

大健康社群助力推动健康家庭建设研究报告

安利公司¹

摘要

随着经济社会的不断发展，人们越来越关注自身的健康状况，作为保障民众自身健康水平的第一道重要防线，健康素养的内涵不断深化，如何提高民众的健康素养水平变得愈发重要。家庭作为健康促进的关键单元，将扮演更重要的角色。2025年我们将实践重心从“泛社群连接”进一步升级为“精准家庭干预”，提出并验证了“社群助力培养家庭首席健康官（CHO），CHO带动家庭成员提升健康素养”这一模式。通过在家庭内部培养一个具备基础健康知识、行动组织能力与沟通动员能力的关键角色，形成“社群赋能个人、个人带动家庭”的传导链条，使健康素养提升走进千家万户，从短期参与健康改善走向长期健康生活方式的养成。研究结果证明，这样的模式是完全可行的。

从“社群连接”到“家庭深耕”

一、政策背景：健康素养提升进入“从倡导到落地”的新阶段

随着人口高质量发展与健康中国战略的不断推进，提升国民的健康素养已不再是单一的健康教育理念，而是包含了慢病防控、居民生活方式转型、

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。

公共卫生体系韧性与社会治理能力等众多方面的基础性、综合性议题。党的二十大报告中指出，推进健康中国建设。人民健康是民族昌盛和国家强盛的重要标志。把保障人民健康放在优先发展的战略位置，完善人民健康促进政策。从国际视角看，联合国在 2025 年审议通过题为《联合国大会第四次关于预防和控制非传染性疾病以及促进精神卫生和健康的高级别会议政治宣言》的决议草案。这是全球首个提出慢病和心理健康一体化管理的文件，其目标为，在 2030 年全球烟草使用者减少 1.5 亿，1.5 亿高血压患者得到有效控制和 1.5 亿人获得可及的心理健康服务。

另一方面，家庭是健康促进的重要单元。家庭作为构成社会的基本单元，是个体身心发展的重要场所，也是联结个体与社会的枢纽。家庭成员可以在生命的各个阶段以其他社会子系统无法做到的方式互相支持，因此家庭在健康促进方面具有无与伦比的影响力²。家庭为慢病、残疾和衰弱的家庭成员提供护理所产生的经济价值，比医疗卫生系统的贡献要大 2 到 6 倍³。正因如此，有越来越多的学者呼吁，要以家庭为中心开展健康促进和疾病护理⁴。所谓“家庭健康”，是指“家庭单位层面的一种资源，由每个家庭成员的健康、能力、行为、性格和成员的互动以及家庭的生理、社会、情感、经济和医疗资源的交叉发展而来”⁵。家庭健康不是个体健康的简单组合，而是既涵盖了家庭成员内部行为、思想的互动，又包含其与外部环境支持的交互，既有家

² Robinson, L. R., Holbrook, J. R., Bitsko, R. H., Hartwig, S. A., Kaminski, J. W., Ghandour, R. M., Peacock, G., Heggs, A., & Boyle, C. A. Differences in Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders Among Children Aged 2–8 Years in Rural and Urban Areas - United States, 2011-2012[J]. *MMWR Surveill Summ*, 2017, 66(8):1-11.

³ Collins, T. L., Yong, K. W., Marchetti, M. T., Miller, K. L., Booths, B., & Falvey, J. R. The Value of Home Health Physical Therapy[J]. *Home Healthc Now*, 2019, 37(3):145-151.

⁴ Barnes, M. D., Hanson, C. L., Novilla, L. B., Magnusson, B. M., Crandall, A. C., & Bradford, G. Family-Centered Health Promotion: Perspectives for Engaging Families and Achieving Better Health Outcome[J]. *Inquiry*, 2020, 57:1143476369.

⁵ Weiss-Laxer, N. S., Crandall, A., Okano, L., & Riley, A. W. Building a Foundation for Family Health Measurement in National Surveys: A Modified Delphi Expert Process[J]. *Matern Child Health J*, 2020, 24(3):259-266.

庭内部资源的共享,也有外部资源的获取⁶。国家卫生健康委办公厅印发的《关于全面开展健康家庭建设的通知》提出,要发挥健康家庭在推进健康中国建设、深化爱国卫生运动、促进人口高质量发展中的关键作用,深入推进家庭健康促进行动,采取有效措施,高质量推进健康家庭建设。

在这一宏观背景下,健康素养提升的内涵正在发生变化:从过去偏重“健康知识普及”,逐步走向“健康能力建构”;从强调“个人知晓”,逐步走向“行为养成与技能掌握”;从“点状干预”走向“系统支持”。现实中,健康信息渠道不断增加,但信息过载、健康谣言与营销性内容也同步增长,造成“看得多、记得少、做得少”的普遍困境。与此同时,慢性病负担上升与老龄化加快,使得健康管理的核心不再是某一次科普活动,而是贯穿日常生活的长期管理能力:包括合理膳食、规律运动、科学睡眠、情绪管理、慢病风险识别、应急急救等一系列可执行、可迁移、可持续的能力组合。

因此,健康素养的提升需要一个能够兼顾“权威内容供给—持续行为支持—稳定场景承接”的综合载体。仅依赖一次性传播或单点式培训,很难实现长期行为改变;仅依赖个体自律,也难以抵消现实生活中的惯性、压力与时间成本。健康中国的“最后一公里”,最终需要回到日常生活本身。

二、研究实践:将大健康社群的成功经验有机复制到健康家庭建设

近年来大健康社群快速发展,在健康动员、知识普及、意识提升、切实行动等方面成效显著,其同伴间的支持、陪伴与督促,社群氛围的持续激励等成功经验,有效降低了健康行动门槛、弥合知易行难的行为差距。

⁶ Crandall, A., Weiss-Laxer, N. S., Broadbent, E., Holmes, E. K., Magnusson, B. M., Okano, L., Berge, J. M., Barnes, M. D., Hanson, C. L., Jones, B. L., & Novilla, L. B. The Family Health Scale: Reliability and Validity of a Short- and Long-Form[J]. *Front Public Health*, 2020, 8:587125.

