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ORIGINAL ARTICLE

Women working at university restaurants: life and work conditions and gender-based violence*

MULHERES TRABALHADORAS DE RESTAURANTES UNIVERSITÁRIOS: CONDIÇÕES DE VIDA, TRABALHO E VIOLÊNCIA DE GÊNERO

MUJERES TRABAJADORAS DE RESTAURANTES UNIVERSITARIOS: CONDICIONES DE VIDA, TRABAJO Y VIOLENCIA DE GÉNERO

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ABSTRACT

This is an exploratory and descriptive study with a quantitative approach that aimed to understand the social production and reproduction processes of women working at university restaurants and the occurrence and the magnitude of gender-based violence committed against them by their intimate partners. The data were collected through semi-structured interviews. The analysis categories used were social production and reproduction, gender and gender-based violence. The interviewees held a subordinate social position during the productive and reproductive periods of their lives. Approximately 70% reported having experienced gender-based violence from an intimate partner (66% psychological violence, 36.3% physical violence and 28.6% sexual violence). Most of the health problems resulting from violence were related to mental health. The results indicate that the situation requires immediate interventions, mostly guided by the instrumentalization of these women and the support by the state and the university as appropriate to address violence.

RESUMO

Estudo exploratório e descritivo de abordagem quantitativa, que teve por objetivos conhecer os processos de produção e reprodução social de mulheres trabalhadoras de restaurantes universitários, a ocorrência e a magnitude da violência de gênero cometida contra elas por seus parceiros íntimos. Os dados foram coletados por meio de entrevistas semiestruturadas. As categorias de análise utilizadas foram produção e reprodução social, gênero e violência de gênero. As entrevistadas ocupam posição de subalternidade social nos momentos produtivo e reprodutivo da vida. Cerca de 70% referiram violência de gênero por parceiro íntimo (66% violência psicológica; 36,3% física e 28,6%, sexual). A maior parte dos problemas de saúde decorrentes da violência tinha relação com a saúde mental. Os resultados indicam que a situação exige intervenções imediatas, pautadas principalmente na instrumentalização dessas mulheres e no apoio do Estado e da Universidade para que façam o enfrentamento da violência que sua realidade exige.

RESUMEN

Estudio exploratorio y descriptivo desde una perspectiva cuantitativa que tuvo por objetivos: conocer los procesos de producción y reproducción social de mujeres trabajadoras de restaurantes universitarios y la ocurrencia y la magnitud de la violencia de género cometida por sus parejas íntimas, contra ellas. La recolección de datos fue realizada por medio de entrevistas semiestructuradas. Las categorías de análisis utilizadas fueron producción y reproducción social, género y la violencia de género. Las entrevistadas ocupan una posición de subalternidad social en los momentos productivo y reproductivo de la vida. Cerca del 70% refirieron violencia de género perpetrada por su pareja íntima (66% sufrieron violencia psicológica, 36.3% violencia física y 28.6% sexual). La mayor parte de los problemas de salud a consecuencia de la violencia tenían alguna relación con la salud mental. Los resultados indican que la situación exige intervenciones inmediatas pautadas principalmente por la preparación y empoderamiento de esas mujeres; en el apoyo del Estado y de la Universidad para el enfrentamiento de la violencia de acuerdo a su realidad.

DESCRIPTORS

Gender identity
Violence against women
Health-disease process
Hierarchy, social

DESCRITORES

Identidade de gênero
Violência contra a mulher
Processo saúde-doença
Hierarquia social

DESCRIPTORES

Identidad de género
Violencia contra la mujer
Proceso salud-enfermedad
Jerarquía social

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INTRODUCTION

Violence is a socially determined historical phenomenon that has manifested itself and left traces throughout the history of humankind. Recently, violence has been a topic of discussion in national and international contexts, given its economic and social impact and its influence on the health of individuals. Aiming to standardize the concept to better establish policies and strategies for combating violence, international organizations have defined violence as follows:

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation[1].

