的基础代谢状况得以优化，健康状况有所提升，超过 57.9%的“总是”参与者能清晰感受到医疗开支呈减少趋势，这也提示，良好的健康管理，具有成为减轻未来经济负担的“预防性投资”。

表 8：不同社群参与频率的参与者的获益情况

不同社群活动参与频率	总是	经常	有时	很少	从不
慢性病控制情况					
控制很好/好转	75.6	59.9	47.9	44.6	0.0
维持不变	23.7	37.1	46.3	48.2	73.3
控制不好	0.6	3	5.8	7.1	26.7
主观评分变化					
身体健康均值变化	0.27	0.19	0.21	0.21	0.16
心理健康均值变化	0.34	0.33	0.10	0.17	0.35
社交关系均值变化	0.30	0.25	0.10	0.18	0.24
主观感受变化					
坚持健康生活方式	91.6%	93.0%	82.7%	72.8%	75.0%
身体状况明显改善	84.2%	75.5%	65.3%	34.6%	40.0%
心情更佳	82.1%	79.3%	70.3%	53.1%	50.3%
认识新朋友/社会支持	68.9%	61.5%	42.6%	28.4%	25.0%
生活质量提升	76.3%	71.0%	57.4%	32.1%	25.0%
医疗开支减少趋势	57.9%	47.5%	33.7%	24.7%	0.0%
幸福感提升	70.0%	60.5%	42.1%	24.7%	31.3%

满意度均值(1-5)	4.71	4.48	4.11	4.06	3.94
非常/比较满意的占比	94.2%	95.2%	81.7%	76.5%	68.8%

（五）社群作用机制

6. 社群的带动作用主要体现在通过情感支持、陪伴和监督使得坚持减重行为更加容易。超过六成参与者直接把社群体验归因于动力与正向强化，61.5%认为“有动力坚持下去”、60.5%感到“被鼓励/认可”，而且这种“被看见”的强化在高频参与者中更突出（如“总是/经常”参与者感到被鼓励认可的比例分别达到 77.4%与 72.6%，显著高于“很少/从不”的 35.0%与 32.3%）。与此同时，社群也在提升归属与表达层面发挥作用：56.6%感到“有归属感、不孤单”，50.0%更愿意表达分享，高频参与者在归属感与分享意愿上同样明显高于低频组，这意味着社群不仅提供信息，更在“情感成本”上为体重管理减负。此外，34.8%的人明确表示社群能帮助自己处理负面情绪，提示其可能通过缓冲压力与情绪波动，间接支持更稳定的生活方式执行；更重要的是，社群整体呈现出一种比较压力可控的安全氛围——感到“被比较/有压力”的仅 9.1%，且在不同参与频率组间大致稳定，说明其更接近支持型而非竞技型环境。

表 9：不同社群参与频率的参与者的社群参与感受

不同社群活动参与频率	总是	经常	有时	很少	从不	合计
感到被鼓励、被认可	77.4	72.6	49.7	35	32.3	60.5
有动力坚持下去	66.7	65	50.6	38	35.5	61.5
有归属感，不再孤单一个人努力	61.6	62.1	40.4	29.9	16.1	56.6
更愿意表达自己、分享过程	10.2	10	7.7	8	9.7	50
能够帮助自己解决过程中的负面情绪	61.6	69.3	59.9	47.4	41.9	34.8
感到被比较、或有一定压力	35.6	39.4	33.3	26.3	25.8	9.1
社群影响不大，主要靠自己驱动	11.3	11.3	13.1	19.7	29	13.5
其他	0.6	1.3	4.2	5.8	12.9	3.0

三、启示

1. 快速老龄化背景下，中国需坚持关口前移、预防为主，并将体重管理纳入慢性病防控与健康促进工程。随着未来中国老龄化进一步深化，在慢性病负担上升与卫生筹资能力约束并存，必须走预防为主的道路。考虑到中国当前的超重肥胖情况，若不加紧将这一问题纳入着重考虑的范畴，其带来的疾病负担很可能会带来很大医疗和照护双重负担，进而演进为对医保资金和财政资金的压力。亟需通过“体重管理年”等政策抓手，编制权威核心知识和指导原则，将干预延伸至基层医务人员和公众可操作的层面，改变以治疗为中心的现状，利用国家层面的制度化链条，将体重管理作为防控慢性病的“第一道防线” 。

2. 推广线上线下相结合的社群支持干预模式，破解“知易行难”的行为困境，以社群补足陪伴、监督、提醒与反馈的执行短板。调研显示，体重管理最大的障碍并非缺知识，而是“尝试过但很难坚持”（占比 43.5%）和缺乏监督（占比 26.6%）。国际上如美国疾控中心的国家糖尿病预防项目，明确将“群体支持”和专业生活方式教练作为核心机制，显著提高了参与者的自我效能。我们的研究也明确提示了社群支持的效果。可考虑借鉴这种“社群支持”作为专业服务的外延层，通过同伴教练和社群机制降低坚持的门槛。

3. 强化社交关系与数字平台的深度联动，通过高频互动保障干预成效。社群不仅是互动的场所，更是提升依从性的核心驱动力，且参与频率与减重效果呈清晰的线性正相关。可考虑建立有关线上平台，利用数字化工具的便捷性与线上社群的人际互动，形成全方位、多维度的支持环境 。这种模式能为参与者提供不可或缺的行为锚定，通过每日打卡与即时反馈，将原本零散的个人行为转化为高度自律的集体共振。

4. 借鉴国际经验构建全方位的支持性环境，让健康选择变得更加容易和低廉。单纯靠喊口号很难对抗结构性的诱因，需要通过规制工具改变社会大环境。例如，墨西哥征收含糖饮料税后购买量平均下降约 6%，新加坡通过 Nutri-Grade 分级标签限制特定等级饮料的广告，智利实施食品标签法后有效降低了居民对高能营养素的摄入。中国在推动社群机制的同时，也可考虑在餐饮场景、外食环境推行热量标注，并在家庭、学校、单位等生活场景中建立“支持性微环境”，让社群互动与宏观政策形成系统性的协同效应。

