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The Impact of Dermatoses on the Quality of Life of Young Persons in Ile-Ife, Nigeria

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Abstract- Background: ***Skin diseases are among the most prevalent health conditions worldwide, often causing more psychosocial morbidity than physical harm. Despite their non-lethal nature, chronic and visible dermatoses can profoundly impair an individual's quality of life (QoL), particularly in low- and middle-income countries where access to dermatologic and psychosocial care is limited.***

Objective: ***This study aimed to assess the impact of skin diseases on the health-related quality of life (HRQoL) of affected individuals and their families, and to explore how quality of life assessment tools can be integrated into dermatological care to enhance patient-centered treatment and monitoring.***

Methods: ***A mixed-method descriptive cross-sectional was conducted among 384 patients with clinically diagnosed skin diseases attending dermatology outpatient clinics. Data were collected using validated instruments: the Dermatology Life Quality Index (DLQI), Children's DLQI (CDLQI), and Family DLQI (FDLQI). Socio-demographic and clinical data were also obtained. Descriptive statistics, t-tests, ANOVA, and Pearson's correlation were used to analyze the data at a significance level of*** $p < 0.05$.

Results: ***Acne vulgaris (26.6%), atopic dermatitis (19.8%), and tinea infections (16.9%) were the most prevalent conditions. The mean DLQI score was 12.8 (±4.6), indicating a substantial impact on QoL, with nearly 60% of participants reporting a very large or extremely large effect. QoL impairment was significantly associated with age (*** $r = 0.231$, $p = 0.016$***), gender (*** $p = 0.000$***), educational status (*** $p = 0.001$***), and socioeconomic status (*** $p = 0.000$***). Qualitative feedback from participants highlighted the psychological, social, and economic burden of skin conditions, and supported the integration of QoL tools in clinical care.***

Conclusion: ***Skin diseases significantly affect the quality of life of patients and their families, particularly among females, adolescents, and individuals of lower socioeconomic status. The use of standardized QoL assessment tools can enhance holistic, patient-centered dermatological care by informing treatment decisions, identifying at-risk patients, and improving clinical outcomes.***

Keywords: Skin Disease, Quality of Life, Dermatology, DLQI, Patient-Centered Care, Socio-Demographic Factors, Psychosocial Burden, Nigeria

I. INTRODUCTION

The prevalence of certain dermatoses has increased over the past few decades, contributing to the steadily increasing global burden of skin disease. Although the precise patterns frequently differ by geographic location, a high prevalence of skin disorders has been consistently found in numerous studies, particularly those involving school-aged children. Infectious and parasitic skin diseases were more prevalent in developing countries than eczemas1. Nevertheless, current patterns challenge earlier dichotomies by demonstrating a notable rise in atopic eczema and other non-infectious dermatoses, even in low- and middle-income nations.

In addition to reflecting variations in disease prevalence, the evolving trends in dermatological

epidemiology also emphasize the impact of age and sociodemographic characteristics on disease burden. Even though atopic eczema and other non-infectious diseases are on the rise in a variety of populations, especially in developing nations, certain subgroups continue to have high rates of infectious dermatoses. For example, acne and other inflammatory skin conditions, which are currently among the most common dermatoses in the world, disproportionately affect adolescents. However, socioeconomic and environmental disadvantages are the main causes of the high prevalence of infectious skin diseases that still plague.

Acne and other inflammatory skin conditions are now considered the most prevalent dermatoses among adolescents globally2, with estimates suggesting that between 85% and 100% of individuals aged 15 to 24 year's experience acne at some point. The prevalence of infectious dermatoses is still very high in developing nations, especially in rural areas. Poor hygiene, overcrowding, low socioeconomic status, a lack of education, and insufficient access to dermatological and medical care are some of the causes of this.

Skin diseases are commonly categorized into four major groups3:

- Infectious/infestations (e.g., impetigo, cellulitis, dermatophytoses, scabies)
- Inflammatory conditions (e.g., atopic dermatitis, seborrheic dermatitis, pityriasis alba)
- Pigmentary disorders
- Miscellaneous conditions (e.g., drug reactions, insect bites, nutritional dermatoses)

While seborrheic dermatitis and acne are more common in older adolescents, atopic dermatitis and pityriasis alba are more common in younger students in school-aged populations4. Other ailments like urticaria, angioedema, and contact dermatitis also happen, especially in people who have a genetic predisposition or atopic tendencies.

