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Barriers and Facilitators to Healthy Dietary Adherence in Older Adults: A COM-B Qualitative Evidence Synthesis

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Abstract. Poor dietary adherence contributes to malnutrition in community-dwelling older adults. This qualitative evidence synthesis aimed to identify barriers and facilitators to healthy dietary adherence among community-dwelling older adults using the COM-B model and to map barriers to Behaviour Change Wheel intervention functions and Behaviour Change Techniques. PubMed, CINAHL and PsycINFO were searched from May 2021 to May 2026. Studies were included if they reported qualitative data on barriers or facilitators to everyday dietary behaviour in community-dwelling adults aged 60 years and older. Data were synthesised using a deductive framework synthesis based on the COM-B model. GRADE-CERQual was used to assess confidence in review findings. Across the included studies, the most frequently reported barrier was lack of nutritional knowledge and difficulty understanding or applying nutrition information, followed by long-standing eating habits, emotional attachment to food, and emotional eating. Key facilitators included encouragement and support from family members, friends, caregivers, or research teams, as well as concerns about burdening children, desire to maintain health, attention to body shape, and positive health feedback. All four core findings had moderate CERQual confidence. Based on these findings, priority interventions should target psychological capability through education and training, and automatic motivation through habit substitution and reducing emotional eating.

Keywords: Older adults, dietary adherence, barriers and facilitators, COM-B model, qualitative evidence synthesis

1. Introduction

The world's population is ageing rapidly, with the share of people aged 65 years or over projected to rise from 10 per cent in 2022 to 16 per cent in 2050 [1]. Malnutrition, defined as a disorder resulting from reduced nutrient intake or assimilation that leads to altered body composition and diminished physiological function, is common among community-dwelling older adults [2]. Shaped by multiple factors, poor dietary adherence, the extent to which a person's eating behaviour follows agreed recommendations from a healthcare provider, is a pathway to malnutrition [3]. Understanding the factors that shape dietary adherence is therefore an urgent public health priority.

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Barriers and facilitators to older adults' dietary behaviours have been widely documented, but they have rarely been organised through a unified behavioural lens. An early review described barriers and facilitators through a psychosocial lens but did not place the findings within a behavioural theory, leaving the evidence largely descriptive [4]. A further meta synthesis drew on the social ecological model and identified determinants at individual, environmental, and intervention levels, yet it lacked the Capability, Opportunity, Motivation-Behaviour (COM-B) model's capacity to map barriers to specific intervention functions [5]. Most recently, a qualitative study applied the COM-B model and confirmed its value for identifying dietary barriers and facilitators among older adults, but its single study design limits the transferability of its findings [6]. Consequently, qualitative evidence on dietary adherence in this population has yet to be synthesised using the COM-B model as a unified framework, and the barriers identified across studies have rarely been mapped to Behaviour Change Wheel (BCW) intervention functions.

This paper synthesises qualitative and mixed-methods evidence on barriers and facilitators to healthy dietary adherence in community-dwelling older adults, using the COM-B model as a coding framework. The identified COM-B barriers will then be mapped to BCW intervention functions and Behaviour Change Techniques (BCTs), so that the findings can directly inform the design of theory-driven dietary interventions for this population.

2. Methods

This paper is a qualitative evidence synthesis guided by the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement [7]. The capability, opportunity motivation-behaviour model served as an a priori coding framework.

2.1. Search strategy

Three electronic databases were searched from May 2021 to May 2026, namely PubMed, CINAHL, and PsycINFO. The search strategy combined four concept groups using the Boolean operator AND, while terms within each group were connected by OR. Population terms included community-dwelling, community-living, older adults, elderly and ageing. Behaviour terms covered diet, nutrition, eating, food intake, dietary adherence and healthy eating. Phenomenon terms comprised barrier, facilitator, determinant, factor, perception and experience. Method terms included qualitative, mixed-methods, interview and focus group.