5. 建立从“健康管理”到“经济减支”的获益链条，推动健康服务的预防性投资转型。良好的健康管理本质上是对未来经济负担的“预防性投资”，因为体重问题具有明显的社会外溢成本。数据显示，高频参与社群活动的群体在慢性病控制上的良好率（75.6%）远超低频组，更有 57.9%的人清晰感受到医疗开支呈减少趋势。未来应探索将基于社群的体重管理模式与商业健康保险、企业员工福利相整合，通过提升个体的社会归属感与主观幸福感，实现从减重成效向医疗开支优化的价值转化，进而缓解老龄化社会带来的公共卫生压力。

Health Communities Contribute to Weight Management

Amway Corporation[1]

Abstract

Overweight and obesity have become a serious public health challenge in China, not only contributing to a significant burden of chronic diseases, but also generating spillover effects in terms of individual behavior and socioeconomic costs. Although policy measures such as the "Weight Management Year" initiative have established a governance framework, weight management in practice remains mired in structural dilemmas, including the "asymmetry between willpower and environment" and the "difficulty in sustaining behavioral change." This research, through an in-depth survey of 1,771 participants across eight cities, validates the core value of the "healthy community" model in overcoming the above-said dilemmas. Research findings show that the community provides not only a place for interaction, but it also offers key external variables that effectively enhance compliance through peer help, supervision mechanisms, and emotional support. Statistics clearly reveal a linear positive correlation between participation frequency and weight loss effectiveness. In a period of 100 days, higher levels of community engagement are associated with more significant improvements in body weight and fat management. More specifically, among those participants who "always" took part in weight management activities, the rate of achieving the weight loss target (≥3%) was as high as 64.7%, compared to only 7.9% among those who "never" participated. In addition, such model effectively leads to systematic optimization of participants' lifestyles, including balanced nutritional intake and the removal of unhealthy habits such as long sedentary hours and staying up late, thereby achieving a healthy pathway of "losing fat without losing muscle." On the

[1] The views expressed in this report are those of the enterprise research and do not represent the official stance or opinions of the forum host and organiser.

psychological dimension, the community significantly alleviates participants' feelings of isolation and enhances their subjective well-being and sense of social support. Furthermore, 57.9% of high-frequency participants reported a perceived trend of reduced medical expenses, suggesting that effective weight management carries certain spillover benefits across psychological and economic dimensions. In sum, China should further advance the intervention threshold by integrating community-based weight management models into the foundational projects of chronic disease prevention and health promotion. Through deep integration of digital tools and social platforms, a comprehensive supportive microenvironment should be established, shifting from mere treatment to systematic social governance and prevention. Such approach is expected to effectively alleviate the public health pressure in the context of an aging society.

1. Overweight and obesity have become major public health challenges globally, urgently requiring a systematic response.

Overweight and obesity are significant public health risk factors. A large body of research as well as international consensus indicates that abnormal body weight is strongly associated with an increased risk of non-communicable chronic diseases such as cardiovascular and cerebrovascular diseases, type 2 diabetes, and certain cancers. It is a key driver of the growing disease burden and healthcare expenditures. Furthermore, weight issues exhibit significant externalities, as changes in individual weight status can, at a macro level, translate into societal costs through channels such as the incidence of chronic diseases, loss of labor productivity, and increased medical security expenditures.

The increase in overweight and obesity in China is characterized by "rapid growth, wide spread, and affecting younger age groups," making it a serious public health concern. According to the National Health Commission, citing data from the *Report on the Status of Nutrition and Chronic Diseases among Chinese Residents (2020)*, the rates of overweight and obesity among Chinese residents aged 18 and above were 34.3% and 16.4%, respectively. These figures represent an increase of 4.2 and

4.5 percentage points compared to 2012, demonstrating a significant upward trend. In addition, the rates of overweight and obesity among children and adolescents aged 6 to 17 years have reached 11.1% and 7.9%, respectively. Abnormal body weight has now widely spread from adults to the younger population. Coupled with factors such as urbanization, changing dietary patterns, and physical inactivity, this trend may establish a cumulative risk pathway from childhood into adulthood. As China is currently undergoing rapid aging, this trend will place significant pressure on the future disease burden. According to a systematic analysis based on the GBD 2021 framework, approximately 3.7 million deaths and 128.5 million DALYs globally in 2021 were attributable to high BMI (BMI > 25), with the primary attributable diseases concentrated in diabetes, ischemic heart disease, hypertensive heart disease, chronic kidney disease, and stroke[1]. According to data published in *The Lancet*[2], a leading international medical journal, China's overweight and obesity rate is at a moderate level globally. Using the WHO/NCD-RisC classification with a BMI ≥ 25 (age-standardized for individuals aged 18 and above), the combined overweight and obesity rate in China was approximately 38% in 2022, significantly higher than Japan's 24% and Vietnam's 18%, and comparable to Korea (36%), while slightly lower than Singapore (41%). The three main concerns are as follows. First, China has the largest absolute number of overweight and obese adults in the world, at approximately 402 million. Second, the upward trend is pronounced: globally, the number of individuals with BMI ≥ 25 rose from approximately 731 million in 1990 to approximately 2.11 billion in 2021—2.89 times the 1990 figure—while the number of obese individuals increased to 4.20 times. By comparison, China's figures for BMI ≥ 25 and BMI ≥ 30 in 2021 were 4.40 and 10.02 times the 1990 levels, respectively; even excluding the effect of population growth, the rapid increase in prevalence rates cannot be overlooked. Third, the adolescent obesity rate is high: according to UNICEF data, China's childhood obesity rate in 2024 was 11.1%, approximately 6 percentage points above the average for middle-income countries (5.5%)[3].

