ORIGINAL ARTICLE

Pediatric burns in low-income countries: an example from Somalia

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ABSTRACT

BACKGROUND: Epidemiological data are needed to develop pediatric burn prevention strategies and guide interventions in low- and middle-income countries.

METHODS: In this observational retrospective study, the characteristics of 140 consecutive pediatric patients who were hospitalized and treated for burns at the Burns Unit of a hospital in Mogadishu, Somalia, between November 2022 and April 2024 were analyzed.

RESULTS: The patients included 50% males and 50% females, with a mean age of 4.96±4.07 years. The most common burn etiologies were hot water (75.7%), open flame (15.7%), and hot oil (8.6%). Burns involving two or more anatomical regions were observed in 44.2% of the cases. The mean total body surface area (TBSA) affected was 16.2±10.42% (min: 4%, max: 90%). Superficial second-degree burns were present in 50.7% of the patients, and deep second-degree burns in 28.6%. No statistically significant relationship was found between gender and burn degree, burn percentage, or burn etiology ($p>0.05$). Analysis by age group revealed a statistically significant but weak association (24%) between the 0-4 years age group and burn degree. This was attributed to a higher proportion of more severe burns in children aged 0-4 years compared to those aged 5 years and older. The most common complication was anemia (37.1%), and no mortality was observed. The average hospital stay was 24.1±27.8 days (range: 2-179 days).

CONCLUSION: This study presents the first epidemiological data on in-patient pediatric burn cases in Somalia, a country classified as low-income. The risk of mortality can be eliminated if effective burn management is provided in pediatric burn cases, even in low-resource countries. These findings support the expectation of survival in major pediatric burns. Nurses and all healthcare professionals share responsibility for the protection and promotion of health. Therefore, training on burn injury prevention strategies should be targeted and implemented in areas where the incidence is high.

Keywords: Burn; burn care; pediatric burn.

INTRODUCTION

Burns are a significant health problem in low- and middle-income countries, where 95% of burn-related deaths occur. In addition to high mortality rates, burns cause body deformities, lifelong disability, and social stigmatization and rejection among survivors. In the Guidelines for Burn Prevention and Care published in 2008, the World Health Organization (WHO) reported the burn-related mortality rate in Africa as 6.1 per 100,000 population per year.[1] Epidemiological data highlight the burden of childhood burns in low- and middle-income countries. One study from 2000 reported that 16,000 children aged 5 years and younger died from burns.[2] In another single-center study focusing on pediatric burn mortality, the rate was reported to be 7.1%.[3] Globally, 111,292 burn-related deaths were recorded in 2019, with the majority occurring in the 1-4 years age group.[4]

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Table 1. Demographic characteristics and burn-related factors of the patients (n=140)

Variable	Mean±SD (Min-Max)	n (%)
Age (years)	4.96±4.07 (1-17)	
Age Distribution		
0-4 years		88 (62.9)
5-9 years		32 (22.9)
10-14 years		13 (9.3)
≥15 years		7 (5.0)
Gender		
Female		70 (50.0)
Male		70 (50.0)
Family Type		
Nuclear		5 (3.6)
Extended		135 (96.4)
Family Income Level		
Low		23 (16.4)
Medium		115 (82.1)
High		2 (1.5)
Average Number of Children per Family	6.68±2.3 (2-15)	
Place of Burn Incident		
Home		139 (99.3)
School		1 (0.7)
Cause of Burn		
Hot water		106 (75.7)
Open flame		22 (15.7)
Hot oil		12 (8.6)
Point of Initial Medical Contact		
Home		20 (14.3)
Emergency Department		108 (77.1)
Outside Center		12 (8.6)
Burn Severity		
≤5% (minor)		2 (1.4)
5%-10% (moderate)		28 (20.0)
>10% (major)		110 (78.6)
Patients Undergoing Surgery		
Yes		79 (56.4)
No		61 (43.6)
Anatomic Burn Locations		
Head		7 (5.0)
Trunk (front)		16 (11.4)
Upper extremity		22 (15.7)
Lower extremity		23 (16.4)
Perineum		1 (0.7)
Trunk (front) + upper extremity		17 (12.1)
Head + upper extremity		2 (1.4)
Lower extremity + perineum		26 (18.6)
Back + upper extremity		3 (2.1)
Head + trunk (front)		4 (2.9)
Trunk (front + back)		3 (2.1)

