ORIGINAL ARTICLE

Local Understandings and First Aid Responses to Burn Injuries: A Phenomenological Study in an Urban Indonesian Community

Hardin La Ramba,[1] Yarwin Yari,[1] Ulfa Nur Rohmah,[2] Fitri Diana Astuti,[3]
Fransiska Anita Ekawati Rahayu Sa'pang,[4] Indra Gilang Pamungkas[5] and Kristoforus Marselinus[1]

[1]*Sekolah Tinggi Ilmu Kesehatan RS Husada, Jakarta, Indonesia*
[2]*Department of Nursing, Faculty of Medicine, Sriwijaya University, Palembang, Indonesia*
[3]*Karya Persada Muna University, Muna, Indonesia*
[4]*Department of Nursing, Stella Maris College of Health Sciences, Makassar, Indonesia*
[5]*Politeknik Negeri Subang, Subang, Indonesia*

ABSTRACT

Background. Burn injuries remain a significant global public health problem, causing substantial morbidity, mortality, and economic burden, particularly in low- and middle-income countries where nearly 90% of cases occur. Despite the importance of timely and appropriate first aid in reducing complications, community responses to burn injuries in many settings continue to rely on traditional or non-evidence-based practices.

Objective. This qualitative phenomenological study explored community-based knowledge and responses related to the causes and first aid of burn injuries.

Methods. The study involved ten (10) purposively selected informants residing in South Mangga Dua Urban Village, Central Jakarta, Indonesia. Data collection methods included semi-structured interviews, direct observations, and focus group discussions (FGDs). Thematic analysis was used.

Results. Three (3) core domains were identified: (1) community perceptions of burn causes and classifications, (2) indigenous first aid practices used in domestic settings, and (3) sources of knowledge and information pathways related to burn first aid. Participants commonly attributed burns to incidents involving fire, hot liquids, and electrical faults. Their understanding of burn severity was limited to superficial assessments, with little awareness of clinical classifications. First aid responses were largely based on traditional practices such as the application of toothpaste, honey, or aloe vera, while evidence-based practices like using running water were rarely mentioned. Notably, most participants relied on familial teachings and informal community experiences as their primary sources of knowledge, with limited exposure to health professionals or verified media content.

Conclusion. Community knowledge is culturally rooted but misaligned with medical standards, potentially leading to unsafe practices. Culturally sensitive health education integrating traditional beliefs and accurate information is essential to improve outcomes in burn injury management.

Keywords: burns, health knowledge, attitudes, practice, first aid, medicine, traditional, health communication, urban population

eISSN 2094-9278 (Online)
Published: April 30, 2026
https://doi.org/10.47895/amp.vi0.12211

Corresponding author: Hardin La Ramba
Sekolah Tinggi Ilmu Kesehatan RS Husada,
Jl. Mangga Besar Raya No. 137–139,
Jakarta 10730, Indonesia
Email: hardinlaramba@gmail.com
ORCiD: https://orcid.org/0000-0001-8727-1193

INTRODUCTION

Burn injuries represent one of the most serious forms of trauma, resulting from exposure to various agents such as heat, radiation, electricity, or chemicals, and can cause extensive damage to the skin and underlying tissues at varying degrees of severity.[1] Globally, both acute and chronic injuries continue to pose substantial challenges to healthcare systems, impacting millions of individuals annually.[2] In high-income countries such as the United States, the financial burden of burn care is estimated to reach approximately 7.5 billion US dollars per year.[1] Meanwhile, the World Health Organization (WHO) reports that around 300,000 fatalities due to burns occur worldwide each year, with the vast majority concentrated in low- and middle-income countries. In Indonesia, epidemiological data on burns are very limited, but the Indonesian National Health Research states that the prevalence of burns is around 0.7% of the total population.[3]

The likelihood of experiencing burn injuries is strongly associated with socioeconomic determinants. Nearly 90% of burn cases are reported in countries with limited economic and healthcare resources, where inadequate housing conditions, lack of education, and occupational hazards increase vulnerability to such incidents.[4] Among the working population, electrical burns are frequently encountered in labor-intensive sectors such as construction, particularly in urban environments with minimal regulatory oversight.[5] Evidence shows that 79.46% of patients who suffered electrical burns were exposed to high-voltage current, with 46.03% experiencing severe burns, and 11.33% suffering from associated trauma-related complications. These injuries may result in serious consequences, including impaired consciousness, neurological deficits, and functional limitations such as muscle weakness or numbness in the limbs.[6]

Severe burns are also commonly associated with long-term disability, psychological distress, and the need for prolonged medical care and rehabilitation. Prompt and appropriate management is essential to prevent infection, support tissue healing, and maintain functional independence.[7] The first 24 hours following injury are considered a critical period in which early intervention can significantly reduce complications.[8] While minor burns may resolve within one week, more extensive injuries often require several weeks of treatment, emphasizing the importance of timely and effective first aid.[9,10]