For classification purposes, violence can be defined according to the aggressor in the following manners: self-directed or self-inflicted (i.e., suicidal behaviors, self-injury and self-mutilation), interpersonal (intrafamilial or committed by an intimate partner) and community and collective (the instrumental use of violence by people who identify themselves as members of a group that is hierarchically above another group or collection of individuals)[1].

Considering this classification, violence against women committed by an intimate partner is considered interpersonal violence. This phenomenon is still not very visible in society, but it has been gradually emerging in political and social environments, along with a search for appropriate responses. Gender-based violence is

> Any act of gender-based violence that results in or is likely to result in physical, sexual, mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life[2].

Regarding women who reported having experienced physical abuse by an intimate partner at some point in their lives, studies on violence against women[1] performed in 48 countries showed an incidence of 69% in places with higher rates and never less than 10% in countries with lower incidence, demonstrating that this form of violence is present in a considerable number of countries, despite numerous social and cultural differences.

In Latin America, physical, psychological and sexual violence against women committed by an intimate partner has a high prevalence; however, this high prevalence is not reflected in the official data because the phenomenon is underreported. The high prevalence is found in studies based on probabilistic estimates applied to population samples representative of those countries[3].

Studies[1-2,4-7] demonstrate the relationship between domestic violence and women's social, physical, mental and emotional health problems. Among other findings, these studies show that women who perform activities linked to the house, such as housewives, cleaning ladies, cooks, servants and maids, have greater vulnerability to injury.

This study aimed to understand the processes of social production and reproduction and the magnitude of gender-based violence committed by intimate partners among female workers at university restaurants. The social reproduction and production profile of these women and how the gender-based violence manifests among them was examined in the attempt to answer the following questions: What are the social reproduction and production profiles of female workers at university restaurants? What is the magnitude of the violence against these women perpetrated by their intimate partners?

It is hoped that the information obtained in this study may support interventions with these female workers that help them face and overcome violent situations, improve existing interventions or establish new ways to recognize and combat violent situations.

Studies demonstrate the relationship between domestic violence and women's social, physical, mental and emotional health problems.

METHOD

This is a quantitative, exploratory and descriptive study based on the theory of praxical intervention in collective health nursing (Teoria da Intervenção Práxica de Enfermagem em Saúde Coletiva-TIPESC) which is

> the dynamic systematization of capturing and interpreting a phenomenon articulated with social production and reproduction processes, relating to the health-disease in a given collectivity, in the framework of its conjecture and structure, within a historically determined social context[8].

The theory comprises capturing the objective reality, interpreting that reality, constructing the intervention project, the intervention itself and the reinterpretation of the objective reality. This study addressed the first and second aspects in greater depth in a way that allowed these aspects to stand out from the others without losing *the characteristic of totality and interpenetration* of the phenomenon[8].

The analysis categories used were social production and reproduction, gender and gender-based violence. Gender assumes an understanding of the relationships established between genders in society, differentiating between biological and social gender. While the former refers to anatomical and physiological differences (i.e., the biological differences between men and women), the latter refers to the relevance that these differences have had in different societies throughout the course of history[9]. The use of the gender perspective to understand violence

against women leads to the analysis of its complexity as gender-based violence[2,6].

Violence against women was analyzed by considering the women as agents of transformation of the reality in which they live. Violence is a problem that they are able to face and overcome as social subjects who, once empowered, are able to develop or rescue their autonomy and make decisions about their own lives in all areas, including domestic and affective ones.

The study scenario was the Superintendent of Social Services of the University of São Paulo (Superintendência de Assistência Social da Universidade de São Paulo-SAS/USP), which in 2011 had 625 employees distributed throughout its five divisions. Of these, the Food Division has the largest number of employees, with 231 employees working in the preparation and distribution of food and related administrative activities. All of the female workers at the university restaurants managed by SAS who had worked at the institution for more than six months were invited to participate in the study and comprised a population of 91 women.

