Brief Report

Implementing Evidence-Based Burn First Aid in a Low-Resource Community: A Brief Report on Culturally Adapted Education

Citation: Smith-Orr V, Reyman ET. "Implementing Evidence-Based Burn First Aid in a Low-Resource Community: A Brief Report on Culturally Adapted Education" (2026) *International Journal of Wound Research* 2(1): 13-23. DOI: https://doi.org/10.64115/ijwr-2026-299

Received: January 28, 2026

Revised: March 1, 2026

Just accepted: March 7, 2026

Published: March 28, 2026

Correspondence: Valerie Smith-Orr - Burns & Plastic Surgery, Triple B Care Projects, Inc., Castillejos, Zambales, Philippines; Email: wandering.angel6@gmail.com

Data Availability Statement: All relevant data are within the paper and its Supporting Information files.

Conflict of Interest: The author(s) declare(s) no conflict of interest.

Funding: This research received no external funding.

Valerie Smith-Orr, *OAM,*[1] **Evelyn T. Reyman**[1]

[1] *Burns & Plastic Surgery, Triple B Care Projects, Inc., Castillejos, Zambales, Philippines*

Abstract

Introduction. Burn injuries are a common source of preventable morbidity in low- and middle-income countries (LMICs). In many communities, burn first aid is influenced by generational traditions and locally available topical remedies, which can replace or delay effective cooling with water recommended in evidence-based guidance.

Programme Approach. This brief report presents Burn Prevention and Treatment Education (BPTE), a culturally adapted burn first aid education programme implemented through a community clinic in a Southeast Asian LMIC. BPTE was intentionally designed as a low-technology intervention for contexts with limited electricity and variable access to running water, using short teaching scripts, visual aids, and repeated reinforcement strategies.

Implementation Observations. The programme core message (*"Cool, Call, Cover"*) was refined through iterative adaptations to improve feasibility and comprehension. Adaptations included using hand water pump imagery to represent water access, practical water collection guidance to address contamination concerns, and continuous clinic-based reinforcement through large printed tarpaulins displayed at the clinic gate.

Conclusions. BPTE illustrates how evidence-based burn first aid education can be translated into feasible, culturally acceptable actions in resource-limited settings. While clinical endpoints were not systematically collected, the report provides implementation-focused insights into barriers, adaptation strategies, and sustainable delivery channels. Future evaluation should integrate structured documentation of first aid actions and escalation patterns to support impact measurement.

Keywords: Scalds, First Aid, Culture, Brief Report

Introduction

Burn injuries are a frequent cause of community-level morbidity across many low- and middle-income countries (LMICs), affecting children and adults and often occurring in the domestic environment.[1,2] In resource-limited settings, the burden of burns is compounded by delayed presentation, limited access to specialized services, and inconsistent delivery of evidence-based first aid guidance at the point of injury.[1,2] Even when health facilities are available, early burn care may be influenced by economic barriers, travel constraints, and gaps in training among frontline providers.

Evidence-to-practice gap in burn first aid

Early first aid is widely recognized as a modifiable factor that may influence the evolution of a burn injury.[3,4] Practical recommendations emphasize prompt cooling with cool running water for an adequate duration, avoidance of ice or extreme cold exposure, and early assessment for referral when severity indicators are present.[3–6] However, the translation of these recommendations into real-world behaviors is not straightforward. In many communities, burn first aid is shaped by generational traditions, social norms, and the availability of locally trusted remedies. Traditional topical substances may be applied with the aim of reducing pain, preventing blistering, or 'sealing' the wound, but these practices can also delay effective cooling, introduce contaminants, or complicate subsequent wound management.[5,7]

Rationale for a low-technology, culturally adapted approach

Implementation challenges are further intensified by contextual factors such as unreliable electricity, variable access to clean running water, and differences in health literacy.[1,7] Educational strategies requiring multimedia tools or formal classroom environments may be difficult to sustain.[2] In this context, culturally adapted, low-technology approaches may offer a feasible pathway to improve community burn first aid practices without placing additional demands on infrastructure.[8]

