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Review article

Racial discrimination and healthcare disparities in sickle cell disease: An integrative review

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ABSTRACT

Sickle cell disease is an inherited genetic disorder that predominantly affects the Black population and can lead to serious complications like stroke and acute chest syndrome, significantly compromising the quality of life of those affected. An integrative literature review was conducted to explore the impact of racial discrimination experienced by patients with sickle cell disease and its influence on the clinical management of the condition. Eleven articles were identified that discussed how the Black population, which often faces vulnerable socioeconomic situations, receives less favorable clinical prognoses given these inequalities. This review emphasizes that institutional racism and racial bias not only lead to higher rates of depression in patients but also influence how healthcare professionals understand and address the disease. This article also examines the relationship between racial discrimination and patient experiences with sickle cell disease, emphasizing the need for more equitable treatment options and for implementing policies that address racial inequalities in healthcare. Additionally, it underscores the importance of social movements in raising awareness of sickle cell disease and influencing health policies.

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Introduction

Sickle Cell Disease (SCD) is an inherited genetic condition characterized by an abnormal form of hemoglobin, causing red blood cells to become sickle-shaped and rigid. This can obstruct blood vessels, leading to pain, organ damage, and an increased risk of serious complications such as strokes. SCD is most common among African populations and those of African descent, but migrations from Africa have resulted in this disease affecting people of all races, including communities in the Mediterranean, India, and the Middle East [1–4].

SCD can lead to chronic hemolytic anemia, increased susceptibility to bacterial infections, systemic vasculopathy, painful vaso-occlusion, and delayed hemolytic transfusion reactions, with the latter two contributing to increased morbidity and mortality rates [3,5]. SCD is also associated with psychosocial dysfunctions due to the interaction between patients, their disease condition, and the social environment, including financial and interpersonal difficulties [6].

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In a study of the global, regional, and national prevalence and mortality burden of SCD, Thomson et al. [7] analyzed data from 204 countries using the Global Burden of Disease Study 2021 (GBD). Based on model-based estimates, they observed a 20.8% increase in the number of deaths resulting from SCD, accompanied by approximate absolute figures of 28,400 deaths in 2000 and 34,400 in 2021. Additionally, they reported a 43.4% increase in total global deaths among individuals with SCD, with totals rising from 262,000 in 2000 to 376,000 in 2021. Many deaths (81,100) were among children under 5 years of age, placing total mortality from SCD 12th among all causes in the GBD globally, while cause-specific mortality from SCD ranked 40th.

Santo [8] reported an average of 517 deaths per year among patients with SCD in Brazil over the past 19 years; SCD was identified as the underlying cause in 70.5% of the cases and as a contributing cause in 29.5%. The average age at death was 29.4 years for men and 33.3 years for women. The National Neonatal Screening Program (PNTN) registered an average of 1,107 live births with SCD between 2014 and 2019 [9].

SCD requires careful and ongoing management to prevent infections and organ damage to improve life expectancy and quality of life [2,5]. The severity of the disease varies due to genetic modifiers as well as socioeconomic factors, such as poverty, housing conditions, nutrition, and access to healthcare, which are all closely linked to poorer disease outcomes [5,10].

Social inequalities, exacerbated by racism, worsen the living conditions of the Black population, contributing to illness and promoting racial inequities in health. These factors influence how this population accesses healthcare services and limit the quality of care provided [11]. Structural racism has been associated with inadequate management of SCD, disparities in research funding, and the stigma that perpetuates inequalities in the affected population [12–15].

Recent research has reported on racial discrimination in healthcare services, particularly in countries with racialized social structures, such as the United States and Brazil. In these settings, where skin color acts as a determinant of inequity, SCD is frequently stigmatized as a condition affecting Black individuals and has, consequently, been historically neglected [12–15]. However, the concentration of published evidence in these countries may reflect greater recognition and documentation of the problem, while racial discrimination in other healthcare systems may remain underrecognized or underreported.

Kalckmann et al. [16] showed that the Black population, whether as health-care users or professionals, experiences racial discrimination. They also found that health service professionals contribute to increased vulnerability among this population by creating access barriers, reducing opportunities for dialogue, and alienating users. In a review on institutional racism, Quadros et al. [11] highlighted that, despite being a widely discussed topic, institutional racism manifests in subtle ways. In a racist society, skin color influences the treatment Black people receive, and social position is not a shield against racial discrimination.