家庭也是社群的一种，家庭相较一般社群组建，成员间更为了解、更容易行动一致、亲密沟通，更容易彼此带动养成健康的生活方式。因此，可将大健康社群的成熟运营经验，有机复制到健康家庭建设中，以家庭作为更高频、更稳定、更具内生动力的核心场景，让健康素养真正扎根日常生活。

这时，“家庭首席健康官”这一角色就显得尤为重要，将在社群中所学的健康知识，积累的交流经验，分享的日常感受有效的带回家庭，带动家中每一位成员落实健康，人人完成健康一小步，健康中国就将迈进一大步。

三、场景升级：为什么必须把“最后一米”落到家庭

家庭是社会最基本的功能单元，也是健康行为发生最密集、最真实的场域。饮食结构、作息规律、运动习惯、情绪沟通、慢病管理与照护决策，大量发生在家庭内部。与一般社群相比，家庭至少具备三项不可替代的优势：

1) 高频性：一日三餐、睡眠作息、日常活动天然在家庭中循环发生，健康干预更容易嵌入生活。

2) 稳定性：家庭成员之间具备长期陪伴关系，形成持续影响与自然监督，更易形成“提醒—执行—反馈”的行动闭环。

3) 扩散性：家庭具备天然的角色分工与代际传递机制，一个人的改变可能带动同住者的同步调整，实现“从个体到群体”的低成本扩散。

因此，2025年我们将实践重心从“社会社群连接”升级为“精准家庭干预”，提出并验证“家庭首席健康官（CHO）”模式：通过在家庭内部培养一个具备基础健康知识、行动组织能力与沟通动员能力的关键角色，形成“社群赋能个人、个人带动家庭”的传导链条，使健康素养提升从屏幕端走向家庭端，从短期参与走向长期习惯。

四、研究设计与实施：构建数字化干预闭环

（一）总体思路：以“1+N”模型实现从个人赋能到家庭扩散

本项目依托“我们行动啦”微信小程序开展，以数字化内容供给与任务机制为基础，构建“社群—家庭首席健康官—家庭成员”的传导结构，形成“1+N”闭环干预模型：“1”指家庭首席健康官：社群先对其进行系统化培训与任务打卡，提升其健康素养与家庭健康组织能力；“N”指家庭成员：由家庭首席健康官回到家庭带动，推动更多成员参与健康生活方式实践与测评。

该模型的关键不在于简单“扩大覆盖”，而在于通过身份赋予与家庭场景承接，把健康行动从“个人努力”转化为“家庭协作”，把健康知识从“我学到”转化为“我们一起用”。社群提供权威内容与持续激励，家庭提供高频场景与稳定监督，两者结合形成可持续的行为改变机制。

（二）实施路径：两阶段干预、连续测评、过程可追踪

项目实施分为两个阶段（如图1）。第一阶段：赋能（15天）：以社群为依托，带动开展为期15天的系统化课程学习与健康生活方式打卡。第二阶段：辐射（21天）：由家庭首席健康官带动家庭成员参与日常健康生活方式实践与打卡。

调研设计不仅关注全部调研者的身心健康，也关注家庭家风、文明低碳、亲密互动等更为广义的健康家庭建设。以健康、绿色、亲密、文明定义健康家庭，并依据这四大维度评估调研结果。

干预设计

大健康社群助力培养家庭首席健康官，进而带动建成健康家庭



图 1：调研干预设计

(三) 样本：家庭首席健康官与家庭成员双人群样本

本次调研主要依托“我们行动啦”微信小程序，通过用户的转发分享推送调查问卷。从 2025 年 5 月至 12 月，历时 7 个月，共 3615 位志愿者参与本次调研，涵盖 2706 位社群成员（家庭首席健康官报名者）以及 909 位家庭成员，认证 520 位家庭首席健康官，316 个健康家庭。

从人群画像看，首席健康官群体呈现明显特征：女性占比 77.1%，51-60 岁人群占比最高（33.3%）。这一群体在家庭中往往承担“照料者”“组织者”的角色，拥有较强的健康管理动机与较稳定的时间投入，是推动家庭健康行动落地的关键“枢纽人群”。家庭成员样本在首席官带动下呈现更广的性别与年龄覆盖，更多男性（37.6%）与相对年轻人群被纳入实践链条，体现出“由家庭核心角色带动扩散”的现实可行性。

五、核心发现：从“个体提升”到“家庭扩散”

（一）家庭首席健康官角色蜕变：从“照顾者”到“健康管理者”

家庭首席健康官模式的关键，不只是让一个人“多学一点知识”，而是通过系统赋能与荣誉激励，使其在家庭内部形成更清晰的健康领导角色，从而推动家庭健康行动的组织化与长期化。数据表明，这种角色变化具有可观的现实效果。

首先，家庭首席健康官在家庭中的影响力得到提升（如图2）。有42.7%的首席健康官表示“在家庭中明显更具有话语权，家人全方位信任我”，较活动干预前提升7.2个百分点。这一变化意味着：当家庭内部出现一个被认可的“健康信息筛选者”和“行动组织者”，家庭健康决策更容易形成一致性，健康行动也更容易获得配合与支持。

其次，家庭活动组织频率与家庭成员沟通交流频率发生显著变化。“家庭关系亲密、经常交流”的占比达到59.5%，相比前测39.7%明显提升；“经常组织家庭活动”自30.6%上涨至44.9%。反映出在连续任务与社群氛围带动下，健康行动更容易从“偶尔参与”转化为“稳定安排”。同时，参与动机更强调“帮助全家养成习惯”“与同伴交流获得支持”等社会性因素，表明健康行动不再是孤立的个人任务，而开始成为一种“可被分享、可被共同完成”的家庭目标。



图 2：家庭首席健康官的家庭影响力提升

更重要的是，首席健康官的提升带来家庭层面的组织能力：他们更愿意在家庭中发起健康讨论、设计共同任务、建立提醒机制。定性调研中，我们观察到一个典型链条：先把健康知识变成家庭可执行的“规则”（例如控油控油、固定运动时段），再把规则变成可持续的“家庭习惯”（例如一起做饭、饭后散步）。这一链条使健康素养从“认知水平”进入“家庭制度”层面，持续性、稳定性更强。

（二）家庭扩散效应：健康素养提升实现“由点到面”低成本扩展

本研究验证了“社群赋能个人—个人带动家庭”的扩散机制：当家庭核心角色被赋能后，家庭成员的知识与行为改变能够更快发生，并在短周期内形成可观的提升幅度。

1. 社群干预后，家庭首席健康官在帮助全家养成健康生活方式（84.4%）、学习健康知识/技能（82.5%）、帮助全家改善健康状况（79.1%）、结伴交友（69.6%）、保持心态平衡（58.9%）、规划家庭健康消费（32.5%）、节省医疗开支（11.9）等方面收获颇丰。