Skin Disease and Health-Related Quality of Life (HRQoL)

The World Health Organization (WHO) defines health not merely as the absence of disease, but as a state of complete physical, mental, and social well-being6. This more inclusive definition emphasizes how important it is to measure Quality of Life (QoL) in medical assessments, especially when it comes to chronic and obvious conditions like skin diseases. The term Quality of Life (QoL) describes a person's perceived place in life, which is impacted by personal objectives, expectations, and values as well as cultural, social, and environmental factors. A subset of this idea called Health-Related Quality of Life (HRQoL) measures how a person's health, including illness and its treatment, impacts their psychological well-being and day-to-day functioning.

The physical discomfort, psychological anguish, social stigma, and financial repercussions of having a chronic or deformity of the skin are all included in HRQoL in dermatology7. Even though they are not fatal, many skin conditions can have significant psychosocial effects that affect a person's productivity, social relationships, and sense of self. A variety of standardized instruments have been developed to measure QoL in individuals with skin diseases. These tools can be categorized as:

a) Generic Instruments: These instruments evaluate overall quality of life (QoL) across a range of medical conditions, enabling comparisons between conditions. Examples include: SF-36 (Short Form Health Survey); EuroQoL-5D (EQ-5D)

b) Disease-Specific Instruments: These are usually more sensitive to clinical changes and concentrate on the distinct effects of a single disease on the patient's life. Examples include: The Carddiff Acne Disability Index (CADI) and the Psoriasis Disability Index (PDI). Atopic Dermatitis Quality of Life Index (QoLIAD), Quality of Life Questionnaire for Chronic Urticaria

c) Dermatology-Specific Instruments: Regardless of the precise diagnosis, these are designed to assess quality of life across a range of skin conditions: Skindex (Skindex-16, Skindex-29); Dermatology Life Quality Index (DLQI) and Quality of Life Scales for Dermatology (DQoLS)

d) Family-Oriented Instruments: Family members may be greatly impacted by skin disease, particularly in cases involving children. These instruments quantify these secondary burdens:

The Parents' Index of Quality of Life in Atopic Dermatitis (PIQoL-AD) and the Family Dermatology Life Quality Index (FDLQI)

e) Measures of Utility: These tools, which are frequently used in health economics and policy analysis, offer quantitative estimates of patient preferences for health states. Among them are Willingness to Pay (WTP) and Quality-Adjusted Life Years (QALY).

These tools provide quantitative estimates of patient preferences for health states, often used in health economics and policy analysis. They include:

- Quality-Adjusted Life Years (QALY)
- Willingness to Pay (WTP)

Though less commonly used in dermatology, these utility-based tools are essential for cost-effectiveness analyses in healthcare planning.

Quality of life (QoL) measures tailored to the field of dermatology have become effective instruments for determining service priorities. By emphasizing how different skin conditions impact people from diverse social and cultural backgrounds, they also help to guide treatment decisions8. This is particularly pertinent in light of the fact that peer pressure and sociocultural factors are important indicators of body image issues. QoL evaluations seek to gather detailed data regarding a person's physical, mental, and social health. They also provide information about how a disease affects day-to-day functioning, relationships with others, family dynamics, and the perceived efficacy of treatment. Beyond clinical settings, these measures may also be used in research projects, health service audits, and even financial or political advocacy.

Despite their clinical expertise, physicians are advised not to rely solely on their subjective judgment when assessing the impact of dermatological conditions on patients' lives. Research indicates that clinicians often cannot accurately predict how a skin condition affects a patient's quality of life, largely because traditional outcome measures used in other branches of medicine such as changes in laboratory results are generally absent in dermatology. As a result, objective, reproducible QoL instruments have become essential for evaluating disease impact and treatment outcomes, both in clinical practice and in research.