The search did not restrict retrieval to studies that explicitly used the COM-B model or any other named theory. This decision was made to avoid excluding qualitative studies that reported barriers and facilitators to dietary adherence without applying a theoretical label to their findings.

2.2. Eligibility criteria

The Population, Interest, Context, Study design (PICoS) framework was applied. For population, studies were eligible when all participants were community-dwelling older adults aged 60 years and older, including those receiving informal care at home and those with common chronic conditions. For interest, studies were required to report barriers to or facilitators of everyday dietary behaviour, addressing overall eating patterns. For context, studies conducted in general community settings in any country or region were included. For study type, qualitative studies and mixed-methods studies with a substantial qualitative component were included.

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For population, studies were excluded when participants resided in nursing homes, assisted living facilities, or hospitals, when all participants were younger than 60 years, or when all participants had end-stage disease or severe cognitive impairment. For interest, studies addressing only single-food or single-nutrient determinants were excluded, as were those reporting descriptive dietary intake data without exploring behavioural reasons. For context, studies focusing on extreme community environments were excluded, as were those recruiting participants solely based on a pre-identified health-risk status or a diagnosed psychiatric condition. For study type, purely quantitative studies, conference abstracts, dissertations, and non-English publications were excluded.

2.3. Study selection and extraction

A single reviewer screened titles and abstracts and then assessed full texts of potentially eligible studies against the PICoS criteria. The number of records at each stage and reasons for full-text exclusions were documented. A flow diagram was prepared to illustrate the selection process. Following study selection, a standardised form collected bibliographic details, study characteristics, participant characteristics, and verbatim statements of barriers and facilitators from each included study.

2.4. Quality appraisal

The Critical Appraisal Skills Programme (CASP) qualitative checklist was used. Each item was rated, yet no study was excluded solely on the basis of its quality score. The appraisal informed interpretation during synthesis, with greater weight given to studies demonstrating stronger transparency in reporting reflexivity and data saturation.

2.5. Data synthesis

A deductive framework synthesis was performed using the six COM-B components [8]. Physical capability refers to physical skills and limitations. Psychological capability covers knowledge and cognitive skills. Physical opportunity includes resource accessibility and economic factors. Social opportunity encompasses interpersonal relationships and cultural norms. Reflective motivation involves conscious plans and beliefs. Automatic motivation captures habits and emotional responses.

The synthesis proceeded through five steps. First, verbatim statements were extracted. Second, each statement was mapped to the most appropriate COM-B component. Third, similar factors within the same component were grouped. Fourth, coding decisions were reviewed for consistency. Fifth, factors not assignable to any component were documented separately.

Following the synthesis, COM-B components containing the most frequently reported barriers were mapped to the nine intervention functions of the BCW, and BCTs were selected from the Behaviour Change Technique Taxonomy for each function. This produced a structured matrix linking COM-B barriers to intervention functions and onward to recommended techniques.

3. Results

3.1. Study selection

A total of 5406 records were identified from PubMed (n = 4781), CINAHL (n = 400), and PsycINFO (n = 225). After 973 duplicates and 12 records of conference abstracts, dissertations, and non-English publications were removed, 4421 records entered title and abstract screening. Of these,

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4225 records were excluded because they were clearly irrelevant to the review topic. Full texts of the remaining 196 reports were sought for retrieval. Full texts could not be obtained for 29 reports.

The remaining 167 reports were assessed against the PICoS criteria. A further 162 reports were excluded for the following reasons. 13 studies included participants in nursing homes, assisted living facilities, or hospitals. 20 studies involved only participants younger than 60 years. Eight studies focused exclusively on participants with end-stage disease or severe cognitive impairment. 24 studies addressed only single-food or single-nutrient determinants. 20 studies reported descriptive dietary intake data without exploring behavioural reasons. 14 studies were conducted in extreme community environments. 18 studies recruited participants solely based on a pre-identified health-risk status or a diagnosed psychiatric condition. 45 studies were purely quantitative. After this process, five studies remained and were included in the qualitative evidence synthesis. The study selection process is shown in Figure 1.