First aid refers to the immediate and initial assistance provided to individuals suffering from injury or acute illness.[11] Its primary objectives include preserving life, alleviating pain and suffering, preventing further harm, and facilitating recovery.[11,12] First aid is not exclusively the domain of medical professionals; in fact, it can be performed by anyone, including laypersons, especially in emergency settings where immediate care is crucial.[13] In recent years, global health agendas have increasingly recognized the value of Psychological First Aid (PFA) and basic emergency care competencies for community members and first responders alike.[14]

Despite ongoing advancements, significant gaps in community knowledge and first aid practices for burn injuries remain, particularly in low-resource urban settings. Many individuals continue to rely on traditional or non-clinical remedies such as the application of toothpaste, raw eggs, or cooking oil to treat burn injuries. These practices are often rooted in generational beliefs and anecdotal experiences rather than grounded in scientific evidence. While culturally ingrained, such methods may unintentionally exacerbate tissue damage and hinder appropriate healing.

This study aims to explore local meanings and provide first aid for burns as interpreted by Indonesian urban communities. It seeks to uncover the beliefs and behaviors that shape these practices and identify commonly accessed sources of information, including family traditions and communal narratives. The findings are expected to inform the development of culturally sensitive, community-based health education strategies. From a nursing perspective, this research is especially valuable, as it provides critical insights for designing effective, evidence-informed interventions that respect cultural norms while addressing misconceptions, ultimately enhancing health outcomes and strengthening trust between healthcare professionals and the communities they serve.

MATERIALS AND METHODS

Research Design

This study adopted a qualitative phenomenological design to explore local understandings and first aid responses to burn injuries in an urban Indonesian community. Phenomenology, rooted in the philosophical traditions of Husserl and Heidegger, seeks to explore the lived experiences of individuals and how they perceive phenomena within their lifeworld.[15] The goal of this design was to explore the subjective meanings and socio-cultural interpretations that community members ascribe to burn injuries and their treatment practices. A phenomenological approach was chosen because it allows for an in-depth exploration of participants' inner worlds, giving voice to their experiences, perceptions, and the embedded cultural logic that shapes health-related behaviors. The study was conducted in South Mangga Dua Urban Village, Central Jakarta, Indonesia, between July and October 2023. Considerations in selecting the location were that the area was densely populated and at risk of fire.

Participants of the Study

Participants were selected using purposive sampling, a strategy widely used in qualitative research to identify individuals with rich and relevant knowledge of the phenomenon under study.[16] The inclusion criteria for participants in this study were as follows: (1) having resided in the South Mangga Dua Urban Village for a minimum of ten years to ensure deep-rooted familiarity with local cultural

Table 1. Demographics and Characteristics of Participants

Participants Code	Age (Years)	Gender
Participant 1 (P1)	37	Male
Participant 2 (P2)	42	Male
Participant 3 (P3)	52	Male
Participant 4 (P4)	53	Female
Participant 5 (P5)	53	Male
Participant 6 (P6)	55	Female
Participant 7 (P7)	56	Male
Participant 8 (P8)	54	Male
Participant 9 (P9)	52	Male
Participant 10 (P10)	60	Male

practices and social dynamics; (2) demonstrating willingness and availability to engage in in-depth interviews, discussions, and observations; and (3) possessing the ability to articulate experiences and perceptions clearly in the local language. A total of ten participants were recruited, with three identified as key informants based on their community roles, availability, and depth of experiential knowledge. The demographic characteristics of the participants are presented in Table 1.

Purposive sampling was deemed appropriate as it enabled the researchers to focus on individuals with lived experiences pertinent to burn injuries and their management in domestic settings, consistent with phenomenological methodology.[17]

Data collection

Data were collected through semi-structured in-depth interviews, focus group discussions (FGDs), and participant observations. This triangulation of methods allowed for a comprehensive understanding of the phenomenon and enhanced the validity of the findings.[18,19] The implementation strategy of the data collection process is presented in Table 2.

In-depth interviews were guided by open-ended questions, encouraging participants to share personal narratives and reflect on their experiences. This aligns with Kvale and Brinkmann's emphasis on dialogue and meaning-making in qualitative interviewing.[20] The researcher who conducted the interview had no relationship or closeness with the participants, so it was certain that he would not interfere with the in-depth interview process. Focus group discussions (FGDs) enabled the researchers to observe shared cultural narratives, social norms, and collective beliefs related to burn causes and first aid. FGDs are especially useful in exploring communal knowledge and contrasting perspectives.[21] FGD was conducted with two groups, each consisting of five people. During the in-depth interview and FGD process, the researcher used an audio recorder and field notes to collect data from participants. Participant observations were conducted to document behavioral practices and physical environments related to burn injury management, such as the household items used for first aid and the conditions of kitchens and living spaces. Checklists are used by researchers during observations.