Aim of the brief report

This brief report describes the development, cultural adaptation, and community delivery of Burn Prevention and Treatment Education (BPTE), a low technology burns first aid education programme implemented through a community clinic in a Southeast Asian LMIC.[8,9] The report focuses on scald injuries, which represented the primary burn mechanism addressed through the clinic's referral pathway and educational outreach during BPTE implementation.[2,10] It outlines the programme rationale, practical design choices, cultural adaptations, implementation approach, and lessons learned to support replication in similar settings. Although scalds were the primary focus in this context, the BPTE framework is conceptually applicable to other common burn mechanisms (e.g., contact, flame, chemical, or electrical injuries), which may be incorporated in future programme extensions.[10,11]

Setting and stakeholders

Setting

BPTE was delivered within the context of a community clinic established to support underserved populations with basic health services, wound care support, and community outreach. The clinic's physical and organizational structure evolved over time, including early stages in a temporary local facility and subsequent development toward a more structured building-based clinic. Environmental challenges, including recurrent severe weather events, influenced clinic operations and highlighted the need for resilient, low-resource approaches to patient education.

From 2014, the clinic programme was supported through Triple B Care Projects, registered with the national Securities and Exchange Commission (SEC) as a non-stock, not-for-profit organisation. In the same year, the initiative was recognised as a Rotary Australia World Community Service

Project, strengthening community partnerships and dissemination capacity.

Programme team

The programme was led by nursing staff with long-term humanitarian engagement and local community integration, including an experienced Australian nurse and a Filipina nurse volunteer. This combination supported continuity of implementation and enabled culturally informed delivery.

Outreach network and partners

Outreach sessions were conducted in community group settings, during clinic visits, and through collaboration with local activities and periodic medical missions. External stakeholder engagement, including community service organizations, contributed to expanded reach during later phases of implementation (Table 1).

Table 1. BPTE programme timeline (key milestones).

Year/Period	Milestone
2012-2013	Consolidation of community clinic activities and early burn and wound care support; initial community engagement and informal education.
2014	Formalization and registration of Burn Prevention and Treatment Education (BPTE); structured community delivery begins.
2016	Revision of BPTE symbols and visual materials to reflect local water access and comprehension needs (e.g., hand pump imagery; 'cool' versus 'cold').
2024-2025	Expanded dissemination supported by community partners (including Rotary-year engagement) and broader outreach activities.
Ongoing	Sustained reinforcement through clinic gate tarpaulins, repeated micro-teaching during routine visits, and iterative refinement informed by community feedback.

The problem observed: burn first aid in practice

Burn first aid practices observed

In the years preceding the structured BPTE programme, burn first aid in the community frequently relied on topical applications and remedies rather than sustained water cooling.[1,3,4] Based on practice records and community reports, cooling was often absent, applied briefly, or interrupted early due to concerns about water use, limited access to running water, or misconceptions about the role of 'cold' in worsening injury.[1,3–5] In some cases, water access required manual pumping or collection from local sources, creating additional barriers.

Barriers to evidence-based first aid adoption

Generational traditions played a substantial role in shaping first aid behaviors. Families often prioritized customary topical substances perceived as protective, soothing, or curative.[1,2] In addition to tradition, several structural barriers were identified as contributing to the persistence of non-evidence-based first aid. These included limited exposure to burn first aid recommendations in frontline training, inconsistent availability of clean water at the point of injury, and economic constraints affecting care-seeking behavior.[1,2,7] Together, these factors created a persistent gap between recommended burn first aid and what was feasible or culturally acceptable in the local context.[1,7]

To contextualize these observations, routinely collected burn first aid records (2013-2025) were encoded into an electronic dataset and summarized descriptively. These records reflect routine documentation and were not originally designed for research purposes. The distribution of documented first aid actions is therefore presented as a descriptive summary of routinely collected records in Table 2, with a detailed breakdown of commonly reported traditional practices provided in Table 3.

Implementation challenge

From an implementation perspective, the challenge was not only to deliver information about best practice, but also to translate evidence-based recommendations into practical steps that could be adopted within the constraints of the community environment.[12] This required a focus on feasibility, safety, and cultural acceptability, rather than reliance on guideline terminology alone.

Table 2. Descriptive summary of routinely collected burn first aid records (2013-2025). International-standard first aid cooling was defined as ≥10 minutes under running water (20 minutes taught as the ideal in BPTE materials). Records reflect routine documentation and were not originally collected for research purposes.

