Self-Care Behaviour In Health Of The Elderly In Viet Nam

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ABSTRACT

This study aimed to examine the behaviors of self-care in health of the elderly in Viet Nam in the current period. The study was performed on 600 elder people from 6 different provinces and cities, in three areas : the North, the Centre and the South of the country. Results of data analysis showed three types of health care behaviors of the elderly in Viet Nam which are responsible, vague and abandoned self-care . The processes and data analysis also show the statistically significant differences in this self-care behaviors by gender, age, living situation, education as well as the work currently that the elderly are assumed.

Introduction

According to the survey results of the General Statistics Office in Viet Nam, the percentage of population aged 60 and above in 2010 is 9,3 %, in 2011 is 9,8 %, in 2012 is 10,2 % and this ratio is predicted to be 20,7 % and 24,8% in 2040 and in 2049 respectively. The index showed that Viet Nam is entering the aging period and the number of elder people is growing quickly. The Goverment had specific and practical policies for the elderly, the attention of social organizations, unions, community and the whole society have contributed to improve the material and spiritual life for them. However, as most of the elderly today are living in villages and were born in wartime, they did not have health protection (70% of them do not have savings and 62,3% of them are in difficult situations). Despite the high average age of death (73 years old), the burden of illness of Vietnam is also high (WHO, 2009). Most of the elderly people in VietNam need taking care of when they are aged, sick and diseased. Meeting these needs of the elderly requires a combination of care assistants who are aware of the elderly psychology, and the elderly's proactiveness in regulating their daily self-care behaviors.

In recent years, many elderly studies in Viet Nam and other countries have focused on the elderly themselves and their relations with the systems of health care and support. The issue of self-care of the elderly is also considered essential because not only the needs of elderly people are met but also the health care effectiveness is increased, reducing the cost of health care services for the society as well as the elderly. In the study titled "National Survey On Self-Care And Old Age" by the University North Carolina at Chapel Hill performed in 1990-199 on the number of object of 3.485 people aged 65 and above, The authors have focused on self-care behaviors of this object group with two main types of behaviour, which are reducing health impairment behavior, prevention and health promotion, healthy lifestyle practices. Sharing the same opinion with this author, Backman (2001) has developed models of self-care of the home-dwelling elderly in Oulu, Finland. Theoretical models that the author based on consist of 4 categories – self-care methods in different situation with different activities and meanings: responsible self-care, (formally) guided self-care, independent self-care and abandoned self-care (Backman & Hentinen, 1999). Each type included a kind of self-care behavior, living experiences and specific future orientation.

The theory is also shows the relation between the functional ability and self-care, satisfaction in life and self-care, self-respect and self-care. Two authors, Backman & Hentinen (2001) pointed out the two major trends of recognized self-care behavior, which are *internal, unambiguous self-care and external, ambiguous self-care. The types of responsible self-care and independent self-care represent the internal, unambiguous self-care. The types of guided self-care (formal) and abandoned self-care represent the external, ambiguous self-care. Specifically: Responsible self-care involves implementation and responsibility in all activities of daily life and also health care and sickness. A prerequisite of responsible self-care is a positive orientation toward future and a positive experience of aging. They also believe in the future and think that when they need help from others they will get it; formally guided self-care includes the implementation of usual uncriticising of medical guidelines and normal activities of daily work. The elderly do what they are told without knowing the reasons. Guided self-care (formal) based on living experiences of self-care of others (Backman & Hentinen 2001); independent self-care is based on the desire to listen to the inner feelings of elderly people.* They followed the way of care of daily activities, health and disease in its earliest. Prerequisite of independent self-care is the purpose of independent life management (Backman & Hentinen 2001). Abandoned self-care is characterized by inability and irresponsibility. Elderly people are not interested in themselves. They did not have capable of managing daily activities. They feel powerless because of various reasons (Backman & Hentinen 2001). Based on studies of Backman and colleagues, Danica Zeleznik (2007) conducted a study on behavior of health self-care of the home-dwelling elderly in Slovenia. The study deal with two main topics : Behaviors of health decline self-prevention relating to medical knowledge and response to health issues and health promotion behaviors relating to physical exercise, communication, working, entertainment, community activities. We realized that types of behavior of health care given by Backman and colleagues as well as by Zeleznik are quite common behaviours among the elderly generally, absolutely suitable for implementing the study on the elderly people group in Viet Nam. Accordingly, we supposed that elderly people in Viet Nam are also perfomed two types of health self-care behavior is responsible self-care and vague self-care.