Research Instruments

The main research instrument in this study was a semi-structured interview guide developed based on the study's objectives and relevant literature on health behavior and community practices. The guide was reviewed by two qualitative experts and a nursing practitioner to ensure clarity and cultural relevance. Open-ended questions were designed to explore participants' knowledge and experiences related to burn injuries and first aid. The list of interview questions used in this study, including their purposes, is shown in Table 3.

Data Analysis

Data were analyzed using thematic analysis, following the six-phase process described by Braun and Clarke: familiarization, coding, theme development, reviewing themes, defining and naming themes, and writing the report.[22] This approach is appropriate for phenomenological studies as it allows the researcher to identify shared meanings across participant experiences while respecting the uniqueness of each voice.

Transcripts were analyzed in the original Bahasa Indonesia, and representative quotes were translated into English. To ensure accuracy and contextual integrity, both

Table 2. Implementation Strategy of Data Collection

Stages of Activities and Time	Activity Description	Participants Activities
Introduction (10 minutes)	1. Research Introduction 2. Explanation of research purposes and scope 3. Informed consent process 4. Agreement on time and participant	1. Introducing themselves 2. Listening to the study explanation 3. Asking a clarifying question 4. Providing informed consent 5. Agreeing to time commitment
Implementation (100 minutes)	1. Conducting a focus group discussion (FGD) 2. Participant Observation 3. In-depth Interviews with key informants	1. Sharing experiences and perspectives 2. Responding to guided questions 3. Engaging in reflective discussion
Closing (10 minutes)	1. Summarizing key discussion points 2. Expressing gratitude to participants 3. Concluding the session formally	1. Listening to the summary 2. Providing feedback 3. Concluding participation

Table 3. List of Questions of the Study

List of questions	Purpose of the question
1. Can you tell me what you know about burn injuries? Have you or your family ever experienced one?	To explore participants' basic understanding and lived experience with burn injuries.
2. In your opinion, what usually causes burn injuries at home or in your neighborhood?	To identify commonly perceived causes of burns in the local context.
3. How do you usually recognize if a burn is minor or severe? What signs do you look for?	To understand how participants classify or assess burn severity visually or culturally.
4. What do you usually do first when someone gets a burn injury at home?	To capture immediate first aid responses in real-life scenarios.
5. What kinds of materials or substances do you apply to a burn, and why?	To explore the specific practices used and the beliefs behind them.
6. Where did you learn these first aid methods or beliefs? Who influenced your actions the most?	To trace the sources of knowledge and transmission of burn-related first aid.
7. Have you ever heard information about burn treatment from a doctor, nurse, or the media? What was your impression of that information?	To examine exposure to formal or external sources of health education and trust in them.
8. How do you usually feel when you have to deal with a burn injury at home, either for yourself or someone else?	To explore emotional responses such as fear, confidence, worry, or helplessness.
9. What challenges or difficulties do you face when treating a burn injury at home?	To identify practical limitations, knowledge gaps, or access-related barriers.
10. What do you think could be done to help people in your community better understand and treat burn injuries?	To gather suggestions and community-driven ideas for education or intervention.

linguistic and cultural meanings were carefully preserved in translation. The results were organized into three main thematic domains: (1) local understandings of burns; (2) first aid practices at home; and (3) sources of knowledge and information. Themes were supported by direct quotations from participants to ground the analysis in lived experience and natural language, in line with phenomenological principles.[23]

Trustworthiness and Rigor

Credibility was enhanced through triangulation of methods and sources, member checking, and peer debriefing. Member checking involved presenting interpreted summaries back to participants to confirm the accuracy of their meanings.[24] Reflexivity was maintained by documenting researchers' assumptions and reflections throughout data collection and analysis. An audit trail was maintained to ensure dependability and confirmability.

Ethical Considerations

The study obtained ethical approval from the Institutional Review Board of the Institute for Research and Community Services (LPPM), Sekolah Tinggi Ilmu Kesehatan RS Husada, under approval number 1988/Ext/STIKes-RSHSD/VI/2023. All participants provided written informed consent. Participant codes were used to protect identity and ensure confidentiality. Data were stored securely in compliance with institutional ethical guidelines.

RESULTS

The results of this study reveal that community understanding of burn injuries is predominantly shaped by everyday experiences and traditional knowledge, rather than informed by medical classifications or clinical guidelines. The analysis is organized into three thematic domains: (1) Local Understandings of Burns, (2) First Aid Practices at Home, and (3) Sources of Knowledge and Information. Each theme is presented using natural language from participant quotations in both Bahasa Indonesia and English translation. A summary of the identified domains and keywords is presented in Table 4.

