Gynaecological cancers in Australia 2025:

AN OVERVIEW

Acknowledgment of Country

We acknowledge the Traditional Custodians of the lands across Australia on which we live, learn and work and pay respect to Elders past, present and future, acknowledging their continuing connection to land, sea and community.

About ANZGOG

ANZGOG is the peak national gynaecological cancer research organisation in Australia and New Zealand. We foster and lead innovative, world-class multidisciplinary research to improve outcomes and quality of life for everyone with a lived experience of gynaecological cancer.

Our vision is clear: **Advancing research, saving lives**.

For over 26 years, ANZGOG has enabled over 60 clinical trials across all types of gynaecological cancer, involving more than 4,500 patients. These trials are delivered through over 80 hospital sites, supported by both local and global research collaborations.

Our growing network includes over 1,500 members across clinical, allied health, and pure research disciplines—alongside community representatives who ensure the voices of women with lived experience are at the centre of everything we do.

www.anzgog.org.au

Suggested citations

The Gynaecological Cancer Transformation Initiative (GCTI) https://www.anzgog.org.au/gcti/
Australian Institute of Health and Wellbeing (AIHW), Cancer data in Australia Report
https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/about

For more information

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Foreword

Gynaecological cancers remain among the most complex, least understood, and under-recognised health challenges facing Australian women. Today, 19 women will be diagnosed with a gynaecological cancer, beginning a journey that is often marked by late diagnosis, limited treatment options, and too often, little support. And this number is on the rise.

Tragically, six women lose their lives from a gynaecological cancer each day in Australia. These cancers are found in the female reproductive system and include uterine, ovarian, cervical, vulvar and vaginal cancer. These cancers collectively contribute to a significant proportion of cancer-related deaths in women. Over the next decade alone, more than 28,500 women are expected to die from these cancers. We know that the loss doesn't stop with the death of the woman. More than 42,900 children are expected to lose their mothers, and thousands of families and communities will bear the emotional and economic burden of this loss.

Despite the scale of this challenge, gynaecological cancers continue to have less research funding, fewer clinical trials, and minimal public awareness compared to other cancers. More than half of all gynaecological cancers are classified as rare or less common, meaning women diagnosed often face limited treatment options, fewer support pathways, and poorer outcomes.

But we are also at a point of transformation.

By advancing research, expanding access to comprehensive molecular profiling and clinical trials and integrating psychosocial support into care, we have the opportunity to deliver more equitable, precise, and life-saving outcomes for all women—regardless of cancer type, geography, or background. In December 2024, the Gynaecological Cancer Transformation Initiative (GCTI) Business Case was developed by ANZGOG in collaboration across the sector and was presented to government.

A key element of the report is the critical need to build awareness of gynaecological cancers to effect change for women and their families, ensuring knowledge of symptoms, best approaches to diagnosis, treatment and care.

This **2025 Gynaecological Cancer in Australia Overview** presents the most current and comprehensive data on the incidence, burden, and outcomes of gynaecological cancers in our country. It also acknowledges the significant inequities experienced by women in rural and regional areas, Aboriginal and Torres Strait Islander women, and women from socioeconomically disadvantaged backgrounds—populations for whom the impact of these diseases is disproportionately high.

We are grateful to the women who have courageously shared their experiences to shape this work. We acknowledge the tireless efforts of clinicians, researchers, advocates, and our wider community who are committed to improving outcomes. At ANZGOG, we know that gynaecological cancer research saves lives. We remain steadfast in our commitment to ensuring gynaecological cancers receive the visibility, urgency, and investment they deserve—so that fewer women are lost, and more women live longer and live well after diagnosis.

Professor Clare Scott AM
Chair ANZGOG

Alison Evans
Chief Executive Officer, ANZGOG

Alison Evans

Table of Contents

About gynaecological cancers in Australia

Overview

Gynaecological cancers are cancers of the female reproductive system and represent the third most common group of cancers affecting women in Australia.

There are five main types: uterine (including endometrial), ovarian, cervical, vulvar, and vaginal cancers. In addition, placental cancer, which occurs during pregnancy, is also classified as a gynaecological cancer.