Institutional racism in health services manifests through policies that fail to address disparities in morbidity and mortality between Black and White populations, a lack of inclusion of racism-related curricula in professional training, and inpatient care characterized by negligence and indifference. This reality is evident in the daily practices of health professionals, through discriminatory and prejudiced attitudes, which pose significant barriers to Blacks when attempting to access their rights [17].

In an investigation on the use of transcranial doppler echocardiography (TCD) for patients with SCD in Brazil during the COVID-19 pandemic, Santos et al. [18] revealed stark disparities. In the southern region of the country in 2019, 75.5% of TCD exams were performed on the White population, which represented 36% of the population with SCD under 19 years of age, while only 7.2% of the exams were performed on the Black population, which represented 23% of the same population. In 2020, the first year of the pandemic, the number of exams decreased to 61.7% for Whites and just 4% for Blacks. These discriminatory practices are underpinned by deep-rooted beliefs among professionals: the misconception that Black people are more resistant to pain, resulting in medical negligence and the minimization of complaints [17].

The National Policy for Comprehensive Health of the Black Population (PNISPN), based on scientific research, professional training, public awareness, and comprehensive care, aims to promote equality in healthcare with a focus on reducing ethnic-racial inequalities. The PNISPN acknowledges health disparities as consequences of socioeconomic and cultural injustices, positioning itself as a crucial tool in the fight against racism. Its effectiveness relies on intersectoral strategies, particularly in health and education, to strengthen social control and transform discriminatory relationships. Considering that equity is a core principle of the Brazilian Unified Health System (SUS), health services must provide targeted treatments to reduce the vulnerability of marginalized populations [11,17].

The objective of this research was to conduct an integrative literature review to identify and discuss racial discrimination against patients with SCD, and the impact of this discrimination on the treatment of the disease. It also aimed to identify potential differences in the experiences of racial discrimination between Black and non-Black patients.

Methods

An integrative literature review was adopted because it is appropriate for addressing focused and well-defined questions, in identifying relevant available evidence, and in using scientific methods that allow other researchers to evaluate the procedures and results [19].

In this context, the study aimed to synthesize evidence on the relationship between racism/racial discrimination and healthcare for people with SCD. The guiding question was structured based on the PICO strategy, considering people with SCD as the population, racism or racial discrimination as the phenomenon of interest, and impacts on healthcare as the context.

For the reference search strategy, the descriptors defined for SCD were “Sickle Cell Disease,” “Anemia, Sickle Cell,” “Doença Falciforme,” and “Anemia Falciforme.” For racism, the descriptors were “Racial Discrimination” or “Racism.” The

databases consulted were the National Library of Medicine (PubMed), the CAPES Periodicals Portal, and the Virtual Health Library (BVS). Eligible studies were full-text articles available online, written in English or Portuguese and published between 2013 and 2022. The exclusion criteria were articles that did not address SCD or racial discrimination, as well as articles that were not available online.

Study selection was carried out through the reading of titles, abstracts, and full texts, according to the established criteria. The included studies were subjected to critical appraisal independently conducted by the authors, regarding methodological quality, considering aspects such as study design, coherence between objectives and methods, consistency of results, and potential biases. The extracted data were organized and analyzed descriptively, enabling the synthesis of evidence and the identification of gaps in the literature.

Results

The search resulted in 114 records, of which 24 were duplicates. Of the remaining 90 records, 65 were excluded after reviewing the titles, since they were not relevant to the focus of SCD concerning racial discrimination or stigmas. After reading the abstracts of the remaining 25 articles, all were selected for full-text review. Of these, 14 were excluded because they did not adhere to the objectives of this integrative review, resulting in a final selection of 11 articles. Figure 1 shows the selection and inclusion process for the articles, and Table 1 provides a summary of the information from the articles included in this review.