From an international perspective, many countries have already begun efforts to provide systematic solutions to address the issue of overweight and obesity:

1. To provide a comprehensive supportive environment, i.e., to use fiscal and regulatory tools to change the social environment, making healthy choices easier and unhealthy choices more costly. Typical tools include: 1) To promote healthy diets through the implementation of a sugar-sweetened beverage (SSB) tax and related fiscal policies. The World Health Organization (WHO) published its guidance on fiscal policies to promote healthy diets in 2024. According to the WHO, as of February 2024, 115 WHO member states have implemented a SSB tax at the national level. Research into the Mexican experience indicates that, following the implementation of the SSB tax, purchases of taxed beverages decreased by an average of approximately 6% relative to the counterfactual scenario. 2) To mandate front-of-pack nutrition labeling and warning labels. In its manual on guiding principles and frameworks for front-of-pack nutrition labeling, the WHO emphasizes a government-led packaging system that is monitorable and evaluable. 3) To implement restrictions on advertising and marketing targeting children and adolescents. In 2023, the WHO proposed to strengthen mandatory regulations of the marketing of high-salt, high-sugar, high-fat foods and non-alcoholic beverages to reduce children's exposure and weaken marketing inducements. 4) To require calorie labeling on menus in dining settings such as restaurants. The U.S. Food and Drug Administration (FDA) introduced requirements for calorie labeling on menus in places such as chain restaurants, extending interventions to out-of-home dining environments and instant consumption scenarios.

2. To encourage overweight and obese individuals to adhere to weight management through methods such as peer support. As a common international practice, this effort emphasizes the integration of weight management into medical and community services, as well as the long-term nature of behavior change and the importance of social support. The core of this effort lies not in one-off educational activities, but it stresses establishing a continuous and trackable support system, in which peer support and community mechanisms are employed to address issues of adherence rates, cost, and coverage. Typical practices include: 1) To improve adherence rates and self-efficacy through the use of a "group sessions + coach" format. For instance, the national diabetes prevention and lifestyle

intervention program of the U.S. Centers for Disease Control and Prevention (CDC) includes a "group support" component, featuring sessions led by trained lifestyle coaches. Participants are supported in achieving weight control and behavior change through mechanisms such as goal setting, self-monitoring, and addressing barriers. 2) To introduce peer support and peer coaching, where coaches are individuals also managing their own weight, providing long-term support. Such model was recognized by a meta-analysis published in the *International Journal of Obesity*[4]. 3) To carry out institutionalized screening and individualized guidance. For instance, Japan's "Specific Health Checkups and Specific Health Guidance" program incorporates risks related to visceral fat obesity and metabolic syndrome into insurer-mandated health checkups and health guidance.

In China, a policy chain for overweight and obesity management is taking shape, moving from advocacy to actionable and institutionalized measures. The "Healthy China Initiative (2019-2030)" identified actions related to healthy lifestyles, providing an overall framework and governance direction for weight management. In 2024, 16 government agencies including the National Health Commission published the Implementation Plan for the "Weight Management Year" Campaign, calling for establishing a supportive environment to enhance public awareness and skills over a period of approximately three years, while emphasizing the development of authoritative core knowledge, guiding principles, and key points for health education for primary healthcare workers. In 2025, the National Patriotic Health Campaign Committee incorporated the "Healthy Weight Management Action" into the Healthy China Initiative and released the annex titled "Healthy Weight Management Action" alongside the Healthy China strategic document. The action paper set goals such as "initially curbing the rising trend of overweight and obesity in the population" by 2030. It also identified the popularization and education of weight management knowledge within families, communities, medical institutions, schools, government agencies, enterprises and institutions, as well as restaurants and canteens, as key tasks. At the technical level, China issued the "Dietary Guidelines for Adults with Obesity," further translating weight management into actionable dietary and lifestyle intervention

recommendations, thereby enhancing operability for primary-level institutions and the public.

Nevertheless, in practical implementation, weight management faces three types of structural challenges: 1) The imbalance between environmental factors and willpower. The World Obesity Federation's *World Obesity Atlas 2025* emphasizes that the rise in obesity and chronic diseases is often the result of multiple system failures, and that relying solely on individual willpower makes it difficult to combat structural drivers over the long term. 2) The long-term nature and recurrent pattern of behavior change. Weight management requires long-term, multi-dimensional habit changes involving diet, exercise, sleep, and stress management, and it often carries a risk of relapse. Without continuous feedback and emotional support, it can be very difficult to translate these efforts into sustained behaviors. 3) Fragmentation of service provision and insufficient accessibility. Professional weight management often requires multidisciplinary collaboration involving nutrition, exercise, psychology, and chronic disease management. However, services in key life settings such as workplaces, schools, and communities are often insufficient.

Given the above-said challenges, to explore "community support" provides clear policy values. 1) The community can enhance adherence rates through shared goals, mutual witnessing, and light yet consistent interaction. Through shared goals, group norms, and mutual witnessing, it can "externalize" a portion of the self-control costs. Furthermore, it can drive lightweight environmental improvements in micro-scenarios such as workplaces, schools, and communities. 2) Addressing the long-term and recurrent nature of behavioral change, the community can help individuals transform short-term goals into sustainable life rhythms through continuous but low-intensity interaction, periodic reviews, and the supervision and empathy of peer coaches. When rebounds or interruptions occur, the community can provide emotional connection and validation, helping to alleviate feelings of shame and isolation. 3) Addressing the fragmentation and insufficient accessibility of service supply, the community can serve as an extension of professional services.

By using standardized toolkits (simple assessments, stratified advice, risk warnings) to achieve initial screening and triage, expanding coverage at a lower cost and creating synergies with macro-level policies. Therefore, against the backdrop of a clearly defined policy framework in China, namely, the "Weight Management Year" campaign, exploring replicable, evaluable, and scalable weight management support models from the perspective of community and peer support holds not only public health significance, but it also provides practical value for social governance while contributing to innovation in the health service system.

