Principles to support anti-racism in midwifery and nursing education and practice - anti racism case studies

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In this guide

- Introduction
- Context
- How we developed the principles
- Principles
- Expectations
- How to adopt these principles
- Supporting tools

Introduction

Back to top

These principles are our contribution to urgently tackling the health inequalities suffered by racially minoritised people. The development of the principles was driven by the Black maternal health crisis which leads to Black, Asian and ethnic minority women and their children being more likely to die, or suffer harm during pregnancy, childbirth or after birth. The document also addresses the bias and discrimination faced by racially minoritised staff in nursing and midwifery.

We recognise that racist and inequitable care can occur across both the midwifery and nursing sectors and this document sets out some of the ways educators, organisations, registrants[1] and employers can address the growing concerns around inequities in care, and racism across health and social care practice, education, and regulation.

We recognise that racism is embedded in structures, policies, processes, power, and culture, not only in individual behaviour and that anti-racism is fundamental to patient safety and public protection.

These principles are intended to strengthen anti racism, bias awareness, cultural safety, curiosity and respect and equitable care in midwifery and nursing education and practice ahead of the introduction of our updated Code in 2027. The updated Code will expressly address these issues in relation to professional accountability, setting the expectations of all midwives, nurses, and, in England only, nursing associates, to recognise, challenge and disrupt instances of racism, bias and behaviours that might adversely affect patient safety and public protection throughout their careers.

> *[1]Throughout this document we have used the word 'registrant' to collectively refer to registered nurses, midwives, and, in England only, nursing associates who are on the NMC register.*

This document sets out principles designed to:

- Strengthen cultural safety, curiosity and respect in practice and education
- Explicitly advance meaningful, sustained anti-racist, bias-aware practice.

Our collective vision is a health and social care sector in which:

- Every member of the public receives equitable, culturally safe, anti-racist, unbiased care
- Students and registrants learn and work in psychologically safe environments where discriminatory behaviours and biases are called out, challenged, and not tolerated
- Education and practice settings demonstrate anti-racist, unbiased values, and behaviours
- Accountability mechanisms drive sustainable culture change across midwifery and nursing professions
- Lived experience from racially minoritised and underrepresented groups shape policy, continuous improvement, and programme development. It is rooted in sectors, processes, quality assurance, and control measures to improve the experience for all
- The impact of intersectional discrimination and intergenerational harm is recognised, along with its effect of reduced trust in healthcare professionals.
- Registrants continue to be culturally curious and acknowledge and act on extinguishing new prejudices originating from world events.

The principles are intended to drive real change, not symbolic compliance. Their success will be judged by whether the actions taken improve safety, belonging, fairness, equity, accountability, and trust for service users, students, and the midwifery and nursing workforce.

Who this document is for This document is for:

- Members of the public who receive health and care from midwives, nurses, and, in England only, nursing associates
- Registrants who are the midwife, nurse and, in England only, nursing associate professionals on the Nursing and Midwifery Council (NMC) Register
- Students who are studying midwifery and nursing on an NMC approved programme in the UK
- Practice learning providers in health and social care who employ midwives, nurses, and, in England only, nursing associates, and who work in partnership with education institutions to provide practice learning placements for students
- Approved education institutions (AEIs) who educate, support, and assess midwives, nurses, and, in England only, nursing associates on NMC approved pre- and post registration education programmes.

Context

Back to top

Persistent inequities and inequality in experiences and outcomes continue to affect racially minoritised service users, students, and registrants, driving the urgent need to enable and strengthen anti-racist practice, bias awareness, cultural safety, curiosity and respect across education and practice for all health and care professionals.

Health outcomes for people receiving care

Evidence from UK research, including the NHS Race and Health Observatory, the Race Equality Foundation, The King's Fund and the Workforce Race Equality Standard, demonstrates that racism, unconscious bias, and lack of cultural safety have direct and measurable impacts on health and care outcomes.

We know that Black, Asian and ethnic minority women and their children are more likely to die or suffer harm during pregnancy, childbirth or after the birth. Racially minoritised service users experience poorer access to services, delays in diagnosis and treatment, and lower quality interactions, including not being listened to or having concerns dismissed.