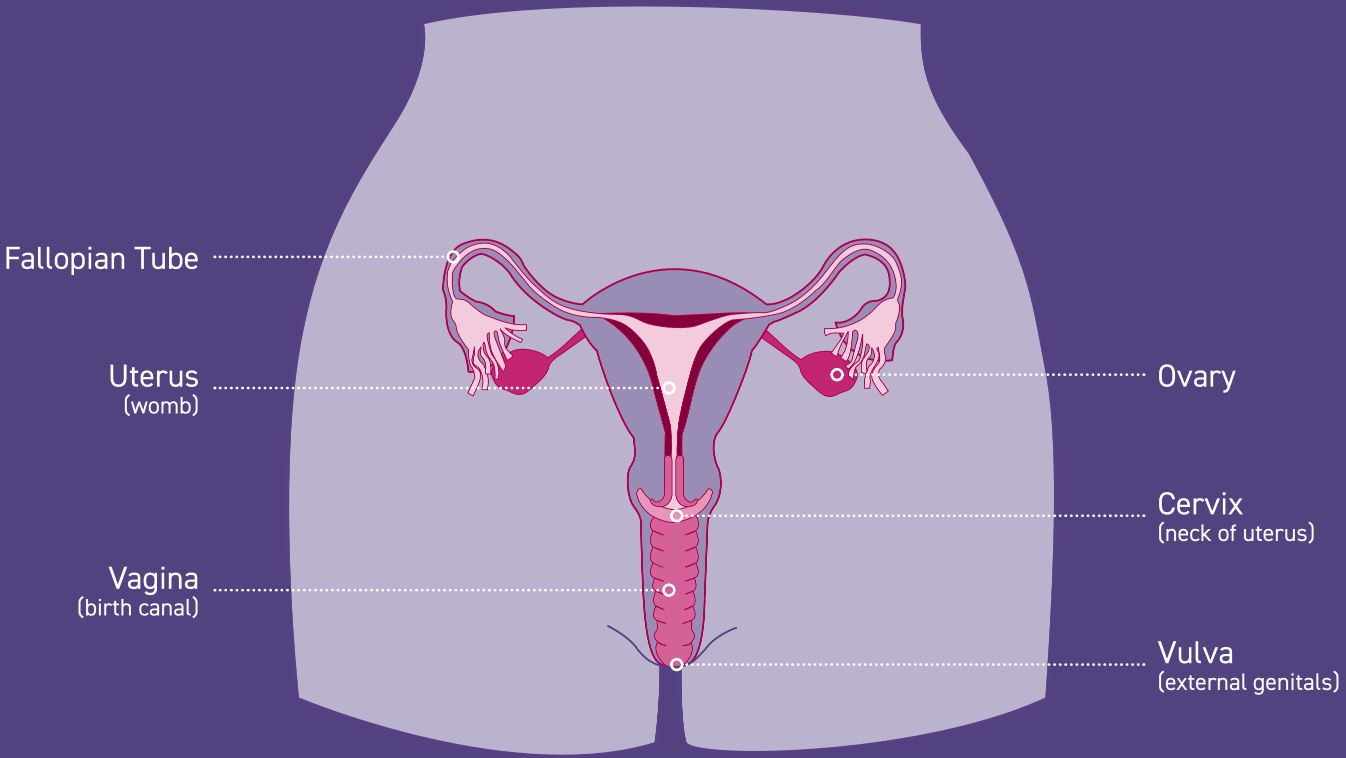
There are more than 230 distinct morphological subtypes of gynaecological cancers. These subtypes differ in terms of their origin, biology, clinical progression, and response to treatment. This diversity presents challenges for diagnosis, management, and research, particularly in rare or less common subtypes.

MAIN

5types

uterine (including endometrial), ovarian, cervical, vulvar, and vaginal.

Figure 1:
Diagram of reproductive organs.



Gynaecological cancers differ from other chronic diseases and from other cancers in several important ways.

They frequently develop without early, easily recognised symptoms. As a result, many women are diagnosed at a later stage, when the disease is more difficult to treat and, in some cases, incurable.

While symptoms may be present, they are often overlooked or misattributed—by women themselves or their healthcare providers.

Despite the impact and complexity of these diseases, awareness of gynaecological cancers remains low. Compared to many common or higher incidence cancers they receive less public attention, fewer resources, receive less funding for research and reduced access to dedicated support services.

Incidence and prevalence

Today, an estimated 26,400 women are living with a gynaecological cancer in the past five years.

On average, a further 19 women in Australia will be diagnosed with a gynaecological cancer every day. These statistics are on the rise. Over the next decade, 86,300 women are projected to receive a diagnosis, which represents a 21% increase compared to current figures.

While these numbers are significant, they do not fully convey the human or societal impact. A gynaecological cancer diagnosis can be isolating and stigmatising. Many women describe feeling invisible, both socially and within the healthcare system. The broader implications — including emotional, economic and care-related burdens — extend beyond the individual to families, communities, and the national health system.

PROJECTED

21%

increase in diagnoses over the next decade.