Head + upper + lower extremities		4 (2.9)
Trunk (front) + upper + lower extremities		2 (1.4)
Whole body		1 (0.7)
Burn Percentage	16.2%±10.42% (4-90)	
Burn Degree		
First Degree		4 (2.9)
Second Degree (Superficial)		71 (50.7)
Second Degree (Deep)		40 (28.6)
Third Degree		25 (17.8)
Bacterial Culture Results		
No growt		119 (85.0)
E. col		4 (2.8)
Proteus spp.		7 (5.0)
Klebsiella spp.		3 (2.1)
Other		2 (1.4)
Local Wound Infection		
Yes		25 (17.9)
No		115 (82.1)
Sepsis		
Yes		34 (24.3)
No		106 (75.7)
Burn-related complications		
None		54 (38.6)
Anemia		52 (37.1)
Sepsis + Anemia		34 (24.3)
Length of Hospital Stay (days)	24.1±27.8 (2-179)	

The prevalence of poverty and unsafe living conditions in rural areas of low-income countries significantly affects the epidemiological profile and risk factors associated with childhood burns. Risk factors such as low socioeconomic status, extended family structures, lack of supervision, the presence of flammable materials, and low maternal education levels are significant contributors to burn injuries.[5,6] The literature has primarily focused on three types of burns: scalds from hot liquids, burns from contact with hot surfaces, and burns from open flames.[7] A study investigating the causes of burns in patients under 18 years of age reported that scald burns, commonly resulting from falling into or spilling hot liquids, occurred more frequently than other types of burns.[7] Despite the availability of studies on childhood burns in high-income countries, epidemiological data for low- and middle-income countries remain insufficient, underscoring the need for comprehensive data to support the development of prevention strategies.[8]

Research findings can provide an evidence-based foundation for the prevention and management of pediatric burns. However, the scarcity of data in low- and middle-income countries hinders the creation of effective action plans. The demographic and prognostic features of pediatric burn patients in East Africa are not well defined, largely due to the rural nature of life in the region.[9] In the absence of a national surveillance system, epidemiological data are often derived from hospital-based studies. Therefore, the development of effective prevention strategies for pediatric burns is contingent upon the availability of robust epidemiological data.[3]

The aim of this study was to investigate the epidemiology of pediatric burns in Somalia, which is classified as a low-income country, and to determine the characteristics of burn injuries at the time of hospital admission.

MATERIALS AND METHODS

This observational retrospective study included 140 consecutive patients diagnosed with pediatric burn injuries who were admitted for treatment to the Burns Unit of the Turkish Training and Research Hospital in Mogadishu, Somalia, between November 2022 and April 2024. Ethical approval for the study was obtained from the Local Ethics Committee prior to commencement (Approval number: 962; Date: 30.03.2024). Inclusion criteria were defined as consecutive patients aged ≤18 years, diagnosed with burn injuries, and admitted to the Burns Unit. Exclusion criteria included burn

injuries occurring outside the study period and patients seen in the Emergency Department who either died or were not treated at the specified hospital. Data collected and analyzed included demographic information, family structure, number of children, family economic status, place of admission, cause of burns at the time of admission, location of burns, burn degree as diagnosed by debridement after admission, and any subsequent complications.

Statistical Analysis

Data obtained in the study were analyzed statistically using SPSS for Windows, Version 25.0 (IBM Corporation, Armonk, NY, USA). The conformity of the data to a normal distribution was assessed using the Shapiro-Wilk W-test. Continuous variables were expressed as mean ± standard deviation, and categorical variables as number and percentage. The Chi-square test was used to analyze categorical data. A significance level 0.05 was applied for all analyses.

RESULTS

A total of 140 pediatric patients hospitalized and treated for burn injuries were evaluated. The cohort included 70 males (50%) and 70 females (50%), with a mean age of 4.96±4.07 years. A significant majority of the families (96.4%) were classified as extended families, with an average of 6.68±2.3 children per family. Only 1.5% of families identified themselves as high-income. Burn injuries occurred at home in 99.3% of the cases, with 41.0% specifically taking place in the kitchen. The most common burn etiologies were hot water (75.7%), open flames (15.7%), and hot oil (8.6%).

Burns were most frequently located on the lower extremities and perineum (18.6%), followed by the lower extremities alone (16.4%) and upper extremities (15.7%). Burns involving multiple anatomical regions were observed in 44.2% of cases. The mean total body surface area (TBSA) affected was 16.2±10.42% (range: 4%-90%). The most common severity was second-degree superficial burns (50.7%), followed by second-degree deep burns (28.6%) and third-degree burns (17.8%).