One example of a particularly pernicious racist stereotype, often openly voiced in maternity services, is that Black women 'don't feel pain' or 'have a higher pain threshold.' This demonstrates how everyday bias can cause avoidable clinical harm, worse outcomes and perpetuate racialised inequities.

Evidence also demonstrates that religious discrimination such as within Jewish and Muslim communities can negatively impact wellbeing, trust, and access to healthcare services. Inequities in health outcomes and experiences can arise in relation to faith, culture, and identity.

These outcomes sit within a wider pattern of structural inequality, where racism intersects with deprivation to compound risk across the life course of individuals. The evidence shows a clear social gradient in health, with those in the most deprived communities experiencing significantly shorter life expectancy and fewer years in good health, alongside rising multimorbidity and premature mortality.

Racially minoritised groups are disproportionately affected by these conditions and by the wider determinants of health, including housing, employment, and access to care.

Collectively, the evidence from the NHS Race and Health Observatory, the Race Equality Foundation, the Marmot Reviews, the NHS Workforce Race Equality Standards, the King's Fund and MBRRACE UK shows that racism, bias and culturally unsafe health and care environments are not only issues of experience, but are associated with increased mortality, greater disease burden, poorer patient safety, and sustained inequalities in health outcomes, representing a significant but avoidable impact on individuals.

The key impacts on health outcomes include:

1. Maternal and infant mortality:

Disparities remain significant, unjust and unfair. According to MBRRACE-UK, Black women are 2.3 times as likely to die from pregnancy-related causes during childbirth or within six months postpartum as White women, and

Asian women are 1.3 times as likely. The figures also show that Black babies are more than twice as likely to be stillborn as White babies, and Asian babies are about one and a half times as likely. Neonatal mortality rates are also higher: Asian and Black babies are around one and a half times as likely to die after the birth (in the neonatal period) as White babies.

2. Mental health and psychological distress: Repeated exposure to racial discrimination is significantly associated with high levels of psychological distress, increased rates of mental ill health, poorer recovery outcomes and, often, a deep mistrust of mental health services.

3. Chronic diseases: Ethnic health inequalities are associated with earlier onset and increased severity of long-term conditions such as hypertension, diabetes, and cardiovascular disease. By their 40s and 50s, many Black and Asian people exhibit health conditions typical of their much older, White counterparts. This is alongside evidence of under-treatment, delayed care-seeking due to fear of discrimination, and reduced trust in services.

4. Inequalities in care and life expectancy: People from racially minoritised groups often report poorer experiences at GP surgeries, lower satisfaction with services, and are less likely to receive preventative care. Additionally, individuals with learning disabilities from racially minoritised backgrounds face a 190% increased risk of premature death compared to their White counterparts. 5. Inequitable care outcomes can be exacerbated by intersectional factors: Social determinants, such as deprivation, being subject to domestic abuse or being LGBTQ+, can also be factors leading to poorer health outcomes.

Workforce

These principles apply across all sectors where registrants work including independent and private providers, social care, and the agency workforce. The expectations, accountability and support are consistent for all registrants regardless of setting.

Within the health and social care workforce in the UK, evidence suggests that racism, unconscious bias, and lack of cultural safety have significant and measurable impacts on staff experience, wellbeing, progression and retention across health and social care.

Data from The King's Fund report (2026) and the NHS Workforce Race Equality Standard consistently demonstrate that staff from racially minoritised backgrounds experience substantially higher levels of discrimination, bullying and inequity, both from colleagues and service users.

These experiences have clear impacts on staff and organisational culture including poorer psychological safety, reduced wellbeing, and reduced levels of staff engagement, in a culture where racism has been described as "deeply entrenched and normalised." Overall, the evidence demonstrates persistent disparities in recruitment, progression, and experiences of discrimination for racially minoritised staff, which are widely understood to reflect the impact of structural racism and implicit bias within organisations.

The evidence goes further to suggest that this leads to inequitable career outcomes, psychological harm, reduced retention, and diminished organisational effectiveness, with consequent risks to patient care and safety.

In addition, many Black, Asian and ethnic minority registrants will have suffered the indignity of patients or service users refusing to receive care from them.