Age group (years)	Cases (n)	Cultural first aid n (%)	International first aid n (%)	None n (%)	Not specified n (%)
0-5	161	95 (59.0)	18 (11.2)	46 (28.6)	2 (1.2)
6-10	34	23 (67.6)	4 (11.8)	8 (23.5)	0 (0.0)
11-17	15	9 (60.0)	3 (20.0)	3 (20.0)	0 (0.0)
≥18	143	88 (61.5)	17 (11.9)	37 (25.9)	1 (0.7)
Total	**353**	**215 (60.9)**	**42 (11.9)**	**94 (26.6)**	**3 (0.8)**

Table 3. Descriptive summary of traditional first aid practices recorded in routinely collected scald-burn records (2013-2025), stratified by age group. Values are reported as n (%), where percentages are calculated within each age group (denominator = total cases in that age group). More than one traditional practice could be recorded for the same case; therefore, column percentages may exceed 100% when summed across practices.

Age group	Cases (n)	Hot water n (%)	Hot oil n (%)	Hot coffee n (%)	Hot chocolate drink n (%)	Hot soup n (%)	Hot noodles n (%)	Hot tea n (%)	Hot liquid jelly n (%)	Hot sauce n (%)
0-5	161	89 (55.3%)	10 (6.2%)	44 (27.3%)	1 (0.6%)	7 (4.3%)	9 (5.6%)	1 (0.6%)	0 (0.0%)	0 (0.0%)
6-10	34	22 (64.7%)	1 (2.9%)	1 (2.9%)	2 (5.9%)	5 (14.7%)	3 (8.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
11-17	15	8 (53.3%)	2 (13.3%)	2 (13.3%)	0 (0.0%)	1 (6.7%)	2 (13.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
≥18	143	77 (53.8%)	40 (28.0%)	13 (9.1%)	0 (0.0%)	8 (5.6%)	3 (2.1%)	0 (0.0%)	1 (0.7%)	1 (0.7%)
Total	353	196 (55.5%)	53 (15.0%)	60 (17.0%)	3 (0.8%)	21 (5.9%)	17 (4.8%)	1 (0.3%)	1 (0.3%)	1 (0.3%)

Programme development and design of BPTE

Programme aims and overview

The BPTE was developed as a pragmatic educational intervention with two complementary aims: 1) to promote burn prevention strategies relevant to domestic and community environments, and 2) to encourage adoption of evidence-based first aid actions following a burn injury.[2,11]

Design principles: low-technology and scalability

The programme was intentionally designed as low-technology and scalable. Educational delivery was structured to function without reliance on electricity, internet access, or multimedia presentations. Instead, BPTE used short and repetitive teaching scripts, clear visual symbols, and printed materials that could be displayed and reused over time. This design choice reflected the realities of resource-limited settings where formal training infrastructure is inconsistent and where education must often occur informally during clinic visits or community gatherings.[2,11]

Educational framework: "Cool, Call, Cover"

BPTE focused on a simplified behavioral framework that could be remembered under stress and communicated across age groups and literacy levels. The core message was built around three actions: Cool, Call, and Cover.[13,14] The teaching approach emphasized practical 'do and don't' instructions, addressing common misconceptions and providing culturally appropriate alternatives to traditional practices where possible.[3,13]

BPTE core content: the "Cool, Call, Cover" framework

The BPTE educational content was centered on

a simple and memorable behavioral sequence suitable for community settings: ***Cool, Call, Cover***.

Cool. Initiate cooling as early as possible using cool running water, aiming to sustain cooling long enough to provide meaningful benefit. Where full access to running water was not available, BPTE reinforced practical alternatives aligned with local resources, while cautioning against unsafe practices such as use of ice or prolonged exposure to extreme cold.[13,14]

Call. Seek early advice or assistance from healthcare staff or the clinic to support assessment, identify warning signs, and determine whether referral or escalation was needed. This step aimed to reduce delays in presentation and to support decision-making for families uncertain about severity.[13,14]

Cover. Protect the burn with a clean covering to reduce contamination and pain, while avoiding traditional topical substances and adhesive or occlusive materials that could trap heat or complicate wound care. The cover step emphasized cleanliness and simplicity rather than the application of products (Figure 1A and 1B).[13,14]

Figure 1. BPTE visual teaching materials used for community burn first aid education. A) Core "Cool, Call, Cover" framework emphasizing 20 minutes of cooling with water and key first actions. B) "Do not use" visual aid discouraging common harmful traditional or household topical applications and reinforcing water-only cooling as the recommended first aid.

