
Risk Behaviors in Adolescents: The Need of a Prevention Model

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Abstract

BACKGROUND

THE ADOLESCENCE - A RISK PERIOD FOR THE HEALTH

The implications of larger aspect with relationship to the health in the course of the adolescence are intimately there related with the transformations verified. The apparent health, that is to say physical development collides with the capacities and psychological characteristics that not always they walk to pair and step (1). However, the whole change constitutes a stressor, that is to say, something that demands an individual's adaptation, mainly if those alterations are lived as menaces to the balance and well to be of the precedent years (1).

Many important behaviours for the health are really begun in this time of the life (2), just as the sexual activity, the alimentary choices and of physical exercise, the consumption of toxins and the conduction of vehicles. And healthy behaviours as these the primary contributions for the disease and mortality in the adolescence (2), it is necessary to refer that many of the attributes psychosocial that regulate the occurrence of the behaviours related with the health are also acquired or consolidated during the adolescence (3).

The change of the illustrations relates during the adolescence also has fundamental importance for the health (4). The behaviours start to have a more significant paper, when compared the parents' influences or other adults. More and more, there is an access more facilitated to materials and harmful substances to the health as the drug, the tobacco, the alcohol, motorized vehicles, etc, and more opportunities for using. As the environment also moves, there is a larger fan of norms, them own not very stable. This facto implies the existence of multiple behaviours models, that accentuate the uncertainty of which will be the appropriate behaviours (4).

This way, the adolescence is a complex period and of considerable risk for the health, but it can also be a critical period for significant interventions of promotion of the health and of healthy lifestyles (5). The World Organization of Health (6) makes reference to some of the changes felt relatively to the problems of health in the adolescence. Enter these they meet:

- alterations at level of the social values and morals, that increase the risks of pregnancy
- diseases of sexual transmission
- accessibility in offer terms and acquisition of alcohol, tobacco and illicit drugs
- alimentary habits

The behaviours of health and lifestyles in the adult age are, in wide majority, the product of the development during the adolescence (7, 8). These behaviours are complex, tends each one of these, several influences or decisive factors.

Observing the statistics is verified that the main death causes and inability in this age, they really have origin in risk behaviours. In the developed countries the accidents of traffic, the suicides and other external causes constitute the causes death leader in the adolescents and adult youths (5). In general those causes are responsible for about of half of all the deaths of the youths with ages understood between the 10 and the 24 years.

The more important mortality causes in Portugal present as main decisive behaviours as, the tobacco consumption, the abuse of the alcohol, not very healthy diets, the conduction risk, toxicdependency and physical inactivity (9).

Trends in the numeric importance of the adolescents' group (10% of the population will be in this age group) and the characteristics of its behaviour, there was of fact a significant flaw in the cares of health and that have been placing the professionals of health before the best need the to know and to understand for form the best they could support them (10, 11). Until there is very little time, almost nothing had been made relatively in particular to the problems of the adolescents' health (11). There is to refer however, that when we spoke in the adolescents' health that stands out it is the fact of they be a healthy group, because it is in these ages that the values of the mortality are lower (12). All the authors are unanimous in considering that is of the behaviours generated by the adaptation difficulty of the adolescent to the psychosocial way in that lives, that bring to an agreement the largest risks for the health (13), in addition it is the own society to create situations to the adolescent capable to affect in a lifetime future.

The diseases linked to the lifestyles and the individual "behaviours constitute, today, a big concern for the professionals of health" (14).

Some studies already effectuate in Portugal reveals preoccupying data:

- The medium age of the first sexual relationships is of 16 years, existing factors precipitants for the begin of the sexual activity, and that it is the coexistence of another risk behaviours, such as, the ingestion of alcohol, tobacco and drugs (15);
- It is in the 13/14 year-old (students to frequent the 8th year) that the lowering risk behaviours of the health begin to settle (16, 17), or else we see:
- 13% of the adolescents have its first "drunkenness" about the 14 years;
- The start of the tobacco consumption he/she locates before the 15 years;
- The consumption of addictive substance (alcohol, tobacco and drugs) it increases with the age being reached a pick in the same age group or superior to the 16 years;
- For the 16 years of the adolescents' age 14,5% already tried illicit substances;
- 14% of the adolescents refer irregularities in it takes it of the small lunch, 18,2% consume sweet

everyday and 5,6% of the adolescents consume two or more teacups of coffee.