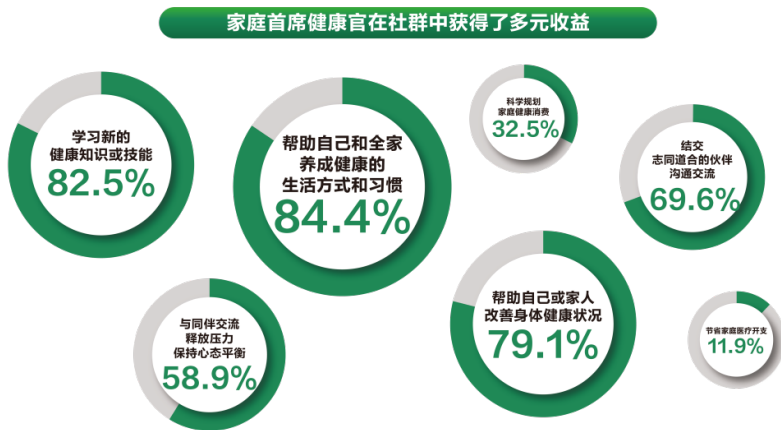


图 3：家庭首席健康官在社群中获得多元收益

2. 在家庭首席健康官的带领下，家庭成员健康素养显著提升，其测评题合格率自 38.7% 升至 77.2%。家庭的健康自评显著上涨（如图 4）。社群干预后，家庭首席健康官健康自评“良好”以上占比上涨 26.5%（71.5% VS 98%）；在家庭首席健康官的带动下，家庭成员健康自评“良好”以上占比上涨 8.6%（80.9% VS 89.5%）。

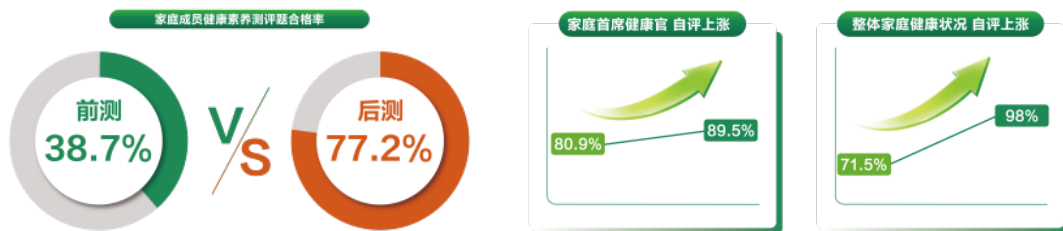


图 4 家庭成员健康状况整体向好

3. 家庭健康生活方式明显改善（如图 5）。三餐不合理（79.6%的人群改善）、户外活动少（74.4%）、饮食高油/高糖/高盐（68.8%）、熬夜（66.9%）均有近 7 成改善；家庭氛围不和谐（53.8%）、过量饮酒（45.5%）、口腔/眼部健康（44.7%）、室内环境改善（35%）等紧随其后，均有不同程度的改善。

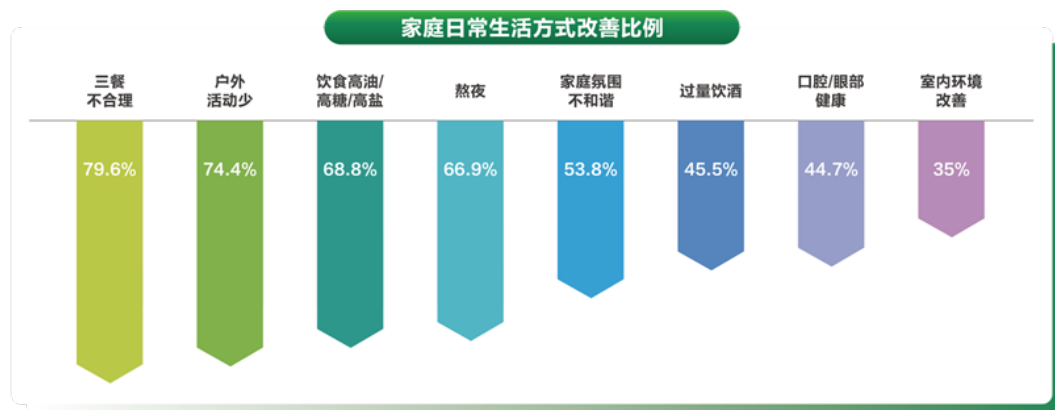


图 5 家庭日常生活方式改善情况

4. 家庭健康困扰显著缓解。86.8%的家庭成员表示健康认知/观念持续向好，饮食合理（76.7%）、坚持运动（66%）、免疫力提升（50.3%）明显改善，体重管理问题改善占比 44%，情绪不佳的改善情况占比 35.8%。

（三）“健康家庭的建设场景”的边际价值

1. 定性调研观察到，例如单人营养膳食改变很容易因社交、情绪与时间压力失败，但家庭共同调整（比如共同减少重油重盐、共同备餐）会把“健康选择”变成家庭默认选项，从而降低反复决策的心理成本；再例如，共同运动、饭后散步等会显著提升坚持概率。同时，家庭任务化设计会把运动从“需要意志力”的行为转化为“家庭相处方式”的一部分，这是巨大的家庭建设价值。

2. 数据显示，绿色家庭建设初见成效（如图 6）。更多家庭开始趋向绿色环保的生活方式，符合“使用低耗能/少排放”家庭上涨比例为 14.3%，符合“绿色出行”“节水节电”家庭上涨比例分别为 8.2%、8.6%，“垃圾分类”“少用一次性用品”“废物循环利用”等均有不同程度的上涨。

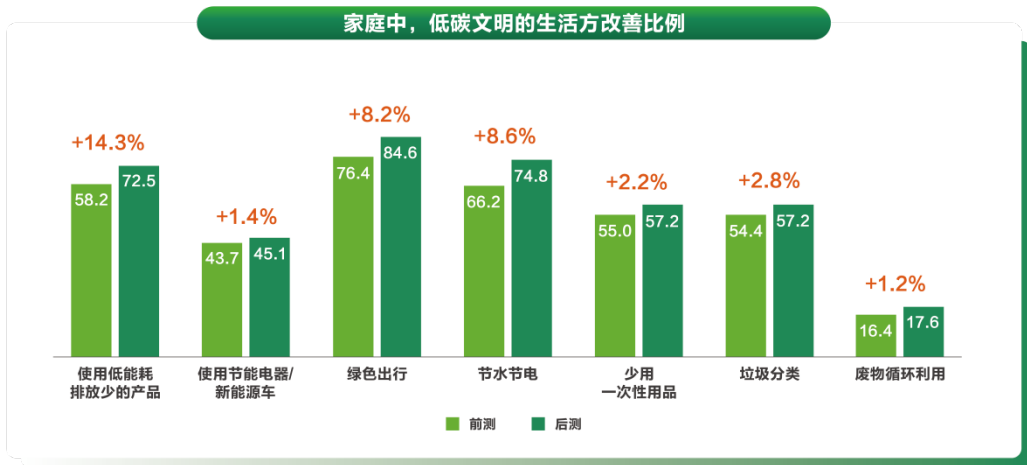


图 6 家庭低碳文明的生活方式改善情况

六、机制建立：社群×家庭的双向赋能闭环

本研究所验证的“家庭首席健康官”模式，本质上是一套双轮驱动机制：社群提供内容与激励的“势能”，家庭提供场景与陪伴的“动能”。两者相互补位，形成健康素养提升的闭环。