2. Insights on findings of special study on healthy communities supporting weight management

2.1 Overview of research methodology and study participants

The research team designed a study protocol to establish a health community focused on weight loss. By integrating social support, peer support, and individual interventions, and through the use of questionnaires and physical measurements at different stages of the intervention, the study aims to analyze the specific effects of community interaction on enhancing weight loss outcomes, improving psychological status, and promoting overall health. The questionnaires covered basic demographic information and body weight self-assessment, weight loss willingness, and past methods/barriers; follow-up questionnaires recorded diet, exercise, daily routine, stress, and emotional eating behaviors over the preceding 30 days, as well as weight relapse, chronic disease management, and physical sensations; and the questionnaires also assessed activity participation frequency, community belonging and peer support, psychological experience, satisfaction, and changes in health and quality of life. The research team recruited 1,771 persons from June to December 2025 in eight cities, namely, Beijing, Chengdu, Guangzhou, Hangzhou, Shanghai, Wuhan, Shenyang, and Xi'an, who were assigned to different groups, where the group head led the weight management community. Each community consisted of a group head and group members. Each group can participate in online activities for collective weight loss, encouraging and

supporting mutual assistance, encouragement, sharing, and joint activities among community members. The group heads played a primary role in supervision and support. Meanwhile, the groups utilized the We Take Action WeChat mini program[2] to conduct questionnaire surveys and track healthy lifestyle habits through check-in records. The research includes four key assessment points. Leveraging questionnaires and InBody data, the research team tracked changes in participants from multiple perspectives, both subjectively and objectively. 1) Baseline assessment: To assess baseline lifestyle habits (diet, exercise, sleep, psychology, social interaction) and current health status scores, also measuring data such as weight and body fat. 2) After 30 days of intervention: To observe preliminary outcomes and psychological feedback, focusing on participants' initial experiences within the community (such as feelings of achievement and recognition), also measuring data including weight and body fat. 3) After 60 days of intervention: To evaluate whether behavioral habits have been formed, examining changes in the difficulty of adherence and milestone improvements in physical condition. 4) On 100th day of intervention: To conduct a final outcome evaluation, including weight loss results, changes in mindset (confidence, anxiety reduction), improvements in quality of life, and overall satisfaction with the community model, also measuring data such as weight and body fat.

This study included a total of 1,771 participants with valid objective data. Among these, 1,295 individuals provided both objective measurements and questionnaire responses. The participant demographics were as follows: 81.9% were female and 18.1% were male, with a median age of 54 years and an average age of 48.4 years. The age distribution was primarily concentrated in the 40-49 (25.3%), 50-59 (33.6%), and 60 and above (21.2%) age groups. Additionally, 28.9% of participants had a bachelor's degree or higher, and 78.2% were engaged in light physical labor.

[2] "We Take Action" (我们行动啦) WeChat Mini Program. This digital tool served as the implementation and data-collection platform for the study: it was used to distribute and collect baseline and follow-up questionnaires (at 30, 60, and 100 days), to record participants' daily healthy-lifestyle check-ins (diet, exercise, sleep, etc.), and to aggregate data for analysing the relationship between community engagement and weight-loss outcomes, psychological status, and overall health. The mini program also included a health education module through which participants could access content on healthy lifestyle practices.

By day 100 of the intervention, questionnaire data and objective physical measurement data were retained for 947 and 1,447 participants, respectively.

Table 1 Samples Collected and Retained

Time	**Sample retained**	**Time**	**Valid Samples**
Baseline Questionnaire	1,294	1st InBody (baseline)	1,778
Day 30 Questionnaire	1,051	2nd InBody	1,545
Day 60 Questionnaire	957		
Day 100 Questionnaire	947	3rd InBody	1,447

2.2 Current status of weight management and the challenges faced

1) Approximately 40% of participants were classified as overweight or obese. Over half of the overweight individuals had issues with body image self-assessment. Participants with obesity reported higher levels of distress and motivation to change. Based on participants' baseline height and weight data, 32.7% were classified as overweight and 10.4% as obese. Among those who were overweight, only 51.3% correctly perceived themselves as having a weight problem. A high proportion, 95.5%, of individuals with obesity reported being troubled by weight management, with 50.0% experiencing significant distress. Among overweight participants, 83.3% reported being troubled by weight management. Participation willingness was high across normal weight, overweight, and obese participants, with over 60% in each group expressing a strong willingness to engage.

Table 2 Levels of distress and corresponding weight management status among participants with different body types (Unit:%)

	Underweight	Normal	Overweight	Obese	Total
Proportion of participants	3.1	53.9	32.7	10.4	100.0
Self-perceived body type					
Fit	20.7	50.3	10.8	4.5	32.6
A bit overweight, just need some moderate control measures	6.9	33.6	37.4	12.4	32.1
Having an issue with being overweight or obese	3.4	9.5	51.3	83.1	30.2
Underweight	69.0	6.6	0.6	0.0	5.1
Troubled by weight issues					
Very much troubled	3.6	4.0	20.4	50.0	13.0
Somewhat troubled	64.3	49.9	62.9	45.5	53.5