However, already given revealed in February of 2001, by the Portuguese Institute of the Drug and Toxicdependency (18), in the ambit of the project ESPAD 99 (European Scholl Survey Project on Alcohol and other Drugs), being the population objective the students born in 1983 that were registered in the 8th, 9th and 10th years of the official teaching and that represented about 83% (3609 students) of the students of this age registered in the official teaching in continental Portugal, they revealed that (18):

- 59% of the students referred to have had at least a tobacco experience along the life and 31% in the last 30 days;
- 78% of the students already tried at least an alcoholic drink along the life and 49% already had an experience of consumption of alcohol in the last 30 days;
- 12% of the students already had an experience of any illicit drug along the life and 5% already consumed in the last 30 days, and the cannabis is the consumed illicit substance.

From the accomplishment of the Conference of Alma-Ata, in 1978 (19), that the concept of promotion of the health went being built and clarified when being considered that, for besides the traditional prevention measures and it fights against the diseases, it was necessary the communities' progressive development that qualified them for the resolution of its problems.

The most important aspect of the promotion of the health is the participation active of the people/community - empowerment (20). The effective participation in all the processes and strategies promoters of health will allow to each person and each community, to possess a high degree of I control about its own life and its health. To turn the people more active in its life process and health they are necessary two conditions (10):

- That the people feel need to obtain information. This should be available, to be actual, and of easy understanding, for form the one that can use;
- That there is development of whole its capacities and competences in the cognitive areas, affective,

psychomotor, sensorial and social. The presence of these conditions allows to the people: a) to read and to interpret the reality, to actuate on the factors of the physical and social middle; b) to create and to fight for the materialization of its life project (10).

The lifestyles and the behaviours, constitute important variables of the process of each person's health/disease or community (21, 22), for the that the education for the health is, more and more, considered as an essential strategy for the promotion of the health. When facilitating the learning of behaviours and conducts, the education for the health is going it contributes to the promotion of the same at the level of the five strategies pointed in the letter of Ottawa: establishment of healthy politics, development of attitudes and individual resources, reinforce of the community action; creation of a favourable way to the health; reorganization of the services of health (23).

At present, education for the health doesn't simply mean modifications in the habits and generating behaviours of disease, but it seeks the people's implication above all in a larger responsibility in the options that say respect to the health and the well-being, in individual terms whether collective, to support on more and more in the promotion of positive attitudes than in the agitation of the spectrum of the disease.

The education for the health presupposes an education for the life. Of there this boarding to demand, in a first moment, the observation and listens active and, in a second time, to be worth of the help of a theory (24). This theory supplies precise information, but the knowledge will become insufficient once it will never substitute the intelligence of the relationships personal and the own intuition (24).

EDUCATIONAL PROGRAMS OF INTERVENTION

The programs of promotion of the health evaluated formally are rare, or at least they are appraised in a very simplistic way. The situation in Portugal doesn't differ of this reality. If we have as quality approach the evaluation of the effectiveness, the number of studies published in the area, raises doubts, because it is properly notorious the absence of references of studies evaluated in terms of promotion of the health in the adolescence. The one that has been verifying is the existence of plenty of studies, merely of exploratory and described character of the found situations, without having had interventions in the sense of modifying the behaviours,

and when interventions existed it is not known as it went to its evaluation.

It is important to know which the effects of the intervention programs in the health, because they can bring considerable benefits to the populations.

If we assist to the facto that human beings and responsible for ourselves, we really can to adopt healthy behaviours. Lilienfeld, one of the contemporary epidemiologists, said the same: "it is above all that habitually makes himself, the way as lives him, what is eaten and drinks, the habits, noxious or hygienical, that are acquired, that empty space above all to condition the health and the man's longevity and that our personal habits are of among the factors under ours control, the most important that can influence the individual health" (25).