（一）社群“势能”：解决“权威—系统—坚持”的外部约束

社群能够集中解决家庭健康管理的三类典型痛点：

1) 权威来源不足：家庭内部经常出现“谁说都不听、只信专家”的信任困境。社群通过专家内容与统一课程体系，提供“可信背书”，使家庭首席健康官在家庭内部更容易建立健康指导的正当性。

2) 学习系统性不足：碎片化信息难以形成体系。社群通过模块化课程与测评题，把健康知识组织成可学习、可复习、可检验的结构，降低学习门槛。

3) 坚持难：社群通过同伴氛围、任务打卡、阶段激励与荣誉体系，降低行动启动成本，并通过持续反馈对抗倦怠。

(二) 家庭“动能”：解决“落地—监督—扩散”的内部机制

社群提供的是“外部支持”，家庭提供的是“内部结构”。家庭场景的优势主要体现在：

1) 高频落地：健康知识在家庭中能被更快转化为行动，尤其体现在饮食、作息、运动等高频行为。

2) 亲密监督：家庭成员之间的提醒具有更低成本与更高到达率；同时共同生活产生自然约束，能减少“今天算了”的弹性空间。

3) 角色赋权与扩散：家庭首席健康官通过身份确认与能力提升，带动家庭成员参与，形成家庭内部的自组织网络，实现低成本扩散。

七、建议与展望：把“可行路径”变成“可复制方案”

(一) 以家庭为基本单元，自上而下构建多层次健康促进网络，形成“社群支持—家庭承接”的常态化机制

1. 以社区为枢纽：依托社区卫生服务中心等基层医疗卫生机构、居委会等，组织家庭参与健康促进活动，推动健康教育从“面对个人”转向“面向家庭”。

2. 以社群为载体：发展覆盖不同人群与不同健康主题的主题社群（如体重管理、运动习惯、慢病自我管理、急救科普等），把“健康科普+行为实践”绑定推进。

3. 以关键角色为抓手：鼓励在家庭内部形成稳定的健康组织者，承担健康信息筛选、家庭行动组织、家内监督提醒等功能，实现“一个人带动一家人”。

4. 以激励机制提升持续性：探索将健康任务完成、参与社群活动与志愿服务、社区积分等机制适度挂钩，通过榜样示范与正向激励增强长期参与动力。

（二）突出健康行为与关键技能建设，聚焦慢病防治、急救能力与健康信息素养的系统提升

1. 慢病防治素养：从常识到可执行路径。围绕高危识别、关键风险因素、家庭监测与就医节点等内容，形成可理解、可操作的家庭慢病管理路径，鼓励建立慢病患者自我管理小组或家庭支持小组，促进规律饮食、运动、监测等行为长期化。

2. 急救关键技能：从认知到行动预案。将急救知识与关键流程纳入社区常态化健康教育，推动“学—测—复—再测”的复训机制，提升家庭在突发情况下的自救互救能力。

3. 健康信息素养：从信息获取到辨识能力。在健康信息高度复杂的环境下，应加强“识别与判断”能力教育，提升公众对权威来源的识别、对谣言与营销信息的辨析能力，减少错误健康决策带来的风险。

(三) 加强跨部门协同与数字化赋能，建设权威健康知识与服务体系，提升触达效率与公平性

1. 建设权威健康知识供给体系：整合卫健系统、疾控机构、医院与专业学会等资源，形成统一的核心健康知识库与标准化材料包，确保内容权威、口径一致、可复用。

2. 推动数字化工具普惠化：在合规前提下，鼓励开发与推广养成类数字化健康教育工具（小程序、APP等），尽量降低中老年群体的使用门槛。

3. 强化平台协作与短视频科普规范化：与媒体和平台合作推进权威健康知识产品，加强对健康信息内容的规范引导与辟谣，提高权威信息可及性。

4. 推进分层服务与重点人群覆盖：针对不同人群（慢病高风险家庭、“一老一小”等）提供分层内容与任务包，避免“一套内容覆盖所有人”的低效供给，提高健康教育的精准性与公平性。

Health Communities Contribute to building Healthy Families

*Amway Corporation*¹

Abstract

Thanks to continuous socio-economic development, people are paying increasing attention to their own health. Health literacy constitutes the first crucial line of defense in safeguarding people's health. As the concept of health literacy deepens, it is increasingly important to improve the public's health literacy level. The family as a key driver for health promotion is playing an even more important role. Therefore, in 2025, we upgraded our practical focus from "broad community connection" to "targeted family intervention." In so doing, we proposed and validated the model of Community Health Officers (CHOs), cultivated in holistic health communities, guiding family members to improve their health literacy. In such model, a key role is cultivated within the family that possesses basic health knowledge, the ability to organize actions, and the skills to communicate and mobilize others. Thus, a transmission chain is formed where "the community empowers individuals, and individuals drive families." In the process, health literacy improvement is happening in countless families; short-term participation in health enhancement activities is transitioned to the cultivation of long-term healthy lifestyles. Research results demonstrate that such model is entirely feasible.

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.

From “community connection” to “family cultivation”

1. Policy Background: Health literacy improvement has moved from advocacy to implementation, entering a new phase.

As the strategy for high-quality population development and the Healthy China initiative continue to advance, improving national health literacy is no longer a singular concept of health education. It has become a foundational and comprehensive issue encompassing multiple dimensions, including chronic disease prevention and control, the transformation of residents’ lifestyles, the resilience of the public health system, and social governance capacity. As per the report to the 20th National Congress of the Communist Party of China, we should advance the Healthy China Initiative, and people’s health is a key indicator of a nation’s prosperity and a country’s strength. Therefore, ensuring people’s health must be a priority strategy and health promotion policies must be improved. From an international perspective, in 2025, the United Nations reviewed and adopted a draft resolution entitled “Political Declaration of the Fourth High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the Promotion of Mental Health and Well-being.” The declaration proposed integrated management of chronic diseases and mental health, a world first. More specifically, the declaration called for reducing the number of global tobacco users by 150 million, ensuring 150 million people with hypertension to have effective blood pressure control, and providing accessible mental health services to 150 million individuals by 2030. The WHO’s Fourteenth General Programme of Work (GPW 14) for 2025-2028 outlines the top-level roadmap for global health management, which includes strengthening Primary Health Care (PHC) and Universal Health Coverage (UHC). The WHO’s Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2023-2030 highlights measures such as salt reduction, sugar reduction, tobacco control, alcohol restriction, universal screening, and community-level chronic disease management. These efforts aim to reduce mortality rates from cardiovascular diseases, cancer,

diabetes, and chronic respiratory diseases, while also improving mental health outcomes. Both the EU's Health Union Strategy (2020–2025) and the Pan American Health Organization (PAHO) Health Agenda for the Americas 2030 integrate chronic disease prevention and control, mental health, and other aspects into a unified approach to health management.