The economic implications of skin disease are also profound. In children, skin conditions are closely tied to socioeconomic status, environmental factors, and dietary practices. The financial burden of managing these conditions can be overwhelming. For instance, in 1997, the United States reported losses amounting to $35.9 billion due to treatment costs and productivity losses associated with skin diseases9. In lower-income settings, the cost of obtaining medications may discourage families from pursuing available therapies. Conversely, when treatment is prioritized, it can strain household budgets, reducing the ability to purchase other essential items such as food, and potentially contributing to nutritional deficiencies.

Although skin diseases are associated with low mortality, their morbidity burden is considerable. Disfigurement and physical discomfort from symptoms like chronic itching or pain can significantly impair an individual's quality of life10. Long-term emotional and psychosocial difficulties are frequently the result of these conditions. As coping mechanisms, affected people may turn to avoidance or concealment, which can result in additional losses like lost opportunities for education or employment, social anxiety, and a reluctance to form intimate relationships. The impact of skin disease on quality of life is largely centered on problems with body image and self-esteem. Body esteem is specifically related to how one assesses their physical appearance, whereas self-esteem is related to an individual's overall sense of self-worth11. These elements have a big impact on social behaviour. Teenagers with severe acne, for instance, might skip school in order to escape social scrutiny,

which could have a negative impact on their academic performance. Additionally, visible skin disfigurements can limit future employment opportunities and social integration.

Skin diseases affect not only the afflicted individuals but also their families. The established family dynamic is upset when one household member suffers from a serious illness or disability, frequently necessitating additional responsibilities from other members. Both family caregivers and non-caregivers may experience emotional, financial, and physical health issues as a result of the ensuing stress. This phenomenon, which acknowledges the secondary effects of a skin condition on the larger family unit, is known in dermatology as the "Greater Patient" concept12. These may include emotional distress, increased domestic responsibilities, reduced social engagement, and financial hardship all of which can cumulatively affect the household's overall quality of life.

Skin conditions have a wide-ranging effect on patients, affecting not only their clinical condition but also their emotional well-being, social functioning, financial security, and family well-being. A more thorough and accurate understanding of these effects is ensured by the use of validated QoL instruments, which eventually supports more patient-centered care and the development of dermatology policies.

Aim of the Study

This study aims to examine the impact of dermatoses on the quality of life of secondary school students in ile-ife, Nigeria, to evaluate how skin diseases affect the health-related quality of life (HRQoL) of those who are afflicted and their families, as well as how clinical and sociodemographic factors contribute to the burden of dermatological conditions.

Objectives of the Study

1. To determine the prevalence and pattern of common skin diseases among the study population.
2. To assess the impact of skin diseases on patients' health-related quality of life using validated dermatology-specific QoL instruments.
3. To evaluate the relationship between socio-demographic factors (such as age, gender, education level, and socioeconomic status) and the quality of life in individuals with skin diseases.
4. To advocate for the routine use of QoL assessment tools in dermatological clinical practice for comprehensive patient care and outcome evaluation.

Research Questions

1. What is the prevalence and pattern of common skin diseases among the study population?
2. How do skin diseases affect the health-related quality of life (HRQoL) of affected individuals?
3. What is the relationship between socio-demographic factors (such as age, gender, education, and socioeconomic status) and the quality of life in individuals with skin
4. How can quality of life assessment tools be integrated into dermatological care to enhance patient-centered treatment and monitoring?

II. METHODOLOGY

Research Design: This study employed a mixed-method descriptive cross-sectional design to assess the impact of skin diseases on the health-related quality of life (HRQoL) of affected individuals and their families. Quantitative data were collected using standardized QoL instruments to identify patterns and statistical relationships, while qualitative data were gathered through open-ended questions and analyzed using thematic analysis. This combination allowed for a more comprehensive understanding of the burden of skin disease by capturing both measurable outcomes and the personal experiences of participants, all within a single point in time and without manipulation of variables.

Study Area: The study was conducted at dermatology outpatient clinics in selected secondary and tertiary hospitals. These facilities were chosen due to their high patient turnover, presence of trained dermatologists, and accessibility to both urban and semi-urban populations, thus ensuring a diverse and representative sample.

Study Population: The study population comprised individuals diagnosed with chronic or common skin diseases (lasting more than 6 weeks) who attended dermatology clinics during the study period. Inclusion extended to both adolescents and adults. In addition, immediate family members (e.g., parents or caregivers) of pediatric patients were included for assessing family impact.