Table 4. Summary Table of Domains and Keywords

Domain	Keywords
1. Local understandings	Hot water, electrical shock, fire, hot oil, and daily domestic accidents
2. First aid practices at home	Aloe vera, honey, toothpaste, butter, soap, and minimal water use
3. Sources of knowledge and information	Family, neighbors, personal experience, social media

Local understanding of burns

Participants commonly identified hot water, electric shocks, and fire as the main causes of burn injuries. The severity of burns was generally interpreted visually or based on the location and extent of visible damage, with no knowledge of clinical classification, such as degrees or surface area. Table 5 presents participants' statements describing their local understanding of burn causes.

Table 6 shows how participants perceived and categorized burn severity based on observable signs. In terms of severity, participants commonly described burns as either minor or very severe, without reference to medical degrees.

Table 5. Statement of the Participants on Local Understanding of Burns

Participants	Statement of the participants
P1	*"Ya luka bakar mah biasanya karena air panas, biasa kan kalau kesiram air panas saat seduh kopi. Itu kejadian sehari-hari di rumah"* (Burns usually happen from hot water, like when spilling it while making coffee. It's a daily occurrence at home)
P4	*"Luka bakar itu bisa karena nyetrika, kadang kena kompor. Anak saya pernah kena panci panas langsung melepuh"* (Burns can come from ironing or touching a stove. My child once got burned by a hot pan, and it blistered immediately)
P5	*"Saya pikir luka bakar itu dari api, misalnya kena korek api atau lilin. Kulit langsung melepuh dan sakit"* (I think burns come from fire, like contact with lighters or candles. The skin blisters quickly, and it's painful)
P7	*"Kalau masak kadang suka kena minyak panas atau air mendidih. Itu sering banget terjadi di dapur"* (When cooking, sometimes you get splashed by hot oil or boiling water. It happens a lot in the kitchen)
P9	*"Di sini sering ada kebakaran kecil. Kayak pas masak terus lupa matiin api, bisa langsung kena percikan"* (Here, small fires happen often, like when someone forgets to turn off the stove and gets burned by the flames)
P10	*"Saya pernah lihat luka bakar karena petasan waktu tahun baru. Anak-anak main, terus nyamber ke baju"* (I once saw a burn from fireworks during New Year's. The kids were playing, and it hit someone's clothes)

Table 6. Statement of the Participants on Local Understanding of Burns in Terms of Severity

Participants	Statement of the participants
P2	*"Kita taunya luka biasa. Gak ngerti itu derajat satu atau dua, pokoknya kalau merah dan sakit ya itu parah"* (We just know it's a wound. We don't understand if it's first or second degree; if it's red and painful, it's serious)
P3	*"Kalau kulitnya hitam atau melepuh parah, saya anggap itu paling parah. Tapi nggak ngerti istilah medisnya"* (If the skin turns black or blisters severely, I consider it the most serious. But I do not understand the medical terms)
P6	*"Luka kecil biasanya saya obati sendiri. Tapi kalau gede dan berair, itu yang saya anggap berat"* (Small burns I treat at home, but if it's big and oozing, I think that's a serious one)
P8	*"Saya nggak tau soal klasifikasi, cuma lihat dari bentuk luka aja"* (I don't know the classifications, I just judge by how the wound looks)
P9	*"Kalau luka lebar dan lama sembuhnya, itu pasti parah. Tapi nggak tau itu masuk apa"* (If it's wide and takes a long time to heal, it must be severe. But I don't know what it's classified as)
P10	*"Pernah lihat luka bakar di tangan tetangga, katanya ringan, tapi saya kira parah karena melepuh besar"* (I saw a burn on my neighbor's hand. They said it was mild, but I thought it was severe because of the big blisters)

First aid practices at home

Traditional remedies dominate first aid responses. Table 7 shows the various first aid practices applied by participants using locally available materials. Most participants mentioned using materials available at home, such as aloe vera, honey, toothpaste, or kitchen items. The use of clean, running water was rarely prioritized.

Sources of knowledge and information

Participants predominantly acquired their understanding of burn causes and first aid through informal and intergenerational sources. Health professionals or formal education were rarely mentioned. Sources of knowledge and information reported by participants are presented in Table 8.

DISCUSSION

Local Understandings of Burns

This study found that the community's understanding of burn injuries is primarily informed by daily experience and inherited local knowledge. Participants perceived burns as injuries caused by exposure to hot water, fire, or electrical currents, reflecting what has been described in previous literature as culturally situated knowledge developed through generations.[25,26] These perceptions align with findings by Nugroho et al. that local knowledge is shaped by immediate surroundings and practical encounters.[27] Participants demonstrated no familiarity with the clinical classification of burns; severity was interpreted solely based on visible signs or the extent of pain.