Not troubled	32.1	46.1	16.7	4.5	33.5
Willingness in weight management					
Very high	39.3	61.5	67.2	65.9	64.2
High	46.4	29.1	27.6	27.3	28.3
Just so so	10.7	8.7	4.9	4.5	6.8
Low	3.6	0.7	0.3	2.3	0.8
Previous weight management attempts					
Never	28.6	9.4	9.8	10.2	9.9
Sustained exercise	60.7	66.4	63.8	50.0	68.7
Dietary calorie intake control	39.3	67.2	69.5	76.1	64.2
Choose meal replacement products	39.3	46.1	45.4	39.8	45.6
Strict dieting (no supper/staple food or intermittent fasting)	10.7	10.6	14.4	27.3	12.8
Liposuction / Acupuncture / Massage, etc.	0.0	2.4	2.6	6.8	2.6
Take weight-loss drugs / Inject semaglutide, etc.	0.0	0.5	2.0	6.8	1.6
Outcomes of previous weight management efforts					
Good	39.3	51.3	32.2	17.0	42.9
Just so so	28.6	43.7	57.5	68.2	48.5
Poor	32.1	5.0	10.3	14.8	8.6
Main reasons hindering weight management					
Go with the flow, no need for deliberate improvement	21.4	29.6	25.6	18.2	27.2
Don’t know how to do it / Don’t know where to start	14.3	16.6	21.3	25.0	18.4
Procrastination, don’t want to take action	21.4	29.9	35.3	39.8	32.3
Have tried but find it difficult to stick with	35.7	36.5	48.9	65.9	43.5
No one to supervise	21.4	25.4	28.2	31.8	26.6
Excessive psychological stress	0.0	5.5	8.9	12.5	6.8
No time/energy	25.0	24.4	25.0	34.1	25.3
Don’t want to put in too much money	21.4	19.8	19.8	26.1	19.7
Lack of necessary conditions for improvement (facilities, etc.)	10.7	8.9	7.8	12.5	8.3
Don’t know / Can’t say for sure	21.4	7.7	6.3	4.5	7.5
Dietary habits issues					

Irregular eating habits / Skipping breakfast	24.1	11.4	15.3	23.6	13.5
Often overeat / Prefer strong flavors	13.8	17.1	25.1	42.7	21.2
Inadequate dietary fiber intake	55.2	42.7	46.0	52.8	43.5
Inadequate protein intake	62.1	39.7	35.1	36.0	36.4
Inadequate vitamin intake	55.2	29.4	33.9	32.6	30.6
Inadequate water intake (less than 1,500-1,700ml)	55.2	38.0	36.0	38.2	37.0
None above	6.9	31.6	29.8	22.5	31.5
Unhealthy habits					
Sedentary, rarely get up/move around.	75.9	40.7	47.6	60.9	44.7
Rarely engage in outdoor activities / Rarely get sunlight exposure	41.4	32.4	29.9	48.3	33.0
Stay up late into the night	48.3	43.1	38.2	52.9	41.8
Frequent alcohol consumption	6.9	2.2	5.0	6.9	3.2
Smoking (including vaping)	0.0	3.2	5.6	8.0	3.8
High levels of daily stress	31.0	25.3	29.0	29.9	26.1
Often alone / Feelings of loneliness	17.2	14.6	14.5	12.6	13.6
None above	6.9	29.2	26.6	18.4	27.9
Exercise habits					
Get up and move around once per hour on average	24.1	28.2	26.0	26.4	27.6
Walk 6,000 steps on average per day	48.3	62.5	60.1	55.2	60.5
Moderate-intensity activity for a minimum of 30 minutes each time, and at least 3 times a week	24.1	38.5	38.2	28.7	36.9
Weekly strength training	6.9	10.9	10.1	5.7	10.3
None above	31.0	18.3	22.2	31.0	21.1

2) Many participants had a history of weight management attempts, with a higher proportion trying to exercise regularly and control dietary calorie intake. However, "having tried but finding it difficult to persist" emerged as the most significant structural barrier. Only 9.9% of participants never attempted weight control. Among all participants, 64.2% and 68.7% tried controlling dietary calorie intake and exercising regularly, respectively. However, "having tried but finding it difficult to persist" emerged as the most prominent structural barrier,

accounting for 43.5% overall, with this proportion increasing significantly with objective body status: 36.5% in the normal weight group, 48.9% in the overweight group, and reaching 65.9% in the obese group. Closely associated with this were "procrastination, don't want to take action" (32.3% overall; 35.3% for overweight, 39.8% for obesity) and "no one to supervise" (26.6% overall; 28.2% for overweight, 31.8% for obesity). These findings suggest that the primary pain points in weight management are not a "lack of knowledge or methods," but rather a "lack of sustainability, external constraints, and feedback." Therefore, the potential value of community-based interventions may lie more in providing sustainable peer supervision, real-time feedback, and emotional support, which may help transform individual intentions and sporadic attempts into a more stable system of adherence. Particularly strong support may be found among overweight and obese populations.

3) Poor dietary structure and intake habits, overall lack of strength training, while sedentary behavior and staying up late were common, collectively impacting the effectiveness of weight management. In terms of diet, prominent issues concerned nutritional structure and intake habits. For instance, 43.5% of participants reported inadequate dietary fiber intake. As body type progresses from normal to obese, the proportion reporting "overeating/preferring strong flavors" increases significantly (normal: 17.1%, overweight: 25.1%, obese: 42.7%). Among common unhealthy habits, "sedentary behavior" is the most prevalent risk factor, affecting 44.7% overall, and is notably higher in the obese group (60.9%). "Staying up late" is also common, reported by 41.8% overall and 52.9% in the obese group. Regarding exercise, while most participants achieve "6,000 steps per day," there is a deficiency in "high-quality exercise structure." Only 36.9% meet the weekly target for moderate-intensity exercise, and the rate for strength training is merely 10.3%. Therefore, weight management requires a strong focus on disseminating scientific methods and establishing systematic behavioral support and social mechanisms to promote structural changes.

2.3 Weight management with community support proves effective

1) Participants in the intervention program demonstrated reduced weight, body fat, and BMI, along with significant improvements in body composition. Furthermore, longer adherence to the intervention was associated with better weight management outcomes. Overall, participants in the intervention program showed decreases in weight, body fat, and BMI: after 30 days, the average weight loss was 0.74 kg, BMI decreased by 0.28, and body fat mass decreased by 0.33 kg. There was a slight increase in average skeletal muscle mass, indicating a trend towards improved body composition. The improvements were greater among participants who persisted to day 100, with an average weight loss of 1.36 kg, a 0.51 kg reduction in body fat mass, and a 0.97-point increase in their InBody score. Using relative weight loss of ≥3% or ≥5% as success indicators, the proportion achieving "≥3% weight loss" increased from 15.6% at 30 days to 35.5% at day 100; the proportion achieving "≥5% weight loss" increased from 5.6% to 15.3%. Regarding body composition quality, 45.2% of participants achieved "fat loss without muscle loss" by day 100, meaning nearly half of the participants followed a healthier weight management pathway.