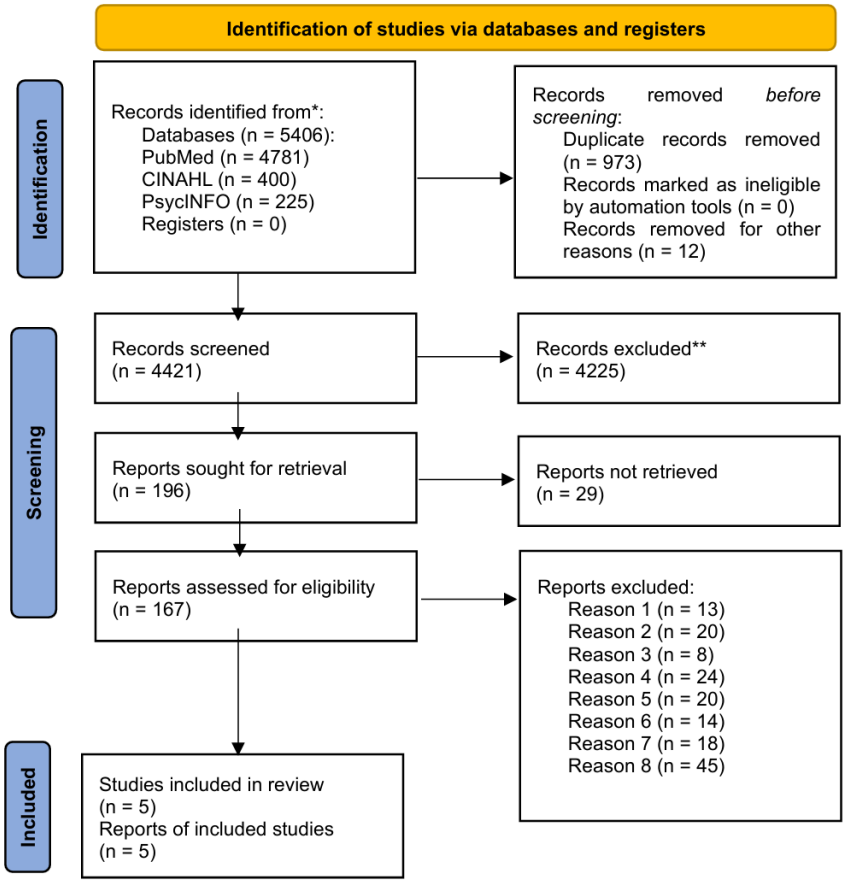

Figure 1. PRISMA flow diagram of study selection

3.2. Study characteristics

The five included studies were conducted in four countries. Two studies were from China [9, 10]. The remaining three studies were from Spain, Austria, and the United States [11-13]. Four studies used a purely qualitative design and employed semi-structured interviews [9-12]. One study employed a mixed-methods design that combined focus groups with a pilot-testing survey [13]. Sample sizes for the qualitative components ranged from 12 to 24 participants. Three studies each

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recruited around 20 participants [9-11]. Eglseer et al. included 24 participants [12]. Rosenkranz et al. included 12 participants in the focus groups [13].

All participants were community-dwelling older adults aged 60 years and older. Two studies recruited participants with specific health conditions. One study focused on overweight or obesity with metabolic syndrome [11]. The other focused on sarcopenic obesity [10]. One study included both older adults in need of care and their informal caregivers [12]. The remaining studies recruited generally healthy community-dwelling older adults [9, 13]. Table 1 summarises the characteristics of the five included studies.