Such limitations highlight the disparity between local conceptual frameworks and biomedical standards. Local knowledge has value and may serve as a culturally relevant foundation for health education.[28] The absence of clinical awareness poses challenges. For example, misjudging the severity of burns can lead to delays in seeking medical care and result in complications such as infection, scarring, or disability.[29,30] Electrical burns remain a significant contributor to burn injury patterns, especially in urban environments with exposed wiring.[31] In addition, trauma from fire-related accidents continues to be a common etiology of burns in densely populated settlements.[32,33] An understanding of burn depth (epidermal, dermal, or subcutaneous) is essential in guiding timely and appropriate treatment.[4] Public health strategies, therefore, should aim to preserve cultural knowledge while introducing evidence-based concepts that enhance community resilience and health literacy.[34]

Table 7. Statement of the Participants on First Aid Practice at Home

Participants	Statement of the participants
P1	*"Biasanya langsung dikasih lidah buaya dari pot depan rumah. Katanya adem dan cepat sembuh"* (We usually apply aloe vera from the pot in front of the house. It feels cool and heals quickly)
P2	*"Kalau saya sih pakai pasta gigi. Itu udah jadi kebiasaan dari kecil, orang tua juga pakai itu"* (I use toothpaste. It's been a habit since childhood; my parents used it too)
P5	*"Madu saya percaya bisa bikin kulit nggak gosong. Biasanya langsung diolesin tipis"* (I believe honey prevents the skin from darkening. I usually apply a thin layer right away)
P7	*"Tetangga pernah bilang pakai mentega, jadi saya coba. Katanya biar gak jadi luka dalam"* (A neighbor once told me to use butter, so I tried it. They said it prevents deep wounds)
P8	*"Saya pernah kasih sabun cair buat bersihin. Gak tahu boleh atau enggak, tapi saya kira membantu"* (I once used liquid soap to clean it. I don't know if it's right, but I thought it would help)
P9	*"Air mengalir cuma sebentar aja, terus langsung saya kasih salep dari warung. Takut kebasahan lama"* (I only used running water briefly, then applied ointment from a local shop. I'm afraid to let it stay wet too long)

Table 8. Statement of the Participants on Sources of Knowledge and Information

Participants	Statement of the participants
P3	*"Saya taunya dari ibu saya. Dia selalu pakai lidah buaya buat luka, jadi saya ikut aja"* (I learned from my mother. She always used aloe vera for wounds, so I just followed)
P4	*"Kalau ada yang luka, biasanya orang sekitar yang bantu. Kasih saran pakai apa, dari pengalaman mereka"* (When someone gets burned, the people around usually help. They give advice based on their experiences)
P7	*"Saya nggak pernah belajar dari sekolah atau rumah sakit. Semua dari pengalaman pribadi"* (I never learned from school or the hospital. Everything is from personal experience)
P8	*"Orang tua dan nenek saya yang ngajarin. Dulu mereka gak ada dokter, jadi pakai cara alami"* (My parents and grandmother taught me. They didn't have doctors before, so they used natural ways)
P10	*"Saya denger juga dari YouTube, tapi lebih percaya kalau yang ngomong itu orang sekitar sini"* (I also hear things from YouTube, but I trust it more if someone from around here says it)

First Aid Practices at Home

First aid practices reported by participants were dominated by traditional methods, primarily the use of aloe vera, honey, toothpaste, and occasionally butter or soap. This aligns with findings from prior studies, which show that traditional healing methods are often based on generational beliefs and communal habits.[25] While some remedies like honey have been supported in clinical literature for their antimicrobial and healing properties, others, such as toothpaste, are not recommended and may even aggravate the burn.[34,35]

The inconsistent or incorrect application of first aid, such as applying inappropriate substances or neglecting the use of running water, can delay healing and increase the risk of secondary complications. While WHO and other international guidelines recommend cooling the burn with running water for 20 minutes within the first three hours, only a minority of participants reported using this method, and most did so briefly.[36] Community reliance on accessible and affordable materials is understandable in low-resource settings, but it underlines the urgent need for clear public health communication.[37]

Understanding the extent and classification of burns is vital before initiating first aid. Participants' lack of awareness of burn degrees indicates a serious gap in health education. Misinterpretation may lead to under-treatment of deep burns or overuse of inappropriate remedies, extending recovery time and increasing the burden on healthcare services.[4,38] Proper identification of burn type, whether superficial, partial-thickness, or full-thickness, should inform immediate response, especially in environments lacking professional care.[34] Therefore, structured training and culturally relevant educational interventions are crucial for improving early burn management at the community level.