Data collection was performed in two stages: the primary data were collected first, followed by the secondary data. The scenario was characterized based on the documentation and statistical data from the databases of the Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística-IBGE), the database of the Unified Health System (Banco de dados do Sistema Único de Saúde-DATASUS) and the State System for Data Analysis Foundation (Fundação Sistema Estadual de Análises de Dados-SEADE), among others.

The primary data were collected through interviews using a semi-structured instrument. An individual questionnaire based on the adaptation of the Abuse Assessment Screen (ASS)[10] and the instrument used in the course ENS-0235: Fundamentals and Practices of Collective Health Nursing, taught in the Department of Collective Health Nursing, Nursing School, University of São Paulo (Escola de Enfermagem da Universidade de São Paulo-EEUSP) were used to collect data about life and work issues related to the health-disease process of the participants.

The instrument included open and closed questions about the data related to the social production and reproduction profiles of the female workers and the occurrence of violent experiences in their lives. If such experiences were reported, questions were asked to determine the types of violence suffered, the aggressors and the types of situation experienced.

After the interviews, the questionnaire responses were entered into Excel spreadsheets and were organized, decoded and categorized. The quantitative data were compiled using tables containing absolute and relative frequencies[11]. In the second stage, Pearson's chi-squared tests of association[12] were performed to assess the associations between the selected variables. For the inferential analysis, a significance level of 5% ($\alpha = 0.05$) was adopted, and all tests were concluded under the two-tailed hypothesis.

The analyses were performed using the statistical functions of the Microsoft Excel 2007 software. The logistic regression analysis and odds ratio calculations were performed using the same software with the Excel add-on EXStat as support[13].

Given that this is a human research study, it met all of the requirements of Resolution No. 196/96 of the National Health Council. The project was evaluated and approved by the Research Ethics Committee (Comitê de Ética em Pesquisa - CEP) of the Nursing School, USP, under Number 969/2010/CEP/EEUSP.

RESULTS

Regarding the characterization of the interviewees, approximately 60% were between 45 and 59 years old, 29.7% were between 35 and 44 years old, 7.7% were between 25 and 34 years old, 4.4% were 60 years old or older, and only 1.1% were between 18 and 24 years old. Among the participants, 45.1% were born in the Metropolitan Region of São Paulo (Região Metropolitana de São Paulo-RMSP), and approximately 30% were born in the states of Northeastern Brazil. Approximately 25% of the participants were born in the countryside in São Paulo state and in states of other Brazilian regions. The majority of the participants (50.5%) were Catholic, 31.9% were evangelical Christians, and 13.2% declared that they had no religion.

Regarding marital status, among the women living with a partner (62.6%), 40.7% were married, 20.9% were separated, and 1.1% were widows who had reestablished a stable relationship. Among the women who had no partner (37.3%), 29.7% were separated, 5.5% were single, and 2.2% were widows.

Most of the interviewees (71.4%) were the household heads; for 26.4% of the participants, the spouse was the head of household; and for 2.2%, another family member held that position. Regarding place of origin, nearly half of the participants (49.5%) were from São Paulo City. Most of them resided in neighborhoods in the West Zone, which neighbors the University. The others lived in municipalities of Greater São Paulo, such as Osasco (17.6%), Taboão da Serra (11%) and Carapicuíba (7.7%).

The participants' living conditions were assessed using the State of São Paulo Social Vulnerability Index (Índice Paulista de Vulnerabilidade Social-IPVS), which seeks to identify areas in the municipalities of São Paulo State where families exposed to different levels of social vulnerability are predominant[14]. In the Metropolitan Region of São Paulo, more than half of the population is exposed to

low to medium vulnerability levels, and 11.5% are exposed to very high vulnerability[14].

Violence with fatal outcome, assessed using the mortality by external causes coefficient, was significantly high in the municipalities where the interviewees were from, ranging from 14.9 in São Paulo City to 26.6/100,000 inhabitants in Osasco[15]. It is noteworthy that the rate of female mortality from external causes in São Paulo City was 23.3/1,000 women between 2000 and 2002, and the female mortality rate related to aggressions and homicide was 7/1,000 women[16].