Meanwhile, the family is identified as a key unit for health promotion. As the basic unit of society, the family provides the crucial environment for individual physical and mental development, serving as the link connecting individuals with the broader community. Family members can support each other at every stage of life in ways that other social subsystems cannot, which is why the family has an unparalleled influence in health promotion.¹ Studies indicate that the economic value generated by families providing care for members with chronic illnesses, disabilities, or frailty is two to six times greater than the contribution of the healthcare system.² Therefore, a growing number of scholars are calling for health promotion and disease care to be centered around the family.³ The so-called “family health” refers to “a resource at the family unit level that is developed from the intersection of each family member’s health, abilities, behaviors, and personality, the interactions among members, as well as the family’s physical, social, emotional, economic, and medical resources.”⁴ Family health is not the simple sum of individual health, but rather it encompasses both the internal interactions of behaviors and thoughts among family members, and the exchanges with external environmental support. It involves both the sharing of resources within the family and the acquisition of external resources.⁵ The Notice on Comprehensively Advancing the Construction of Healthy Families, issued by the General Affairs Office of China’s National Health Commission, proposes to leverage the key role of healthy families in advancing the Healthy China initiative, deepening the patriotic health campaign, and promoting high-quality population development. It also calls for promoting family health and adopting effective measures to advance the healthy family initiative.

Against the above-said macro backdrop, the connotation of health literacy improvement is undergoing a transformation: shifting from past emphasis on “health knowledge popularization” to a focus on “health capacity building”; moving from “individual awareness” to “behavior formation and skill acquisition”; and transitioning from “point-based interventions” to “systemic support.” In reality, while health information channels are expanding, the simultaneous increase in information overload, health misinformation, and commercialized content has created a widespread dilemma where people are “exposed to much, retain little, and act on even less.” Meanwhile, the rising burden of chronic diseases coupled with the accelerated population aging process means that the core of health management is no longer a one-time science popularization activity, but rather the long-term management capacity integrated into daily life, involving a combination of actionable, transferable, and sustainable skills such as balanced nutrition, regular exercise, healthy sleep patterns, emotional regulation, chronic disease risk identification, and emergency first aid.

In sum, enhancing health literacy requires a comprehensive platform that integrates “the supply of authoritative content, sustained behavioral support, and stable contextual engagement.” Relying solely on one-time communication or isolated training sessions makes it difficult to achieve long-term behavioral change. Depending only on individual self-discipline is also insufficient to counteract the inertia, stress, and time costs inherent in daily life. The “last mile” of the Healthy China initiative must ultimately lead to the fabric of everyday life itself.

2. Research and Practice: Organically Replicating the Successful Experience of the Holistic Health Community in Promoting Healthy Families

Recent years have seen rapid development of holistic health communities, which has helped drive notable success in health mobilization, knowledge dissemination, and awareness enhancement while encouraging tangible health actions. Effective practices—such as peer support, companionship, mutual supervision, and the

sustained motivation fostered within the community atmosphere—have successfully lowered the barriers to taking health actions and bridged the gap between knowing and doing.

Families constitute a form of community. Given general community formations, family members, as part of community formation, have a deeper understanding of each other, find it easier to act in unison, communicate more intimately, and are more readily able to motivate each other to cultivate healthy lifestyles. Therefore, the mature operational experience of building holistic health communities can be organically replicated in promoting healthy families. By leveraging the family as a core setting with higher frequency interaction, greater stability, and stronger internal motivation, health literacy can be effectively promoted in everyday life.

In such process, the role of “the Family Chief Health Officer” becomes particularly important. This Family Chief Health Officer effectively brings the health knowledge learned, the communication experience accumulated, and the daily insights shared within the community back to the family, motivating every family member to put health into practice. When everyone takes that small step towards better health, the Healthy China initiative will make a giant leap forward.

3. Scenario Upgrade: Why the Last Mile Must Lead to the Family

The family represents the basic functional unit of society. It also provides the real scenario where health behaviors most frequently occur. Dietary patterns, daily routines, exercise habits, emotional communication, chronic disease management, and caregiving decisions largely take place in the family. Compared to general communities, families possess at least three irreplaceable advantages:

1. High frequency: Three meals a day, sleep schedules, and other daily activities naturally occur within the family. Therefore, health interventions can be more easily integrated into everyday family life.

2. Stability: The long-term companionship among family members creates sustained influence and natural supervision, making it easier to form a closed loop of action involving “reminders, execution, and feedback.”

3. Diffusion: The family naturally provides mechanisms for role differentiation and intergenerational transmission. A change in one person can lead to simultaneous adjustments among those living together, enabling low-cost diffusion “from an individual to the whole group.”

Therefore, in 2025, we shifted our practical focus from “social community connection” to “targeted family intervention,” proposing and validating the concept of the “Family Chief Health Officer (CHO),” whereby a key figure within the family is cultivated who possesses basic health knowledge, organizational skills for action, and the ability to communicate and mobilize others, and a transmission chain of “community empowering the individual, the individual motivating the family” is formed. In so doing, health literacy enhancement is happening not only in front of the screen, but it is taking root in the family setting, and short-term participation in health activities is evolving into long-term health habit formation.

4. Research Design & Implementation: A Digital Intervention Loop Is Constructed

4.1 Overall Approach: Realizing the Transition from Individual Empowerment to Family Diffusion through the “1+N” Model

Our project is implemented backed by the “We Action” WeChat mini-program, whereby a transmission structure of “Community — Family Chief Health Officer — Family Members” is established on the basis of digital content provision and task-based mechanisms, forming a “1+N” closed-loop intervention model. 1 refers to the Family Chief Health Officer. First, the health community provides him or her with systematic training and task check-ins to enhance his or her health literacy and capacity for organizing family health activities. N refers to family members. Back home, the Family Chief Health Officer mobilizes family members, encouraging them to take part in health actions and assessments.