Making reference to the beginnings proposed by the World Organization of Health to Europe, we could say that the success would be summed up if three great objectives was gotten (26): - to give more life a years (it puts 2); - to give more health to the life (it puts 3); - to give more years to the life (it puts 5).

The intervention priorities in the epidemic context of promotion of the health and prevention of the disease, they can be summarized in three components (26):

- Modification of the behaviours and manners (styles) of life. This is without a doubt one of the objective priority;
- Reorganization of the sectors conditionals of health;
- Improvement of the quality of the cares of health.

Inside of this ambit, the intervention that makes her the level of the family and of the school, above all in relation to the habits socially acquired it is of extreme importance (27).

If we assist to the fact that the more important mortality causes in Portugal present as main decisive behaviours as, the tobacco consumption, the abuse of the alcohol, not very healthy diets, the conduction risk, toxicdependency and physical inactivity (8), he becomes of course the indicators they point for the importance of valuing strategies actives of promotion of the health and of prevention of disease.

It is in this context that, whether the pré-adolescence,

whether the adolescence they have been coming to be considered fundamental stages of the life cycle for the promotion of the health, due to the fact of many risk behaviours for the health if they begin in this age group and the habits of health be not still completely formed, being that the young susceptible of new learnings (28).

The intervention programs, besides they include information on the behaviours unsuitable, they have to contemplate the changes of attitudes and modelling of behaviours. Necessary and to have in attention the age level, the school age and the addressees' of the intervention programs cultural specific.

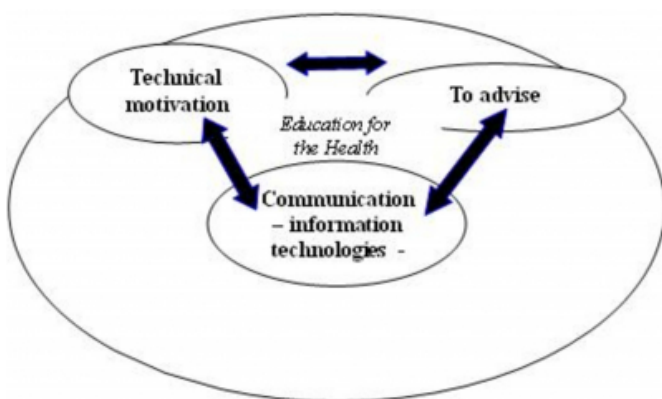
The educational program of intervention was drawn tends in attention the model of promotion of health developed by Pender (29), and the implications (modification of risk behaviours / maintenance of the habits of health) that this intervention model would provoke in the model of promotion of the health.

This model is composed by a triad of elements (fig.1), to know:

- Technical motivation, above all in the formation of attitudes through faiths and clarification of values;
- To advise, in situations that worry the youths and in crisis situations;
- Communication, using processes of the information technologies.

Figure 1

Figure 1: Intervention Model



It is intended with this model to act and to provoke alterations in the model of promotion of health, once its components can interfere in an or more axes of the model of Promotion of the Health, in way the one that can be positive to final resultant, that is abandonment of risk behaviours and

maintenance of behaviours of health.

With view to an explanation of the model, we can say that:

- Relatively to the components technical motivation and to advise, during the school year 2000/2001, in three different moments (one in each period) there were partition of information and experiences, approaching the whole problem of the risk behaviours, using strategies actives of group dynamics. There was always flexibility in this information /formation group and change of opinions, not having defined contents in a rigid way previously. Besides, the whole partition of information was completed with distribution of pamphlets concerning the problems that were approached and discussed.
- In what he says respect to component of the communication, using processes of the information technologies, and also to component to advise, a “site” was built for consultation in the Internet (<http://www.jovemsaudavel.com> - now it can be seen in: <http://7mares.terravista.pt/jovemsaudavel>), elaborated in agreement with the identified risk behaviours and in agreement with the needs of information of the population in cause, that it approaches all the necessary subjects to the explanation of the same ones, and with the possibility of, through mail electronic the students to be illustrious of eventual doubts and subjects that want to place. The site was available in October of 2000, being ever since accessible 24 hours a day. The site was “ on line “ until October of 2001.