Table 1. Characteristics of included studies

Country	Study Aim	Study Design	Data Collection	Sample Size	Participant Characteristics
Spain	To explore perceived health impacts, barriers, and facilitators of adherence in an RCT based on the MedDiet and lifestyle interventions	Qualitative study	In-depth semi-structured interviews	17	Community-dwelling; overweight/obesity and metabolic syndrome; aged 60 to 81 years
China	To explore the mechanisms underlying eating behaviours among Chinese older adults using the COM-B model	Qualitative descriptive design	Semi-structured interviews	20	Community-dwelling; aged ≥60 years; Zhenjiang, Jiangsu Province
Austria	To explore barriers, facilitators, and support needs for maintaining a healthy diet among community-dwelling older adults in need of care and their informal caregivers	Descriptive qualitative study	Semi-structured individual interviews	24	Community-dwelling; older adults in need of care (median age 82 years, IQR 81-86)
USA	To develop and evaluate a new instrument to measure the capability, opportunity, and motivation for healthy eating behaviours among community-dwelling older adults	Mixed methods	Focus groups and pilot-testing survey	12	Community-dwelling, English-speaking; aged 65 years and over

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Table 1. (continued)

China	To explore the experiences of older people with sarcopenic obesity during the implementation of dietary behavioural change intervention	Qualitative study	Semi-structured individual interviews	21	Community-dwelling; sarcopenic obesity; mean age 68.19 years (SD 6.30)

3.3. Barriers and facilitators mapped to the COM-B model

Barriers and facilitators mapped to each COM-B component are presented in Table 2 and Table 3 respectively. Physical capability refers to the physical skills, strength, and stamina needed for healthy eating. Barriers included chronic health conditions, chewing difficulties, and fatigue that limited food choices and increased reliance on convenience foods [9, 12]. No facilitator for physical capability was explicitly reported.

Psychological capability involves the knowledge and cognitive skills to understand nutrition information. Barriers included lack of nutritional knowledge, difficulty understanding food labels or online content, limited digital literacy, and underestimating the need for a food diary [9-13]. Facilitators were improved knowledge through education, the ability to distinguish food types, and verification of information through family [9-12].

Physical opportunity is defined as environmental resources such as money, time, and food access. Barriers comprised high food costs, poor availability of fresh vegetables, living alone causing cooking difficulties, abundant unhealthy foods in shops, and the Chinese shared-meal system [9, 10, 12]. Facilitators included affordable and accessible healthy foods, home-grown vegetables, and positive feedback from scales [10, 12].

Social opportunity refers to influence from other people and cultural norms. Barriers involved lack of family support, caregiving for grandchildren, poor caregiver communication, loss of autonomy in food choices, prioritising children's taste preferences, and restrictive cultural norms [9-12]. Facilitators included encouragement from family, support from caregivers or research teams, shared meals, and good communication [9-12].

Reflective motivation involves conscious plans, beliefs, and evaluations. Barriers encompassed declining motivation over time, the belief that change is not worthwhile in old age, lack of clear goals, fear of eating the wrong foods, the belief in not wasting food from past poverty, and misunderstanding of costs in cost-benefit reasoning [9-13]. Facilitators were concern about burdening children, desire to maintain health, attention to body shape, a sense of commitment to research, and positive health feedback [9-11].

Automatic motivation comprises habits and emotions that drive behaviour without conscious thought. Barriers were long-standing eating habits difficult to change, emotional eating triggered by stress, forgetting to keep a food diary, and emotional attachment to food as a source of pleasure [9-12]. Facilitators included turning healthy eating into habits and using a food diary as a daily routine [10, 12].