The included studies were predominantly qualitative and observational in design and were conducted in Brazil and the United States, involving different age groups of individuals with SCD. Analysis of these articles shows the recurring presence of racism and racial discrimination in both institutional settings and interpersonal relationships, particularly in healthcare services. In these contexts, the findings converge on the invalidation of pain, delays in care, and inadequacies in clinical management. Some studies distinguish racial discrimination from discrimination associated with the disease itself, indicating the coexistence and overlap of these phenomena in patients' experiences.

Overall, the results point to an association between the perception of racism and poorer health outcomes, including greater pain intensity, worse quality of life, and the presence of depressive symptoms. Factors such as age, gender, and socioeconomic context appear to shape these experiences. Studies also describe coping strategies adopted by individuals, ranging from avoidance responses to forms of active coping. From a methodological perspective, there is a predominance of convenience samples and limitations related to selection and information biases, in addition to heterogeneity in the methods used to measure the investigated phenomena.

Discussion

As a chronic condition, the clinical manifestation and prognosis of SCD are intrinsically linked to individual self-care, as well as environmental and socioeconomic factors. Housing conditions, food quality, education level, family income, access to leisure, and adequate information are key determinants of the quality of life for people with SCD [20,21]. Furthermore, stress, abrupt temperature changes, dehydration, infections, iron-rich or poor-quality diets, and physical or mental fatigue worsen the health conditions of these individuals, increasing their vulnerability and predisposition to symptoms and disease-related complications [22].

The chronic and debilitating nature of the disease significantly increases the risk of premature mortality and severe clinical complications, including stroke, splenic sequestration crises, and acute chest syndrome. These conditions not only impact an individual's self-esteem but also affect their family relationships and sociocultural interactions, with repercussions for work and educational trajectories, thereby contributing to mental suffering and restrictions in social mobility [20,22,23].

The Black population is the most affected by SCD and, due to racial prejudice, is disproportionately represented in the most socioeconomically vulnerable strata of society. This makes these individuals more susceptible to a more unfavorable clinical conditions and prognosis [20,23,24]. In this regard, Mougianis et al. [25] showed that racism is associated with worse health outcomes, including negative impacts on quality of life mediated by depressive symptoms among young people hospitalized with SCD in the United States.

SCD was first identified in 1910 by James Herrick. It emerged in a global context marked by the prevalence of eugenic practices and the notion of the medical 'improvement' of humans, and has since been linked to racial, social, and political factors. The first half of the twentieth century was characterized by intense debate over national identity, alongside the expansion of eugenic practices and theories aimed at racial improvement under the perspective of human evolution. In this setting, SCD became a symbol of African ancestry, while Afro-descendants were assigned the stigma of having 'inferior' blood, whose genetic inheritance should be eliminated in the name of 'racial improvement' of the Brazilian population [26].

Silvio Almeida [27] contributes to our understanding as to why SCD remains marked by invisibility and failures in care within the SUS. According to him, racism manifests in three interdependent and mutually reinforcing dimensions, individual, institutional, and structural, all of which are expressions of the same systemic racism. At the institutional level, racism materializes in the systematic reproduction of racial inequalities through norms, practices, and processes that, although formally neutral, produce discriminatory effects and undermine the effectiveness of the rights of Black people. From this perspective, insufficient training of health professionals regarding SCD may be understood as an expression of an educational and scientific structure that has historically neglected conditions predominantly affecting the Black population.

Within the healthcare system, institutional racism acts as a mediation between social structure and care practices, manifesting in inequitable access to services, limited training focused on ethnic-racial specificities, underreporting of health problems, including SCD, and insufficient

Table 1 – Summary of the characteristics of the articles included in the review.