Microbiological cultures showed no bacterial growth in 85% of patients. Sepsis was diagnosed in 24.3% of cases, all of whom also had anemia, while 17.9% had local wound infections. No burn-related complications developed in 38.6% of the patients, with anemia being the most frequently observed complication (37.1%). The mean length of hospital stay was 24.1±27.8 days (range: 2-179 days). The demographic data and burn-related factors are presented in Table 1.

No statistically significant relationship was found between gender and burn degree, burn percentage, or cause of burn ($p>0.05$). In the analyses conducted by age group, a statistically significant but weak association (24%) was identified between the 0-4 years age group and burn degree. This was attributed to a higher frequency of more advanced burn degrees in the 0-4 years group compared to children aged ≥5 years. Second-degree superficial and second-degree deep burns were more frequently observed in the 0-4 years group, with the leading causes being hot water (Fig. 1), open flames (Fig. 2), and hot oil (Fig. 3), respectively (Table 2.

DISCUSSION

According to the World Bank income classifications, countries are categorized based on Gross National Income per capita, an indicator related to a country's level of development. As of the World Bank's 2022 update, Somalia was classified as a low-income country.[9] The WHO's 2022 Africa Health Statistics Atlas reported that no health-related epidemiological data were available for the region.[10] Given this situation, available epidemiological data are limited to local and single-center studies. A systematic review published in 2016, which provided an overview of global burn epidemiology, noted that reporting conclusive results in low-income

Table 2. Burn characteristics by age groups

	0-4 Years n (%)	>5 Years n (%)	p
Cause of Burn			
Hot water	70 (66.0)	36 (34.0)	
Open flame	12 (54.5)	10 (45.5)	
Hot oil	6 (50.0)	6 (50.0)	
Burn Degree			p<0.05
First Degree	2 (50.0)	2 (50.0)	
Second Degree (Superficial)	49 (69.0)	22 (31.0)	
Second Degree (Deep)	26 (65.0)	14 (35.0)	
Third Degree	11 (44.0)	14 (56.0)	

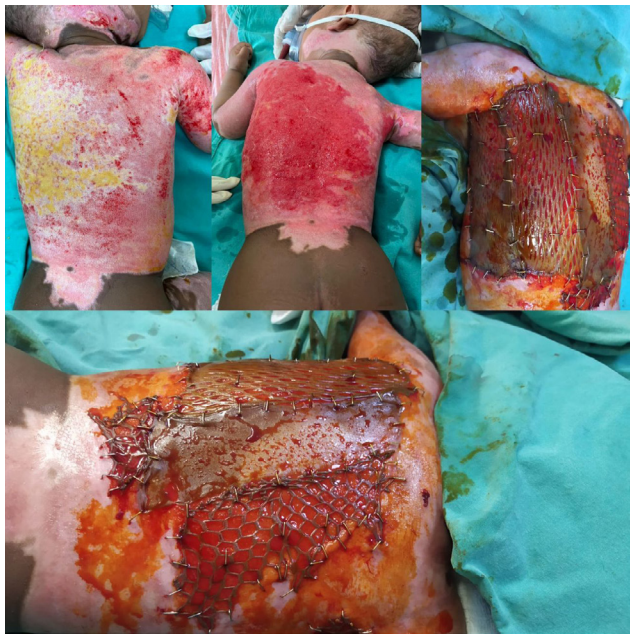

Figure 1. Burns caused by hot water.

Figure 2. Burn injuries resulting from open flames.

countries was difficult due to the lack of data and publications. The review emphasized the urgent need for epidemiological studies on burns, especially in low-income settings.[11]

The current study represents the first investigation into epidemiological data on pediatric burn cases requiring hospitalization in Somalia, which is categorized as a low-income country. Previous research in similar settings reported that the mean age of pediatric burn patients was 4.0±3.6 years, with over half being male, and that hot water was the leading cause of burn injuries (68.5%).[7] A study conducted in South Africa found a mean age of 25 months, 58% of the sample were male, and the most frequently encountered type of burn injury in this pediatric group was scalding, at a rate of 84%.[12] Our findings were consistent with these studies.