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Table 2. Barriers to healthy dietary adherence mapped to the COM-B components

COM-B component	Barrier	Supported studies
Physical capability	Chronic health conditions limiting food choices, e.g., diabetes, hypertension, gastrointestinal disorders, pain, dental problems, dementia	[9, 12]
	Chewing or swallowing difficulties preventing consumption of certain healthy foods	[9]
	Fatigue or mobility limitations increasing reliance on convenience foods	[9]
Psychological capability	Lack of nutritional knowledge or misconceptions about healthy diets for older adults	[9-12]
	Difficulty understanding or applying nutrition information, e.g., technical terms, food labels, online misinformation	[9, 11-13]
	Limited digital literacy for using food delivery apps or online health resources	[9]
	Underestimating the need to keep a food diary due to routine eating patterns	[10]
Physical opportunity	High cost of healthy foods or financial constraints	[9, 12]
	Poor availability of fresh vegetables near home	[9]
	Living alone leading to cooking difficulties and food waste	[9]
	Abundant availability of unhealthy foods at home or in supermarkets	[12]
	Chinese shared-meal system making individual portion estimation difficult	[10]
Social opportunity	Lack of support from family members or partners, or provision of unhealthy foods	[9, 11, 12]
	Caregiving responsibilities for grandchildren limiting time for own diet	[10, 11]
	Poor communication with caregivers, including language barriers	[12]

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Table 2. (continued)

	Loss of autonomy in food choices due to others deciding what to cook	[9, 12]
Social opportunity	Prioritising children's or grandchildren's taste preferences over own health needs	[10]
	Cultural norms restricting food choices, e.g., avoiding meat during festivals	[9]
Reflective motivation	Declining motivation and difficulty sustaining dietary discipline over time	[9, 11, 12]
	Belief that changing diet is not worthwhile in old age or that food no longer matters	[11, 12]
	Lack of clear dietary action plans or goals	[10, 11]
	Fear of eating the wrong things leading to anxiety and excessive restriction	[9]
	Belief in not wasting food stemming from past experiences of poverty	[10]
	Misunderstanding of "costs" in cost-benefit reasoning, equating costs mainly with money	[13]
Automatic motivation	Long-standing eating habits that are difficult to change	[10-12]
	Emotional eating triggered by stress or loneliness	[9]
	Forgetting to keep a food diary	[10]
	Emotional attachment to food and pursuit of pleasure from eating	[11]

Table 3. Facilitators to healthy dietary adherence mapped to the COM-B components

COM-B component	Facilitator	Supported studies
Physical capability	Not explicitly reported	
Psychological capability	Improved nutritional knowledge through education, courses, or guidance	[9-12]
	Ability to distinguish food types, e.g., staple vs. non-staple foods, protein sources	[10]

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Table 3. (continued)

Psychological capability	Verification of nutrition information through family or healthcare providers	[9]
Physical opportunity	Affordable and accessible healthy foods, e.g., supermarkets, farmers' markets, delivery services	[12]
	Home-grown vegetables or cellar storage providing fresh ingredients	[12]
	Positive feedback from tools such as food scales or weight scales	[10]
Social opportunity	Encouragement and support from family or friends	[9-12]
	Support from caregivers, instructors, or research teams, including empathy, individualised advice, problem-solving, and continued contact	[10-12]
	Shared meals with family increasing appetite and adherence	[12]
	Good communication and trust with caregivers	[12]
Reflective motivation	Concern that no one would care for them if they fell ill, and reluctance to burden children	[9-11]
	Desire to maintain or improve health, e.g., for grandchildren or better quality of life	[9-11]
	Attention to body shape or appearance, e.g., wearing nice clothes, reducing abdominal fat	[10, 11]
	Sense of commitment and responsibility to scientific research	[11]
Automatic motivation	Positive feedback from health improvements, e.g., weight loss, blood pressure reduction, pain relief	[10, 11]
	Turning healthy eating into habits, e.g., eating vegetables instead of snacks while watching TV	[12]
	Food diary becoming a daily routine, giving structure to retirement life	[10]

3.4. Results of quality appraisal

Using the CASP Qualitative Checklist, the five included studies scored between 8 and 10 out of 10, indicating good methodological quality. Common limitations were insufficient reporting of

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researcher reflexivity and unclear data saturation statements [13]. No study was excluded based on quality alone.