The key of such model lies not in simply expanding coverage, but in transforming health actions “individual efforts” into “family collaboration” and turning the process of gaining health knowledge from mere learning by an individual into using the knowledge together, all through role assignment and integration into the family context. The health community provides authoritative content and sustained motivation, while the family offers a high-frequency context and stable supervision. The combination of the two forms a sustainable mechanism for behavioral change.

4.2 Implementation Path: Two-Phase Intervention, Sustained Assessments, Traceable Progress

The project implementation takes place in two phases (see Figure 1). Phase I: Empowerment (15 days) —Backed and led by the health community, a 15-day systematic course learning and healthy lifestyle check-in program.

Phase II: Diffusion (21 days) —The Family Chief Health Officer leads family members to take part in daily health actions and implement the daily check-in program.

Our research and design focus not only on the physical and mental well-being of all participants but also on broader aspects of healthy family development, such as family values, civility, low-carbon lifestyles, and close-knit interactions. A healthy family is measured on health, green, closeness, and civility. The overall assessment result arrives following evaluating these four dimensions.

Intervention Design

The holistic health community helps cultivate the Family Chief Health Officer, who in turn leads in building a healthy family.

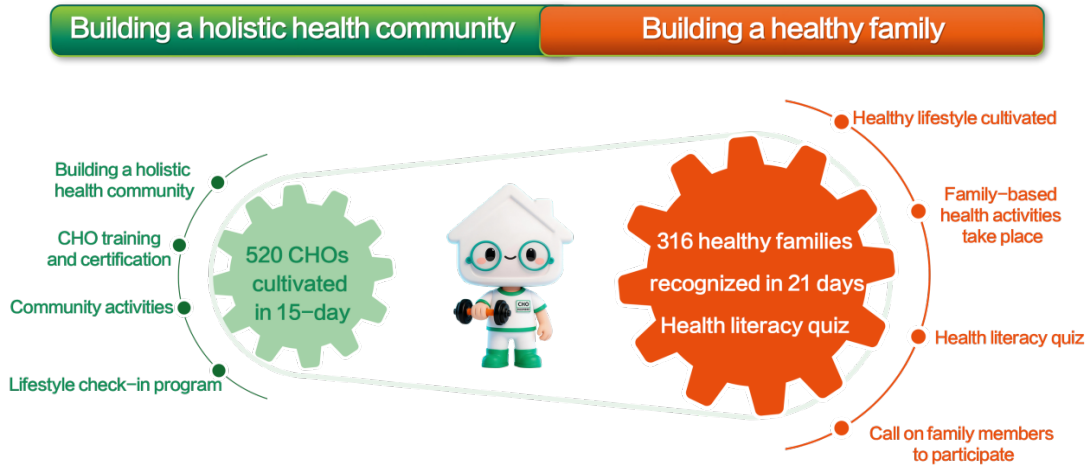


Figure 1 Research and Intervention Design

4.3 Samples: Dual-Population Sample of CHOs and Family Members

Conducted primarily via the “We Take Action” WeChat mini-program through questionnaires shared by users, this survey ran from May to December 2025 over a period of seven months. Altogether 3,615 volunteers took part in the survey, including 2,706 community members (CHO applicants) and 909 family members. In the process, 520 CHOs were certified, and 316 healthy families recognized.

From a demographic perspective, the CHO group exhibits distinct characteristics: females account for 77.1%, and the 51-60 age group is the largest (33.3%). The CHO group often assumes the roles of “caregivers” and “organizers” within the family, possessing strong motivation for health management and relatively stable time commitment. They serve as the key “hub population” driving the implementation of family health actions. Driven by them, the family member sample demonstrates broader gender and age coverage, with more males (37.6%) and relatively younger individuals being integrated into the practice chain. This reflects the practical feasibility of “diffusion driven by core family members.”

5. Key Findings: From “Individual Enhancement” to “Family Diffusion”

5.1 Transformation of the CHO role: from caretaker to health manager

The key to the role of the CHO lies not in allowing the CHO to learn more, but in encouraging the CHO to play a more distinct role in the family as the health leader. Through systemic empowerment and honor incentives, the CHO mobilizes family health actions in a way that makes such actions institutionalized and sustained. Statistics show that the transformation of the CHO role creates tangible effects.

Firstly, the CHO enjoys an even bigger influence in the family (see Figure 2). 42.7% of CHOs report they “obviously have more say in the family, and enjoy complete trust among family members in all aspects.” Such percentage represents a 7.2% increase over before the intervention. Such change suggests that, when there is a recognized “health information screener” and “action organizer” within the family, it becomes easier to achieve consensus in family health decisions, and health actions are more likely to receive cooperation and support.

Secondly, significant changes occur in the frequency of organizing family activities as well as the frequency of communication among family members. 59.5% families report “close relations and frequent exchange,” a significant increase from 39.7% over before the intervention. Also, the proportion of respondents who “often organize family activities” increases from 30.6% to 44.9%, suggesting health actions are more easily transformed from “occasional participation” into “stable routines” thanks to continuous tasks and the community atmosphere. Meanwhile, motivation for participation in health actions tends to focus on such social factors as “helping the whole family cultivate habits” and “exchange with peers for support,” which suggests health actions are no longer isolated individual tasks, but they have become family goals that can be shared and achieved together.

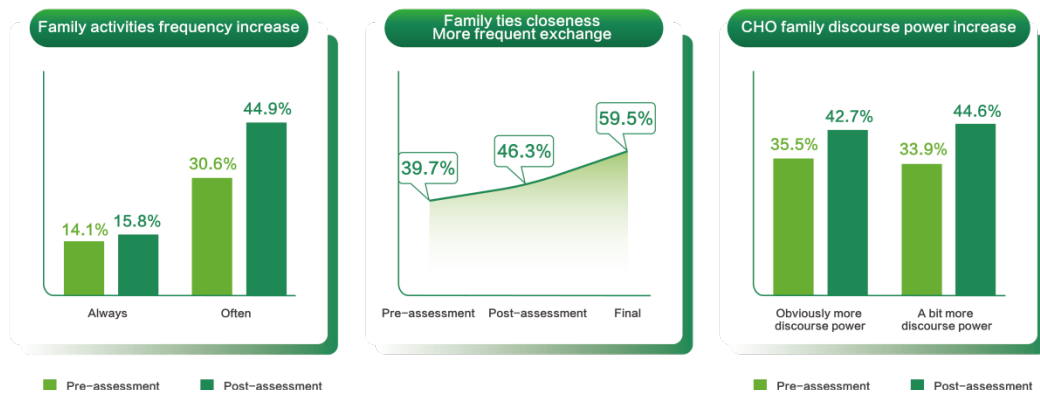


Figure 2 The Enhancement of CHO's Family Influence

More importantly, the enhanced CHO role provides enhanced organizational capacity at the family level. They are more willing to initiate health discussions, design joint tasks, and establish reminder mechanisms within the family. In the qualitative research, we have identified a typical chain: health knowledge is first transformed into actionable “family rules” (e.g., controlling salt and oil intake, scheduling fixed exercise times), and then these rules are turned into sustainable “family habits” (e.g., cooking together, taking a walk after meals). This chain elevates health literacy from the level of “cognition” to the level of “family institution,” resulting in greater sustainability and stability.