Sources of Knowledge and Information

The study revealed that most participants gained their knowledge of burn causes and first aid through informal pathways, such as parents, neighbors, personal experience, and local traditions. This is consistent with literature describing indigenous knowledge transmission as largely oral, experiential, and context-dependent.[25,27] Although social media digital platforms like YouTube were occasionally mentioned, participants expressed greater trust in community-based information, reflecting low health literacy and skepticism toward formal sources.[29,39]

This strong reliance on informal knowledge pathways can either facilitate or hinder health outcomes. When community practices align with clinical recommendations, such as the use of honey, they can serve as a valuable complement.[35] However, when they diverge, such as using toothpaste or butter, they may delay healing or worsen the injury.[34,40] As such, nurses and community health workers should position themselves as trusted sources of reliable information who can build on existing cultural practices while correcting harmful misconceptions.[25,34]

The integration of culturally grounded education with accurate, evidence-based content is essential. Community health promotion must go beyond information dissemination to actively engage families, community leaders, and local influencers in behavior change strategies.[41] By aligning health messages with cultural values and language, healthcare providers can foster acceptance and improve burn care outcomes in similar low-resource, urban contexts.

Limitations

This study has several limitations that should be acknowledged. First, the findings are based on a relatively small number of participants within a single urban community, which may limit the transferability of the results to other settings or cultural contexts. Second, although reflexivity was maintained throughout the research process, the researcher's professional background in nursing and community health might have subtly influenced data interpretation despite efforts to minimize bias. Third, the study relied on participants' self-reported experiences and recollections, which may be subject to recall bias or social desirability bias.

CONCLUSION AND RECOMMENDATIONS

This study found three themes, including local understanding of burns, first aid practice at home, and the source of knowledge and information. The findings reveal that although community members possess culturally rooted understandings of burn causes primarily hot water, fire, and electrical accidents, they lack familiarity with medical classifications and severity levels. Traditional beliefs and intergenerational experiences strongly influence perceptions and decision-making in managing burns, often without the support of formal health information.

First aid practices were predominantly based on the use of aloe vera, honey, toothpaste, and other locally available substances, with minimal application of evidence-based approaches such as running water. Participants' knowledge was shaped largely by informal sources, family, neighbors, and personal experience rather than health professionals or structured education. These insights highlight the need for health promotion strategies that respect cultural norms while incorporating accurate, evidence-based burn care education to improve outcomes and prevent complications.

To address the identified knowledge gaps, health promotion initiatives should be tailored to the community's cultural context by integrating local beliefs with clinically accurate information. Public health authorities, in collaboration with nurses and community leaders, are encouraged to develop and deliver educational programs using familiar communication channels. These efforts should emphasize the importance of correct burn classification and immediate treatment using safe, effective methods particularly the use of running water while dispelling harmful practices that are culturally accepted but medically inappropriate.

Future studies could expand to include participants from diverse communities and occupational backgrounds, apply triangulation with observational or participatory methods, and explore intervention-based approaches to enhance community preparedness in burn first aid practices.

The study reinforces the crucial role of nurses as educators and change agents in community health. Culturally competent nursing care involves recognizing local traditions while guiding communities toward safer practices. Nurses should actively engage with families and local leaders to build trust, promote health literacy, and deliver targeted interventions that align with community values. By integrating traditional wisdom with scientific knowledge, nurses can contribute significantly to improving first aid responses and fostering long-term health resilience within urban communities.

Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

All authors declared no conflicts of interest.

Funding Source

None.