3.5. From barriers to intervention targets

To translate the identified barriers into actionable intervention strategies, the BCW framework was used [8]. For each COM-B component, the most relevant intervention functions were selected based on the BCW principles. Each intervention function was then linked to illustrative BCTs from the BCT Taxonomy v1 [14]. This mapping is descriptive and theory-driven, aiming to inform the design of future dietary interventions for community-dwelling older adults. It does not prescribe specific interventions but rather highlights potential targets for behaviour change. The complete mapping is presented in Table 4.

Table 4. Mapping of COM-B barriers to intervention functions and example BCTs

COM-B barrier dimension	BCW intervention functions	Example BCTs
Physical capability	Training, Enablement	4.1 Instruction on how to perform the behaviour; 8.1 Behavioural practice/rehearsal
Psychological capability	Education, Training	5.1 Information about health consequences; 4.1 Instruction on how to perform a behaviour
Physical opportunity	Environmental restructuring, Enablement	12.1 Restructuring the physical environment; 12.5 Adding objects to the environment
Social opportunity	Environmental restructuring, Modelling	6.1 Demonstration of the behaviour; 12.3 Restructuring the social environment
Reflective motivation	Education, Persuasion, Incentivisation	1.1 Goal setting (behaviour); 1.2 Problem solving; 5.1 Information about health consequences
Automatic motivation	Incentivisation, Modelling, Restructuring	8.2 Behaviour substitution; 11.2 Reduce negative emotions; 7.1 Prompts/cues

4. Discussion

4.1. Confidence in the evidence

The Grading of Recommendations Assessment, Development and Evaluation Confidence in the Evidence from Reviews of Qualitative research (GRADE-CERQual) approach was used to assess confidence in four core review findings [15]. The first finding was that lack of nutritional knowledge and difficulty understanding or applying nutrition information are barriers to healthy dietary adherence, supported by five studies [9-13]. The second finding was that long-standing eating habits, emotional attachment to food, and emotional eating are barriers, reported in four studies [9-12]. The third finding was that encouragement and support from family members, friends, caregivers, or research teams facilitates healthy dietary adherence, also supported by four studies [9-12]. The fourth finding was that concerns about burdening children, desire to maintain health, attention to body shape, and positive health feedback are reflective motivation facilitators, found in three studies [9-11].

A summary of the four findings and their CERQual assessments is provided in Table 5. Methodological limitations were moderate concerns for all four findings due to insufficient reporting of researcher reflexivity and predominantly female samples. Coherence was a minor concern for

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each finding, as the results were consistently reported across studies without contradictory data. Adequacy of data was a minor concern for the first three findings with four or five studies each, but moderate concern for the fourth finding with only three studies. Relevance was a minor concern for all findings because every included study directly matched the review population of community-dwelling older adults. Based on these assessments, all four findings received an overall moderate confidence rating. This indicates each finding is likely to be a reasonable representation of the phenomenon of interest, although some uncertainty remains.

Table 5. Summary of qualitative findings and CERQual assessments

Review finding	COM-B component	Supporting studies	Methodological limitations	Coherence	Adequacy of data	Relevance	Overall confidence
Lack of nutritional knowledge and difficulty understanding or applying nutrition information	Psychological capability barrier	[9-13]	Moderate concerns	Minor concerns	Minor concerns	Minor concerns	Moderate
Long-standing eating habits, emotional attachment to food, and emotional eating	Automatic motivation barrier	[9-12]	Moderate concerns	Minor concerns	Minor concerns	Minor concerns	Moderate
Encouragement and support from family members, friends, caregivers, or research teams	Social opportunity facilitator	[9-12]	Moderate concerns	Minor concerns	Minor concerns	Minor concerns	Moderate

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Table 5. (continued)

Concerns about burdening children, desire to maintain health, attention to body shape, and positive health feedback	Reflective motivation facilitator	[9-11]	Moderate concerns	Minor concerns	Moderate concerns	Minor concerns	Moderate