Therefore, it was concluded that the places where the study subjects live display significant social vulnerability, high rates of urban violence, and in particular violence against women with fatal outcome. This is in agreement with what the women themselves reported: nearly half (49.5%) reported feeling exposed to violence in the places where they live. Additionally, the risks of contact with vectors (rats and insects) and traffic accidents (38.5% and 35.2%, respectively) were significant. The risks of stream contamination by garbage and chemical waste (17.6%), landslip and flooding (6.6%) and other risks (6.6%) were also noted. It is noteworthy that 25.3% of women did not consider themselves exposed to risks.

Although the municipalities from which they originated have high levels of social vulnerability, the interviewees had access to consumer goods. Most of them (69.2%) lived in their own homes, 13.2% lived in a house provided by others, 11% paid rent and 6% lived in invaded or occupied properties. All of the participants lived in brick houses, of which 89% had finishing and 11% did not. The total number of rooms in the household varied from two to 17, with an average of six rooms per household. Of the total interviewees, 89% considered their home to have adequate natural ventilation, 80.2% reported having adequate natural lighting and 63.7% reported not having mildew or mold. In addition, all of the participants' homes had access to basic sewage services.

Among the most common leisure activities reported by the participants were walking in the city (54.9%), watching television (38.5%), visiting friends/relatives (37.4%), going to the cinema (30.8%), watching/participating in sports (26.4%), reading (26.4%) and going to the theater (12.1%). The remaining participants (13.2%) reported other leisure activities, such as dancing, knitting and crochet and cooking. Political participation was common among the interviewees: 81.3% did not participate in any groups, associations, unions or political parties, 9.9% were involved in a labor union and 1.1% were members of groups linked to political parties.

Among the participants, 87.9% claimed to have at least one health problem, and only 12.1% claimed to have no health problems. The most frequently mentioned problems were musculoskeletal disorders, which were noted by 63.7% of the interviewees. These problems are strongly associated with labor practices, i.e., they are considered occupational diseases. Next most common were mental health problems, which were reported by 33% of women and included depression, panic syndrome, mood disorder, insomnia and anxiety. More than half (54.9%) reported continuous medication use. Approximately 20% of the participants took antihypertensive drugs; 14.3% took psychoactive drugs, 11% took dyslipidemia drugs, 9.9% took contraceptives, and 8.8% continuously used painkillers and anti-inflammatory drugs. The majority (68.8%) attended only the University Hospital of the USP for follow-up or health treatments.

Regarding social production, approximately 70% of the participants were kitchen assistants or cooks who performed activities related to handling, preparing and distributing food. Another 16.5% performed administrative activities (e.g., administrative assistants, assistant cashiers and stock clerks). Managerial positions were occupied by 13.2% of the interviewees (e.g., nutritionists and nutrition technicians). Most of the workers (51.7%) had partial to total working restrictions based on a classification used by nutritionists to operationalize the work schedules according to the Specialized Service in Safety Engineering and Occupational Medicine (Serviço Especializado em Engenharia de Segurança e em Medicina do Trabalho-SESMT). Such restrictions are triggered by occupational illnesses acquired during the labor process.

The women's responses indicated that having a formal and stable job represents a strengthening potential, although it also represents exhaustion caused by the exploitative nature of the work, which greatly contributes to the deterioration of their quality of life. Among the most cited risks in the workplace were falling (76.9%) and the possibility of developing or worsening musculoskeletal diseases (67%). Stress in the workplace was cited by 63% of the participants, and 31.9% reported feeling exposed to aggression from patrons.

Violence in social relationships was reported by approximately 70% of women, and intimate partners were mentioned as the aggressors in 86.7% of the cases. In 8.4% of the cases, other male relatives were the aggressors; only one woman mentioned a stranger as the aggressor. Regarding the nature of violence in adulthood, 66% reported psychological violence, 36.3% reported physical violence, and 28.6% reported sexual violence. The association between psychological, physical and sexual violence accounted for approximately 15% of the cases. Psychological violence was the most frequent type. The intimate partner was the most-cited aggressor. It is noteworthy that bosses were mentioned as aggressors by 5% of the interviewees. At the time of the interview, a significant percentage of the women had experienced the most recent episode of violence less than 1 year ago, which indicates that psychological violence is present in the lives of approximately 40% of women. The other characteristics of psychological violence are shown in Table 1.