The concept of self-care

World Health Organization (WHO) has warned people of look after their health, live healthy without medicine for three measures: Proper nutrition, exercise and uphold personal responsibility in life. Old age is often associated with weakness. In the old age, the happiest is to live healthy, live long and live usefully. Health created other pleasure. Knowing how to take care of health is a necessary for everyone, especially for elderly people.

Self-care is a relatively common term in the field of health care. Healthy expert and also pathological expert have accepted self-care as a measure to compensate for medical health problem consciously (DeFriese, Woomert, Guid, Steckler & Konrad, 1989). Then, this term is used as expanded meaning as the participation role of those who did not have expertise in shaping the processes and results of care they recieved from the experts, an ex-

panded role in self-managment of chronic diseases.

In 1983, the World Health Organization (WHO) defined "selcare in health refers to the activities individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals". According to Slovar Slovenskega (2005), self-care means taking care of yourself. Self-care is the part of personal lifestyle which shaped by values and beliefs acquired from specific cultures. Backman & Hentinen (1999) argued that self-care seems to be connected with personal knowledge of elderly men or women. Self-care is personal care that each person need to regulate the functions and the development of their own everyday (Goldstein & al.,1983; Orem and al., 2001; Allender & Spradley, 2001). Self-care is considered to be a critical element to the problem of health care and disease prevention (Aggleton & Chalmers 1985, Orem 1991, Toljiamo & Hentinen 2001, William 2004).

Self-care concerned quite closely with gender, age and education level: According to Lantz (1985), most of documents showed that women tend to take self-care better than men do and women feel herself in good or very good health, they are characterized by self-disclosured/expressed happiness at a high level. This has been recognized by Whetstone & Reid (1991) that women's views about clinical health are more related to them than to men. Elderly men tend to reporttheir health more poorly than elderly women and young people do in similar health conditions. Other data supported view that the elderly have a more pessimistic view of health than young people do. Poor education and social economy are connected to poor perception of health (Allardt, 1993; Miller & al., 1996; Amaducci, 1997; Kivinen & al, 1998; Sabovic, 2004). In addition, for the people who have a high level of education, the access and the cognition of self-care in health are likely to have more advantages.

Method.

Sampling

The population of this study consists of 600 elderly people (from 60 to 80 years-old) who now living in 6 provinces/ cities of Viet Nam (Ha Noi, Thai Binh, Nghe An, Khanh Hoa, Ho Chi Minh, Kien Giang). These provinces/cities repesent three regions within Vietnam (Northern, Central and Southern). The data obtained does not show the statistically significant differences of the age (p>0.05). The demographic characteristic of the sample are represented in Table 1:

Table 1: Background information of inquiry participants

demographic characteristics	Criterions	N	%
Age	60-65	248	41.3
	65-75	308	51.3
	>75	44	7.3
Living situation	Live alone	26	4.3
	Live with wife/ husband	152	25.3
	Live with wife/ husband and children	311	51.8
	Live with children	82	13.7
	Live with relatives	7	1.2
	Live with friends	22	3.7

Sex	Male	444	74.0
	Female	156	26.0
Current work	Manual work	162	27.0
	Intellectual work	134	22.3
	Housekeeping	213	35.5
Educational background	No diploma	93	15.5
	Primary school	78	13.0
	Secondary school	240	40.0
	High school	86	14.3
	Vocational school/ College	92	15.3
	University and higher	11	1.8