Our latest annual insight report, published in February 2026, focused on the professionals on our Register, gathering information from 37,961 registrants. 40% of respondents said they had experienced discrimination, most often on the grounds of ethnicity or age. This is particularly concerning given that the NMC Register is more ethnically diverse than ever – a third of the total workforce at 33.2%. These findings are a stark reminder of the urgent need to tackle unacceptable behaviours that drive people out of the midwifery and nursing professions. Research suggests that structural racism is still deeply embedded, and the pace of change in reducing health inequalities remains slow.

These behaviours, in any setting, directly contradict the standards set by the NMC.

While AEIs increasingly seek to decolonise curricula and improve cultural responsiveness, progress remains variable, highlighted by inconsistent leadership, competing priorities and uneven implementation

How we developed the principles

Back to top

The NMC anti-racism principles have been developed through the following process:

- Support of expert reference groups and critical readers with members from the four UK nations
- Consideration of NMC evidence, current health and social care reports and drawing upon research and evidence-informed practice around cultural safety and the importance of anti-racist care in improving health outcomes for racially minoritised groups
- Stakeholder engagement with professionals and service users who work in, influence and support anti-racist practice, bias awareness, and cultural safety, curiosity, and respect

Principles

Back to top

The principles recognise that racism is embedded in structures, policies, processes, power, and culture, not only in individual behaviour. Effective anti-racism should therefore address professional conduct, organisational design, leadership decisions, and regulatory influence.

This includes recognising and addressing all forms of racism and discrimination, including anti-Jewish hate and anti-Muslim hate, and other forms of prejudice based on identity, culture, ethnicity, and faith, as they manifest within healthcare systems.

While these principles address racism explicitly, the evidence is clear that tackling racial injustice improves safety, equity, and inclusion for all marginalised groups, recognising intersectionality and local context.

1. Culture, equity and inclusion

- Individuals and organisations should recognise anti-racism as fundamental to patient safety and public protection and as a legal requirement. Midwifery and nursing practice must actively address racism, religious hate, and other forms of discrimination, alongside racialised inequities, as core components of safe, effective, and compassionate care
- This requires embedding anti-racist practice, bias awareness, cultural safety, curiosity and respect and having professional curiosity and equity as core expectations across education, practice learning, assessment, and continuing professional development (CPD)
- Cultural humility, respect, and responsiveness are essential elements of professional conduct, and include self-reflective practice, valuing lived experience, and recognising and addressing both conscious and implicit bias
- Action should be taken at individual, organisational and sector level. All have a responsibility to raise concerns in line with our Raising Concerns guidance2, to challenge racist behaviour and practice, and interrupt bias where these are seen, to ensure that the care provided does not further entrench structural inequalities. This also includes individuals consciously monitoring their own biases
- Individuals and organisations should ensure that care, education, and supervision are culturally safe, as defined by those receiving them. This includes actively preventing harm, humiliation, exclusion, and power-based inequities
- Registrants must always uphold anti-racist values, recognising that conduct outside professional settings, including on social media and in public or political activity can affect public trust in the profession. They must not engage in or endorse racist or discriminatory behaviour in any context
- Providers and AEIs should address structural inequities, remove barriers to equitable care, and ensure curricula reflect diverse perspectives to prepare learners to address health inequalities and structural injustice

2. Learning, education and workforce diversity developments

- Workforce development should prioritise patient safety, wellbeing, inclusion and belonging, ensuring learning environments model culturally safe, curious, and respectful, anti-racist, bias aware practice and explicitly respond to intersectional challenges
- Educators, practice supervisors, and assessors should be equipped to deliver inclusive, evidence based teaching, ensure fair and unbiased assessment processes, and support and embed reflective and reflexive practice, including the ability to recognise and respond to intersectional bias, awarding gaps and differential attainment. This includes measuring, publishing, and acting on award and attainment gaps
- AEIs should develop proactive interventions to interrupt and challenge race discrimination and bias, for instance by using evidence-based learning resources
- One example of how AEIs can disrupt bias would be to share the film 22+1 with student midwives. 22+1 is a short film that outlines a woman's journey following a late miscarriage. It explores the story of an interracial couple navigating the grief of pregnancy loss, while confronted with the underlaying layer of racism in the health and care sector
- AEIs should also ensure education around privilege and intersectionality to embed understanding of anti-racism and equality principles more widely