Table 1 - Characteristics of the psychological violence experienced by the interviewees during adulthood - São Paulo, SP, Brazil, 2012

Variables	Factor	Total	N	%
Psychological Violence	Yes	91	60	65,9
When did this situation happen?	1. Since first meeting the aggressor/Always/Entire life	47	8	17
	2. In the first 5 years of marriage		20	42,6
	3. Between 5 and 10 years of marriage		8	17
	4. After 10 years of marriage		5	10,6
	Does not know		6	12,8
	Did not answer		13	-
How many times has it happened?	1 time	58	4	7,1
	2 times		2	3,4
	3 times		2	3,4
	Several times		48	82,7
	Does not know		2	3,4
	Did not answer		2	-
When did it last happen?	1. Between 1 year age and today	48	18	37,6
	2. 1-5 years ago		3	6,2
	3. 5-10 years ago		3	6,2
	4. More than 10 years ago		14	29,2
	Does not know		10	20,8
	Did not answer		12	-
Who was the aggressor?	Stranger	60	1	1,6
	Ex-husband		25	41,7
	Brother/Sister		3	5
	Husband		20	33,3
	Husband and ex -jusband		2	3,3
	Husband e Brother/Sister		1	1,7
	Boyfriend		4	6,7
	Father/ Uncle/ Aunt		1	1,7
	Professional		3	5

Tabela 2 - Characteristics of the physical violence experienced by the interviewees during adulthood - Sao Paulo, SP, Brazil, 2012

Variables	Factor	Total	N	%
Physical Violence	Yes	91	33	36,3
When did this situation happen?	1. Since first meeting the aggressor/Always/Entire life	26	4	15,4
	2. In the first 5 years of marriage	26	13	50
	3. Between 5 and 10 years of marriage	26	3	11,5
	4. After 10 years of marriage	26	6	23,1
	Did not answer		7	-
How many times has it happened?	1 time	32	5	15,7
	2 times	32	4	12,5
	3 times	32	2	6,2
	Several times	32	20	62,5
	Does not know	32	1	3,1
	Did not answer		1	-
When did it last happen?	1. Between 1 year age and today	28	1	3,6
	2. 1-5 years ago	28	3	10,7
	3. 5-10 years ago	28	3	10,7
	4. More than 10 years ago	28	17	60,7
	Does not know	28	4	14,3
	Did not answer		5	-
Who was the aggressor?	Ex-husband	33	21	63,7
	Sister	33	1	3
	Brother	33	1	3
	Husband	33	7	21,2
	Father	33	3	9,1

Physical violence occurred less frequently than psychological violence (36.3%). The intimate partner was also cited as the main aggressor (84.9%). In contrast with psychological violence, approximately 60% of women experienced the last episode of physical violence more than 10 years ago. Other characteristics of this type of violence are shown in Table 2.

The women's age at marriage correlated inversely with the odds of being physically abused as an adult. The odds ratio for each additional year of age at marriage is 0.88 (p=0.026) for the likelihood of suffering; i.e., for each additional year, the probability of abuse is lower. Thus, women who marry at ages older than 30 years have less than a 20% chance of suffering abuse, according to the logistical model. With each year less in age at marriage, her likelihood of being abused increases by 12%.

There was also an association between a woman's exposure to violence in the place where she lives and her likelihood of experiencing physical violence (OR=2.48/p=0.021).