Table 3 Examining the weight management outcomes of intervention participants through various indicators

	Sample number	**Change by day 30**	**Change by day 100**
Objective indicators			
Weight (kg)	1,426	-0.74	-1.36
BMI	1,426	-0.28	-0.51
Body fat (kg)	1,324	-0.33	-0.51
Bone muscle(kg)	1,283	0.08	0.17
InBody score	1,274	0.53	0.97
Key achievement rate			
≥3% Weight loss target achievement rate	1,426	15.60	35.50
≥5% Weight loss target achievement rate	1,426	5.60	15.30
Fat loss without muscle loss (body fat ↓ and skeletal muscle ≥ 0)	1,247	40.90	45.20

2) Intervention participants who were initially obese or overweight showed greater improvements, demonstrating enhanced health benefits. In this study, overweight and obese individuals achieved relatively more significant health improvements through scientific intervention. Over the 100-day period, obese participants experienced an average weight loss of 3.51%, equivalent to a reduction of 2.82 kg, and a decrease in body fat mass of 1.57 kg. This was followed by the overweight participants, who achieved an average weight loss of 2.79%. Furthermore, the intervention effectively helped with the ideal body composition result of "fat loss with muscle gain" among overweight and obese participants. Over 51.6% of participants in the obese group successfully achieved a healthy state of losing fat while preserving muscle, and this proportion reached 45.5% in the overweight group.

Table 4 Weight management outcomes among intervention participants with different body types

Body types	**Underweight**	**Normal**	**Overweight**	**Obese**
Percentage change in body weight on day 100	0.24	-1.56	-2.79	-3.51
Body weight change (kg) on day 100	0.02	-0.92	-1.94	-2.82
Body fat change (kg) on day 100	0.61	-0.14	-0.9	-1.57
Bone muscle change (kg) on day 100	0.04	0.2	0.07	0.11
InBody score change on day 100	0.82	0.69	1.04	1.32
⩾3% achievement rate (%)	6.67	31.2	43.16	45.03
⩾5% achievement rate (%)	4.44	11.88	18.59	25.83
Fat loss while no muscle loss (%)	20	42.56	45.51	51.66

3) Participants engaged in community activities showed significantly better weight loss outcomes compared to those who did not participate. Furthermore, a clear linear relationship was observed: the higher the frequency of participation in activities, the greater the weight loss effect. During the 100-day observation period, the weight management outcomes of the participants who took

part in community activities were comprehensively better than those who did not take part. After 100 days, those who took part in community activities lost an average of 1.93 kg (an average reduction of 2.81%). Their performance in fat loss (-0.65 kg) and muscle gain (+0.25 kg) was also significantly better than the non-participating persons (fat loss -0.38 kg, muscle gain +0.16 kg). The "≥3% weight loss rate" in the participating group reached 45.1%, a clear advantage over the 34.5% in the non-participating group. Among those who participated in community activities, participation frequency was highly correlated with outcomes. The group that "always" participated in community activities achieved an average weight loss of 4.14%, with 64.7% of participants losing 3% or more of their body weight, and 45.5% achieving fat loss without muscle loss. In stark contrast, the group that "never" participated saw an average weight loss of only 0.61%, with a success rate of only 7.9% for the weight loss target and only 20.0% achieving fat loss without muscle loss. This strong contrast fully demonstrates that the community is not merely a place for interaction, but a core external variable for enhancing behavioral adherence and ensuring the efficient achievement of weight management goals.

Table 5 Weight management outcomes of those who took part in community activities and those who did not

	Those who participated in community activities	**Those who did not participate**
After 30 days of intervention		
Change in average body weight (kg)	-1.06	-0.62
Change rate in average body weight (%)	-1.58	-1
Change in average body fat (kg)	-0.5	-0.23
Change in average bone muscle (kg)	0.08	0.03
Change in average InBody score	0.65	0.16
≥3% weight loss achievement rate (%)	29.9	20.5
≥5% weight loss achievement rate (%)	9.6	5.7
After 100 days of intervention		
Change in average body weight (kg)	-1.93	-1.33
Change rate in average body weight (%)	-2.81	-2.09
Change in average body fat (kg)	-0.65	-0.38
Change in average bone muscle (kg)	0.25	0.16
Change in average InBody score	1.2	0.61
≥3% weight loss achievement rate (%)	45.1	34.5
≥5% weight loss achievement rate (%)	21.2	14.5

Table 6 Weight management outcomes of those with different frequencies of community activity participation

Frequency of community activity participation	**Always**	**Often**	**Sometimes**	**Barely**	**Never**
After 30 days of intervention					
Change in average body weight (kg)	-1.46	-0.72	-0.58	-0.29	-0.26
Change rate in average body weight (%)	-2.25	-1.12	-0.87	-0.36	-0.45
Change in average body fat (kg)	-0.71	-0.34	-0.24	-0.02	-0.27
Change in average bone muscle (kg)	0.11	0.06	0.06	0.07	-0.02
Change in average InBody score	1.11	0.5	0.26	-0.22	0.2
≥3% weight loss achievement rate (%)	39.4	14.7	14.8	8.5	4.8
≥5% weight loss achievement rate (%)	12.1	5.1	4.7	1.7	0
Fat loss and no muscle loss %	39.8	43.1	34.6	36.7	39.1
After 100 days of intervention					
Change in average body weight (kg)	-2.74	-1.29	-1.16	-0.72	-0.37
Change rate in average body weight (%)	-4.14	-1.98	-1.72	-1.04	-0.61
Change in average body fat (kg)	-1.11	-0.39	-0.4	-0.16	-0.06
Change in average bone muscle (kg)	0.08	0.25	0.18	0.06	0.24
Change in average InBody score	1.19	1.12	0.71	0.76	0.18
≥3% weight loss achievement rate (%)	64.7	29.8	24.3	17.6	7.9
≥5% weight loss achievement rate (%)	34.1	12.1	11.1	7.4	2.6
Fat loss and no muscle loss %	45.5	40.5	43.0	44.1	20.0