- Organisations should foster and embed psychological safety, enabling meaningful feedback, promoting allyship and advocacy for all, safe speaking up and raising concerns processes. This should include support for those who do raise concerns, enabling supportive team cultures that value diversity and promote patient safety

3. Community and person-centred practice

Practice should be grounded in co-production with service users, their families, and communities, ensuring engagement is trauma informed, ethical, and respectful – particularly for those experiencing inequalities and inequities

- Practice must recognise and respond to the cultural and faith-based needs of individuals and communities, including those of Jewish and Muslim service users and other minority communities, ensuring care is respectful, informed, and free from discrimination
- Lived experience should clearly feed into assurance, evaluation and improvement cycles, including through case studies, service user engagement and feedback loops in implementation
- Registrants should proactively challenge racist stereotypes such as 'Black women don't feel pain' or 'Black women have a higher pain threshold', or sickle cell sufferers' pain being classed as drug seeking behaviour. These stereotypes can lead to service users receiving care that is not culturally sensitive nor individualised or person-centred, resulting in inferior care
- Registrants should always be aware of intersectional factors that can exacerbate inequitable outcomes of care, such as, but not limited to, social determinants such as low socio economic status, being subject to domestic abuse or being LGBTQ+
- Registrants and students should prioritise respect, collaboration with individuals in their care, autonomy, and continuity of care, building trusting relationships that improve outcomes for all
- Develop, strengthen, and embed a sector that understands and considers at all stages of education and practice both the macro and micro context of lived experiences and how that impacts on care delivery

4. Assurance, accountability and sector improvement

- The sector should demonstrate inclusive, accountable leadership and team cultures and translate principles into clear implementation pathways
- Leaders at all levels should contribute to shared learning and should demonstrate accountability for anti-racist practice and outcomes
- Chief Nursing Officers, Chief Midwifery Officers, or other executive sponsors, should consider providing regular, confidential opportunities – such as biannual meetings – for students to share experiences, raise concerns, and be heard in a psychologically safe environment
- Organisations should embed anti-racism within governance, decision-making, and performance frameworks, ensuring sustained and measurable change
- Accountability for equitable, anti-racist practice applies to individuals, providers and AEIs, requiring documentation, active responses to discrimination, support, and reflective learning, recognising that diversity is complex and multidimensional
- Anti-racism should be visible and reinforced through the Code, standards, proficiencies, education requirements, and quality assurance processes. It should be seen as core professional practice, not an additional or optional expectation
- Ongoing monitoring, evaluation, and data use are essential to identify inequalities, and target areas of intervention, with practical steps taken to address inequalities identified and act as a vehicle to drive continuous improvement and support sector wide collaboration. Impact of interventions on patient safety should be measured and regularly reported through properly governed assurance mechanisms

Expectations

Back to top

These expectations place anti-racist practice at the core of safety, quality, and governance. They support the delivery of equitable, culturally safe, curious, respectful, anti-racist practice across education and professional settings.

This section is for people receiving care, provider organisations/practice learning settings, registrants, midwifery and nursing students, and AEIs.

We recognise that individuals can fulfil many of these roles at once – for example, a registrant can also be a service user, and an employer. Individuals should consider the principle or principles that most apply at the time, acknowledging that context may change this position.

1. Partnership – the public, patients, service users, their families, and communities

Services should be designed and delivered in partnership with the people who use them, ensuring that all engagement is ethical, respectful, and informed by an understanding of equity.

Expectations:

- Engagement with communities – particularly those experiencing inequities – should be trauma-informed, respectful of cultural and personal choices, and being mindful of individual context and experience of health and care services and sectors
- Practices such as care and support of bereaved families should actively avoid retraumatisation and promote autonomy, recognising that bereavement may look different for different groups and that cultural norms may dictate how loss of life is handled
- Collaboration with individuals, families and communities should be prioritised to support improved outcomes
- Models of care that support the building of trusting relationships (relational continuity) should be supported where appropriate
- Learning materials and curricula should be developed to reflect that service users will come from a diversity of communities, with differing needs, ensuring that messages are delivered in a way that reflects individual communities' learning methods, recognising that not all communities are written language users

2. Care provider organisations – employers, practice placement partners

Organisations hold responsibility for ensuring the environments in which care and learning take place are equitable, inclusive, and culturally safe.