4.2. Comparison with existing reviews

Walker-Clarke et al. listed factors such as social support, eating alone and long-standing eating habits [4]. These factors were presented descriptively without explaining how they influence behaviour. This synthesis confirms these factors are important but explains them differently. Social support is placed in social opportunity. Eating alone is placed in physical opportunity. Long-standing eating habits are placed in automatic motivation. This matters because each component requires a different intervention. Social opportunity needs environmental restructuring. Physical opportunity needs adding objects to the environment. Automatic motivation needs habit substitution. Walker-Clarke et al. did not map their factors to intervention functions. This synthesis connects each factor to a specific intervention function from the BCW.

Chen et al. grouped lack of nutritional knowledge and lack of interest or low motivation as individual-level attitudes [5]. The socio-ecological model does not separate these two types of factors. This synthesis separates them. Lack of nutritional knowledge is psychological capability. Lack of interest or low motivation is reflective motivation. This separation matters because psychological capability requires education and training. Reflective motivation requires persuasion and goal setting. These two intervention functions are different. Chen et al. treated both deficits as a single category. This synthesis draws a clear line between psychological capability and reflective motivation and then attaches BCTs to each separately.

4.3. Limitations

Several limitations of this paper should be acknowledged. The discussion is organised into three distinct areas: methodological implementation, the evidence base and transferability of findings. The paper has several methodological implementation limitations. First, the search was restricted to three databases and did not include grey literature such as conference proceedings or dissertations, which may have resulted in the omission of relevant studies. Second, only English-language publications were included, which may have excluded relevant non-English studies and biased the findings towards English-speaking contexts. Third, the search time frame was limited to publications released between May 2021 and May 2026, excluding earlier high-quality studies and potentially missing valuable evidence. Fourth, study screening, data extraction, and quality appraisal were performed by

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a single reviewer rather than by two independent reviewers, which may have increased the risk of selection bias and coding errors.

The evidence base itself also presented several constraints. Firstly, only five studies met the inclusion criteria, which limits the volume of evidence available for synthesis and precludes any meaningful exploration of publication or dissemination bias. Secondly, three of these five studies recruited participants with specific health conditions, which means that some identified barriers and facilitators may not fully represent generally healthy community-dwelling older adults. Thirdly, the majority of participants across studies were female, with one study including only women, which limits the review's ability to capture barriers and facilitators specific to older men. Fourthly, most study samples were relatively well educated, particularly the US sample, which may have influenced the reported ease of understanding nutrition information and the perceived acceptability of dietary interventions.

The transferability of the findings to other contexts is limited. Specifically, all included studies were conducted in upper-middle-or-high-income countries, so the findings may have limited direct applicability to low-income settings. Moreover, culturally specific barriers identified in the review, such as the Chinese shared meal system or the Mediterranean emphasis on family support, may not generalise to populations with different dietary traditions or family dynamics. Additionally, socioeconomic factors, including access to affordable healthy foods and digital infrastructure for online food delivery, vary considerably across countries, which means that physical opportunity barriers such as food cost and access may be more or less relevant depending on a country's economic context and digital infrastructure.

4.4. Implications

4.4.1. Implications for practice and policy

The GRADE-CERQual assessments confirmed moderate overall confidence for the two barrier findings. Within this level, two additional criteria guided the priority ranking: the number of supporting studies and cross-cultural consistency. These criteria, together with the moderate confidence level, help prioritise which barriers to address in practice and policy.

The highest priority is lack of nutritional knowledge and difficulty understanding or applying nutrition information, supported by five studies from four countries. The most relevant intervention functions are education and training. The BCTs are 5.1 Information about health consequences and 4.1 Instruction on how to perform a behaviour. For individual older adults, instruction on how to perform healthy eating behaviours can be delivered through hands-on workshops. Older adults can practise reading food labels and estimating portion sizes using real food packages. This applies technique 4.1. For community health services, group-based nutrition courses should provide information about health consequences of poor diet in older age. Explaining how inadequate protein intake leads to muscle loss and falls helps older adults understand why change matters. This uses technique 5.1. For policymakers, funding for digital literacy training is needed. Many older adults cannot use food delivery applications or online health information. Removing this digital barrier improves access to healthy food options, supporting the delivery of techniques 4.1 and 5.1.