In addition to the three core actions, BPTE included brief guidance on when to seek urgent care, such as in the presence of large burns, circumferential injuries, burns involving the face, hands or genital areas, burns in young children, suspected inhalation injury, or worsening symptoms (Figure 2).[15–17]

Taken together, the BPTE core materials aimed to translate evidence-based burn first aid into actions that were feasible and culturally acceptable within a low-resource community setting. By prioritizing clarity, repetition, and visual cues, the programme sought to standardize key messages while leaving room for contextual adaptation based on local water access, beliefs, and care-seeking pathways.[12,13]

Cultural adaptation and practical delivery

Iterative adaptation process

Cultural adaptation was treated as an iterative process rather than a single design phase.[18,19] Early programme delivery highlighted that some guideline concepts required translation into locally meaningful symbols and practical instructions.[18] BPTE materials were therefore revised over time to improve comprehension and feasibility.[18,20]

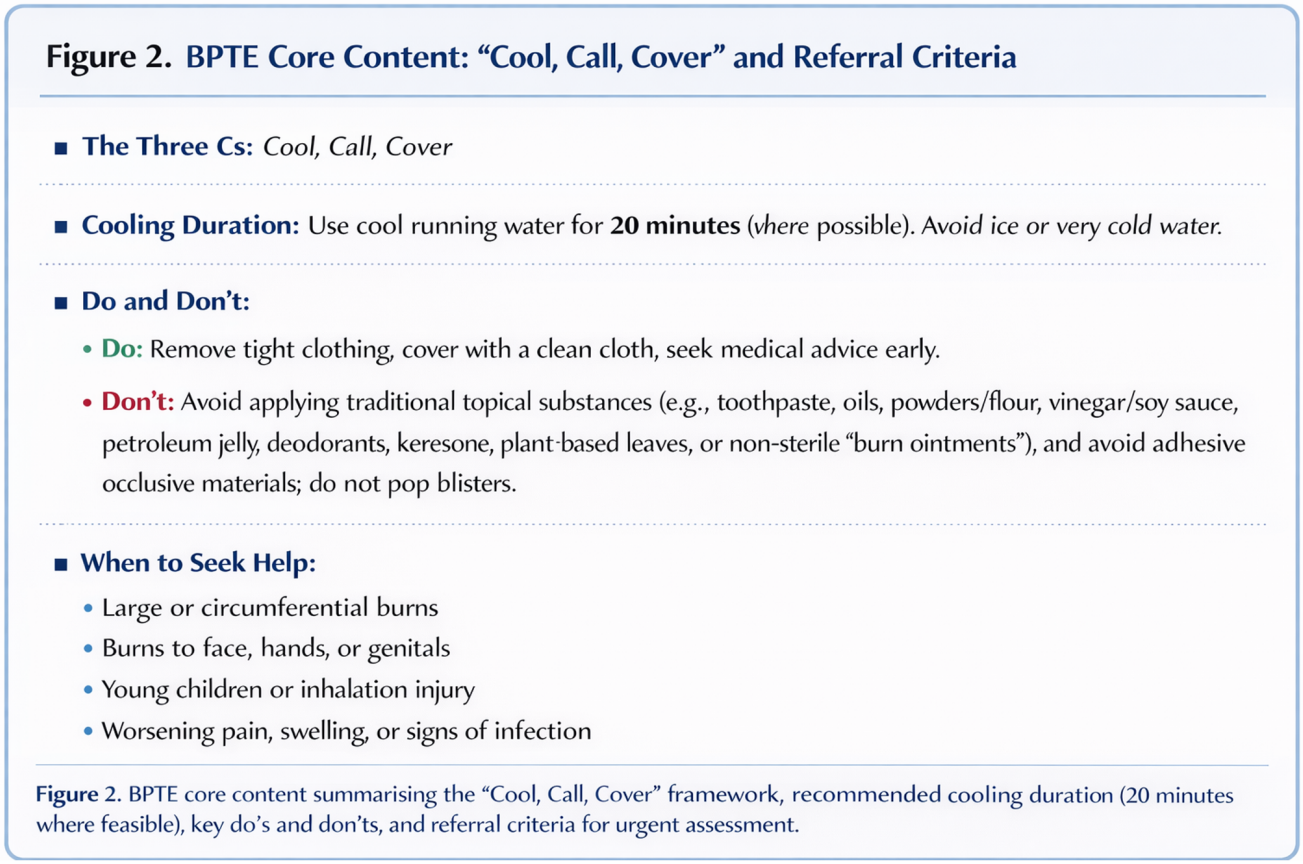

Figure 2. BPTE summary box of burn first aid messages, including the "Cool, Call, Cover" framework, recommended cooling duration (20 minutes where feasible), key do's and don'ts, and referral criteria for urgent assessment.

Adapting to limited water access

One major adaptation involved the representation of water access. In settings without piped running water, the concept of continuous water cooling was difficult to visualize.[3,13] To address this, a hand water pump ('bomba pump') was used as a familiar symbol of obtaining water. Visual materials also distinguished 'cool' from 'cold' to reduce misconceptions that cooling required extremes of temperature.[3,5,13]

Water source safety and contamination concerns

Water source safety was also incorporated into programme content. Where river water collection was relevant, BPTE integrated locally appropriate instructions such as collecting water upstream to reduce contamination risk, while also highlighting safety concerns and discouraging unsafe behavior near open water. These instructions were framed to support practicality without creating fear-based messaging.[7]

Visual reinforcement and micro-teaching

Printed visual materials were designed for long-term visibility. Large tarpaulins displaying the core message were placed at the clinic gate, ensuring repeated exposure for patients and families. This passive reinforcement supported recall and created opportunities for brief 'micro-teaching' during routine interactions.[13,21]

