Itineraries of reconstruction of the bodies of women attacked with chemical agents in Bogotá, Colombia

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Abstract: This article explores experiences of care-seeking for the physical, social and psychological reconstruction of women attacked with chemical agents in the city of Bogotá, Colombia. Based on an ethnographic design, observational and discursive information was collected in formal and nonformal therapeutic settings, and in-depth interviews were conducted with survivors and health professionals. The data was analyzed from a narrative-critical approach. The findings show divergent interpretations within health care systems on what constitutes the reconstruction of a body attacked with chemical agents in a context marked by profound inequalities in access to health.

➤ **Keywords:** Therapeutic Itineraries. Acid attacks. Health Care Models. Gender violence. Health inequality.

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Introduction

In 2012 various journalistic sources (EL ESPECTADOR, 2012; FEMINICIDIO. NET, 2012) and official reports (INSTITUTO NACIONAL DE MEDICINA LEGAL Y CIENCIAS FORENSES, 2012; FISCALÍA GENERAL DE LA NACIÓN, 2012) denounced a high number of attacks with chemical agents on women in Colombia, leading in the following years to unprecedented media and political attention on this phenomenon. Although during those years "the real magnitude of accidental and intentional injuries" was unknown (Instituto Nacional de Medicina Legal y Ciencias Forenses [INMLCF], 2013), the figures presented by mass media, used in political speeches or made visible from the academic field (GUERRERO, 2013),[1] invited to understand these attacks as a public health problem and a manifestation of gender violence. These attacks, in fact, mainly affect young women with scarce resources and low educational level in countries with high rates of inequality and macho cultures in the Global South (PECK, 2012), showing how political, economic and institutional forces are intertwined in this kind of violence (KLEINMAN; DAS; LOCK, 1997).

In Colombia, the development of the legislative framework on the subject began in September 2011, with the legislative course of a first bill (DIAZ GRANADOS, 2014); the visibility of the problem prompted the enactment in 2013 of Law 1639, which seeks *to strengthen the measures for prevention, protection and comprehensive care for victims of crimes with acid, alkalis or similar or corrosive substances*. In 2014, the following were issued: Resolution 2715, which establishes that chemical substances must be subject to retail sales control registration; Resolution 4568, establishes the Protocol for emergency care to victims; and Decree 1033, establishes the operation of the regulatory regime for the sale of these substances, the Comprehensive Care Route (*Ruta de Atención Integral*) for victims and reinforces the guarantee of comprehensive health care. This year, the Ministry of Health and Social Protection issued Circular 016, which urges the Health Service Provider Companies -EPS (*Empresas Prestadoras de Servicios de salud*)[2] to exempt the victims of violence caused by attacks with chemical agents from the payment of moderating fees and co-payments. In 2016, Law 1773 (known as *Ley Natalia Ponce de León*), provides for increasing the penalty for aggressors and for those who traffic, possess or manufacture chemical or radioactive substances and introduces attacks that

deform the face as an aggravating circumstance of the penalty. The following year, through external circular 0008 of August 24, 2017, the National Superintendence of Health indicates to the EAPBs, IPS and Territorial Entities, the implementation of the Comprehensive Care Route for victims, to ensure priority access to intersectoral care (health, justice, protection and actions aimed at favoring occupation or labor continuity, as established in Decree 1033 of 2014). Finally, on July 12, 2019, Law 1971 is issued, which "seeks to prioritize health care rights and promote access to work for victims of attacks with corrosive chemical substances or agents to the skin".

Despite the legislative development, the experiences of several women in Bogotá who seek services reveal difficulties in accessing health care, justice and protection measures that exacerbate their suffering. After describing the methodology and a brief theoretical framework centered on conceptualizations from medical anthropology, this article will describe the situated processes of physical, social and psychological reconstruction of women in Bogotá who have experienced this form of violence. First, it will describe the experiences of access to intervention measures on the body inscribed in the formal health care systems, taking into account the way in which the economic and cultural capital of the survivors influences them; then, it will describe strategies of burned women who, outside the hegemonic discourses of law and science, create mechanisms to deal with the aftermath of these attacks.