This intervention model for us built and implemented, had the privilege of allowing to the student, under our orientation, to carry out a paper active in the construction of its learning and development, becoming a subject active of its own learning. Any project promoter of health has as objective to create the conditions for the students (in this case) they develop its potentialities fully (or empowerment), and acquiring competences for they take care of itself own and if they relate appropriately with the middle (30).

OBJECTIVES

They constitute the main objectives of this study:

- To identify, and in agreement with the concern

degree, that the students refer as behaviour of risk face to the health;

- To determine the behaviours of each student's risk;
- To introduce an educational program of intervention to decrease of the risk behaviours that are identified;
- To verify in that measured there are alterations, in the risk behaviours and in the healthy behaviours relatively to the health, after the introduction of the educational program of intervention, in the aspects related with:
- the sleep; - the hygiene; - the alimentation; - the tobacco consumption; - the consumption of having drunk alcoholic; - the sexual relationships; - the consumption of illicit drugs

MATERIALS AND METHODS

This was an experimental study, but to be more precise this kind of study was a test case, since it was supposed to verify if there were changes in students concerning risk behaviour and if there was or not a maintenance of healthy behaviours derived from the experimental application of an educational program of intervention.

The adopted methodology was the following: a) production and pre-test of the data gathering, b) application of the data gathering - exploratory study (diagnosis of the situation), c) construction of the educational program of intervention, d) test pilot of the educational program, e) division of the population in two groups (sample by clusters), f) introduction and manipulation of the independent variance (educational program of intervention) in the experimental students group, g) new appliance of the data gathering instrument (three applications separated approximately by a period time of a year).

RESULTS

When to employ the intervention model for us proposed and implemented, and in what says respect to component Communication - information technologies, that is, consults of the "site " (<http://www.jovemsaudavel.com>) with resource to the mail electronic, has been verify interesting aspects and to retain. Since October of 2000 and to October of 2001, the site was visited 1732 times for the 9th year-old students that are part of the experimental group, what gives an average of about 6 visits for student to the "site". Also in relation to the

mail electronic there was plenty of adherence on the part of the students, once we obtained 223 requests (e-mails) of explanation of doubts and subjects, what corresponds at 81% of the population that it is part of the experimental group.

Most of the doubts and subjects placed by the students of the experimental group, whether they are of the masculine sex, whether they are of the feminine sex, they refer to aspects related with the sexuality, being followed the tobacco consumption, drunk alcoholic and drug illicit with identical percentages.

CHARACTERISATION

Among the 674 students, who were part of the exploratory study (1st moment), 52,2% belonged to the female sex and 47,8% to the masculine one. After the students' division in different groups, we verified that in the experimental group 51,2 % of the students were of the female sex and 48,8% of the masculine one. Their ages were between 12 and 17 years old (an average of 14.3 years old and a standard deviation of 1.10). Most of the students (39,0%) had older brothers and lived with their parents (85,0% father and mother). The more usual mothers' job was housekeeper and in the case of fathers most of them were a production worker (30,0%).

What it comes to the control group students, 52,9% belonged to the female sex and 47,1% to the masculine one. Their ages were situated between 12 and 17 years old (average of 14.08 years old and standard deviation of 1.03). Most of them (37,7%) had older brothers and the biggest percentage lived with their parents (mother and father – 87,9%). Their mothers were generally householders and their fathers were production workers (32,6%).

From the first moment of the data gathering instrument to the second and third moments, there were a loss of 79 students (49 of the control group and 30 of the experimental group).

When the students were specifically questioned about behaviours they thought they could cause problems or danger for health, we obtained (whether from the control group students or from the experimental group students and in all stages of the study) four fundamental categories given by students: consumption of illicit drugs, alcoholic drinks and tobacco, and problems connected to sexuality. These categories appeared more frequently as being categories with a large lack of information during the 1st moment of the research in the experimental group students, but during the 2nd and 3rd stage of the study they weren't anymore.