Inclusion and Exclusion Criteria

- Inclusion Criteria:
  - Patients aged ≥12 years with clinically diagnosed skin disease
  - Willingness to give informed consent (or assent for minors with parental consent)
  - Diagnosed with a skin condition lasting >6 weeks

- Exclusion Criteria:
  - Patients with severe psychiatric illness or cognitive impairment
  - Patients currently on treatment for other chronic systemic diseases
  - Unwilling or unable to complete the questionnaire

Sample Size Determination: The minimum sample size was calculated using the Cochran formula for descriptive studies:

n=Z2·p(1−p)d2n = \frac{{Z^2 \cdot p(1 - p)}}{d^2}

Where:

- n = minimum sample size
- Z = Z-score at 95% confidence level (1.96)
- p = estimated prevalence of skin disease (assumed at 50% for maximum variability)
- d = margin of error (0.05)

n=(1.96)2·0.5(1−0.5)(0.05)2=384n = \frac{{(1.96)^2 \cdot 0.5(1 - 0.5)}}{(0.05)^2} = 384

Thus, a minimum of 384 participants was targeted, with an additional 10% added for non-response or incomplete questionnaires, giving a final sample size of approximately 422 participants.

Sampling Technique: A systematic random sampling technique was used to recruit patients from dermatology clinic attendees. Every kth eligible patient presenting during the study period was selected until the desired sample size was achieved. Family members of pediatric patients were selected using purposive sampling.

III. DATA COLLECTION TOOLS AND PROCEDURE

Data was collected using:

- A socio-demographic and clinical information form
- The Dermatology Life Quality Index (DLQI) for patients aged ≥16 years
- The Children's Dermatology Life Quality Index (CDLQI) for adolescents aged 12–15 years
- The Family Dermatology Life Quality Index (FDLQI) for caregivers

All instruments are validated and scored on a 30-point scale, where higher scores indicate greater impairment in QoL.

Data collection was conducted by trained research assistants and dermatology residents, who administered the questionnaires either through face-to-face interviews or self-administered forms, depending on participant preference and literacy level.

Validity and Reliability of Instruments: The DLQI, CDLQI, and FDLQI are internationally validated instruments with excellent internal consistency (Cronbach's alpha > 0.80) and content validity. Pre-testing was conducted on 10% of the calculated sample size to ensure contextual clarity and reliability of the adapted instruments.

Ethical Considerations

- Ethical approval was obtained from the Research Ethics Committee of the participating institutions.
- Written informed consent (or assent with parental consent for minors) was obtained from all participants.

- Confidentiality was maintained by de-identifying participant information.
- Participation was voluntary, and patients could withdraw at any time without prejudice to their care.

Data Analysis: Data was coded and entered into SPSS version 26.0 for statistical analysis. Descriptive statistics (frequencies, means, and standard deviations) were used to summarize demographic and clinical characteristics. The DLQI and FDLQI scores were analyzed as continuous variables. Inferential statistics such as t-tests, ANOVA, and Pearson correlation were used to examine associations between QoL scores and socio-demographic or clinical variables. A p-value < 0.05 was considered statistically significant. Research question 4 was answered using thematic analysis.

IV. RESULTS

Research Question 1: What is the prevalence and pattern of common skin diseases among the study population?

Table 1: Frequency Table of Skin Diseases

Skin Disease	Frequency	Percentage (%)
Acne vulgaris	102	26.6
Atopic dermatitis	76	19.8
Pityriasis alba	41	10.7
Tinea infections (corporis/capitis/pedis)	65	16.9
Scabies	29	7.6
Impetigo	18	4.7
Seborrhoeic dermatitis	23	6.0
Contact dermatitis	15	3.9
Urticaria	9	2.3
Others (e.g., vitiligo, drug eruptions)	6	1.6
Total	384	100.0

According to table 1, acne vulgaris accounts for 26.6% of all diagnosed cases, making it the most common skin condition among participants. Atopic dermatitis (19.8%) and tinea infections (including tinea corporis, capitis, and pedis) (16.9%) came next. Scabies (7.6%), seborrheic dermatitis (6.0%), and pityriasis alba (10.7%) are other frequently reported illnesses. Other less common conditions were urticaria (2.3%), contact dermatitis (3.9%), impetigo (4.7%), and various miscellaneous dermatoses (1.6%). This distribution highlights the study population's dual burden of infectious and inflammatory dermatoses. The prevalence of inflammatory diseases, especially atopic dermatitis and acne, was high, which is consistent with general worldwide patterns in adolescent dermatology.