Authors	Country	Object	Result	Bias
Carvalho et al. 2021 [31]	Brazil	Analyze the characteristics of stigma in interactions involving people with pain and SCD, and the coping strategies they adopt.	Individuals with SCD often experience stigma during interactions, which can include disbelief in their reports of pain, labeling, and blaming them for their lack of health improvement. They may face discrimination and racism, as well as inadequate pain assessment and delays in receiving care. To cope with these challenges, individuals adopt various strategies, such as remaining silent, hiding symptoms, displaying aggressiveness, taking risks, reading religious texts and hymns, and attending church. Four categories of stigma emerged from the analysis: interactions with family members, the general public, healthcare professionals, and strategies for coping with stigma.	Selecting study participants based on convenience sampling can introduce selection bias. The majority of participants were users of public health services, had a low level of education, and were of Black ethnicity.
Figueiró & Ribeiro 2017 [20]	Brazil	Understand the manifestations of racial and class discrimination experienced by individuals with SCD.	The quality and infrastructure of health services are directly affected by the race and social class of users. Institutional racism is a widespread form of prejudice in healthcare that primarily impacts individuals with lower socioeconomic status. This issue arises from both racial discrimination and the limitations imposed by SCD.	The study, which is based on reports from 33 participants treated at a blood center, may be subject to selection, memory, and information biases, particularly since the ethnicity of some participants was not clearly specified.
Haywood et al. 2014 [30]	United States	The study aims to fill knowledge gaps by exploring perceived discrimination in healthcare among patients with SCD. It describes their perceptions of discrimination by health professionals and its relationship with the chronic suffering caused by the disease.	The results indicate that patients with SCD clearly distinguish between racial discrimination and disease-related discrimination, although the methodology used does not clarify how these distinctions are made. A higher incidence of both racial and illness-related discrimination by healthcare professionals than anticipated was reported. Racial discrimination was linked to age and the difficulty in convincing professionals about their pain, while illness-related discrimination was associated with older age, frequent emergency room visits, daily chronic pain, fewer good days per week, and greater pain intensity on those good days.	Potential selection bias may exist, since patients were selected from the waiting rooms of two clinics specializing in SCD.
Hood et al. 2022 [21]	United States	Evaluate the connection between stigma, racial prejudice, and healthcare disparities, and how these factors affect the quality of life of African-American children with SCD, considering demographic differences.	Older girls reported a higher perception of racial prejudice and a worse health-related quality of life. Regression models indicate that health stigma and age are significant factors affecting quality of life. Furthermore, a poorer quality of life was observed in older girls with a high perception of racial prejudice, pointing to a complex interaction between age, gender, and racial prejudice in determining the quality of life for individuals with SCD.	The study may be subject to selection bias, as it only considered children and adolescents accompanied by parents with an IQ above 70. Additionally, patients and guardians who did not speak English were excluded.
Lages et al. 2017 [24]	Brazil	Report on a survey conducted at a public health center in Belo Horizonte, which explores the perceptions of health team members and users about prejudice as a determinant of health and their knowledge of sickle cell anemia.	The study results highlight the presence of institutional racism in public health, with prejudice contributing to depression and a lack of knowledge about sickle cell anemia among both healthcare teams and system users.	The study may have selection and information biases. Out of 70 professionals, only 40 received questionnaires, and 15 responded, which may reflect a specific interest in the topic. Additionally, the user sample, selected based on convenience, and the assistance provided to illiterate users may have introduced further biases.

Table 1 (*continued*)