Implementation approach: delivery channels and sustainability

BPTE was delivered through multiple channels to maximize reach and sustainability. Community sessions were conducted with local groups, including informal gatherings and outreach events. In parallel, the clinic served as a stable site for repeated reinforcement. Patients and families could receive short teaching interactions during consultations, supported by the constant visibility of educational messaging on-site.[13,21]

Partnerships and community legitimacy

The programme also benefited from partnership-based dissemination. Engagement with community service organizations supported broader exposure and created social legitimacy for the educational content. Such partnerships were valuable in bridging the gap between healthcare recommendations and community norms, particularly where practices were strongly influenced by elders and household decision-makers.[22]

Sustainability features

A defining feature of BPTE was its minimal resource requirement. The programme was built to remain functional under variable conditions, including interruptions to electricity supply and limited availability of teaching equipment. By prioritizing reusable printed materials, simple scripts, and repetition, BPTE aimed to function as an ongoing community support tool rather than a one-time intervention.[13,14]

Implementation observations and lesson learned

Barriers encountered

Several practical barriers were consistently encountered during BPTE implementation. Limited access to clean running water affected the feasibility of prolonged cooling. In some households, the water source required manual pumping, and families were reluctant to allocate time and resources to sustained cooling.[3,5,7] Misconceptions about temperature effects, including fear that 'cold' could worsen injury, also limited uptake.[5,23,24] In addition, traditional topical practices were deeply embedded and socially reinforced, making behavior change gradual rather than immediate.[23,24]

Enablers and successful components

Despite these barriers, multiple enabling factors supported programme delivery. The simplicity of the core message facilitated recall and allowed rapid teaching in informal settings.[13,25] Repeated exposure through clinic-based visual materials helped reinforce the message over time.[13,25] Cultural adaptation increased acceptability by aligning recommendations with locally meaningful symbols and addressing real constraints rather than insisting on idealized

Table 4. Key barriers, cultural adaptations, and practical solutions supporting BPTE implementation.