Methodology

In order to capture the diverse discourses and interlocutors that participate and shape situated experiences of seeking treatment for reconstruction, we started from an ethnographic model informed by the postulates of feminist epistemology and research practice (GREGORIO GIL, 2019; ESGUERRA MUELLE, 2019; ESTEBAN, 2004; ABU-LUGHOD, 1990; HARAWAY, 1988). For this, we conducted participant observation in the city of Bogotá between 2016 and 2020 in formal and informal spaces of intervention, which included: visits to a public hospital in the capital with expertise in burn care; two foundations; two government institutions (one national and one district) involved in the formulation of projects and care for survivors; attendance at six events organized by groups of survivors; visits to their homes and work spaces; and participation in spaces convened by academic or governmental organizations. The frequency of the meetings was always variable but we held more than 50, some of them individual, others collective.

The observational data, recorded in written and photographic form, were complemented with semi-structured interviews with two plastic surgeons who are experts in the care of burn victims and in-depth interviews with three women who have been attacked, presumably by partners or ex-partners, but whose cases have remained unpunished. They share more than 10 years of experience in seeking care and have actively participated in academic and governmental discussions on the subject. The interviews were transcribed and subjected from an interpretive approach to a narrative-critical analysis (BEIRAS; CANTERA ESPINOSA; CASASANTA GARCIA, 2017). This included an analysis based on grounded theory (STRAUSS; CORBIN, 2008) through open, axial and selective coding of the information with the assistance of the Atlas.ti software. Subsequently, a narrative analysis was carried out through which the information collected was triangulated with literature from the critical tradition of medical anthropology and gender studies, in order to identify both the possibilities, difficulties and barriers to access present in the trajectories offered by officialdom, as well as the alternatives sought by women to reconstruct their bodies.

Theoretical framework

The discussions and reflections developed in this text are articulated around concepts of medical anthropology, especially Kleinman's (1978) postulates on health care systems. These are social and cultural systems linked to particular forms of social relationships and institutional environments, which are impacted by external socio-political, historical, economic, epidemiological and technological factors, and are related to internal psychophysiological and behavioral processes. According to Kleinman, there are at least three social fields (or subsystems of care) in which *sickness* is experienced and mechanisms are generated to deal with it: the popular, which includes family contexts associated with sickness and its care, and social networks and community activities; the professional field, dominated mainly by biomedicine and endorsed by legislative frameworks in Western contexts; and the *folk* subsystem, constituted by non-professional subjects who attend to sickness through cures not endorsed by the dominant medical-legal systems. Each field provides different explanatory models and definitions of health, sickness and care, and contains and organizes beliefs, expectations, roles and legitimized relationships within the subsystem creating diverse *clinical realities*. These systems contain, then,

the cultural constructions of the experience of sickness, and the strategies and evaluation criteria that guide decisions on the choice of health care practices and assessment of therapeutic efficacy.

The various subsystems do not establish mutually exclusive boundaries: they coexist without being framed in an integrated and coherent model (ALVES; SOUSA, 1999). The transit between them, the experiences and the individual or collective projects formed from a set of possibilities, and the choices made to provide care responses, are what will mark the *therapeutic itineraries* as a whole. According to Alves and Sousa (1999), these refer to "a set of plans, strategies and projects directed towards a preconceived objective: the treatment of the affliction" (p. 133, own translation), which forms an articulated unit established by actions that follow one another or overlap in a way that is not necessarily predetermined or schematized.