Materials

Base on Backman's theory of home self-healthcare (2001) and Danica Zeleznik's research of self-care of the home-dwelling elderly people living in Slovakia, we built a measure of self-healthcare behaviors of the home-dwelling ederly people living in Viet Nam. This measure include of 2 subscales: the vague self-healthcare behaviors relating to medical knowledge, the ways of response to healthy problems; the responsible self-healthcare behaviors relating to the practice, communication, work, hobbies and social works.

The measure includes 72 items (according to Likert measure) divided into 2 subscales as we know. One subscale contains 36 items- 18 positive items and 18 negative items. It permits us to get the general score of self-healthcare behaviors of ederly people and 2 component score of 2 subscales which we have mentioned.

The process of verifying and building this scale has been made in the investigation on the first participants test can be 292 vietnamese elderly people, aging from 60 to 82 years-old, including 182 males (62.3%) and 110 females (37.7%). Before analyzing factors, all negative items' ve coded inversely. All the items whose loaded coefficient <0.4 have rejected (Burn & Grove 2005). We collect 28 items (loaded coefficient over 0.4) and 3 main factors after analyzing factors by varimax rotation method. Based on items's content, the factors've called by vague self-care behavior, responsible self-care behavior, abandoned self-care behavior (independent of 2 others factors).

These 3 factors accounted for 56.61% of the variance in the component solution. The Kaiser-Meyer-Olkin (KMO) is 0.55, the Bartlett's result test is 0.000 and the Cronbach's alpha coefficient for the total scale is 0.84. For each subscale (component), this coefficient follows: α = 0.85 for responsible self-care behavior, 0.86 for vague self-care behavior, 0.74 for abandoned self-care behavior. The values of Cronbach's alpha coefficient showed high reliability (internal consistency reliability) of the scale. So we decide to use this 28 items-scale for the official sample group of research.

To confirm the structure of the scales obtained above, we conducted a formal investigation on the 600 participants who are Vietnamese elderly people, including 444 males (74%) and 156 females (26%). The analytical results confirmed the reliability of the scale obtained (α= 0.87 for the total score). Loading factors're displayed in Table 2 :

Table 2 : Loaded factors after using varimax rotation method

No	Items	Components		
		Responsible self-care	Vague self-care	Abandoned self-care
1	Talking about passed events with others	.584		
2	Consulting the medical staff when need help		.841	
3	Doing what you like		.840	
4	Adhering to instructions of doctors in the use of medicines	.459	.650	
5	Easy- going of taking medicine/medicines used freely			.593
6	Just following the treatment that the doctor has given		.820	
7	Learning about health issues		.758	
8	Like talking, sharing with others	.619		
9	Always base on beautiful days in the past to be more confident when the personal life is dificult		.620	
10	Accepting things will come in the future		.543	
11	Trying to make the individual needs even when the disease appears		.591	
12	Participate in various activities to be happier life	.516		-.456
13	Stay at home, even though the disease has progressed any way			.696
14	There are not enough health to do anything			.782
15	Don't do anything for the future			.772
16	Search the information that relate with self- health	.581		
17	Excerise and sport	.700	.499	
18	Participate in community activities of elderly-people	.880		
19	Helping others in the possibility of self	.686		
20	Periodic health checking	.791		
21	Go to the hospital or medical facility for health checks	.714		
22	Not spend time for self			.510
23	Behave with other adequately		.530	
24	Don't overwork	.542	.644	
25	Participate in charity works		.604	
26	Helping children / grandchildren in the family	.811		
27	Travel, relax	.703		
28	Use of folk remedies of traditional clinics to improve health	.493		
Extraction Method: Principal component Analysis Rotation Method: Varimax with Kaiser Normalization a.Rotation converged in 6 iterations				