Table 3 - Characteristics of the sexual violence experienced by the interviewees during adulthood - São Paulo, SP, Brazil, 2012

Variables	Factor	Total	N	%
Sexual Violence	Yes	91	26	28,6
When did this situation happen?	1. Since first meeting the aggressor/Always/Entire life	19	3	15,8
	2. In the first 5 years of marriage	19	11	57,9
	3. Between 5 and 10 years of marriage	19	3	15,8
	4. After 10 years of marriage	19	2	10,5
	Did not answer		7	-
How many times has it happened?	1 time	26	5	19,3
	2 times	26	1	3,8
	3 times	26	1	3,8
	Several times	26	19	73,1
When did it last happen?	1. Between 1 year age and today	19	2	10,6
	2. 1-5 years ago	19	2	10,5
	4. More than 10 years ago	19	8	42,1
	Does not know	19	7	36,8
	Did not answer		7	-
Who was the aggressor?	Ex-husband	26	14	53,9
	Husband	26	9	34,6
	Boyfriend	26	1	3,8
	Cousin	26	2	7,7

There was a relationship between a woman's partner's use of alcohol and her likelihood of experiencing physical violence during adulthood. Based on the odds ratio, this relationship was quantified (OR=5.74/p=0.004), meaning that the partner's use of alcohol increases the chance of the occurrence of violence because a woman with a partner who consumes any amount of alcohol has a 574% greater chance of experiencing violence than does a women with a partner who does not consume alcohol.

Sexual violence was the least common form of violence (28.6%). The intimate partner was cited as the aggressor more often in cases of sexual violence than in other types of violence (92.3%), and 42.1% of the participants last experienced sexual violence more than 10 years ago (Table 3).

Regarding the three types of violence, the variables that showed statistical associations were those related to race/ethnicity (in general, black women are more likely to suffer violence), age (women aged 60 years or older are more likely to suffer sexual violence), social class (access to potentially strengthening factors, such as leisure activities, as well as greater education level, were inversely related to the occurrence of all types of violence). Owning a residence was inversely related to sexual violence.

Regarding coping by women who face violent situations, of the 66 who reported having experienced at least one type of violence, only 43 (65.2%) sought help. Among the most common actions taken were seeking support from family (46.5%) and from the mental health nurse who worked at SAS until 2010 (23.3%). The Public Prosecutor's Office, the Reference Centers for Women and the Forensic Medicine Institute (Instituto Médico Legal-IML) were not mentioned. The women's responses were strongly marked by their resilience, i.e., the ability to become stronger after experiencing an adverse situation, such as violence.

Health problems resulting from violence were reported by 59.1% of the respondents. Most violence-related health problems were related to mental health.

DISCUSSION

The majority of the female workers surveyed belonged to a subordinate social class, although they had access to consumer goods that provide certain social status, such as home ownership.

The places from where they originated, and therefore those where their social reproduction processes occurred, were generally in the periphery of Greater São

Paulo, which has high rates of urban violence and violence against women. Social indicators show that these municipalities exhibit social vulnerability. Social inequality and gender inequality, expressed by violent marital relationships, greatly compromise the social reproduction of these women by the interposition of inequity generated by two different categories: class and gender[17].

During the productive period, it was found that a formal and stable job represents a strong potential for strengthening and favors the process of financial autonomy. Women become individuals as a result of having formal, stable work, which provides a potentiating condition for breaking the cycle of violence committed by an intimate partner[4,17]. However, employment also creates the potential for exhaustion because of the exploitative nature of the type of work these women do, which requires intense physical effort, weight-lifting and repetitive movements performed under adverse conditions, such as high temperatures and noise pollution. These factors lead to occupational diseases, which greatly affect the women's quality of life.

The frequency with which the interviewees reported experiencing violence (70%) was highly significant compared with the results of other population-based studies[1,4-5], which found variations between 40% and 54.2%. Some authors explain that the high rates of violence against women observed in population-based studies most likely reflects nearly three decades of activism and institutional responses attempting to combat this type of violence[4,7]. Although these measures are not reflected in lower rates of violence against women, they make violence against women more visible and less acceptable. Thus, the reduced acceptability and greater sensitivity to this phenomenon encourages expressions of dissatisfaction and revolt from the women who experienced it.