The concept of *therapeutic itinerary*, in dialogue with the *health care system*, emphasizes the incorporation of the cultural dimension in the care processes and questions both the approach to the analysis of the "behavior of the sick" that prioritizes individualistic and voluntarist readings of the action, and the postulates that assume that the search for health services is framed only within the possibilities granted by professional, biomedically oriented devices (ALVES; SOUSA, 1999). This calls for approaches that make it possible to establish relationships between the sociocultural dimension and the singularized behavior of individuals. Individual aspects are informed by cultural representations related to sickness and care systems, as well as by socio-structural conditions that shape access to different care possibilities. It also attempts to account for the singularity, partiality and provisionality of care responses, as well as the way in which meaning-making action is always involved in their construction (TAVARES, 2017).

The idea of "reconstruction" in the case of chemical agent attacks includes attention to the physical, social and psychological consequences. However, in the itineraries presented here, we explore the responses that focus on the restoration of *scars*. These marks, in their double aesthetic and functional dimension, are the consequences of the main attention and care: their treatment involves passing through various subsystems of care that support divergent interpretations of sickness and therapy. In transit, walking and going through spaces and discourses to reconstruct tissues damaged by acid, the way in which various forms of care or treatment are combined or articulated becomes evident (KLEINMAN, 1978).

Situated experiences of the reconstruction process: access barriers and social class

In Colombia, the right to health was expressly constitutionalized in articles 44 and 49 of the 1991 Political Constitution as an inherent right of the individual. In 1993, through Law 100, the health system was reformed to achieve universal coverage. Through this, a model of insurance and provision of individual services was established with the objective of guaranteeing access to health promotion, protection and recovery services to all people and promoting equity, understood as the gradual provision of similar quality services regardless of the ability to pay. In 2015, through the enactment of Law 1751 (*Ley Estatuaria de Salud*), the General System of Social Security in Health (*Sistema General de Seguridad Social en Salud*, SGSSS) is regulated and redefined, health is conceived as a fundamental, autonomous and inalienable individual and collective right, and a model based on the social determinants of health is adopted.

The affiliation regimes of the system are: the contributory, which is based on the voluntary or mandatory payment of a monthly fee, the amount of which depends on the income and working conditions of the affiliated person; the subsidized system, which is paid by the State for persons identified in levels 1, 2 and 3 of the so-called SISBEN (*Sistema de Selección de Beneficiarios para programas sociales*), designed to identify and classify persons who, due to their scarce resources, do not contribute economically to the system; and the exceptional systems, which cover persons belonging to the military or police forces and workers of Ecopetrol (Colombian oil company), among others. The Obligatory Contributory (*Plan Obligatorio de Salud Contributivo,* POS-C) or Subsidized (*Plan Obligatorio de Salud Subsidiado* POS-S) Health Plan contains the activities, procedures and health interventions, as well as the drugs, supplies and other benefits included in the plan, which represents the general framework of coverage for the health system. The Capitation Payment Unit (*Unidad de pago por capitación,* UPC) is the annual value recognized for each of the members of the SGSSS to cover the benefits of the Mandatory Health Plan (POS) in the contributory and subsidized regimes. The companies providing health services (EPS) are in charge of managing and providing the services contemplated in these plans. There are also the NON-POS services and benefits, which must be covered by applying to other resources of the system, such as those of the FOSYGA,

for the contributory regime, or those of the Territorial Health Funds (FTS), for the subsidized (MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL, 2016).

This SGSSS model was based on the idea of efficiency, universality and financial solidarity in the provision of services, however, some of its proposals are far from being fulfilled and the main challenges are related to inequity in access, State regulation in the face of private initiatives, scarce financing, EPS corruption, fragmentation and universal coverage through minimum service packages that do not correspond to the health needs of citizens (GAVA, 2016).

Colombian legislation establishes that in case of attacks all actions, procedures and interventions necessary to address both aesthetic and functional sequelae of injuries must be financed by the public health system, through any of the affiliation regimes. In discussion spaces between governmental and non-governmental organizations (field diary, 03-05-2017) some of the difficulties have been identified to ensure that victims receive timely and adequate care in all stages of care (pre-hospital, emergency, hospitalization and outpatient), among which are bureaucratic barriers that hinder or prevent survivors' access to services and the lack of inputs and professional training necessary to provide adequate care.