Base on items's contents of each factor, we get 3 factors with items such as:

Responsible self-care: Items 1, 8, 12, 16, 17, 18, 19, 20, 21, 26, 27, 28 (α = 0,88)

Vague self-care: Items 2, 3, 4, 6, 7, 9, 10, 11, 23, 24, 25 (α = 0,88)

- Abandoned self-care: Items 5, 13, 14, 15, 22 (α = 0,77)

Methodology
The choice of method
Research about the self-care behavior of people in general and elderly people in particular always make the researchers met difficult in the choice of research method suitable because of the diversity and complexity of the research problem. Therefore, we have decided to choose the cross - sectional study.

Quantitative research methods were used as the main methods of this research, allowing to elucidate self-care behavior of the elders as well as their relationship with the independent variables such as age, gender, living situation, work and educational leve. With a reliable material, this research method allows to apply on a large number of population and to calculate the possible influences between the variables.

Besides, this study also used qualitative research methods to complete the lacune of quantitative research methods, making the research results more reliable.

The process
All samples of the research are selected randomly with the support of the elderes'club in every provinces/cities and also the districts where the study to be investigated. The participants must meet the following criteria:

1. The person is over 60 years old
2. The person does not have a profound hearing problem
3. The person does not have a severe mental problem

The person volunteers to answer the questionnaire without incurring any strings attached. For those who may have difficulty in reading and writing, we help them to read each question and write down the answers directly to the questionnaire on their behalf. In other words, we are always disponible at the moment when the elders answer the questionnaire to assist them when needed. In the process of answering the questionnaire, if the person could find it difficult (tired, no time ...) and do not want

to continue to complete it, we respect their decision.

The confidentiality of the information obtained is guaranteed. The participation of the elder in research is anonymous.

Data analysis.

Statistical calculations were performed using SPSS (Statistical Package for the Social Sciences) version 16.0. We can say that SPSS supports all the statistical methods used in this research. Specifically, we have used the descriptive statistical analysis to calculate the average score, percentage data analysis as well as the statistical inference to understand the correlation, the nexus that may appear between the variables of the research. Factor analysis method was also used as one of the main research method.

Results

The correlation between the dimensions of self-care behavior of the eldes in Vietnam.

The data in Table 3 shows the correlation with statistical significance between the dimensions of self-care behavior of the elders in Vietnam and this behavior in general, knowing that this is a very significant relationship for responsible self-care behaviors (r=0.77; p<0.001) and vague self-care behaviors (r = 0.84; p <0.001). However, the result does not recognize the correlation with statistical significance between abandoned self-care behavior and responsible self-care behavior (r = -0.007, p> 005). This is similar to the vague self-care behavior (r = -0.092, p <0.005). We believe that this result can be fully explained because, as we mentioned above, initially, the authors has the desire to set a scale of elders' self-care behavior with two sub-scales which rer-esponsible self-care behavior and vague self-care behavior. However, based on the results of the factor analysis, we believe that it would be more objective and rational to accept the scale of 3 sub-scales, in which, all the negative items would be in the third sub-scale (nominated "abandoned self-care behavior). Therefore, it is absolutely logical that the research results do not indicate the correlation with statistical significance between the 2 level of self-care behavior (responbible and vague) and this dimension of self-care mentioned "abandoned".

Table 3: Correlation between the dimensions of behavioral health self-care for the elderly

		Self-care behavior in general	Abandoned self-care behavior	Vague self-care behavior	Responsible self-care behavior
Self-care behavior in general	r (Pearson)	1	.305**	.767**	.841**
	Sig. (2-tailed)		.000	.000	.000
	N	600	600	600	600
Abandoned self-care behavior	r (Pearson)	.305**	1	-.092*	-.007
	Sig. (2-tailed)	.000		.024	.871
	N	600	600	600	600
Vague self-care behavior	r (Pearson)	.767**	-.092*	1	.487**
	Sig. (2-tailed)	.000	.024		.000
	N	600	600	600	600
Responsible self-care behavior	r (Pearson)	.841**	-.007	.487**	1
	Sig. (2-tailed)	.000	.871	.000	
	N	600	600	600	600

**. Correlation is significative at 0.01 (2-tailed).
*. Correlation is significative at 0.05 (2-tailed).

Elders' self-care behavior in Vietnam by gender, age, current work, education background and life circumstances.