Authors	Country	Object	Result	Bias
Mota et al. 2022 [23]	Brazil	Investigate the formation and neglect of SCD in Brazil, based on insights obtained from long-term participatory qualitative research conducted in Bahia.	The authors argue that merely acknowledging health inequalities between White and Black populations in Brazil is insufficient, identifying racism as a driving factor behind the neglect of SCD. They highlight the challenges faced by patients, such as the lack of specialized care, the absence of comprehensive national data, resource limitations, and comorbidities. Additionally, the authors emphasize the critical role of social movements in raising awareness of the disease and influencing health policies and treatments.	The article does not provide details about the sample population, making it difficult to analyze potential biases.
Mougianis et al. 2020 [25]	United States	The study aimed to investigate the relationships between perceived racism, symptoms of depression, and quality of life in adolescents hospitalized with SCD.	The authors propose a model illustrating how perceived racism, depressive symptoms, quality of life, and social support interact in adolescents with SCD. The results indicated that perceived racism led to an increase in depressive symptoms, which negatively impacted quality of life. Furthermore, social support from individuals with SCD intensified the relationship between perceived racism and depressive symptoms.	Potential selection bias exists, since the study only included participants hospitalized due to a pain crisis caused by SCD. Those who did not speak English or had conditions that made it difficult to complete the questionnaire, thus cognitive deficits or disease complications were excluded.
Rodrigues et al. 2023 [32]	Brazil	Describe and evaluate how the perception of prejudice against patients with SCD impacts their quality of life.	The study revealed that prejudice significantly worsened the quality of life for patients with SCD, particularly in the physical domain. These findings highlight the harmful impact of prejudice on individuals with SCD and emphasize the need for strategies to mitigate these effects and enhance their quality of life.	The study, which is based on reports from patients over 14 years old at a hematology center, may be subject to memory, information, and selection biases, influenced by the perception of prejudice and the patients' conditions.
Silva et al. 2020 [26]	Brazil	Examine the connection between eugenics and racism linked to SCD, using the Population Screening Program (PTP) in Salvador, Bahia, as a case study where social mobilizations prevented its implementation.	The analysis of the Population Screening Program (PTP) revealed racist and eugenicist content that advocated for limiting the reproductive rights of women with SCD. This discourse caused significant indignation among the Black women interviewed.	Potential selection bias exists, as the study included only 10 women who expressed interest in participating.
Wakefield et al. 2018 [22]	United States	Evaluate the impact of perceived racial prejudice in medical settings on the health and quality of life of young people with SCD.	All participants reported experiencing at least one instance of racial prejudice. The analysis of these events resulted in four categories and twelve subcategories: perpetrator of prejudice (colleagues, authorities, general public), type of racial prejudice (explicit, implicit), behavioral reaction (confrontation, evasion), and emotional response (dysphoria, anger, indifference, inferiority, anxiety). Most participants reported experiences of racial bias and health stigma, which were correlated with greater pain and a lower quality of life. The findings emphasize the need to address racial bias and health stigma in both research and care for youth with SCD.	Possible selection bias is present, as participants were chosen for convenience during a medical consultation or hospitalization. The study included only African-American, English-speaking patients who reported perceived racial bias or completed the questionnaire.

Table 1 (*continued*)

Authors	Country	Object	Result	Bias
Wakefield et al. 2017 [33]	United States	Examine the prevalence of perceived racial prejudice and health-related stigma among youth with SCD, and its relationship to psychological and physical well-being. Assess how often adolescents and young people with SCD perceive racial bias, both in healthcare services and society at large.	Most participants confirmed experiences of racial prejudice and health stigma. The results indicate that greater perceived racial bias is associated with increased pain and more perceived health problems. Among the participants, men reported a better quality of life. Perceived health stigma was shown to decrease quality of life, while lower levels of racial bias were linked to better quality of life and less reported pain. Health stigma and racial bias were found to be correlated, regardless of SCD severity. Although most participants exhibited signs of clinical depression, no association was found between racial bias, health stigma, and depression.	Potential selection bias exists, as participants were chosen for convenience during medical consultation or hospitalization. The study included only African-American, English-speaking patients and may have introduced information bias due to financial compensation for completing the questionnaire.