The results of the current study were found to be in line with the literature from other low-income countries. Additionally, the family structure of pediatric burn patients was typically extended, with most families having a medium to low economic status and an average of six or more children. Considering that most burn cases occurred at home, particularly in the kitchen, crowded family environments, economic challenges, and especially floor-level stoves used for cooking (Fig. 4) can be considered key predisposing factors for scald burns in children.

Figure 3. Burn injuries caused by hot oil.

These risk factors are clearly preventable. Great care must

Figure 4. Floor-level cooking stoves.

be taken when using hot water or preparing food. Given the high treatment and care costs associated with burn injuries, the World Health Organization has reported that preventative measures are cost-effective. Nurses and all healthcare professionals are responsible for promoting and preserving health. Therefore, targeted family education on burn injury prevention strategies should be developed and implemented in regions with high incidence.

The anatomic localizations of pediatric burns in the current study were most frequently observed in the lower extremities and perineal region. In a previous study conducted in Africa examining the general characteristics of burns, the most common anatomic sites were in the upper part of the body. These were often the result of curiosity-driven behaviors, such as touching, pulling, or grasping objects, especially among toddlers who had just begun to walk.[13] Differences in the anatomic localization of burns between countries and regions are likely due to factors such as social living conditions, the education level of the family, and whether children have access to flames or hot liquids.

According to the American Burn Association guidelines, burn severity is classified based on the total body surface area affected (%). Pediatric burns involving ≥10% TBSA are considered major, 5-10% as moderate, and <5% as minor.[3] In the current study, half of the cases involved burns covering more than 10% TBSA and were classified as superficial and deep second-degree burns, most commonly affecting children aged 0-4 years. It was also observed that many of the patients lived in rural areas and often presented late to the hospital, which may be a contributing factor to increased burn severity. Patients are often admitted to the Burns Unit after first being evaluated in the Emergency Department. Preventing the causes of severe burns, such as preparing food and hot liquids in areas inaccessible to children, and placing hot substances above floor level, is essential when planning parental education on burn prevention and first-aid interventions.

Decreases in hemoglobin levels due to intraoperative or repeated surgical debridement shortly after burn injury can lead to anemia as a result of both the burns themselves and their treatment.[14] While acute blood loss is one of the primary causes of anemia, other contributing factors include reduced hemoglobin concentration during the resolution of the acute phase and the demands of surgical wound healing.[14] In the pediatric group included in this study, burn-related anemia can be explained by the high TBSA involvement, which is consistent with the literature, and by the fact that more than half of the patients underwent surgical intervention. Following major burns, there is an increase in catecholamines, acute-phase reactants, and inflammatory cytokines. These create a catalytic effect on whole-body catabolism, inefficient glucose utilization, and a dysregulated host immune response.[15] Burns patients are at significant risk of infection and sepsis due to these physiological changes. Burn depth, TBSA%, and the use of invasive or urinary catheters have been reported as risk factors for the development of infection-related complications. The literature emphasizes a strong correlation between infections and cases involving >20% TBSA. Infection and sepsis are the leading causes of morbidity and mortality in both pediatric and adult burns patients. Despite advances in burn care, sepsis-related mortality rates remain high.[8,16] The current study was conducted in the Burns Unit of a training and research hospital where multidisciplinary care is provided. Although septic conditions were observed in the pediatric cases during follow-up, a systematic treatment and care approach was implemented. This included regular debridement at intervals, dressing follow-up, and the use of antimicrobials, which helped keep sepsis under control and prevented mortality in all patients. The most important factor contributing to recovery without mortality in pediatric burn cases has been associated with the systematic approach to infection control, particularly the presence of specialist healthcare professionals in hospitals with dedicated pediatric burn units. In the literature, the most significant predictor of mortality in pediatric burn cases has been linked to limited access to intensive care services.[17] Pediatric burn care ranges from simple to complex and advanced management.[18] In low-income countries, the lack of anesthesiologists, nurses, and surgeons specialized in pediatric burns, as well as the lack of access to pediatric-specific products, has been associated with the inability to provide comprehensive, multidisciplinary care.[19,20,21]

In the Burns Unit where this research was conducted, pediatric burn care is provided across the full spectrum, from basic to complex cases. With this comprehensive approach, no sepsis-related mortality was observed in the pediatric patients included in this study, and the results are consistent with findings reported in the literature.[18,19,20,21]

Some research in the literature has reported prolonged hospital stays in burn patients. The length of hospital stay has been associated with survival after burn injury and the implementation of key aspects of burn care, including wound closure, infection control, and reduction of the hypermetabolic response.[22]