RISK BEHAVIOURS IDENTIFIED

Concerning risk behaviours and its prevalence in the last twelve months just before the students cross examination, we verified the following results:

SLEEP

In relation to sleep, during the 1st stage of the study in the experimental group, 43,6% of students presented risk behaviours which lessened to 35,8 % in the 2nd stage and lightly increased to 38,9% in the 3rd moment. In the control group 32,3% of students revealed risk behaviours, having raised 52,4% during the 2nd moment and reduced to 47,0% in the 3rd ;

Figure 2

Table 1: Distribution of the risk behaviours with relationship to the sleep, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	Z ²	p
1st moment	Yes	125	125	8,945	0,005
	No	162	262		
2nd moment	Yes	92	177	16,181	<0,001
	No	165	161		
3rd moment	Yes	100	159	3,927	0,048
	No	157	179		

To know the educational program of intervention it influenced the students, went analyse the alterations that happened of the 1st for the 2nd moment, so much in the experimental group as in the group of I control. In the experimental group we observed that 17 students that had risk behaviours in the beginning in rest terms, they stopped having ($\chi^2_{Mc} = 17,000$ p <0,001), and in the group I control, contrarily, 77 didn't have initially and they started to have ($\chi^2_{Mc} = 77,000$ p <0,001).

Of here, we can infer that the educational program of intervention, is condition for the decrease of the risk behaviours with relationship to the sleep in the students of the experimental group.

HYGIENE

Connected to hygiene, in the experimental group, 47,7% of the students demonstrated risk behaviours in the 1st stage, which reduced to 39,7% in the 2nd moment and increased to 42,4% during the 3rd one. Among the control group 43,2% of the students showed revealed risk behaviours having lessened to 39,1% in the 2nd moment and then to 38,2% during the 3rd ;

Figure 3

Table 2: Distribution of the risk behaviours with relationship to the hygiene, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	Z ²	p
1st moment	Yes	137	167	1,398	0,237
	No	150	220		
2nd moment	Yes	102	132	0,025	0,875
	No	155	206		
3rd moment	Yes	109	129	1,097	0,295
	No	148	209		

In the experimental group we observed that 21 students that had risk behaviours in the beginning with relationship to the hygiene, they stopped having ($\chi^2_{Mc} = 21,000$ p <0,001), and in the group I control, 19 students that had risk behaviours in the beginning with relationship to the hygiene, they stopped having ($\chi^2_{Mc} = 8,166$ p=0,007)

Of the 2nd for the 3rd moment, in the experimental group, 7 students didn't have risk behaviours they start to have ($\chi^2_{Mc} = 7,000$ p=0,016), while in the group of I control, 5 students with risk behaviours with relationship to the hygiene, to the 2nd moment stop having ($\chi^2_{Mc} = 1,285$ p=0,453). We can affirm that the educational program of intervention that it was put into practice didn't have influence in the decrease of the risk behaviours with relationship to the hygiene in the experimental group.

ALIMENTATION

Relatively to alimentation, in the experimental group, at the 1st moment 93,4% of the students gave evidence of risk behaviour that reduced to 91,4% in the 2nd stage and lightly increased during the 3rd moment (92,2%). In the control group 91,7% of the students pointed out risk behaviours; these raised 93,5% in the 2nd moment which were maintained during the 3rd stage;

Figure 4

Table 3: Distribution of the risk behaviours with relationship to the alimentation, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	Z ²	P
1st moment	Yes	268	355	0,640	0,424
	No	19	32		
2nd moment	Yes	235	316	0,897	0,344
	No	22	22		
3rd moment	Yes	237	316	0,361	0,548
	No	20	22		

In the experimental group we observed that 5 students that had risk behaviours in the beginning in terms of risk behaviours with relationship to the alimentation, they stopped having ($\chi^2_{Mc} = 2,666$ $p=0,219$), and in the group I control, 6 didn't have initially and they started to have ($\chi^2_{Mc} = 3,571$ $p=0,125$).