SCD: Sickle cell disease; IQ: Intelligence quotient

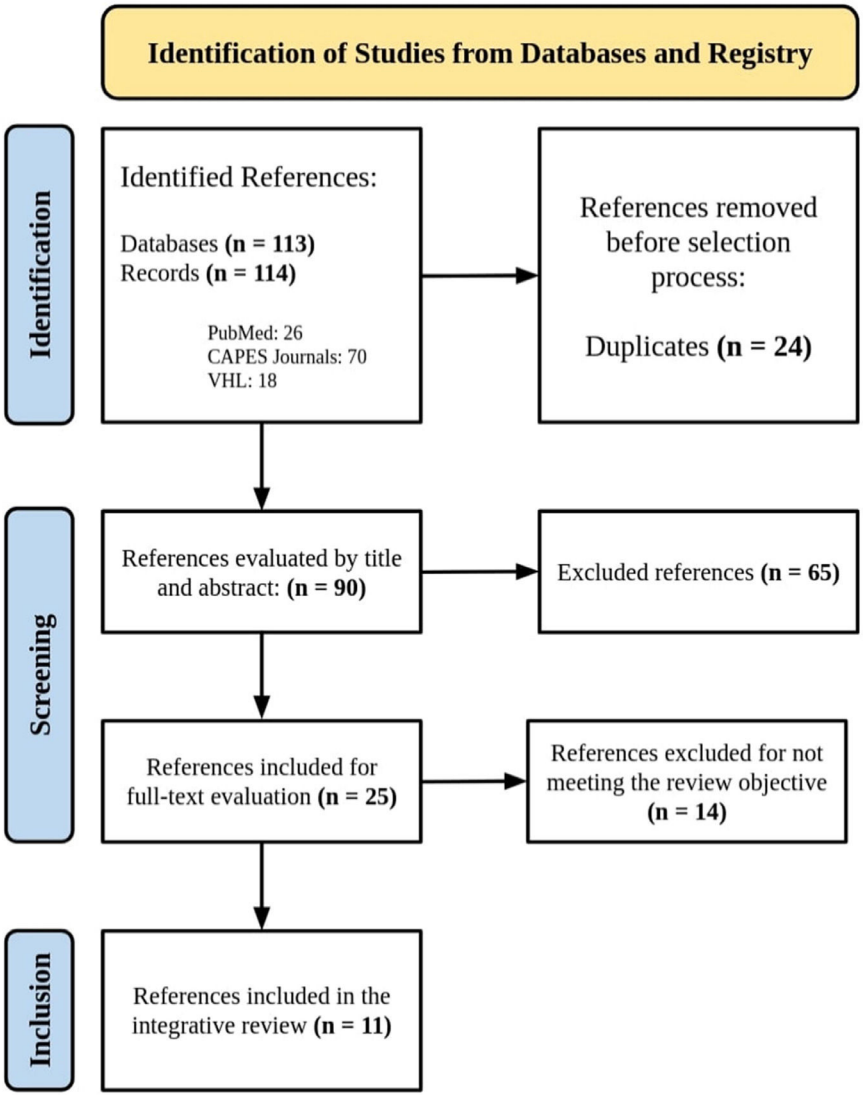

Figure 1 – Flowchart outlining the study selection process.

implementation of racial equity policies. As argued by Kabengele Munanga [28], racism operates implicitly within institutions and so neglect toward diseases that predominantly affect the Black population should not be understood as an isolated event, but rather as an unfolding of a social structure that devalues these bodies. Therefore, in light of Silvio Almeida [27] and Munanga [28], institutional racism in the health sector should not be seen as an episodic or accidental phenomenon, but as a concrete expression of a racist social structure that hierarchically organizes bodies and unequally defines the right to life and health.

This reality corresponds to what Abdias do Nascimento [29] describes as genocide through assimilation and abandonment, in which the Black population is subjected to conditions of existence that limit the possibility of dignified survival. Chronic pain, vaso-occlusive crises, preventable infant mortality, and the reduced life expectancy associated with SCD cannot be dissociated from the racial relations that structure the Brazilian healthcare system. It is therefore no longer sufficient merely to recognize racism as a social determinant of health; rather, it is essential to incorporate an antiracist perspective into public policies, professional training, and the organization of healthcare services.

The reviewed articles emphasize the delicate boundary between the effects of racial discrimination and the stigma attributed to SCD, both of which reverberate in the treatment of people living with the disease. Five of the articles address stigma together with racism and discuss how this affects the prognosis of people with SCD [20,21,26,30,31].

Stigma plays an important role in the experience of individuals with SCD because people respond to stigmatization in either positive or negative ways, directly affecting their physical and mental health. When the response is positive, individuals may act in defense of their health and self-esteem. However, a negative response may lead to mental health problems such as low self-esteem, depression, unhealthy habits, and social isolation, all which stem from the sense of inferiority imposed by society. In situations of racism, some individuals choose to confront the situation verbally, whereas others, aware of the stigma and prejudice involved, prefer to avoid confrontation [22,31,32].

In their article on how people with SCD experience and cope with stigma, Carvalho et al. [31] categorized these relations into three main areas: interaction with family members, social life, and relationships with health professionals. Within family relationships, people with SCD frequently face disbelief and contempt, being seen as a “burden” because of their inability to contribute economically and their need for continuous care. Contradictorily, family members may also discredit patients’ reports of pain and fatigue, a behavior that deserves further exploration [31].

In social life, people with SCD experience significant pressure and a tendency toward isolation as many activities may be harmful to their health. Even so, they often subject themselves to conditions that deteriorate their physical well-being in order to avoid discrimination and isolation, which may result in pain crises or worsening symptoms, including limitations in the practice of sports, an important means of social interaction and inclusion [31].