An important finding of this study was that the risk of mortality can be significantly reduced if effective burn management is provided for pediatric burn cases in low-income countries. Effective burn injury management involves systematic care in a Burns Unit, where comprehensive treatment is provided. This includes intermittent debridement and dressing changes, infection control through antibiotics, anemia management, nutritional support, and access to intensive care. This finding supports the expectation of survival for pediatric patients with major burns. Moreover, burns are largely preventable through family education, home safety precautions, and appropriate first-aid interventions. The risk of morbidity and mortality can be further reduced through timely access to healthcare services during the acute phase and management by a professional healthcare team.[23,24]

CONCLUSION

This study is the first to examine the epidemiological characteristics of pediatric burn cases in Somalia. The findings show that the majority of cases occurred in the 0-4 years age group, scald burns were the most common cause, and the lower extremities and perineal region were the most frequently affected body areas. The results also indicate that proper burn management can significantly reduce mortality risks for pediatric patients in low-income countries. It is recommended that families be educated on burn prevention strategies and that access to healthcare services be improved.

Ethics Committee Approval: This study was approved by the Somalia–Türkiye Recep Tayyip Erdoğan Training and Research Hospital Ethics Committee (Date: 30.03.2024, Decision No: 962).

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REFERENCES

1. World Health Organization. A WHO plan for burn prevention and care. Available from: https://iris.who.int/handle/10665/97852. Accessed July 21, 2025.
2. Peden M, McGee K, Sharma G. The injury chart book: A graphical overview of the global burden of injuries. Geneva: World Health Organization; 2002.
3. Chelidze KI, Lim CC, Peck RN, Giiti G, Leahy N, Rabbittsx A, et al. Predictors of mortality among pediatric burn patients in East Africa. J Burn Care Res 2016;37:e154-60. [CrossRef]
4. Yakupu A, Zhang J, Dong W, Song F, Dong J, Lu S. The epidemiological characteristic and trends of burns globally. BMC Public Health 2022;22:1596. [CrossRef]
5. Forjuoh SN. Burns in low- and middle-income countries: A review of available literature on descriptive epidemiology, risk factors, treatment, and prevention. Burns 2006;32:529-37. [CrossRef]
6. Banerjee S, Shumba C. A systematic review of epidemiological patterns and proposed interventions to address pediatric burns in Nigeria. Afr Health Sci 2020;20:991-9. [CrossRef]
7. Santiso L, Tapking C, Lee JO, Zapata-Sirvent R, Pittelli CA, Suman OE. The epidemiology of burns in children in Guatemala: A single center report. J Burn Care Res 2020;41:248-53. [CrossRef]
8. Greenhalgh DG. Sepsis in the burn patient: A different problem than sepsis in the general population. Burns Trauma 2017;5:23. [CrossRef]
9. Our World in Data. World Bank income groups, 2024. Available from: https://ourworldindata.org/grapher/world-bank-income-groups. Accessed July 21, 2025.
10. World Health Organization. Atlas of African Health Statistics, 2022. https://aho.afro.who.int/atlas/af. Accessed July 21, 2025.
11. Smolle C, Cambiaso-Daniel J, Forbes AA, Wurzer P, Hundeshagen G, Branski LK, et al. Recent trends in burn epidemiology worldwide: A systematic review. Burns 2017;43:249-57. [CrossRef]
12. Banga AT, Westgarth-Taylor C, Grieve A. The epidemiology of paediatric burn injuries in Johannesburg, South Africa. J Pediatr Surg 2023;58:287-92. [CrossRef]
13. Kalayi GD. Burn injuries in Zaria: A one year prospective study. East Afr Med J 1994;71:317-22.
14. Posluszny JA Jr, Gamelli RL. Anemia of thermal injury: Combined acute blood loss anemia and anemia of critical illness. J Burn Care Res 2010;31:229-42. [CrossRef]
15. Williams FN, Lee JO. Pediatric Burn Infection. Surg Infect 2021;22:54-7. [CrossRef]
16. Rhodes A, Evans LE, Alhazzani W, Levy MM, Antonelli M, Ferrer R, et al. Surviving sepsis campaign: International guidelines for management of sepsis and septic shock: 2016. Crit Care Med 2017;45:486-552.
17. Puthumana JS, Cooney CM, Hultman CS, Redett RJ. Global hospital infrastructure and pediatric burns. J Burn Care Res 2022;43:548-51. [CrossRef]
18. Esparaz JR, Anderson SA, Chen MK, Beierle EA. Who manages burn injuries in children? A program director survey evaluating burn training during pediatric surgery fellowship. J Pediatr Surg 2022;57:127-9. [CrossRef]
19. Ahuja RB, Bhattacharya S. Burns in the developing world and burn disasters. BMJ 2004;329:447-9. [CrossRef]
20. Albertyn R, Bickler SW, Rode H. Paediatric burn injuries in Sub Saharan Africa--An overview. Burns 2006;32:605-12. [CrossRef]
21. Tripathi S, Kaur H, Kashyap R, Dong Y, Gajic O, Murthy S. A survey on the resources and practices in pediatric critical care of resource-rich and resource-limited countries. J Intensive Care 2015;3:40. [CrossRef]
22. Jeschke MG, Herndon DN. Burns in children: Standard and new treatments. Lancet 2014;383:1168-78. [CrossRef]
23. Radzikowska-Büchner E, Łopuszyńska I, Flieger W, Tobiasz M, Maciejewski R, Flieger J. An overview of recent developments in the management of burn injuries. Int J Mol Sci 2023;24:16357. [CrossRef]
24. Merchant M, Hu SB, Miller C, Ahmadi T, Garcia E, Smith MI. Comprehensive management of severe burn injuries: A multidisciplinary approach from resuscitation to rehabilitation. Emerg Care Med 2025;2:26. [CrossRef]