Of the 2nd for the 3rd moment, in the experimental group, 235 students maintained the risk behaviours and 2 that didn't have they start to have ($\chi^2_{Mc} = 2,000$ $p=0,500$), while in the group of I control, 315 students maintained the risk behaviours with relationship to the alimentation, and 1 student to the 2nd moment stopped having ($\chi^2_{Mc} = 0,000$ $p=1,000$).

We can conclude that the educational program of intervention that it was put into practice, didn't have influence in the decrease of the risk behaviours with relationship to the alimentation in the experimental group.

In this item of the alimentation it is necessary to do reference to some found data. Whether in the students of the experimental group, whether in the students of the group of I control and in the three different moments, the students' percentages that:

- takes the small eat lunch everyday, it varies between 60,0 and 73,0%;
- eats lunch everyday, it varies between 74,0 and 80,0%;
- has dinner everyday, it varies between 79,0 and 84,0% (whether is in the small lunch, lunch and dinner, the feminine sex is what has lower percentages in it takes it of these meals);
- ingests almost everyday sweet, it varies between 33,0 and 41,5%;
- ingests vegetables almost everyday, it varies between 58,0 and 65,0%;
- ingests milk almost everyday, it varies between 77,0 and 82,0%;
- ingests coffee almost everyday, it varies between 15,0 and 24,0%.

TOBACCO

What it comes to tobacco, in the experimental group and in

the 1st moment of the study, 18,8% of the students indicated risk behaviours, having reduce to 8,2% (in the 2nd stage) and increased to 11,7 % during the 3rd moment. Among the control group 13,7% of the students presented risk behaviours which came up to 19,8% (2nd moment) and then lessened to 17,8% in the 3rd ;

Figure 5

Table 4: Distribution of the risk behaviours with relationship to the tobacco consumption, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	χ^2	P
1st moment	Yes	54	53	3,235	0,072
	No	233	334		
2nd moment	Yes	21	67	15,726	<0,001
	No	236	271		
3rd moment	Yes	30	60	4,201	0,040
	No	227	278		

In the experimental group we observed that 27 students that had risk behaviours in the beginning in terms of tobacco consumption, they stopped having ($\chi^2_{Mc} = 27,000$ $p < 0,001$), and in the group I control, contrarily, 32 didn't have initially and they started to have ($\chi^2_{Mc} = 32,000$ $p < 0,001$). Of the 2nd for the 3rd moment, in the experimental group, 9 students that didn't have risk behaviours they start to have ($\chi^2_{Mc} = 9,000$ $p=0,004$), while in the group of I control, 7 students with risk behaviours to the tobacco consumption, to the 2nd moment stop having ($\chi^2_{Mc} = 7,000$ $p=0,016$).

Of here, we can infer that the educational program of intervention, is condition for the decrease of the risk behaviours with relationship to the tobacco consumption in the students of the experimental group.

ALCOHOLIC DRINKS

Referring to alcoholic drinks consumption, at the 1st stage of the study in the experimental group, 58,5% of the students revealed risk behaviours, having reduced to 34,6% and to 44,0% in the last stages. In the control group, 44,2% of the students indicated risk behaviour which raised 45,9% during the 2nd moment and 47,0% in the 3rd ;

Figure 6

Table 5: Distribution of the risk behaviours with relationship to the consumption of alcoholic drinks, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	χ^2	P
1st moment	Yes	168	171	13,575	<0,001
	No	119	216		
2nd moment	Yes	89	155	7,608	0,006
	No	168	183		
3rd moment	Yes	113	159	0,555	0,456
	No	144	179		

In the experimental group we observed that 55 students that had risk behaviours in the beginning in terms of consumption of alcoholic drinks, they stopped having ($\chi^2_{Mc} = 55,000$ $p < 0,001$), and in the group I control, contrarily, 17 didn't have initially and they started to have ($\chi^2_{Mc} = 9,800$ $p = 0,003$).