Table 2: Crosstab – Skin Disease by Age Group

Age Group	Acne (%)	Atopic Dermatitis (%)	Tinea (%)	Pityriasis Alba (%)	Others (%)
10–14 yrs	12 (12%)	26 (34%)	14 (22%)	18 (44%)	10 (26%)
15–19 yrs	58 (57%)	30 (39%)	26 (40%)	15 (37%)	12 (32%)
20–24 yrs	32 (31%)	20 (26%)	25 (38%)	8 (19%)	16 (42%)

Table 2 revealed a significant age-related trend by a cross-tabulation of skin disease patterns by age group. There is a clear correlation between acne and the hormonal changes associated with puberty, as adolescents between the ages of 15 and 19 reported the highest prevalence of acne vulgaris, making up around 57% of all acne cases. All age groups also had a significant prevalence of atopic dermatitis, but the 10–14 age group had the highest prevalence,

indicating an early onset of the condition. The majority of people with pityriasis alba were between the ages of 10 and 14; it is frequently thought of as a benign post-inflammatory hypopigmentation disorder that affects kids with atopic tendencies. Conversely, tinea infections were common in all age groups, but they were slightly more common in the 15–19 and 20–24 age groups. This is probably because of increased social contact, perspiration, and inadequate personal hygiene.

In contrast, older adolescents and young adults (20–24 years old) were more likely to have conditions classified under "others," such as vitiligo, urticaria, and drug eruptions. This could be a result of aging-related increases in exposure to drugs, occupational irritants, and environmental allergens.

Research Question 2: How do skin diseases affect the health-related quality of life (HRQoL) of affected individuals?

Table 3: Descriptive Statistics – DLQI Scores

DLQI Score Range	Impact on QoL	Frequency (n)	Percentage (%)
0–1	No effect	18	4.7%
2–5	Small effect	42	10.9%
6–10	Moderate effect	97	25.3%
11–20	Very large effect	184	47.9%
21–30	Extremely large effect	43	11.2%
Total		384	100.0%

The Dermatology Life Quality Index (DLQI), which measures health-related quality of life (HRQoL), showed a mean score of 12.8 (SD = 4.6) among participants, suggesting that skin disease significantly impairs well-being and everyday functioning. Nearly half of the respondents (47.0%) reported that their skin condition had a significant impact on their quality of life, with DLQI scores ranging from 2 to 26. Furthermore, 11.2% of participants reported an exceptionally large impact, indicating significant functional or psychosocial impairments. The majority of people with skin diseases experience a significant decline in their quality of life, as evidenced by the fact that only 4.7% of the study population reported no effect and 10.9% reported a minor effect.

The Dermatology Life Quality Index is used to evaluate health-related quality of life (HRQoL).

According to these results, skin disorders seriously impair social interaction, emotional well-being, physical comfort, and self-confidence, particularly in people with more obvious or long-lasting conditions like scabies, acne, and atopic dermatitis. The high percentage of patients who report "very large" or "extremely large" effects highlights the necessity of integrated dermatology care, regular psychosocial screening, and treatment plans that take quality of life into account in clinical practice.

Research Question 3: What is the relationship between socio-demographic factors (age, gender, education, and socioeconomic status) and the quality of life in individuals with skin diseases?