With the exception of psychological violence, which showed a very high frequency, the frequency of the other types of violence are in agreement with Brazilian population-based studies[4,18-19]. Intimate partners were identified as aggressors by more than 84% of the women, regardless of the type of violence, followed by other male relatives, confirming what the literature[4,18,20-21] states when differentiating violence against women from violence against men. While men are usually attacked in public spaces by strange men, women are attacked by their intimate partners in their homes.

As observed in other studies[4,20,22-23], the partner's use of alcohol was strongly related to the occurrence of violence against women by intimate partners.

Although the literature does not indicate an age range in which women are more vulnerable to experiencing violence committed by the partner, it has been found that the younger women are when they marry, the greater their chances are of experiencing physical violence by a partner. This finding may have support in young women's lack of financial autonomy and in the double subordination (generational and gender-based) that women often experience when they marry young[2].

Resilience was observed in most of the interviewees. It provides a very fertile ground for interventions that aim to promote health and quality of life in these women. By acquiring the capacity for resilience, women in violent situations obtain the individual and social tools needed to overcome this problem [24].

Health problems resulting from experiencing gender-based violence committed by intimate partners are strongly related to mental health, which agrees with previous studies[2,4,19,21-22] indicating that there is a strong relationship between domestic violence and health problems in women. Health problems in general, and psychological distress in particular, are considered non-fatal effects of violence; however, they have devastating and often irreparable consequences. These findings seem to indicate that the mental health problems that were so often reported by the female restaurant workers and that greatly compromise their quality of life may be related to domestic violence because such problems were so common among workers who had experienced violence.

Acknowledging the suffering caused by violence may allow both the professional and the woman to avoid feeling powerless when facing a violent situation. Thus, reducing this highly complex phenomenon a nonspecific diagnosis (depression, for example) leads to a drug intervention and a referral for psychotherapy, which the women regards as being cared for and the health professional regards as work accomplished[7,9]. However, combatting violence against women goes beyond the scope of health care and requires the commitment and involvement of various sectors, such as social, legal and psychological services, women's police stations, shelters and the Public Prosecutor's Office, among others.

CONCLUSION

This study revealed a phenomenon that, until now, was ignored among the SAS workers: the prevalence of gender-based violence committed by their intimate partners. However, it is necessary to present some relevant limitations inherent to this study to better understand this phenomenon. First, the fact that the researcher/interviewer was a staff member at SAS, which was the study scenario, might have caused some women not to talk about violence they had experienced for fear that facts about their private life would be exposed in the workplace. Second, the interviews were not conducted in a private environment; rather, they occurred in the restaurants, which often did not have the physical structure to allow a private interview place, and interviews were interrupted several times because of the proximity of colleagues. This situation inhibited some women from providing in-depth

responses to the interview questions, and the women often avoided the questions that dealt with violence. Finally, another limitation of this study is the inability to generalize the results presented here to other situations and populations, given the particularities of the studied population.

This study revealed that gender-based violence is a highly prevalent phenomenon among female workers at university restaurants. However, this type of violence is a small part of the total that the woman experience. The study found that violence occurs in every realm of their lives: in the areas where they live, which are marked by urban violence; in their homes, in the form of violence committed by intimate partners; at work, first from the work process itself, which is exploitative, and then as the violence committed by their bosses, which demonstrate class and intragender violence. These women are considered subordinates during their productive and reproductive stages of life, and this subordination may be related to increased vulnerability to gender-based violence.

Based on the results reported herein, one can conclude that gender-based violence committed by an intimate partner is highly prevalent among female workers at university restaurants and is determined by the way these women are regarded at times of social production and reproduction.

As a center of excellence for knowledge production, it is expected that the products of the University of São Paulo be translated into benefits for the community, especially in terms of a gender-based practice arising from this knowledge. Thus, the results of this study are expected to support interventions for the SAS workers that help them to recognize, face and overcome the violent situations that they face in their daily lives. Furthermore, we intend to stimulate further studies that might provide information about this growing field of knowledge, which still has many gaps to be filled.

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