Of the 2nd for the 3rd moment, in the experimental group, 24 students that didn't have risk behaviours they start to have ($\chi^2_{Mc} = 24,000$ $p < 0,001$), the same happening in the group of I control, in that 4 students that didn't have risk behaviours with relationship to the consumption of alcoholic drinks, they start to have ($\chi^2_{Mc} = 4,000$ $p = 0,125$).

We can say that the educational program of intervention, went the condition to a decrease of risk behaviours to have existed, with relationship to the consumption of alcoholic drinks in the students of the experimental group.

It's necessary refer, that the students of the masculine sex, whether they belong to the experimental group, whether to the group of I control and in the different moments of the study, they consume in larger percentage the beer, appearing in second place the champagne as consumed alcoholic drink. It is curious to verify that in the students of the feminine sex, whether they belong to the experimental group, whether to the group of I control and in the different moments of the study, it happens the opposite in fact, that is, the alcoholic drink that is consumed in larger percentage it is the champagne, being followed the beer.

SEXUAL RELATIONSHIPS

Concerning the existence of sexual relationships, first 31,4% of the students in the experimental group demonstrated risk behaviours; these lessened to 13,6% in the 2nd moment and raised to 20,2% during the 3rd stage. In the control group, 22,5% of the students presented risk behaviours, which increased to 26,9% and lightly reduced to 25,1% during the

3rd stage;

Figure 7

Table 6: Distribution of the risk behaviours in what respects to the existence of sexual relationships, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	χ^2	P
1st moment	Yes	90	87	6,708	0,010
	No	197	300		
2nd moment	Yes	35	91	15,482	<0,001
	No	222	247		
3rd moment	Yes	52	85	1,989	0,158
	No	205	253		

In the experimental group we observed that 40 students that had risk behaviours in the beginning in terms of existence of sexual relationships, they stopped having ($\chi^2_{Mc} = 40,000$ $p < 0,001$), and in the group I control, contrarily, 34 didn't have initially and they started to have ($\chi^2_{Mc} = 31,114$ $p < 0,001$).

Of the 2nd for the 3rd moment, in the experimental group, 17 students that didn't have risk behaviours they start to have ($\chi^2_{Mc} = 17,000$ $p < 0,001$), while in the group of I control, 6 students with risk behaviours to the existence of sexual relationships, to the 2nd moment stop having ($\chi^2_{Mc} = 3,571$ $p = 0,125$).

The condition that determined the decrease of the risk behaviours, with relationship to the existence of sexual relationships in the students of the experimental group, went to use of the educational program of intervention.

In this item of the existence of sexual relationships, it is necessary to call the attention for some data, preoccupying that were found. In the 1st moment of the study, most of the students didn't use any measure of protection into the sexual relationships, being this, valid for both sexes and for the two study groups.

In the 2nd moment of the study, in the experimental group and relatively to the masculine sex, of the 31 students that had sexual relationships, 9 didn't use protection measures and in the 4 students' feminine sex that had sexual relationships, 3 didn't use protection measures. These numbers, relative to the experimental group, they went up to the 3rd moment: 17 students of the masculine sex and 6 of the feminine sex had unprotected sexual relationships. When we analysed the group of I control in the 2nd and 3rd moment of the study, the numbers reveal the opposite of the situation found in the students of the experimental group. In

the 2nd moment, of the 62 students of the masculine sex that they had sexual relationships, 47 didn't use protection measures. Of the 28 students of the feminine sex that they had sexual relationships, 24 didn't use protection measures. In the 3rd moment of the study, the found numbers are identical to the 2nd moment: 44 students of the masculine sex and 21 of the feminine sex had unprotected sexual relationships.

It is necessary, still, to say that the students whether of the experimental group, whether of the group of I control, of both sexes, and in the different moments of the study, that they had protected sexual relationships, they used as middle of protection the masculine preservative.

ILLICIT DRUGS

In regard to the illicit drugs consumption, in the first moment of the study and among the experimental group, 4,5% of the students pointed out risk behaviours. They reduced to 0,4% in the 2nd stage and increased to 1,6% during the 3rd moment. In the control group, 17,8% of the students presented risk behaviours, having also reduced to 13,9% during the 2nd stage and raised to 15,1% in the 3rd moment.