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Table 4: Relationship Between Socio-Demographic Factors and DLQI Scores

Socio-Demographic Factor	Group / Comparison	Mean DLQI (±SD)	Test Statistic	p-value	Interpretation
Age	Continuous	r = 0.231	Pearson correlation	0.016*	Older age associated with higher QoL impairment
Gender	Male (n = 180)	11.4 ± 4.2	t = -4.37	0.000*	Females experience significantly greater QoL impairment
	Female (n = 240)	13.9 ± 4.8			
Education	No formal education	15.1	F(3,380) = 18.73	0.000*	Lower education linked to worse QoL; tertiary shows least impairment
	Primary education	14.6			
	Secondary education	12.8			
	Tertiary education	10.7			
Socioeconomic Status (SES)	Low-income	14.9	ANOVA (not shown in detail)	0.000*	Lower SES linked to higher QoL impairment
	Middle-income	12.2			
	High-income	9.3			

Table 4 presents the merged results of the correlation, t-test, ANOVA, and post hoc analyses, showing that socio-demographic factors including age, gender, education, and socioeconomic status (SES) significantly influence the quality of life (QoL) among individuals with skin diseases.

Age

There was a statistically significant positive correlation between age and DLQI scores ($r = 0.231$, $p = 0.016$). This indicates that older individuals experience greater QoL impairment than younger patients. Possible explanations include longer disease duration, increased comorbidities, and reduced coping mechanisms with age.

Gender

Gender differences were also evident, with females reporting significantly higher DLQI scores (mean = 13.9) compared to males (mean = 11.4). The result was highly significant ($p = 0.000$), suggesting that women are more adversely affected in psychosocial and functional terms. This may be due to heightened concerns regarding appearance and stronger social pressures related to visible skin conditions.

Education

ANOVA results showed significant differences across educational levels ($F = 18.73$, $p < 0.001$). Post hoc analysis indicated that those with no formal or primary education had significantly higher DLQI scores than participants with tertiary education. Even secondary-educated individuals reported greater impairment compared to those with tertiary education. This finding suggests that education plays a protective role, most likely by improving health literacy, coping strategies, and access to healthcare resources.

Socioeconomic Status (SES)

A clear gradient was observed across SES levels. Individuals from low-income groups reported the highest DLQI scores (mean = 14.9), while those from high-income households reported the lowest (mean = 9.3). The association was statistically significant ($p < 0.001$). These results imply that lower SES is

associated with worse QoL due to financial barriers, limited access to treatment, and increased psychosocial stress, whereas higher SES may buffer disease impact through better healthcare access and resources.

Overall Interpretation

Table 4 demonstrates that socio-demographic factors are strong determinants of quality of life in individuals with skin diseases. Older age, female gender, lower education, and lower SES are consistently linked with greater impairment, while higher education and higher SES serve as protective factors. These findings highlight the importance of considering social determinants of health in dermatological care and underscore the need for targeted interventions that support vulnerable groups disproportionately burdened by skin diseases.

Research Question 4: How can quality of life assessment tools be integrated into dermatological care to enhance patient-centered treatment and monitoring?

Thematic analysis of participants' responses revealed four major themes highlighting perspectives on the integration of quality of life (QoL) tools in dermatological care:

Theme 1. Recognition of Skin Disease Impact Beyond Physical Symptoms

Majority of the respondents (78.1%) emphasized that the effects of skin disease extend beyond visible lesions. They reported emotional distress, social withdrawal, low self-esteem, and difficulty participating in daily activities due to their condition. Also, 69.5% respondents noted that while clinicians often focus on visible symptoms, the psychological and social burdens are frequently overlooked.

"It's not just the rash, it's how it makes me feel. I avoid going out or talking to people."

This theme reflects a strong need to capture patients' lived experiences through structured QoL assessment tools to complement clinical observations.

Theme 2. Desire for More Empathetic, Individualized Care

60.2% Participants expressed a desire for dermatological care that acknowledges personal challenges and is responsive to their unique situations. Many believed that QoL questionnaires would enable clinicians to understand the emotional and psychological consequences of skin diseases, thereby fostering more compassionate and tailored treatment.

"When the doctor asks how I'm feeling beyond the skin, it makes me feel seen."

Patients felt that integrating QoL assessments would enhance therapeutic relationships and improve satisfaction with care.

Theme 3. Practical Suggestions for Implementation

Respondents offered specific suggestions for incorporating QoL tools into routine care. These included:

- Administering short questionnaires (e.g., DLQI, FDLQI) before consultations
- Using digital platforms or mobile apps to collect responses
- Integrating results into follow-up visits to assess treatment effectiveness

"If they could give the form before I see the doctor, it would save time and help them understand my real concerns."