In the case of the women participating in this research, these difficulties are increased by the fact that some of them do not meet the criteria to be covered by the subsidized system, and do not have stable jobs or sufficient resources to enable them to make continuous monthly contributions to the contributory system. Thus, they are frequently left without health coverage, which generates discontinuity in biomedically oriented treatments, delaying or making aesthetic and functional recovery impossible.

These barriers are experienced by survivors as renewals of the violence:

> The barriers in the lack of timely attention, in the lack of medicines, in the late response to the assignment of a medical appointment, when we arrive at the clinic or the hospital, after a long day, to be able to ask for a medical appointment and get there and they look at us and tell us: 'no, that is not covered by the POS, that is not catalogued as reconstructive surgery, but as aesthetic'. Let's say that the identification of all those barriers, those barriers that women have expressed, telling their stories... that somehow are intertwined not because of the chemical, not because of the aggression, not only because of that, but also because of the lack of institutional response that has been exercised on this issue with us [...] Unfortunately the violence exercised by the aggressor against the victims, is not as great as the violence exercised by the State or the Institution against the victims (Interview with survivor, October 2017).

The barriers are related to inequities in the distribution of health care services and resources, which mainly affect those who are far from urban centers. On the other hand, the economic, social and cultural capital of survivors is one of the main factors to which victims and health professionals attribute inequities within the SGSSS. Referring to the case of Natalia Ponce (a recognized victim with higher capital than most survivors), one of the participants in this research points out the way in which her capital influences her reconstruction process:

> If you see, look: they bring Natalia's skin from Holland [...]. She is still in therapy. Every day they gave her therapy! They brought her the siliconized mask, they massaged her, they guaranteed her the therapies, they did the infiltrations [...] look at her and look at Rosa: [...] exactly the same thing happened to her, but one had the guarantee of... and the other did not. And both were treated in the same hospital and by the same doctors. Look at the two of them and not only the two of them! Look at Natalia and look at the rest: from there down, what happened? (Survivor interview, April 2019).

Although Natalia was treated five years after Rosa, [3] which could be an advantage due to a greater acquisition of competencies and skills by the medical team and an improvement in the technologies, the inequality in the way of intervening on the sicknesses seems to be linked to economic, social and cultural factors (MENENDEZ, 2005) and in this case a structural classism is evident in the differential use of the competencies of the professionals and the resources of the health system, according to the social position of the survivor. Rosa encountered multiple refusals from the EPS, which forced her to go through intricate and revictimizing itineraries, unlike Natalia, to whom "they bring her skin from Holland".

The barriers to access, the suffering and revictimization that mark the experiences within the formal system for these women and the search for treatments centered on aesthetics, lead them to put into practice a set of treatment alternatives that appeal to creativity and co-construction and that combine ideas and knowledge from the formal and informal systems of care.

Healing physicians, tattoos and modeling: mediations of care mobilizing non-formal therapeutic alternatives

Formal health care networks based on biomedical models have the disadvantage of being associated with multiple barriers to access and of prioritizing the reconstruction of functionality, downplaying -or even sometimes at the expense of- aesthetic reconstruction, considered superfluous by many professionals. Both

disadvantages especially affect historically excluded groups. Faced with the lack of response to the treatment needs of the subjects, knowledge, values and practices of non-formal systems appear, both popular and folk, which find space as a manifestation of indispensable processes for the diversification of the dominant culture. As Martínez Hernáez and Correa Urquiza (2017) state, "certainly, suffering appears as a crossroads that moves to the opening of horizons, to questioning and to disorientation" (p. 268).