Self-care behavior in health and gender

To figure out the difference between male and female in self-care behavior in health, the t-test was conducted for each dimension of the self-care behavior of elders in particular, as well as

the self-care behavior in general. The results of this analyse are shown in Table 4:

Table 4: Self-care behavior and gender

	Male (N=444) Mean (Ecart-type)	Female (n=156) Mean (Ecart-type)	t
Self-care behavior in general	72.7 (8.3)	75.9 (6.2)	5.18**
Responsible self-care behavior	31.4 (5.1)	33.03 (2.9)	4.81**
Vague self-care behavior	29.3 (4.4)	30.9 (2.5)	5.66**
Abandoned self-care behavior	11.9 (2.9)	11.9 (2.6)	0.15*

*p>0.05; **p<0.001

In general, we found that older women in Vietnam tend to perform more positive self-care behavior than men do. Compared to this group, women show that they pay more attention to responsible self-care behavior as well as vague self-care behavior. This reflects the reality that the more woman get older the more they express their particular attention to the weakening of the body, the change of their appearance, therefore they often worry about their own health more than men do. In addition, the result also show once again that women feel easier to share their thoughts, their emotions, as well as to participate in community activities (responsible self-care behaviors): "my husband can stay at home all day reading newspapers, but I must see my friend, or other housewives in the neighbor", "I have to speak out loud the thing that annoys me, or else, I can't be relaxtive".... The same thing happens with the vague self-care behavior. We easily reached consensus that women tend to obey/ follow the instructions of others than men. Therefore, it is a general trend of gender that they follow the instructions of their doctor when they have health problems. Some of them even "uncritically believe and follow what the doctor says," without any question because "although doctor have explained, it's always difficult for me to understand my disease so many time, it's better to do what he says ".

The data in Table 4 does not indicate the difference with statical signifiance between men and women for the abandoned self-care behavior (p> 0.05).

Self-care behavior in health and age

Medicine has stated that: people can not help being older, human aging is inevitable, also there has not been any way to achieve "immortality", but health care and improvement of the capacity of adaptation will slow down the aging process. Status of the aging period is determined by the physiological – psychological activities of individuals. According to age groups, do Vietnamese elderly have differences in health care behaviors or not? The analysis of variance (ANOVA) allows us to affirm that there are the differences significatives in health care behaviors according to age of sample of this research (F = 19,635; p <0.001).

Table 5: Comparison of mean of the self health care behaviors of the elderly with age

	Age	N	Mean	Ecart-type	F	Sig.
General self health care behaviors	55-65	248	75.80	6.707	19.635	0,000
	55-60	308	71.71	8.230		
	>75	44	73.02	8.481		
	Total	600	73.50	7.891		

In other words, the age of Vietnamese elderly seem to have a major impact on their self health care behaviors. The elderly of group age from 55 to 65 admitted that they have more responsible and vague self care behaviors than the other age groups do. Subjects aged from 65 to 75 seem to pay the least attention to self health care issues. Which means these people barely involved in community activities, rest and recreation; at the same time, they also make less use of health services than the other age groups do. We expect to find a reasonable answer for the results of this study based on the specific terms of Vietnamese culture. Accordingly, the elderly in this age mostly play the role of "grandparent" in their family. As grandparents, they spend all the time caring for their children while their parents are in their work time. Grandparents simultaneously undertake the housework to help their own children. Therefore, they do not have much time left to take care of themselves. Moreover, in Vietnam, almost of the elderly consider supporting their children and grandchildren is their responsibilities and joys in life. This way of thinking has been passed down from generations to generations and continues to be inherited and developed by recent Vietnamese elderly.