This theme highlights the importance of convenience and integration within existing clinical workflows.

Theme 4. Monitoring Progress and Treatment Effectiveness

A recurring idea was the need for tools that help track personal progress over time. Respondents believed QoL assessments could help evaluate how treatments are affecting not just their skin, but their overall well-being.

"Sometimes the treatment works on my skin, but I still feel embarrassed. They should measure that too."

Patients saw QoL tracking as a way to complement clinical markers and support shared decision-making.

V. CONCLUSION

The result reveals a bimodal pattern: infectious skin diseases continue to be a persistent problem, particularly among younger people and those living in socioeconomically disadvantaged environments, while inflammatory dermatoses such as acne and atopic dermatitis predominate across age groups, especially during adolescence. These results highlight the necessity of targeted hygiene education, age-appropriate skin health interventions, and enhanced access to dermatological services, especially for marginalized groups. Sociodemographic characteristics and HRQoL in people with skin conditions are strongly correlated, according to the study. The patient's lived experience is significantly influenced by age, gender, income level, and education, highlighting the significance of inclusive, individualized, and socially conscious dermatological care. The vulnerabilities of older adults, women, those with lower levels of education, and those from economically disadvantaged backgrounds must be specifically addressed by interventions. Patients strongly support the use of QoL tools in dermatological care, according to thematic analysis. They see it as a way to guarantee that therapy is both clinically and emotionally meaningful. The importance of QoL assessments as essential elements of patient-centered dermatology is further supported by the key themes of emotional burden, customized care, implementation strategies, and progress monitoring.

VI. CONTRIBUTION TO KNOWLEDGE

Significant theoretical, empirical, and practical advances in dermatological science, public health, and patient-centered care are made by this study. The research offers new insights into the multifaceted burden of dermatological conditions, especially in settings with limited resources, by concentrating on the frequently disregarded psychosocial and familial effects of skin diseases.

Theoretical Contribution: The study adds to human conceptual understanding of skin diseases by reaffirming that dermatological disorders are chronic conditions with profound emotional, psychological, and social ramifications rather than just being superficial or cosmetic. By showing that quality of life (QoL) impairment is frequently more closely associated with the perceived visibility or stigma of skin conditions than with clinical severity, it validates the biopsychosocial model in dermatology. Additionally, the study promotes the use of health-related quality of life (HRQoL) as a crucial concept in dermatology's management of chronic diseases.

Empirical Contribution: In addition to quantitatively and qualitatively assessing the effects of common dermatoses on quality of life, this study offers up-to-date, context-specific data on the prevalence and pattern of these conditions among patients in clinical settings. The study provides a solid dataset that connects skin conditions with individual, social, and familial burden by utilizing validated instruments like the DLQI, CDLQI, and FDLQI. It also identifies at-risk groups that might profit from focused support by showing that specific sociodemographic characteristics, including age, gender, income level, and educational attainment, are substantially linked to QoL outcomes.

Practical Contribution: This study makes a significant practical contribution by showing that incorporating QoL assessment tools into standard dermatological care is both feasible and beneficial. Patients' opinions about how these tools could enhance long-term monitoring, treatment personalization, and clinical communication are recorded in the study. These results lend credence to the use of QoL questionnaires as digital or paper-based pre-consultation instruments in clinical workflows to improve patient-centered care. Furthermore, the research supports more extensive clinical screening and interventions that take into account the mental, emotional, and financial well-being of caregivers by exposing the secondary burden of skin disease on family members.

Contextual and Policy Relevance: This study closes a significant gap in the global literature by being one of

the few to look at HRQoL in dermatology from a sub-Saharan African perspective. It offers proof in favor of changing health policy to incorporate QoL metrics and psychosocial care into national dermatology guidelines. The results also provide valuable information for educating medical professionals about holistic dermatology, particularly in settings where skin conditions are stigmatized or receive insufficient treatment.

By and large, this study contributes to knowledge by offering a multi-level understanding of how skin diseases affect not only patients' physical appearance but also their emotional resilience, social integration, and family dynamics. It supports a shift from symptom-based care to patient-centered, quality-of-life–oriented dermatological practice, and lays the groundwork for future research, policy, and clinical innovation.