These possibilities are explored and created in collective spaces favored by the work of various foundations led by survivors. The foundations Reconstruyendo Rostros, Natalia Ponce de León and Kinsugi, not only participate in institutional scenarios to influence public policy. In these spaces, several survivors (the groups in the various meetings range from two to a little more than twenty women) share experiences, address the subjective aspects brought about by the injury, expand the mechanisms of intervention on the body and provide new directions in therapeutic itineraries. There, they carry out transactions of knowledge, meanings and experiences that focus, on the one hand, on facing economic needs (they make jewelry, sew or create handmade products to sell) and, on the other hand, on sharing solutions to face the denials or undesired results of the care process from the formal health system, sharing information and management mechanisms for access to services provided by health professionals, both reconstructive and aesthetic, who provide free services that are denied through the public system. Moreover, in these places they explore and put into practice resources that exceed the possibilities of biomedicine and that, from *folk* and *popular* knowledge, allow reformulating the ideas of health, body and treatment, showing that biomedicine is not the only knowledge that can be used to achieve reconstruction.

The *folk* system addresses the needs of physical recovery through strategies that are far from the evidence-based logic of biomedicine. An example of this was a meeting organized by two survivors with a "healing doctor", who through a "visualization" technique promised to reduce the extent of scars by up to 80% (field diary note, 2016, session with doctor-healer).

The doctor was a living José Gregorio Hernández[4]. His long and complex explanations and his actions accounted for the "hybridization between therapeutics and bio-medical and mystical representations, at the center of a whole flow of transactions between hegemonic and subaltern ways of defining and treating

sickness" (FERRÁNDIZ, 2004, p. 156). Even with a lexicon similar to that of a printed medical encyclopedia, the magic and mysticism of its practice was far from the scientific rationality of biomedicine. This scenario illustrates how, in the itineraries of seeking care, the various subsystems do not establish mutually exclusive boundaries, but on the contrary can coexist without necessarily being framed in an integrated and coherent model (ALVES; SOUSA, 1999).

On the other hand, within the framework of the *popular* (Kleinman, 1979), strategies such as tattooing, the use of costume jewelry, which in the reiteration of its use becomes a body, and modeling emerge. These are part of the set of prostheses for the construction of a new corporeality -understood as the material condition of subjectivity- (GROTZ, 1995), in which is inscribed a claim for the aesthetics lost by the effects of acids and autografts, which leave scars in areas of skin unaffected by chemicals.

The practice of tattooing occurs both individually and collectively. Collective practice has the advantage of giving a place to common suffering among survivors that is ignored by those who have not gone through such experiences. In a *tatuatón* in 2019 (field diary, October 2019), 10 women accessed a tattoo and piercing center and covered with colorful inks some of their scars; both burn marks and "*scars that no one sees*" (inductive category that accounts for the unwanted records of biomedical practices by the taking of autografts):

> my second (tattoo), is this one; it is on the scar on my back, where they took out (an autograft) for my neck [...] is that for me, before the successful neck surgery, which was the one that gave me mobility... They had tried to do it before, that is why I have so many scars... that is the only one that I say has an important meaning, because this scar, if it was worth it. So here, he is making me a swallow, the tattoo has just been done (interview with survivor, November 2019).

Using the ideas of Le Breton (2017), in the act of marking the skin with the tattoo they answer and resignify the suffering and attend to the consequences of identity rupture resulting from the pain imposed by the attack or surgical interventions. The consented pain of the needle that pierces and marks the scar with ink, not only helps to transform the skin visually, but in the rite that surrounds the tattoo, opens the field to create and confirm a statement about the self, about the capacity to act and intervene one's own body and about the definitions of what reconstruction means, which is not limited to the functional but to the aesthetic, the psychological and the social. Tattooing, in these cases, allows "to reorganize and stabilize the traumatism

of the victim's world, providing her with a "voice on the skin" where the real voice is forbidden" (p. 70); and when this is elaborated in collective, the conjugation of the voices that denounce her suffering allows to give place to what has been ignored and rejected for so long.