Figure 8

Table 7: Distribution of the risk behaviours with relationship to the consumption of illicit drugs, for study group and in the several moments

Moments of the Study	Risk Behaviours	Experimental group	Group of Control	χ^2	p
1st moment	Yes	13	13	0,609	0,435
	No	274	374		
2nd moment	Yes	1	16	9,929	0,002
	No	256	322		
3rd moment	Yes	4	16	4,537	0,033
	No	253	322		

In the experimental group we observed that 10 students that had risk behaviours in the beginning in terms of consumption of illicit drugs, they stopped having ($\chi^2_{Mc} = 10,000$ $p=0,002$), and in the group of I control, contrarily, 8 didn't have initially and they started to have ($\chi^2_{Mc} = 8,000$ $p=0,008$).

Of the 2nd for the 3rd moment, in the experimental group, 3 students didn't have risk behaviours they start to have ($\chi^2_{Mc} = 3,000$ $p=0,250$), while in the group of I control, the 16 students with risk behaviours to the consumption of illicit drugs maintained us ($\chi^2_{Mc} = 0,000$ $p=1,000$).

We can say that the educational program of intervention influenced the appearing of risk behaviours with relationship to the consumption of illicit drugs, in the students of the experimental group.

It is important to refer that all the students whether of the experimental group, whether of the group of I control, independently of the sex, they consumed as illicit drug the cannabis. In all the cases, the cannabis was smoked.

CONCLUSIONS

We know that the health results of a group of determinant that exceed broadly what can be obtained by the exclusive intervention of the systems of health. It is also consensual that the sector of the health, although of the largest importance, it just contributes in way to parcel out for the level of health of a population. Sectors as the atmosphere, the alimentation, the activity economic and industrial, the education, the work, the social solidarity and many others they determine in an important way the existent health.

Thus, for the adduced reasons, it seemed us important to contribute for the obtaining, on the part of the youths, of more won in health.

To hear, to question and to notice the interested ones, here represented by the students of the 8th year belonging to the south zone of the district of Vila Real, the necessary starting point to that a community intervention in promotion/education terms for the health could have success went, especially because, only the deepened knowledge of the phenomenon about the reality in that he intends to act, it allows the effectiveness of the actions.

To reflect in the most important and salient aspects of the study that we developed since the beginning of the year 2000, is imperious to stand out some of them:

1. The intervention model for us built, and implemented, in the students that were part of the experimental group, composed by a triad of elements, concretely, the technical motivation, the advise and the communication using processes of the technologies of information, it allowed to the students to carry out a paper active in the construction of its own learning. For besides that important slope, the students acquired competences for they take care of itself own and if they relate appropriately with the middle, reaching like this the knowledge for the health.

2. The fact of her have found differences among the two study groups, in what says respect to the several risk behaviours, was due above all to the introduction and manipulation of the independent variable (programs educational of intervention) in the students of the experimental group. However, the study exhibition some significant differences for the variable sex (whether in the students of the experimental group, whether in the students of the group of I control). The students of the masculine sex, comparatively with the students of the feminine sex, they consume drunk alcoholic, they consume more tobacco, they consume more illicit drugs and they have more sexual relationships.
3. To component communication - technologies of information -, that is, consults with resource of the "site" to the mail electronic, of the intervention model for us implemented, she came to bring significant advantages for the students. The fact of her to build an address electronic, that cannot correspond in anything to the name and the student's sex, she does with that a larger adherence exists on the part of the students, facilitating them the placement of doubts, subjects and requests of explanation in a more informal way.
4. Another of the important aspects to stand out, is the fact that the educational program of intervention that it was put into practice, besides having contributed to the decrease of the risk behaviours each one "per itself", did with that the simultaneous involvement in several risk behaviours, it had decreased significantly.

The results that we find, tells us that the students belonging to the experimental group, present less risk behaviours than the students belonging to the group of I control, in:

- a) to the sleep
- b) to the tobacco consumption
- c) to the consumption of alcoholic drinks
- d) to the existence of sexual relationships
- e) to the consumption of illicit drugs

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