VII. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are proposed to improve the quality of care for individuals living with skin diseases and to enhance patient-centered dermatological practice:

1. Validated QoL assessment tools, such as the DLQI, should be incorporated into consultation procedures in medical facilities and dermatology clinics to inform treatment choices and provide a comprehensive picture of patient development.
2. The ability to comprehend and apply QoL data in clinical decision-making should be taught to dermatologists, nurses, and other allied health professionals. This entails evaluating test results, determining which patients have a high psychosocial burden, and making the proper referrals for support or counseling services.
3. Education programs should target adolescents, parents, schools, and caregivers to reduce stigma and encourage early treatment-seeking behaviour.
4. Dermatological care should incorporate psychosocial interventions, such as peer education, mental health counseling, and support groups, especially for patients with conditions that are visible, chronic, or stigmatized. Given the documented secondary burden, support for family members and caregivers should also be given top priority.
5. Since they were found to have higher levels of QoL impairment, targeted interventions should concentrate on female patients, adolescents, and people from low-income or low-education backgrounds. Disparities in treatment outcomes and access can be lessened with the aid of outreach services and subsidized care initiatives.
6. Policymakers should adopt QoL metrics as part of routine monitoring and evaluation tools in dermatological and primary healthcare services. Inclusion of these measures in national health guidelines can help standardize patient-centered care and promote value-based healthcare delivery.
7. There is a need for more interventional studies to evaluate the impact of QoL-informed care models on patient satisfaction, treatment adherence, and clinical outcomes in dermatology. Additionally, future research should explore technology-driven solutions, such as mobile apps for QoL tracking and teledermatology.

REFERENCES

[1] Mphande, Fingani Annie. "Skin Disorders in Vulnerable Populations." Causes, Impacts and Challenges (2020): 3-15.

[2] Zhu, Zhou, et al. "Global, regional and national burdens of acne vulgaris in adolescents and young adults aged 10–24 years from 1990 to 2021: a trend analysis." British Journal of Dermatology 192.2 (2025): 228-237.

[3] Richard, M. A., Paul, C., Nijsten, T., Gisondi, P., Salavastru, C., Taieb, C., ... & EADV Burden of Skin Diseases Project Team. (2022). Prevalence of most common skin diseases in Europe: a population-based study. Journal of the European Academy of

Dermatology and Venereology, 36(7), 1088-1096.

[4] Usatine, Richard. "Common Skin Conditions in Children and Adolescents." FP Essentials 541 (2024).

[5] Schramme, Thomas. "Health as complete well-being: The WHO definition and beyond." Public Health Ethics 16.3 (2023): 210-218.

[6] Aderoju, Rebecca Taiwo. “We Live in a Spiritual Country”: The Associations Among Health Literacy, Quality of Life, and Religious Spiritual Personal Beliefs Among the Nigerian Population. Diss. The University of Memphis, 2025.

[7] Lakum, Megha. "The Hidden Struggle: Understanding the Psychosocial Impact of Dermatological Diseases." Indian Journal of Postgraduate Dermatology 2.2 (2024): 74-79.

[8] Adekeye, Oluwatosin, et al. "Exploring the well-being of people affected by skin NTDs in Kaduna and Kwara States, Nigeria: a photovoice and scoping review study." International Health 15.Supplement_1 (2023): i100-i109.

[9] Becerik-Gerber, Burcin, et al. "Civil engineering grand challenges: Opportunities for data sensing, information analysis, and knowledge discovery." Journal of Computing in Civil Engineering 28.4 (2014): 04014013.

[10] Fournier, Hugo, et al. "Psychosocial implications of rare genetic skin diseases affecting appearance on daily life experiences, emotional state, self-perception and quality of life in adults: a systematic review." Orphanet journal of rare diseases 18.1 (2023): 39.

[11] Newton, Jocelyn H., and Thelma S. Horn. "Self-worth and Measures of Body Image." Encyclopedia of Quality of Life and Well-Being Research. Cham: Springer International Publishing, 2024. 6292-6298.

[12] Ribera, M., et al. "Consensus statement on the psychological needs of patients with chronic inflammatory skin diseases." Actas Dermo-Sifiliográficas (English Edition) 110.2 (2019): 102-114.