In order to offer a more specific look to the results obtained above, we also conducted an analysis of variance for each aspect of seft health care behaviors for the elderly. The results obtained are presented in the Table 6 below:

Table 6: Comparison of mean of aspects of seft health care behaviors of the elderly with age

Seft care behaviors	Age	N	Mean	Ecart-type	F	Sig.
Responsible	55-65	248	33.18	2.73	18.53	0.000
	55-60	308	30.89	5.47		
	>75	44	30.81	5.73		
	Total	600	31.84	4.69		
Vague	55-65	248	29.58	4.98	0.66	0.515
	65-75	308	29.86	3.05		
	>75	44	29.23	4.01		
	Total	600	29.70	4.03		
Abandoned	55-65	248	13.03	1.95	46.73	0.000
	65-75	308	10.96	3.18		
	>75	44	12.97	0.98		
	Total	600	11.97	2.81		

From the data in the table 6, we discovered that age did not seem to affect all aspects of self health care behaviors of Vietnamese elderly. Specifically, these behaviors were different according to age groups on the aspect of responsible self care behavior (F = 18:53; p <0.001) as well as abandoned self care behavior (F = 46.73; p <0001), by contrast, we do not recognize any statistically significant difference between different age groups on the aspect of vague self health care behaviors (F = 0.66; p> 0.05).

Self health care behaviors and current work

The comparison of means allows us to recognize the statistically significant difference between self health care behaviors of the elderly and their current work at the time of the survey. This difference is reflected in the self health care behaviors in general and in each particular aspect.

Table 7: Mean comparison of self health care behaviors of Vietnamese elderly and their current work

Current work		Self care behaviors			
		Responsible	Vague	Abandoned	General
Manual work	Mean	30.98	28.38	12.37	71.74
	N	162	162	162	162
	Ecart-type	5.06	5.74	2.02	8.04
Intellectual work	Mean	32.72	30.09	12.12	74.94
	N	134	134	134	134
	Ecart-type	4.39	2.98	2.47	8.02
House work	Mean	31.91	30.21	11.10	73.23
	N	213	213	213	213
	Ecart-type	3.56	2.47	3.52	6.34
Total	Mean	31.83	29.60	11.77	73.20
	N	509	509	509	509
	Ecart-type	4.34	4.00	2.89	7.45
p		0.003	0.000	0.000	0.001

From the date results presented in Table 7, we discovered that Vietnamese elderly who are doing intellectual work (officers of "association elderly", ward staff....) at the time of the survey tend to practice self health care behaviors more positively than other groups. The elderly who are doing manual work rate themselves weakest in the implementation of self health care behaviors.

Specifically, the data showed that the elderly are doing the intellectual work which is clearly expressed in responsible self-care behaviors for health compared to two other groups: "I take physical examination annually to follow up the health status of myself ", "I think that if the elderly don't participate in community activities, exercise and sports, they can not be happy and healthy ".... Elderly who stay at home doing house work recognize themselves that they have a bias towards vague self-care behaviors in this area. For abandoned self-care behaviors, research results indicate that the elderly are doing the manual work carrying out these acts clearly than others. We came up with this research results because when elderly does their manual work (in the fields, breeding, etc), they have no favorable conditions to be interested in taking care of their own health. Once they get sick or diseases, it will be more simple for them to stay at home, buy medicine by themselves and use medication following what they see in their experiences: "If I make the consultation to doctor and discover my sickness without running cure, I will not be comfortable, but if I get cured who will do the work? ". Meanwhile, elderly staying at home doing housework have more time to take care of their health. They often visit health facilities and follow the instructions of the medical staff when they have health problems. Completely different to the groups who still perform manual labor job or stay at home doing housework, groups who are doing the intellectual work have more opportunities to interact with other people and entertain. Therefore, they have more opportunities to practice responsible self-care behaviors for health themselves in order to have a better life.