When health professionals become agents of stigma toward people with SCD, healthcare delivery is negatively affected. The consequences may include discrimination, delays in care, and discourteous treatment. This is perceived by people with SCD, who see their pain being devalued and poorly diagnosed, and who may even be blamed for not improving. This, in turn, results in physical and psychological suffering [20,31].

This may be related to the intense pain caused by vaso-occlusion or ischemia, and to its consequences, which lead people with SCD to repeatedly seek care in hospital emergency departments. This frequent need for emergency care or even hospitalization due to pain crises may lead health professionals to question the legitimacy of these demands [20,21].

This situation is aggravated by the fact that the recommended treatment for acute pain generally involves opioids, which carry a risk of dependence as a side effect. Stigma and prejudice, often present among these professionals, may lead them to believe, without scientific basis, that these individuals are chemically dependent, thereby discrediting their complaints and their pain [20].

It is important to note that the concept of stigma in SCD, as discussed by Figueiró and Ribeiro [20] and Hood et al. [21], is not primarily driven by racial prejudice, but is instead linked to the clinical condition of the disease. However, this distinction is made within a conceptual and didactic effort, since racial prejudice and stigma are interconnected and share the same origin, namely the prevalence of the disease among Afro-descendant populations. There is no doubt about the importance of racism and stigma faced by patients with SCD, especially regarding the worsening of pain, even though the exact mechanisms through which this occurs remain unclear [30].

Racial prejudice, as defined by Wakefield et al. [33], refers to negative beliefs, attitudes, or behaviors directed toward a person or group based on racial differences. It may be explicit, manifested by a racial group that consciously sustains derogatory understandings about Black people and openly expresses offensive or pejorative views.

On the other hand, implicit racial prejudice refers to situations in which individuals, although not consciously making negative associations with a racial group, still reproduce the same depreciative associations about Black people in an unconscious and diffuse manner. This manifests through unintentional exclusion or differential treatment in spontaneous contexts, thereby contributing to the operation of institutional racism and to the production of inequalities and inequities [20,22].

Racist ideology, by relegating individuals to a position of inferiority in social treatment, gives rise to feelings of sadness, anger, self-devaluation, and self-blame. This results in stress and mental suffering, as people may internalize blame for living through such situations [22,24,31].

This study has limitations that should be considered when interpreting the results. The methodological heterogeneity of the included studies and the predominant use of convenience samples may introduce selection bias and limit the comparability and generalizability of the findings. The concentration of studies in specific contexts (Brazil and the United States)

also restricts the extrapolation of results. In addition, the inclusion of only English and Portuguese language articles may have contributed to selection bias. Finally, the interrelationship between racism and stigma associated with SCD represents an analytical challenge when attempting to distinguish between these phenomena.

Conclusion

This integrative review showed that racial discrimination acts as a structural determinant that compromises the treatment and quality of life of patients with SCD. The findings demonstrate that systemic racism manifests in healthcare settings as differential treatment, often characterized by negligence in pain management and by the discrediting of clinical complaints, reflecting the historical dehumanization of Black bodies.

The impact of this discrimination extends beyond healthcare facilities, generating emotional and physical stress that may trigger the exacerbation of SCD symptoms. This review also showed that stigma associated with both the disease and race limits educational and professional development, as well as family support networks, making social well-being an inseparable component of therapeutic success.

However, further studies are needed on the relationship between self-care and family and social relationships, which may affect people with SCD even more frequently than their relationship with healthcare services. This is a gap identified in the literature and could contribute to a better understanding of the demands and needs of these individuals, as well as the strategies they use to cope with the disease.

In response to the proposed objective, it is concluded that confronting racial discrimination is imperative to ensure equity in SCD care. The healthcare network must move beyond a strictly biological model and adopt a comprehensive and humanized approach that recognizes and mitigates the barriers imposed by institutional racism, with the aim of preserving self-care and improving the clinical prognosis of these patients.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used ChatGPT (OpenAI) to improve language and readability. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Of all forms of inequality, injustice in health care is the most shocking and inhumane - **Martin Luther King Jr.**

Conflicts of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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