REFERENCES

1. Abubakar A, Ajuji M, Yahya IU. Comparison of deep transfer learning techniques in human skin burns discrimination. Appl Syst Innov. 2020;3(2):1-15. doi: 10.3390/asi3020020.
2. Rostami B, Anisuzzaman DM, Wang C, Gopalakrishnan S, Niezgoda J, Yu Z. Multiclass wound image classification using an ensemble deep CNN-based classifier. Comput Biol Med. 2021;134(June):104536. doi: 10.1016/j.compbiomed.2021.104536. PMID: 34126281.
3. Abubakar A, Ugail H, Bukar AM. Assessment of human skin burns: a deep transfer learning approach. J Med Biol Eng. 2020;40(3):321-3. doi: 10.1007/s40846-020-00520-z.
4. Greenhalgh DG. Management of burns. N Engl J Med. 2019 Jun; 380(24):2349-59. doi: 10.1056/NEJMra1807442. PMID: 31189038.
5. Lu JL. Statistics on trends of occupational injury and related injuries in the Philippines. Acta Med Philipp. 2021;55(6):604-15. doi: 10.47895/AMP.V55I6.3328.
6. Jimenez ACD, Napa NN, Dy Ching Bing–Agsaoay D. Challenges in the rehabilitation management of a patient with Spinal Cord Injury Without Radiographic Abnormality (SCIWORA) secondary to high-voltage electrical burn injury with multiple disabilities: a case report. Acta Med Philipp. 2022;56(4):111-5. doi: 10.47895/AMP.V56I4.4117.
7. Gonzales JAA, Bing-Agsaoay DODC. Rehabilitation of geriatric burn patient post-meek micrograft with bilateral partial calcanectomy: a case report. Acta Med Philipp. 2024 Jan;58(1):79-83. doi: 10.47895/amp.vi0.6115. PMID: 38939850; PMCID: PMC11199362.
8. Ladhani HA, Yowler CJ, Claridge JA. Burn wound colonization, infection, and sepsis. Surg Infect (Larchmt). 2021;22(1):44-8. doi: 10.1089/sur.2020.346. PMID: 33085576.
9. Hughes A, Almeland SK, Leclerc T, Ogura T, Hayashi M, Mills JA, et al. Recommendations for burns care in mass casualty incidents: WHO Emergency Medical Teams Technical Working Group on Burns (WHO TWGB) 2017-2020. Burns. 2021;47(2): 349–370. doi: 10.1016/j.burns.2020.07.001. PMID: 33041154; PMCID: PMC7955277.