Self-care health behaviors and education background.

To verify the possible effects of education background on health self-care behaviors of Vietnamese elderly, we continue to conduct an analysis of variance (ANOVA) to these variables. Results are presented in Table 8 below:

Table 8: Comparison of mean between health self-care behaviors of elderly and education background

	Education background	N	Mean	Ecart-type	F	Sig.
Self-care behaviors in general	No qualifications	93	75.21	9.79	2.76	0.018
	Elementary	78	71.11	8.25		
	Secondary	240	73.55	6.67		
	High School	86	74.09	6.44		
	Vocational and college	92	72.80	9.47		
	Undergraduate and postgraduate	11	75.72	2.61		
	Total	600	73.50	7.89		

The results presented in Table 8 shows the significant statistical difference between health self-care behaviors of the elderly and their education level (F = 2.76; p <0.05). In particular, we recorded an average score nearly equal to 2 groups "not qualified" and "undergraduate and postgraduate". Is this an illogical result? We believe the answer is found in the specific culture and history of Vietnam. Accordingly, we find that the current Vietnamese elderly in general as well as the population of this research in particular was mainly born and grew up during the war time. At that time, they couldn't afford to go to school (if they could, they can only enter in academic popular class – *lop học bình dân*

học vụ). With self-learning efforts, they could read and write at a certain level, but they did not have qualifications recognized by the educational system of the country. However, that does not mean they do not have the knowledge, especially in the field of health care. In contrast, perhaps they have no qualifications then sometimes they are afraid of being sick, afraid to act against the instructions of the doctor and the medical staff in general.

Health self-care behaviors and living circumstance.

Table 9: Comparison of mean between elderly' health self-care behaviors and their living circumstance

Self-care behaviors in general	Living circumstance	N	Mean	Ecart-type	F	Sig.
	Living alone	26	72.81	11.64		
	Living with husband/wife	152	74.69	5.43		
	Living with husband/wife and children	311	73.68	8.44		
	Living with children	82	69.69	8.16		
	Living with relatives	7	82.00	0.00		
	Living with friends	22	75.00	0.00		
	Total	600	73.80	7.89	6.66	0.000

The results presented in Table 9 shows the significant statistical difference between health self-care behaviors of the elderly and their living circumstance (F=6.66; p<0.001).

Data in Table 9 indicate that the group of elderly living with rela- tives/friends tends to care more positive, in stark contrast to the group living with children. We found that although there have been certain changes in the Vietnamese family's structure today but apparently the trend of a traditional family still reigns. Accordingly, Vietnameses generations often live together under one roof. Taking care of their parents is one of the child's responsibilities. Therefore, while living with their child, Vietnamese elderly believe that they have a solid mental and physic support when they get sick. This is completely different to the group of people living together with relatives / friends. For this group, they are afraid to be dependent on others. So, they are really paying attention to their health and practicing health self-care the most positive: *"I do not have children so I live with my sister and her family. I always try my best to stay healthy. It is embarrassed only to think that you make others to serve you when you get sick."*

Discussions
Our research aims to understand the health self-care behaiors of the Vietnamese elderly living at home as well as factors related to these behaviors. We have tried to collect data from the different regions of the country in order to obtain the most objective and reliable data. We found that the results reflect the actual diversity, rich in behavioral health care of Vietnamese Elderly at the present. While the majority of the documents about the health care of the elderly in Vietnam belong to the fields of medicine, gerontology, sociology, results of this study contribute to complete the system of research on the elderly in the domain of psychology in the world in general and in Vietnam in particular. However, we also realize that these are preliminary results of this field in Vietnam. The research results will be much more objective if done on a larger number of sample.

Acknowledgement

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