The second priority is long-standing eating habits, emotional attachment to food, and emotional eating, supported by four studies from three countries. The appropriate intervention functions are incentivisation, modelling, and restructuring. The BCTs are 8.2 Behaviour substitution, 11.2 Reduce negative emotions, and 7.1 Prompts or cues. For individual older adults, habit replacement strategies can be introduced. Replacing a familiar unhealthy snack with a healthy alternative, such as eating

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cherry tomatoes instead of crisps while watching television, is one example using technique 8.2. Visual reminders, such as a sticky note on the refrigerator saying vegetables first, serve as prompts or cues to trigger the new routine using technique 7.1. For healthcare providers, emotional eating requires reducing negative emotions. Brief stress management counselling helps older adults recognise emotional hunger and use non-food coping strategies such as calling a friend or taking a short walk. This uses technique 11.2. For policy makers, funding for community-based mental health and social connection programmes can be prioritised. Subsidising group exercise classes or social dining clubs for older adults creates environments that naturally reduce emotional eating triggers, indirectly supporting techniques 11.2 and 8.2.

4.4.2. Implications for future research

Future research should address the methodological, evidence base, and transferability limitations identified in this review. Methodologically, subsequent qualitative evidence syntheses should adopt broader search strategies including non-English publications and grey literature, extend the search time frame, and use independent dual reviewer screening to reduce bias. Regarding the evidence base, primary studies need more diverse samples. Older men, generally healthy older adults, and individuals with lower educational backgrounds are underrepresented. Larger sample sizes would also enable meaningful exploration of publication or dissemination bias.

For transferability, research from low-income countries and cross-cultural comparative studies are needed. Randomised controlled trials comparing combinations of intervention functions will help identify the most efficient approaches. Subsequently, intervention research should test the recommended BCTs in different cultural and socioeconomic settings. Finally, digital tools should be designed to support older adults with limited digital literacy rather than assuming universal online access.

5. Conclusion

This qualitative evidence synthesis identified barriers and facilitators to healthy dietary adherence among community-dwelling older adults using the COM-B model. Five studies from four countries were included. The most frequently reported barrier was lack of nutritional knowledge and difficulty understanding or applying nutrition information. The second most common barrier was long-standing eating habits, emotional attachment to food, and emotional eating. Key facilitators included encouragement and support from family members, friends, caregivers, or research teams, as well as concerns about burdening children, desire to maintain health, attention to body shape, and positive health feedback.

The COM-B model proved useful for organising diverse qualitative evidence. Mapping the identified barriers to BCW intervention functions and BCTs provided a theory-driven pathway for intervention design. The highest priority for future interventions should be improving psychological capability through education and training, followed by addressing automatic motivation through habit substitution and reducing emotional eating.

All four core review findings received a moderate confidence rating from the GRADE-CERQual assessment. This indicates they are likely to be reasonable representations of the phenomena of interest, though some uncertainty remains. However, the review has several limitations. Only five studies met the inclusion criteria. The search was restricted to English-language publications and three databases. Most participants were female and well educated, and all studies came from upper-middle-or-high-income countries.

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These limitations directly inform future research priorities. Future qualitative syntheses should include non-English and grey literature and use independent dual reviewer screening. Primary studies must recruit more diverse samples, specifically older men, generally healthy older adults, and individuals with lower education. Research from low-income countries is urgently needed to test transferability. Intervention studies should evaluate the recommended BCTs across different cultural and economic settings. Overall, this synthesis provides an evidence-based foundation for designing interventions to support healthy eating in later life.

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