4) Community support helps cultivate healthier lifestyles, thus serving as a crucial pillar for successful weight management. More community activities can support participants in establishing and maintaining healthy lifestyles. Taking six habits with low baseline adoption rates as examples, the frequency of community participation showed a highly synchronized growth curve with the degree of lifestyle improvement. Looking at the 100-day observation period, high-frequency participants ("always" and "often") demonstrated high self-discipline in nutritional balance, with their adherence rates for adequate dietary fiber and protein intake remaining stable at a high level of 75%–80%. In contrast, the adherence rate for low-frequency participants during the same period was only about 30%, and it dropped by 23 percentage points compared to the 30-day mark. Regarding physical activity, the high-frequency group maintained an extremely high adherence rate of over 80% for "avoiding sedentary behavior." Furthermore, on the most challenging indicator of "adhering to strength training," the high-frequency group still maintained an execution rate of 35%–40%, whereas less than 5% of the "never" group could persist. High-frequency participation helped cultivate consistent nutritional patterns and exercise habits, which in turn provided sustained metabolic benefits for the body, thereby forming sustainable health improvements.

Table 7 Lifestyle improvements among those with different frequencies of community activity participation

	Always	**Often**	**Sometimes**	**Barely**	**Never**
On day 30					
Sufficient dietary fiber	80.2	74.2	60.3	41.6	51.6
Sufficient protein	81.9	81.6	68.6	54.7	58.1
Enough hydration	80.2	79.5	66.7	55.5	58.1
Not sedentary	84.2	72.1	62.5	51.8	54.8
Sleep early	80.8	79.5	70.2	63.5	45.2
Sustained strength training	36.7	30.2	16.7	7.3	9.7
On day 60					
Sufficient dietary fiber	80.0	79.3	62.4	47.0	37.9
Sufficient protein	84.6	83.3	74.1	52.1	44.8
Enough hydration	81.1	82.3	67.5	56.4	55.2
Not sedentary	90.3	78.0	67.8	64.1	48.3
Sleep early	84.6	81.2	75.3	64.1	44.8
Sustained strength training	46.9	33.6	11.4	14.5	13.8
On day 100					

Sufficient dietary fiber	77.8	72.9	59.9	46.9	28.6
Sufficient protein	75.5	80.4	66.8	53.1	33.3
Enough hydration	72.7	75.9	60.8	53.1	33.3
Not sedentary	81.5	76.4	68.5	65.3	42.9
Sleep early	74.1	79.3	66.8	60.2	52.4
Sustained strength training	41.2	34.7	17.2	11.2	4.8

2.4 Weight management with community support yields positive spillover effects.

5) Participation in community activities can enhance participants' individual psychology and sense of social belonging, thus providing a value amplifier that enhances quality of life. Statistics show that, as the frequency of community activity participation increased, participants not only enjoyed a clear advantage in chronic disease management (with 75.6% of "always" participants reporting good control), but they also reported improvements in subjective well-being and better social support. Among high-frequency participants, 70% reported they felt a clear increase in their sense of happiness, and nearly 69% gained stronger social support and benefitted from interpersonal connections. This psychological and emotional enrichment led 94.2% of them to feel satisfied with the overall intervention effect. Furthermore, in terms of subjective evaluation results, such social engagement and systematic lifestyle improvement directly formed the underlying logic for "economic cost reduction." When scientific weight management and regular exercise became the norm, participants' basic metabolic conditions were optimized, and their health status improved. Over 57.9% of "always" participants clearly perceived a decreasing trend in their medical expenses. This also suggests that effective health management can act as a "preventive investment" to alleviate future economic burdens.

Table 8 Benefits experienced by participants with different frequencies of community activity participation

Participants with different frequencies of community activity participation	**Always**	**Often**	**Sometimes**	**Barely**	**Never**
Chronic disease control					
Good control /conditions improving	75.6	59.9	47.9	44.6	0.0
Conditions unchanged	23.7	37.1	46.3	48.2	73.3
Poor control	0.6	3	5.8	7.1	26.7
Change in subjective assessment					
Mean change in physical health	0.27	0.19	0.21	0.21	0.16
Mean change in mental health	0.34	0.33	0.10	0.17	0.35
Mean change in social connection	0.30	0.25	0.10	0.18	0.24
Change in subjective perception					
Adherence to a healthy lifestyle	91.6%	93.0%	82.7%	72.8%	75.0%
Significant improvement in physical condition	84.2%	75.5%	65.3%	34.6%	40.0%
Better mood	82.1%	79.3%	70.3%	53.1%	50.3%
Made new friends / Received social support	68.9%	61.5%	42.6%	28.4%	25.0%
Better quality of life	76.3%	71.0%	57.4%	32.1%	25.0%
Decreasing trend of medical expenditure	57.9%	47.5%	33.7%	24.7%	0.0%
Enhanced sense of well-being	70.0%	60.5%	42.1%	24.7%	31.3%
Mean satisfaction level (1–5)	4.71	4.48	4.11	4.06	3.94
Proportion of those who feel very/relatively satisfied	94.2%	95.2%	81.7%	76.5%	68.8%