ORİJİNAL ÇALIŞMA - *ÖZ*

Düşük gelirli ülkelerde pediatrik yanıklar: Somali'den bir örnek

AMAÇ: Düşük-orta gelirli ülkelerde pediatrik yanık önleme stratejileri geliştirmek ve harekete geçmek için epidemiyolojik verilere ihtiyaç vardır.
GEREÇ VE YÖNTEM: Bu gözlemsel retrospektif çalışmada, Kasım 2022 ile Nisan 2024 arasında Somali, Mogadişu'daki bir hastanenin Yanık Ünitesi'nde pediatrik yanık tanısıyla hastaneye yatırılan ve tedavi edilen 140 ardışık hastanın özellikleri analiz edildi.
BULGULAR: En sık görülen yanık etyolojileri sıcak su (%75.7), alev (%15.7) ve sıcak yağ (%8.6) olarak değerlendirildi. Yanıkların %44.2'sinin iki veya daha fazla anatomik lokasyonda meydana geldiği analiz edildi. Hastaların %50'si erkekti ve ortalama yaş 4.96±4.07 idi. Tüm pediatrik hastalardaki ortalama yanık yüzdesi %16.2±10.42 (min %4-maks %90) iken; yanık dereceleri sıklıkla %50.7'sinde ikinci derece yüzeysel ve %28.6'sında ikinci derece derindi. Cinsiyet ile yanık derecesi, yanık yüzdesi ve yanık oluşum nedenleri arasında istatistiksel olarak anlamlı bir ilişki bulunmamıştır ($p>0.05$). Ancak 0-4 yaş grubu 5 ve üzeri yaş grubu ile karşılaştırıldığında 0-4 yaş grubu ile yanık dereceleri arasında istatistiksel olarak düşük %24 anlamlı ilişki bulunmaktadır. Bu durum 0-4 yaş grubundaki çocukların yanık derecelerinin 5 ve üzeri yaş grubundakilere göre daha ileri düzeyde olabileceği ile ilişkilidir. En sık görülen komplikasyon (%37.1) anemiydi ve mortalite görülmedi. Ortalama hastanede kalış süresi 24.1±27.8 (2-179) idi.
SONUÇ: Araştırmamız, düşük gelirli ülke kategorisinde yer alan Somali bölgesindeki pediatrik yanık vakalarına ilişkin ilk epidemiyolojik veridir. Düşük gelirli ülkelerde pediatrik yanık vakalarında etkili yanık yönetimi sağlanırsa ölüm riski ortadan kaldırılabilir. Bu sonuç, majör pediatrik yanıklarda hayatta kalma beklentisini desteklemektedir. Hemşireler ve tüm sağlık profesyonelleri sağlığın korunması ve geliştirilmesinden sorumludur. Bu nedenle, yanık yaralanması önleme stratejileri konusunda eğitim, insidansın yüksek olduğu bölgelere hedeflenmeli ve uygulanmalıdır.

Anahtar sözcükler: Pediatrik yanık; yanık; yanık tedavisi.

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