Barrier observed	Why it matters	BPTE adaptation	Practical solution
Limited electricity / no multimedia tools	Restricts formal teaching sessions and digital materials	Low-technology delivery model	Printed visuals, reusable banners, short teaching scripts
Variable access to piped running water	Cooling may be perceived as infeasible or impractical	Use of locally meaningful water-access symbols	Hand water pump ('bomba pump') imagery; alternative water access guidance
Concerns about water contamination (e.g., river sources)	May discourage cooling or prompt topical remedy use	Practical water safety messaging	Upstream water collection guidance; emphasis on cleanest available water
Misconceptions about 'cold' worsening burns	Leads to brief cooling or avoidance of water	Clarification of 'cool' vs 'cold'	Simple visuals and scripts differentiating safe cooling from extreme cold/ice
Strong reliance on traditional topical remedies	Delays evidence-based cooling and increases wound care complexity	Do/Don't teaching framework	Non-judgmental messaging and replacement with clean cover + early advice
Safety risks near open water (e.g., drowning risk)	Potential harm during first aid attempts	Explicit safety warnings within BPTE	Supervised cooling practices; avoid unsafe water settings
Economic barriers and delayed care-seeking	May limit escalation and follow-up	Emphasis on early contact and triage advice	'Call' step encourages early consultation and referral decision-making
Sustaining education over time	Single sessions may not change behaviors	Passive reinforcement strategy	Large tarpaulins at clinic gate; micro-teaching during routine visits

conditions.[12,20] Finally, sustained engagement by nursing staff and community partners supported continuity, which appeared essential for gradual behavior change (Table 4).[13,14]

Interpretation and implications for practice

Importantly, BPTE implementation highlighted that behavior change is rarely driven by information alone. Rather, change requires a combination of feasible alternatives, trusted messengers, and reinforcement within the settings where decisions are made.[12,26,27]

Lessons learned

The BPTE experience offers several practical lessons relevant to clinicians and educators working in similar contexts: 1) Simple behavioral frameworks are more likely to be retained and applied than complex messages. Short scripts such as 'Cool, Call, Cover' reduce cognitive load during a stressful event and are easier to teach across diverse audiences.[13,14,28] 2) Repeated exposure is a critical driver of education effectiveness in community settings. Passive reinforcement through visible clinic materials can complement outreach sessions and allow repeated micro-interactions that support learning over time.[13,29] 3) Cultural adaptation improves feasibility and trust. Guideline concepts should be translated into locally relevant symbols and supported by realistic strategies for common constraints, such as limited water access or fear-based misconceptions.[18,20] 4) Safety considerations must be integrated into first aid education. Where open water sources are used, education should include practical warnings and alternatives to prevent accidental harm.[30] 5) Community partnerships strengthen dissemination and legitimacy. Collaboration with local organizations can expand reach and reduce resistance by embedding the message within respected community networks.[31,32]

Recommendations for replication

Based on these lessons, replication of BPTE or similar programmes may priorities: 1) a simple core message; 2) low-technology educational materials; 3) continuous on-site reinforcement; and 4) iterative refinement informed by community feedback.[13,20,31]

Limitations

This brief report primarily reflects scald injuries as the main focus of BPTE teaching and clinic referrals; other burn mechanisms (e.g., contact, flame, or gas-related burns) may be common in the broader community and should be addressed in future extensions of the programme. This brief report has limitations typical of practice-based narrative work. The programme was implemented as a community education initiative rather than as a prospective research study. Clinical outcomes such as burn depth progression, healing time, infection, referral rates, or hospital admission were not systematically captured in a standardized format, limiting the ability to quantify clinical effectiveness. Historical records were derived from routine practice documentation and were not designed for research purposes; early documentation was incomplete during the earliest phases of clinic development.

Despite these limitations, the value of the report lies in its detailed description of implementation barriers and culturally adapted solutions relevant to real-world settings. Such practice-based insights can complement formal evaluations by informing feasible programme design in similar LMIC contexts.

Conclusion

BPTE demonstrates that culturally adapted, low-technology burn first aid education can be delivered sustainably in resource-limited environments shaped by generational traditions. By focusing on feasibility, clear behavioral messaging, visual reinforcement, and community partnerships, the programme provides a pragmatic model for improving burn first aid knowledge and supporting gradual behavior change. Future evaluation work may incorporate structured monitoring of first aid actions and outcomes to quantify impact and refine scalability.