Expectations:

- Organisations should examine and address structural biases that influence behaviours and outcomes
- Organisations should understand that anti-racism is core business, not a project or short-term and needs investment in the resources, capability, and infrastructure required to implement anti-racism effectively
- In consideration of the experiences of internationally educated registrants, barriers to equitable care and staff progression should be removed
- Fair and equitable access to learning, support and professional development should be promoted
- Practice learning environments should model anti-racist practice, bias awareness and interruption, and cultural curiosity, safety and respect, recognising and addressing discrimination and inequity that can occur across professional boundaries and multidisciplinary teams
- Organisations should implement clear expectations, enforce and outline consequences for racist behaviour, making it clear that it will not be tolerated and use data effectively to demonstrate progress and impact over time
- Strong partnerships with AEIs should be enabled to ensure inclusive, culturally safe learning. In practice settings, students should be exposed to a diversity of individuals, with a variety of perspectives and contexts
- Practice supervisors and assessors should model inclusive behaviours and evidence-based care
- Power imbalances, inequity, racism, and other discrimination experienced by students on placement should be addressed
- Providers should support just and reflective learning cultures that avoid blame while maintaining accountability
- Safe channels for speaking up and raising concerns about discrimination or unsafe practice should be developed and embedded. Organisations should create environments where speaking up is safe and should protect individuals, particularly racially minoritised students and early career professionals from retaliation or disadvantage
- Team cultures should be respectful, inclusive and value diverse voices
- Workforce wellbeing should be prioritised, particularly in emotionally demanding settings
- Organisations should demonstrate inclusive, accountable leadership with clear implementation pathways
- Incidents of discrimination or inequity should be documented, captured in data, and actively addressed
- Regular self-reporting, gap analyses, and quality improvement actions should be undertaken
- Organisations should contribute to sector-wide leadership, collaboration, co-production, and shared ownership. This includes working collaboratively across regulators, professional bodies, governments, and communities to align expectations, share learning, and strengthen collective impact
- Organisations should publish actions and progress on racial inequity within their own quality metrics

3. Registrants – professionals on the NMC Register

Registrants are expected to uphold inclusive, culturally safe, anti-racist practice in line with professional standards and regulatory expectations. Expectations:

- Registrants should proactively challenge racist stereotypes such as 'Black women don't feel pain' or 'Black women have a higher pain threshold,' or sickle cell sufferers' pain being classed as drug seeking behaviour. These stereotypes can lead to service users receiving care that is not culturally sensitive nor individualised or person-centred, resulting in inferior care
- Registrants should value lived experience, placing individuals at the centre of care
- Registrants should demonstrate ongoing self-reflection, cultural humility, and openness to diverse perspectives
- Registrants should engage in ongoing learning, reflection, and professional development to support continuous improvement
- Conscious and implicit bias should be recognised and challenged both by the individual and registrants and they should act in ways that challenge racism
- Individuals should challenge inequitable practice wherever it occurs
- Concerns regarding unsafe or inequitable sectors should be escalated and reported

- Registrants should recognise trauma and its impact on service engagement
- Registrants should recognise intersectionality and address its impact on care, adapting care so that it is personalised and person-centred
- Registrants should ensure that care supports autonomy and avoids retraumatisation
- Registrants are accountable for their practice, including obligations regarding equality, diversity, and inclusion and they must ensure that their practice always reflects this

4. Midwifery and nursing students

Students should be supported to develop the knowledge, skills, and behaviours for anti-racist practice to enable them to practise safely, inclusively and with cultural humility.

Expectations:

- Students should be supported to identify gaps in cultural knowledge and develop bias awareness.
- Students should be learning in practice environments which are anti-racist, bias aware and culturally safe and should raise concerns where this is not the case
- Psychological safety should enable cultural curiosity, meaningful feedback, and reflective and reflexive supervision for students and this should be demonstrated through regular reporting and assurance mechanisms
- Students should have access to safe channels for speaking up about discrimination and unsafe practice, for example through Speak Up Guardians or the NMC's Raising Concerns policy. Students should be made aware of this at each learning placement by the provider and where this is not the case, students should speak to academic staff
- Students should actively develop cultural awareness, curiosity and understanding through exposure to diverse communities, perspectives and lived experiences, recognising that the populations they encounter during training may differ from those they support in future practice. They should value diversity and reflect on how limited exposure, or understanding may contribute to unconscious bias and inequitable care
- Students should try to engage in opportunities to share experiences, raise concerns, and be heard through regular, confidential listening opportunities with senior leaders (e.g. Chief Nursing Officers/Chief Midwifery Officers) where these are offered
- Students can expect assessment processes that are fair and minimise bias
- Students can expect that placement environments should address and mitigate unhealthy power dynamics between educators and learners, including psychologically unsafe learning environments. Where this is not the case students should raise concerns with academic staff
- Students are expected to practise with cultural curiosity and respect, ensuring that they are supporting personalised patient-centred care

5. Approved education institutions (AEIs)

AEIs have a central role in ensuring that curricula, assessment, and learning environments equip future professionals to deliver culturally safe, equitable and anti-racist care.

Expectations:

- AEIs should proactively educate students about the damage that results in health care through the tolerance of racist stereotypes, such as 'Black women don't feel pain' or 'Black women have a higher pain threshold,' sickle cell sufferers' pain being classed as drug seeking behaviour, the higher prevalence of racially minoritised service users being sectioned under the mental health act and low pain thresholds being linked to other racially minoritised groups
- AEIs should provide opportunities and time for students to develop cultural humility, bias awareness and an understanding of privilege and intersectionality
- AEIs should ensure students are exposed to diverse communities, cultures and lived experiences throughout education and practice learning, recognising that local populations may not reflect the diversity of the wider population. Programmes should proactively develop cultural awareness, curiosity and understanding to reduce the risk of future bias arising from limited exposure or experience
- AEIs should examine and address structural biases within educational sectors
- AEIs should ensure that curricula prepare students to address inequalities and structural injustice and support them to work with a diverse range of people
- AEIs should make proactive interventions to interrupt and challenge race bias. Learning content should use contemporary resources as tools to inform learning, such as the short film 22+1, to reflect diverse communities and avoid narrow or dominant models of health
- AEIs should actively explore the influence of social media and political activism on learning cultures
- Academic staff should be equipped to model inclusive practice and support cultural safety and respect within education
- Academic staff should be reflective of their communities. AEIs should ensure wherever possible that their academic staff are reflective of the diversity within their local communities 22
- AEIs should ensure fair assessment processes and prioritise psychological safety and wellbeing in learning environments
- AEIs should undertake ongoing monitoring, evaluation, and data driven improvement of student outcomes
- AEIs should collaborate with sector partners, recognising that health and care is delivered by multi-professional teams, to promote

equitable standards and share good practice
- Individuals involved in education and supervision should act fairly and without bias. Organisations should identify and address racial inequities in recruitment, teaching, supervision, assessment, progression, and disciplinary processes
- Awarding gaps, progression decisions, and differential attainment should be recognised, measured, addressed, and reported

How to adopt these principles

Back to top

Effective implementation is governance, data infrastructure, evaluation, and ongoing learning within organisations and within the NMC itself.

Anti-racism requires humility, reflection, and continuous improvement to have measurable impact on health outcomes, patient safety, public protection, and staff wellbeing.

Supporting tools

Back to top

A gap analysis, available on the NMC website, will capture varying organisational starting and progress points. This approach should be used to support organisations and individuals to improve maturity over time, ensuring continued compliance with the principles.

Timeline:

- Universities may wish to use the gap analysis matrix to ascertain their starting point in time for the beginning of the new academic year and commence work on aligning course content to the principles, reporting development via annual self-reporting cycles in 2027
- Healthcare settings may wish to complete the gap analysis and use this self-assessment to address any identified gaps in training and service provision by the end of September 2026. A repeat self-assessment should be completed in 2027
- The NMC's revised Code – the professional standards of practice and behaviour for nurses, midwives, and, in England only, nursing associates, will include the mandated behaviours to ensure education and practice continues to be anti-racist, bias aware, culturally curious, safe, and respectful, and it will be published in October 2027

Measuring impact

Undertake a survey within the year to gain feedback from students, registrants, and service users. A gap analysis matrix and case studies to support the principles can be found on the NMC website