5.2 Diffusion Effect in the Family: Better Health Literacy, Low-Cost Expansion over a Whole Area from One Point

This research has validated the diffusion mechanism where one person empowered by the community can mobilize the whole family. When the core role in a family is empowered, knowledge and behavioral changes among family members can occur more rapidly, leading to a considerable degree of improvement within a short period.

1. Following community intervention, the CHO reports significant gains in several areas: helping the whole family cultivate healthy lifestyles (84.4%), learning health

knowledge/skills (82.5%), helping the whole family improve their health status (79.1%), making friends and socializing (69.6%), maintaining mental balance (58.9%), planning family health-related consumption (32.5%), and saving on medical expenses (11.9%).

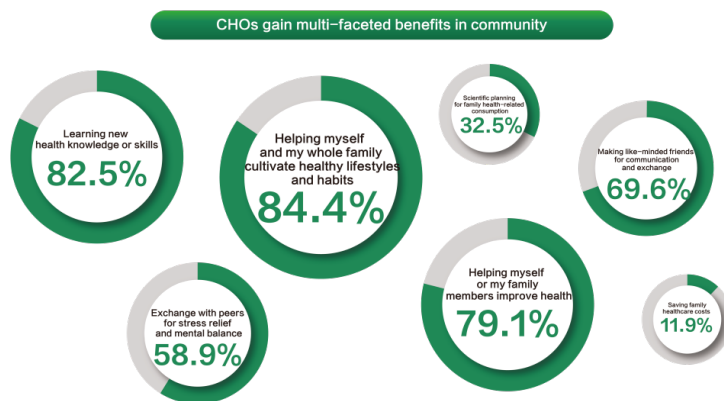


Figure 3 Multi Benefits Gained by CHOs in Communities

2. Led by the CHO, health literacy of family members has significantly improved, with the pass rate on assessment questions rising from 38.7% to 77.2%. Self-rated family health status has also markedly increased (see Figure 4) . Following community interventions, the proportion of CHOs rating their own health as “good” or above has risen by 26.5% (from 71.5% to 98%). Driven by the CHOs, the proportion of other family members rating their health as “good” or above has increased by 8.6% (from 80.9% to 89.5%).

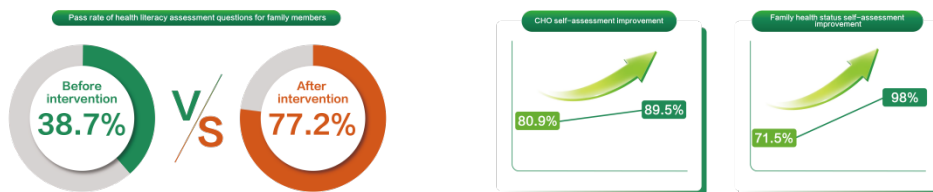


Figure 4 Overall Improvement in Family Member Health Status

3. Family healthy lifestyles have significantly improved (see Figure 5). Nearly 70% of participants report improvements in the following areas: diets acceptable in oil/sugar/salt (79.6% of people improved), regular meals (74.4%), sufficient outdoor activities (68.8%). In addition, improvements are also seen, to varying degrees, in areas such as acceptable alcohol consumption (45.5%), less smoking (44.7%), and indoor environmental improvements (35%).

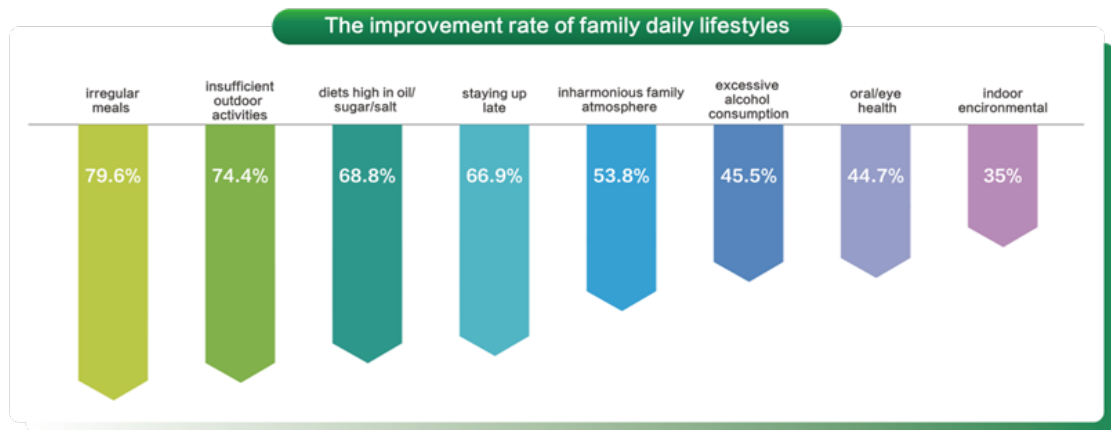


Figure 5 Improvements in Daily Family Lifestyles

4. Family health concerns have been significantly alleviated. 86.8% of family members report sustained improvements in health awareness and concepts. Notable enhancements have been seen in dietary habits (76.7%), consistent exercise (66%), and immunity (50.3%). Weight management issues have been improved for 44% of respondents, while 35.8% have seen improvements in emotional well-being.

5.3 Marginal value of promoting healthy families

1. Qualitative observations show, for example, that individual dietary changes are often easily derailed by social pressures, emotional states, or time constraints. However, when adjustments are made collectively as a family—such as jointly reducing heavy oil and salt or preparing meals together—“healthy choices” become the family’s default option, thereby reducing the psychological cost of repeated

decision-making. Similarly, joint activities like exercising together or taking a walk after dinner significantly increase the likelihood of adherence. Furthermore, framing these as family tasks transforms exercise from a behavior requiring willpower into an integral part of “family interaction,” which holds immense value for family building.

2. Statistics suggest initial success in building green families. More families are adopting environmentally friendly lifestyles (see Figure 6). The proportion of families reporting adherence to “using low-energy/low-emission” practices has increased by 14.3%. Increases have also been seen in families adopting “green commuting” (8.2%) and “water and electricity conservation” (8.6%). Practices such as “waste sorting,” “reducing single-use items,” and “recycling waste materials” also show varying degrees of increase.