Acknowledgements

The authors acknowledge the contribution of local community members, volunteers, and partner organizations who supported outreach activities and the sustained visibility of BPTE

educational materials. In particular the Rotary Australia World Community Service (RAWCS) programme, via RC Freshwater Bay Western Australia, Rotary Club of Subic, Zambales, Philippines; Triple B Care Projects Board member: President Ferdinand C Dado; Dr Rizal Salih Jr MD, Community Physician; Ms Hilda Hermosa, Board Secretary, Mr Kevin Hamdorf, Board Member (Australian). The authors would like to thank Biagio Nicolosi RN, MSN, Editor in Chief, and Kristina Stiles MSc RN, Guest editor of this issue, for their literary guidance and personal support.

References

1. Forjuoh SN. Burns in low- and middle-income countries: a review of available literature on descriptive epidemiology, risk factors, treatment, and prevention. *Burns.* 2006 Aug;32(5):529–37. https://doi.org/10.1016/j.burns.2006.04.002.
2. Price K, Lee KC, Woolley KE, Falk H, Peck M, Lilford R, Moiemen N. Burn injury prevention in low- and middle-income countries: scoping systematic review. *Burns Trauma.* 2021;9:tkab037. https://doi.org/10.1093/burnst/tkab037.
3. Griffin B, Cabilan CJ, Ayoub B, Xu HG, Palmieri T, Kimble R, et al. The effect of 20 minutes of cool running water first aid within three hours of thermal burn injury on patient outcomes: a systematic review and meta-analysis. *Australas Emerg Care.* 2022 Dec;25(4):367–76. https://doi.org/10.1016/j.auec.2022.05.003.
4. Singer YM. Effect of <20-minutes of cool running water <3 hours on burn patient outcomes: a systematic review. *J Burn Care Res.* 2023 Aug 29;44(Suppl 2):S181. https://doi.org/10.1093/jbcr/irad045.259
5. Cuttle L, Pearn J, McMillan JR, Kimble RM. A review of first aid treatments for burn injuries. *Burns.* 2009 Sep;35(6):768–75. https://doi.org/10.1016/j.burns.2008.10.011.
6. Markenson D, Ferguson JD, Chameides L, Cassan P, Chung KL, Epstein J, et al. Part 17: first aid: 2010 American Heart Association and American Red Cross Guidelines for First Aid. *Circulation.* 2010 Nov 2;122(18 Suppl 3):S934–46. https://doi.org/10.1161/CIRCULATIONAHA.110.971150.
7. Allorto NL. Primary management of burn injuries: balancing best practice with pragmatism. *S Afr Fam Pract (2004).* 2020 Sep 4;62(1):e1–4. https://doi.org/10.4102/safp.v62i1.5121.
8. Turner C, Spinks A, McClure R, Nixon J. Community-based interventions for the prevention of burns and scalds in children. *Cochrane Database Syst Rev.* 2004;(3):CD004335. https://doi.org/10.1002/14651858.CD004335.pub2
9. Wasiak J, Cleland H, Campbell F. Dressings for superficial and partial thickness burns. *Cochrane Database Syst Rev.* 2008 Oct 8;(4):CD002106. https://doi.org/10.1002/14651858.CD002106.pub4
10. Peck MD. Epidemiology of burns throughout the world. Part I: distribution and risk factors. *Burns.* 2011 Nov;37(7):1087–100. https://doi.org/10.1016/j.burns.2011.06.005.
11. Rybarczyk MM, Schafer JM, Elm CM, Sarvepalli S, Vaswani PA, Balhara KS, et al. A systematic review of burn injuries in low- and middle-income countries: epidemiology in the WHO-defined African Region. *Afr J Emerg Med.* 2017 Mar;7(1):30–7. https://doi.org/10.1016/j.afjem.2017.01.006.
12. Proctor EK, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Adm Policy Ment Health.* 2011 Mar;38(2):65–76. https://doi.org/10.1007/s10488-010-0319-7.
13. Cowley LE, Bennett CV, Brown I, Emond A, Kemp AM. Mixed-methods process evaluation of SafeTea: a multimedia campaign to prevent hot drink scalds in young children and promote burn first aid. *Inj Prev.* 2021 Oct;27(5):419–27.https://doi.org/10.1136/injuryprev-2020-043909.
14. Baillie M. *Cool, call, cover can be crucial first aid for burns* [Internet]. Queen Victoria Hospital. 2021 [cited 2026 Jan 26]. Available from: https://www.qvh.nhs.uk/2021/10/cool-call-cover-can-be-crucial-first-aid-for-burns/
15. American Burn Association. *Burn patient referral guidelines* [Internet]. [cited 2026 Jan 26]. Available from: https://www.ameriburn.org/burn-care-team/resources/guidelines-for-burn-patient-referral
16. ISBI Practice Guidelines Committee, Steering Subcommittee, Advisory Subcommittee. ISBI practice guidelines for burn care. *Burns.* 2016 Aug;42(5):953–1021. https://doi.org/10.1016/j.burns.2016.05.013.
17. Hollywood E, O'Neill T. Assessment and management of scalds and burns in children. *Nurs Child Young People.* 2014 Mar;26(2):28–33. https://doi.org/10.7748/ncyp2014.03.26.2.28.e390.
18. Barrera M Jr, Castro FG, Strycker LA, Toobert DJ. Cultural adaptations of behavioral health interventions: a progress report. *J Consult Clin Psychol.* 2013 Apr;81(2):196–205. https://doi.org/10.1037/a0027085.
19. Marsiglia FF, Booth JM. Cultural adaptation of interventions in real practice settings. *Res Soc Work Pract.* 2015 Jul;25(4):423–32. https://doi.org/10.1177/1049731514535989.
20. Wiltsey Stirman S, Baumann AA, Miller CJ. The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implement Sci.* 2019 Jun 6;14(1):58. https://doi.org/10.1186/s13012-019-0898-y.
21. Emond A, Cowley L, Kemp A. Using social media for injury prevention: the experience of the SafeTea campaign. *Inj Prev.* 2021 Mar;27(Suppl 2):A52–A53. https://doi.org/10.1136/injuryprev-2021-safety.137.
22. Clayton JL, Utz RL, Aruscavage N, Bybee SG, Bigger SE, Iacob E, et al. Using community engagement with FRAME: framework for reporting adaptations and modifications to evidence-based interventions. *Contemp Clin Trials Commun.* 2024 Dec;42:101398. https://doi.org/10.1016/j.conctc.2024.101398.
23. 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 Mar;45(2):440–9. https://doi.org/10.1016/j.burns.2018.08.021.