10. Manalili LG, Dy Ching Bing-Agsaoay DO, Leochico CFD. Clinical utility of musculoskeletal ultrasound in localizing heterotopic ossification of the hip in a patient with chronic burns: a case report. Acta Med Philipp. 2022;56(4):116-20. doi: 10.47895/AMP.V56I4.4168.
11. Singletary EM, Zideman DA, Bendall JC, Berry DC, Borra V, Carlson JN, et al. 2020 International Consensus on First Aid Science with Treatment Recommendations. 142;2020. doi: 10.1161/CIR.0000000000000897. PMID: 33084394.
12. Alkhalifah KM, Almutairi F, Almohaimeed NS, Alhumaidan LS, Alsulaim L. Perception, Awareness, and practices related to burn first aid among the general population in Qassim Region, Saudi Arabia. Cureus. 2023;15(9). doi: 10.7759/cureus.45879. PMID: 37885545; PMCID: PMC10598412.
13. Minna S, Leena H, Tommi K. How to evaluate first aid skills after training: a systematic review. Scand J Trauma Resusc Emerg Med. 2022;30(1):1-11. doi: 10.1186/s13049-022-01043-z. PMID: 36348427; PMCID: PMC9641962.
14. Wang L, Norman I, Xiao T, Li Y, Leamy M. Psychological first aid training: A scoping review of its application, outcomes and implementation. Int J Environ Res Public Health. 2021;18(9). doi: 10.3390/ijerph18094594. PMID: 33926108; PMCID: PMC8123604.
15. Creswell JW. Qualitative Inquiry & Research Design: Choosing Among Five Approaches. Third Edit. SAGE Publication, Inc; 2013.
16. Patton, Quinn M. Qualitative Research & Evaluation Methods. Fourth Ed. SAGE Publication, Inc; 2015.
17. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Adm Policy Ment Health. 2015;42(5):533–544. doi: 10.1007/s10488-013-0528-y. PMID: 24193818; PMCID: PMC4012002.
18. Denzin NK. The Research Act: A Theoretical Introduction to Sociological Methods. In: 1st Edition. Routledge; 2009. p. 379. doi: 10.4324/9781315134543.
19. Carter N, Bryant-Lukosius D, Dicenso A, Blythe J, Neville AJ. The use of triangulation in qualitative research. Oncol Nurs Forum. 2014;41(5):545-7. doi: 10.1188/14.ONF.545-547. PMID: 25158659.
20. Brinkmann S, KvaleS. Doing Interviews. 2nd Edition. SAGE Publications Ltd; 2018. doi: 10.4135/9781529716665.
21. Krueger RA, Casey M. Focus Groups: A Practical Guide for Applied Research. In: 5th Edition. SAGE Publications; 2015. p 361.
22. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101. doi: 10.1191/1478088706qp063oa.
23. van Manen M. Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. 2nd Edition. Routledge; 1997. p. 220. doi: 10.4324/9781315421056.
24. Lincoln YS, Guba EG. Naturalistic Inquiry. SAGE Publication, Inc.; 1985. p 416.
25. Šakić Trogrlić R, Duncan M, Wright G, van den Homberg M, Adeloye A, Mwale F, et al. External stakeholders' attitudes towards and engagement with local knowledge in disaster risk reduction: are we only paying lip service? Int J Disaster Risk Reduct. 2021;58(October 2020). doi: 10.1016/j.ijdrr.2021.102196.
26. Prohaska T, Burholt V, Burns A, Golden J, Hawkley L, Lawlor B, et al. Consensus statement: loneliness in older adults, the 21st century social determinant of health? BMJ Open. 2020;10(8):e034967. doi: 10.1136/bmjopen-2019-034967. PMID: 32788184; PMCID: PMC7422633.
27. Fernández-Llamazares Á, Lepofsky D, Lertzman K, Armstrong CG, Brondizio ES, Gavin MC, et al. Scientists' warning to humanity on threats to indigenous and local knowledge systems. J Ethnobiol. 2021;41(2):144-69. doi: 10.2993/0278-0771-41.2.144.
28. Hill R, Adem Ç, Alangui WV, Molnár Z, Aumeeruddy-Thomas Y, Bridgewater P, et al. Working with indigenous, local and scientific knowledge in assessments of nature and nature's linkages with people. Curr Opin Environ Sustain. 2020;43(December 2019):8-20. doi: 10.1016/j.cosust.2019.12.006.
29. Šakić Trogrlić R, Wright GB, Duncan MJ, van den Homberg MJC, Adeloye AJ, Mwale FD, et al. Characterising local knowledge across the flood risk management cycle: A case study of Southern Malawi. Sustain. 2019;11(6). doi: 10.3390/su11061681.
30. Zhang P, Zou B, Liou YC, Huang C. The pathogenesis and diagnosis of sepsis post burn injury. Burn Trauma. 2021;9. doi: 10.1093/burnst/tkaa047. PMID: 33654698; PMCID: PMC7901709.
31. Bailey ME, Sagiraju HKR, Mashreky SR, Alamgir H. Epidemiology and outcomes of burn injuries at a tertiary burn care center in Bangladesh. Burns. 2019;45(4):957-63. doi: 10.1016/j.burns.2018.12.011. PMID: 30612889.
32. Lami FH, Al Naser RK. Epidemiological characteristics of burn injuries in Iraq: a burn hospital-based study. Burns. 2019;45(2):479-83. doi: 10.1016/j.burns.2018.03.005. PMID: 30600127.
33. Girma Gessesse F, Asmamaw Yitayew Y. Epidemiology of burn injury among children's attended felege hiwot referral hospital in Bahir Dar Town, Amhara Regional State, Ethiopia, 2017. J Pediatr Neonatal Care. 2020;10(1):21-27. doi: 10.15406/jpnc.2020.10.00408.
34. Honnegowda TM, Kumar P, Udupa P, Rao P. Epidemiological study of burn patients hospitalised at a burns centre, Manipal. Int Wound J. 2019;16(1):79-83. doi: 10.1111/iwj.12995. PMID: 30240126; PMCID: PMC7949184.
35. Batac MCR, Ann M, Sison C, Cervancia CR, Eleanore M, Nicolas O. Honey and propolis have antifungal property against select dermatophytes and Candida albicans. Acta Med Philipp. 2020;54(1):11-6. doi: 10.47895/amp.v54i1.1084.
36. Harish V, Tiwari N, Fisher OM, Li Z, Maitz PKM. First aid improves clinical outcomes in burn injuries: Evidence from a cohort study of 4918 patients. Burns. 2019;45(2):433-9. doi: 10.1016/j.burns.2018.09.024. PMID: 30337155.
37. Griffin BR, Frear CC, Babl F, Oakley E, Kimble RM. Cool running water first aid decreases skin grafting requirements in pediatric burns: A cohort study of two thousand four hundred ninety-five children. Ann Emerg Med. 2020;75(1):75-85. doi: 10.1016/j.annemergmed.2019.06.028. PMID: 31474480.
38. Bennett CV, Maguire S, Nuttall D, Lindberg DM, Moulton S, Bajaj L, et al. First aid for children's burns in the US and UK: An urgent call to establish and promote international standards. Burns. 2019;45(2):440-9. doi: 10.1016/j.burns.2018.09.003. PMID: 30266196.
39. Shahbazi M, Bunker D. Social media trust: Fighting misinformation in the time of crisis. Int J Inf Manage. 2024;77(March):102780. doi: 10.1016/j.ijinfomgt.2024.102780.
40. Jeschke MG, van Baar ME, Choudhry MA, Chung KK, Gibran NS, Logsetty S. Burn injury. Nat Rev Dis Prim. 2020;6(1). doi: 10.1038/s41572-020-0145-5. PMID: 32054846; PMCID: PMC7224101.
41. Corbin JH, Oyene UE, Manoncourt E, Onya H, Kwamboka M, Amuyunzu-Nyamongo M, et al. A health promotion approach to emergency management: effective community engagement strategies from five cases. Health Promot Int. 2021;36:I24-38. doi: 10.1093/heapro/daab152. PMID: 34897448; PMCID: PMC8667549.