The use of colorful costume jewelry on burned forearms or necks is also a common practice of intervention on the body, which functions as a prosthesis to hide the scars in these areas of the body. While some of the women express their anguish at the absence of these prostheses (either due to forgetfulness or to the requirements of some workplaces), others symbolize the abandonment of their use as a transition towards the acceptance of their own body and scars, which shows the temporariness and transience of the mechanisms of care available in the different spaces: the procedures and the choice of strategies reflect at the same time procedures with their own life, pain and body.

These meeting spaces are also offered as a platform to care for, nurture and transform corporeality. Through dance and modeling, acid attack survivors expose their bodies and reclaim their sensuality. Events such as "*Modelos por un día (Models for a day)"*, organized by the Reconstruyendo Rostros Foundation in 2015, the performance *"La oscuridad te muestra las estrellas (Darkness shows you the stars)"* by the *furiosa* dance group in 2019, "*Zumbatones*" and smaller events are evidence of how the union of bodies in movement deconstructs conceptions about aesthetics or disability.

Tattoos and these spaces of encounter of bodies in actions of visibility conquest, are therapeutically effective. The first ones intervene on the flesh generating results unthinkable from biomedicine. The latter make it possible to address the subjective aspects of injuries, making it possible to contest positions (victim, disabled, "monster") and to reconstruct new ways of being in the world. The identities that are constructed as a group through the implementation of these mechanisms question and transgress the cultural and medical norm of gender and disability, creating new spaces of subjectivity in which the possibility of conquering the social space of recognition is claimed.

Discussion

In the itineraries of these women, we identified how the forms of segregation and stigmatization prevalent in an unequal society are embodied in the barriers to access to treatment and in the difficulty of the system to break with these

structural difficulties. Pain and deformity inscribe the attacked body in a situation of vulnerability and stigmatization that is revived by the barriers to access to health, work and ultimately to any improvement in the quality of life of the survivors.

In its itineraries, the therapeutic is not restricted to the possibilities offered by biomedicine, but extends to experiences that shape corporeality and health understood as the different ways of walking through life, according to Canguilhem's expression (1971). The therapeutic alternatives of these itineraries do not replace the therapeutics based on the bio-pathological model, but rather question the idea of a "repaired" body that is limited to the always imperfect restoration of aesthetics and bodily functions, but above all they denounce the indolence of its ways of acting on suffering and the inequality of a system that generates inequitable ways of dignifying the body and providing opportunities for its reconstruction.

The folk and popular practices that are part of the described itineraries allow a subjective reconstruction that goes beyond resistance and denunciation of the official systems. But they also give new meaning to the pain and suffering resulting from the attack inflicted by those who leave an indelible mark with violence and by a system that, by attending to health conditions from a reduced and inequitable viewpoint, also leaves marks. These experiences allow us to consider, as has been discussed in other Latin American works (GERHARDT, 2006; ABADÍA BARRERO; OVIEDO MANRIQUE, 2010; CABRAL *et al.*, 2011; LIMA; BAPTISTA; VARGAS, 2017), that not only sickness or disability are an expression of social dynamics, but so are the itineraries of seeking care.

The events and encounters allow these survivors to look at each other and themselves in a dynamic of resistance and complicity and to detach themselves from the violence and dehumanization that once marked their skin, in an attempt to deny their agency and their experience; that is, their capacity to feel affection and to make decisions about their lives (HAQUE; WAYTZ, 2012). In these encounters, women are able to show their affections and restore their agency in relation to their lives and bodies.

Taking into account these findings and agreeing with Alves and Souza (1999), Menéndez (2005) and Venturiello (2012), the knowledge and use of information on therapeutic itineraries by professionals and health services, allows offering care more in line with the needs of women, giving priority to strategies that rescue their integration, autonomy, creativity and co-responsibility, generating alternatives

that overcome the shortcomings of the hegemonic model of biopathology (PERDIGUERO GIL; TOSAL HERRERO, 2007).