24. Kattan AE, AlShomer F, Alhujayri AK, Addar A, Aljerian A. Current knowledge of burn injury first aid practices and applied traditional remedies: a nationwide survey. *Burns Trauma.* 2016 Nov 2;4:37. https://doi.org/10.1186/s41038-016-0063-7.
25. 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 2,495 children. *Ann Emerg Med.* 2020 Jan;75(1):75–85. https://doi.org/10.1016/j.annemergmed.2019.08.446.
26. Bandura A. Health promotion by social cognitive means. *Health Educ Behav.* 2004 Apr;31(2):143–64. https://doi.org/10.1177/1090198104263660.
27. Michie S, van Stralen MM, West R. The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implement Sci.* 2011 Apr 23;6:42. https://doi.org/10.1186/1748-5908-6-42.
28. Sweller J. *Cognitive load theory.* In: Psychology of Learning and Motivation [Internet]. Elsevier; 2011 [cited 2026 Jan 26]. p. 37–76. https://doi.org/10.1016/B978-0-12-387691-1.00002-8.
29. Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behaviour. *Lancet.* 2010 Oct 9;376(9748):1261–71. https://doi.org/10.1016/S0140-6736(10)60809-4.
30. Spinks A, Turner C, Nixon J, McClure RJ. The "WHO Safe Communities" model for the prevention of injury in whole populations. *Cochrane Database Syst Rev.* 2009;(3):CD004445. https://doi.org/10.1002/14651858.CD004445.pub3
31. Wallerstein N, Duran B. Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *Am J Public Health.* 2010 Apr;100(Suppl 1):S40–6. https://doi.org/10.2105/AJPH.2009.184036.
32. Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AMN. Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. *Glob Health Action.* 2015;8:29842. https://doi.org/10.3402/gha.v8.29842.