2.5 Mechanisms of How the Community Plays Its Role

6) The driving force of the community is mainly reflected in making it easier to adhere to weight loss behaviors through emotional support, companionship, and supervision. Over 60% of participants directly attributed their community experience to motivation and positive reinforcement: 61.5% felt "motivated to keep going," and 60.5% felt "encouraged/recognized." This reinforcement of being "seen" was more pronounced among high-frequency participants (e.g., 77.4% and 72.6% of "always/often" participants felt encouraged/recognized, significantly higher than the 35.0% and 32.3% in the "rarely/never" group). Meanwhile, the community also played a role in enhancing belonging and self-expression: 56.6% felt "a sense of belonging, not alone," and 50.0% were more willing to express and share. High-frequency participants also scored significantly higher on sense of belonging and willingness to share compared to the low-frequency group. This indicates that the community provides more than just information; it reduces the "emotional cost" of weight management. Furthermore, 34.8% explicitly stated that the community helped them manage negative emotions, suggesting it may indirectly support more consistent lifestyle execution by buffering stress and emotional fluctuations. More importantly, the community provided an overall safer atmosphere with more controllable stress levels – only 9.1% felt "pressured" or "being compared with other people." The rate remained relatively stable across different participation frequency groups, suggesting the community provides a more supportive environment, rather than one that makes people feel the stress of competition.

Table 9 Perceptions of community participation among those with different frequencies of community engagement

Those with different frequencies of community engagement	**Always**	**Often**	**Sometimes**	**Barely**	**Never**	**Total**
Feel encouraged, recognized	77.4	72.6	49.7	35	32.3	60.5
Have the motivation to carry on	66.7	65	50.6	38	35.5	61.5
Have a sense of belonging, no longer working alone	61.6	62.1	40.4	29.9	16.1	56.6

More willingness in self-expression and sharing experiences	10.2	10	7.7	8	9.7	50
Have the feeling that the community can help me manage negative emotions	61.6	69.3	59.9	47.4	41.9	34.8
Feel the stress, also feel that I'm being compared with others	35.6	39.4	33.3	26.3	25.8	9.1
The community does not have a big impact; I'm motivating myself	11.3	11.3	13.1	19.7	29	13.5
Others	0.6	1.3	4.2	5.8	12.9	3.0

3. Enlightenment

1) In the context of rapid aging, China must persist in shifting the focus to prevention-first and integrating weight management into the foundational projects of chronic disease prevention and health promotion.

As the country continues to age, we will face the coexistence of a rising burden of chronic diseases and constraints on health financing capacity, making it imperative to adopt a prevention-first approach. Given the current prevalence of overweight and obesity in China, if we fail to treat the issue as an urgent one, the resulting disease burden is likely to impose a significant dual toll, not only affecting medical treatment, but also complicating care provision. This could, in turn, escalate into pressure on medical insurance funds and fiscal resources. There is an urgent need to leverage policy initiatives such as the "Weight Management Year" campaign to develop authoritative core knowledge and guiding principles. These efforts should translate interventions into actionable measures for primary healthcare workers and the public, shifting away from a treatment-centered model. By utilizing a national-level institutional framework, weight management can be established as the "first line of defense" in preventing and controlling chronic diseases.

2) We must promote an intervention model that combines online and offline community support to overcome the behavioral dilemma of "knowing but not doing." We must also utilize communities to fill the gaps in execution, providing companionship, supervision, reminders, and feedback.

Research indicates that the biggest obstacle in weight management is not a lack of knowledge, but rather "having tried but finding it difficult to persist" (accounting for 43.5%) and a lack of supervision (accounting for 26.6%). Internationally, programs like the U.S. CDC's National Diabetes Prevention Program incorporate "group support" and professional lifestyle coaches as core mechanisms, thus significantly enhancing participants' self-efficacy. Our own research also clearly demonstrates the effectiveness of community support. It is worth considering adopting the "community support" model as an extension of professional services, using peer coaches and community mechanisms to lower the barrier to adherence.

3) We must strengthen the deep integration of social connections and digital platforms to ensure intervention effectiveness through high-frequency interaction.

The community is not merely a place for interaction, but it represents a core driver for enhancing adherence. A clear positive linear correlation exists between participation frequency and weight loss outcomes. It is worth considering establishing relevant online platforms, leveraging the convenience of digital tools and the interpersonal interaction of online communities, so as to create a comprehensive, multi-dimensional supportive environment. Such model can provide indispensable behavioral anchors for participants. Through daily check-ins and real-time feedback, it transforms what were once sporadic individual actions into highly disciplined collective action.

4) We must draw on international experience to build a comprehensive supportive environment that makes healthy choices easier and more affordable.

Mere slogans cannot counteract structural barriers; it is necessary to use regulatory tools to change the broader social environment. For instance, following the implementation of the SSB tax in Mexico, purchases decreased by an average of approximately 6%. Singapore uses the Nutri-Grade labeling system to restrict advertising for beverages of certain grades, and Chile's food labeling law effectively reduces residents' intake of high-energy nutrients. While China promotes community-based mechanisms, it could also consider implementing calorie labeling in dining settings and out-of-home eating environments.

Furthermore, establishing “supportive micro-environments” in key settings such as homes, schools, and workplaces would allow community interaction and macro-level policies to create systematic synergy.

5) We must establish a benefit chain from “health management” to “economic cost reduction,” promoting the transformation of health services towards preventive investment.

Effective health management is essentially a form of “preventive investment” against future economic burdens, given the significant social spillover costs associated with weight issues. Data shows that the rate of good chronic disease control among high-frequency community participants (75.6%) far exceeds that of low-frequency groups, and 57.9% clearly perceive a decreasing trend in their medical expenses. In the future, we should explore integrating community-based weight management models with commercial health insurance and corporate employee benefits. By enhancing individuals’ sense of social belonging and subjective well-being, this can facilitate a value transformation process, whereby weight loss outcomes lead to reduced medical expenditures, thus alleviating the public health pressure of an aging society.

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