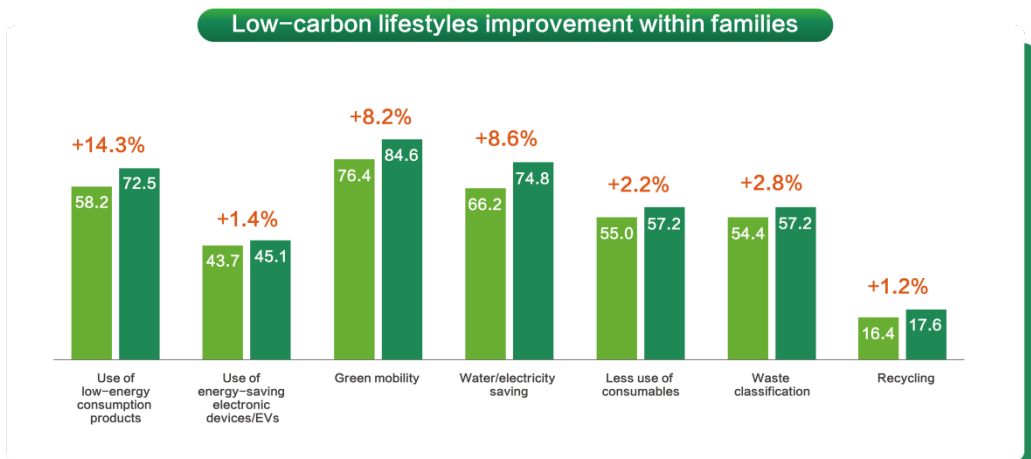


Figure 6 Improvements in Low-Carbon and Civilized Family Lifestyles

6. Mechanism Formation: Community × Family bidirectional empowerment closed loop

The CHO model validated in this research, in essence, represents a dual-wheel driven mechanism, whereby the community provides contents and incentives as momentum and the family provides the setting and companionship as kinetic energy. Community and family complement each other to provide a closed loop for health literacy improvement.

6.1 Community momentum to address the external constraints of “authority — system — persistence”

The community addresses three typical pain points in family health management:

1) Lack of authoritative sources: Families often face a trust dilemma where “no one listens to anyone, only experts are trusted.” The community provides a “credible endorsement” through expert content and a unified curriculum system, making it easier for the CHO to establish legitimacy for health guidance within the family.

2) Lack of systematic learning: Fragmented information is difficult to form into a coherent system. The community organizes health knowledge into a learnable, reviewable, and testable structure through modular courses and assessment questions, lowering the barrier to learning.

3) Difficulty in persistence: The community lowers the cost of initiating action through peer atmosphere, task check-ins, phased incentives, and an honor system, while combating burnout through continuous feedback.

6.2 Family kinetic energy to address the internal “implementation-supervision-diffusion” mechanisms

While the community provides external support, the family offers the internal structure. The family setting provides the following key advantages:

1) High-frequency implementation: Health knowledge can be translated into action more quickly within the family, particularly evident in high-frequency behaviors such as diet, daily routine, and exercise.

2) Intimate supervision: Reminders among family members have lower costs and higher reach; meanwhile, living together creates natural constraints, reducing the leeway for “letting it slide today.”

3) Role empowerment and diffusion: The CHO, through role confirmation and capacity building, motivates family members to participate in health actions, thus forming a self-organizing network within the family and achieving low-cost diffusion.

7. Recommendations and Outlook: Transform “feasible pathways” into “replicable solutions”

7.1 Using the family as a basic unit, build a multi-level health promotion network from top down, backed by normalized mechanisms of “community support plus family integration”

1) The community provides the hub: Backed by community health service centers, primary healthcare institutions, neighborhood committees, etc., families are mobilized to participate in health promotion activities, shifting the focus of health education from “individual-oriented” to “family-oriented.”

2) The community plays the carrier role: Thematic communities covering different population groups and various health goals (such as weight management, exercise habits, chronic disease self-management, first aid science popularization, etc.) are developed, thus promoting the integration of “health science popularization” with “behavioral practice.”

3) Key roles are starting points: A stable health organizer is encouraged within the family, responsible for functions such as screening health information, organizing family health actions, and providing intra-family supervision and reminders, thereby achieving the goal of “one person motivating the whole family.”

4) Incentive mechanisms help enhance sustainability: Explore how to link up the completion of health tasks, participation in community activities, volunteer

services, and community points mechanisms, so as to better motivate long-term participation through role modeling and positive incentives.

7.2 Focus on health behaviors and key skill development, while emphasizing systematic improvement of chronic disease prevention and control, first aid capabilities, and health information literacy

1) Literacy on chronic disease prevention and control: From general knowledge to actionable pathways.

Focusing on high-risk identification, key risk factors, home monitoring, and medical consultation thresholds, develop understandable and actionable pathways for family chronic disease management. Encourage the formation of self-management groups or family support groups for chronic disease patients to promote the long-term habituation of behaviors such as regular diet, exercise, and monitoring.

2) Key first aid skills: From awareness to action plans.

Integrate first aid knowledge and key procedures into routine community health education, promote a retraining mechanism of “learning — testing — reviewing — retesting,” and enhance the capacity for self-rescue and mutual aid within families during emergencies.

3) Health literacy: From information acquisition to discernment ability.

In an environment of highly complex health information, education on “identification and judgment” abilities should be strengthened. This will enhance the public’s ability to recognize authoritative sources, distinguish between rumors and marketing information, and reduce risks associated with incorrect health decisions.

7.3 Strengthen cross-sector collaboration and digital empowerment, build authoritative health knowledge and service systems, and improve the efficiency and equity of outreach.

1) Build an authoritative health knowledge supply system:

Integrate resources from health commission agencies, disease control institutions, hospitals, and professional societies to form a unified core health knowledge base and standardized material packages, thus ensuring content is authoritative, consistent in messaging, and reusable.

2) Promote the popularization of digital tools:

While ensuring compliance, encourage the development and promotion of digital health education tools (such as mini-programs and apps) for habit formation, with an eye on minimizing barriers for older users.

3) Strengthen platform collaboration and standardize short video science popularization:

Cooperate with media and platforms to promote authoritative health knowledge products, strengthen the regulation, guidance, and rumor debunking of health information content, and improve the accessibility of authoritative information.

4) Promote tiered services and enhance coverage of key populations:

Provide tiered content and task packages to different population groups (such as families at high risk for chronic diseases, older adults, and children), so as to address inefficiency as a result of the one-size-fits-all approach, while improving the precision and equity of health education.

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