The case of acid attack survivors in Colombia is an emblematic example of unequal societies where, even with limited economic, human and technological resources for care, class differences mark inequities in access to services and in the recognition of the right to health in the broad sense of the word, an aspect that has also been described in other Latin American contexts (GARCIA-SUBIRATS *et al.,* 2014). One of the main limitations of this study is not accounting for how other differential factors such as race, geographic origin or level of disability, among others, intersect to shape the experiences in these itineraries. However, this case provides elements for reflection on the need to strengthen processes of structural and cultural transformation that allow for the recognition of the legitimacy of suffering without differentiation, allowing each subject to live a better life.[5]

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Notes

[1] In subsequent years, different monitoring mechanisms record cases. From 2015 to 2018, the National Institute of Health (INS, 2015, 2016, 2017) published reports to more accurately account for the incidence at the national level: 69 cases in 2015 (43 women and in 26 men); 48 cases in 2016 (27 in women and 21 men); 54 cases in 2017 (23 men and 31 women); and 48 cases in 2018 (29 men and 19 women). In 2019 the INMLCF (2019) reported 16 attacks perpetrated in the context of domestic violence (3 men and 13 women) and in 2020 the District Secretariat for Women (2021) made known a total of 6 attacks on women in the country's capital.

[2] EPSs are public or private entities in charge of managing and providing the services contemplated in the health plans of the contributory and subsidized systems.

[3] Assaulted woman who participated in this research and to whom another survivor refers in the above quote. The name of this participant has been replaced in this text to preserve her anonymity and privacy.

[4] He was a Venezuelan physician and philanthropist declared blessed by the Catholic Church, who in the Spanish-speaking world is credited with several miracles in the cure of diseases, often achieved through rites that combine medical, magical and mystical references.

[5] L. Franco Cian: research design; data collection and analysis; substantial contribution to the conception, writing and revision of the article within the framework of the PhD research in Gender Studies at the Rovira and Virgili University (Spain). S. Rivera-Largacha: substantial contribution to the conception, drafting and revision of the article.

Resumen

Itinerarios de reconstrucción de cuerpos de mujeres atacadas con agentes químicos en Bogotá, Colombia

El objetivo de este trabajo es analizar las experiencias de búsqueda y acceso a procedimientos para la reconstrucción física, social y psicológica de mujeres atacadas con agentes químicos en la ciudad de Bogotá. A partir un diseño etnográfico se recolectó información observacional y discursiva en escenarios de intervención formal y no formal sobre los cuerpos y se realizaron entrevistas en profundidad a sobrevivientes y a profesionales de la salud. Los datos fueron analizados a partir de un enfoque narrativo-crítico. Los hallazgos evidencian interpretaciones divergentes dentro de los sistemas cuidado de la salud sobre lo que constituye la reconstrucción de un cuerpo atacado con agentes químicos en un contexto marcado por grandes desigualdades en el acceso a la salud.

➤ **Palabras clave:** Ataques con agentes químicos. Itinerarios terapéuticos. Modelos de Atención de Salud. Violencia de género. Desigualdad en Salud.

Resumo

Itinerários de reconstrução de corpos de mulheres agredidas com agentes químicos em Bogotá, Colômbia

O objetivo deste trabalho é analisar as experiências de busca e acesso a procedimentos de reconstrução física, social e psicológica de mulheres agredidas com agentes químicos na cidade de Bogotá. Com base em um delineamento etnográfico, recolheu-se informação observacional e discursiva em cenários formais e não formais de intervenção sobre os corpos e realizaram-se entrevistas em profundidade a sobreviventes e profissionais de saúde. Os dados foram analisados a partir de uma abordagem narrativa-crítica. Os achados mostram interpretações divergentes nos sistemas de saúde sobre o que seria a reconstrução de um corpo agredido com agentes químicos em um contexto marcado por grandes desigualdades no acesso à saúde.

➤ **Palavras-chave:** Ataques com agentes químicos. Itinerários terapêuticos. Modelos de Atenção em Saúde. Violência de gênero. Desigualdade em saúde.