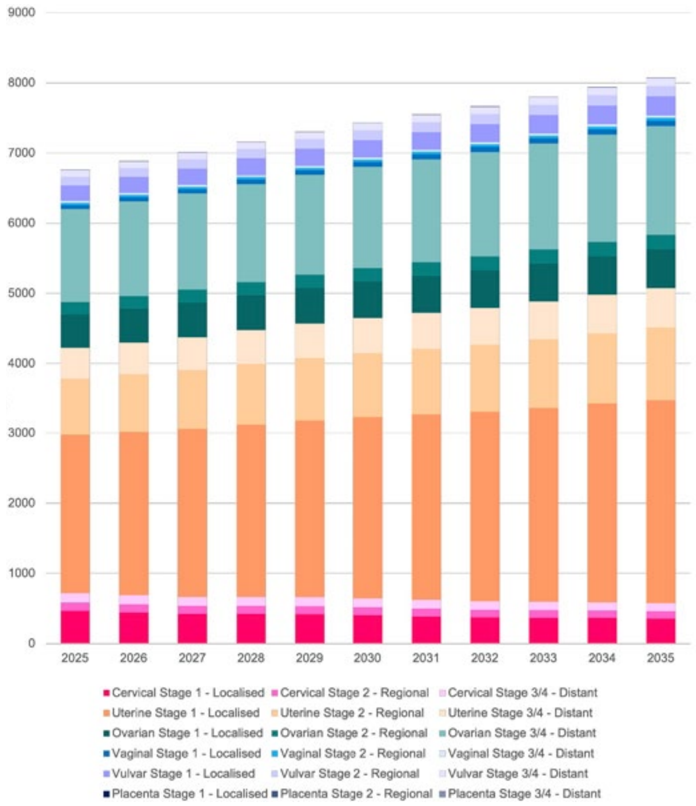


Figure 4: Gynaecological cancer incidence 2025- 2035

Rare and less common cancers

KEY FACTS

MORE THAN

55%

of gynaecological cancers are classified as rare, less common or low survival.

MORE THAN

90%

of women diagnosed with a gynaecological cancer in Australia do not have access to comprehensive molecular profiling.

More than 55% of gynaecological cancers are classified as rare, less common or low survival.

According to Rare Cancers Australia, a rare cancer is defined as having fewer than 6 diagnoses per 100,000 people per year, and a less common cancer has fewer than 12 diagnoses per 100,000.

Rare and less common cancers are often difficult to diagnose and have limited evidence-based treatment options. In many cases, they are resistant to standard treatments and are associated with lower survival rates. For most of these cancers, there are no national screening programs or reliable early detection methods available — cervical cancer is the only exception.

Currently, most women are managed under broad major type care pathways, however for rare and less common cancers, the heterogeneity of subtypes do not respond to this broad treatment approach, meaning more targeted and personalised treatment approaches are required.

Advances in genomic and molecular profiling technologies are identifying more rare subtypes, but integration of these technologies into routine care remains limited.

Today, more than 90% of women diagnosed with a gynaecological cancer in Australia do not have access to comprehensive molecular profiling. This includes technologies that have been shown by Omico and the Zero Childhood Cancer Program to significantly improve survival and treatment outcomes.

Barriers to the adoption of comprehensive molecular profiling in routine clinical practice include a lack of established guidelines, gaps in clinician knowledge for interpreting test results and complex genomic data, lack of reimbursement and a lack of resources and systems, particularly in resource-constrained and regional hospitals.

Mortality

Gynaecological cancers continue to be a leading cause of cancer-related deaths among Australian women.

On average, six women die each day from one of these cancers. Over the next ten years, it is projected that more than 28,500 women will lose their life from a gynaecological cancer.

These cancers are among the top four causes of cancer-related death in Australian women. The overall five-year survival rate for all gynaecological cancers is 70.5 per cent; however, this figure masks considerable variation between cancer types.

Notably, survival outcomes for certain gynaecological cancers—such as ovarian and vaginal cancers—have shown minimal improvement over recent decades. The five-year survival rate for these cancers remains at a figure comparable to the average survival rate for all cancers in 1975 (49 per cent), underscoring a lack of progress over the past 50 years.

Survival rates are particularly poor for women diagnosed at an advanced stage, which remains common across all gynaecological cancers. The five-year survival rate for women with advanced or late-stage disease drops to below 30 per cent, meaning that fewer than three in ten women survive beyond five years post-diagnosis.

Women diagnosed with rare or less common gynaecological cancers—who represent over 55 per cent of all new diagnoses—also face low survival rates. These women often encounter limited treatment options and a scarcity of evidence-based care pathways, further compounding their risk.

Disparities in mortality are pronounced across different population groups. Women residing in regional, rural, and remote areas, Aboriginal and Torres Strait Islander women, and those from lower socioeconomic backgrounds experience significantly higher mortality rates. These inequities are driven by differences in timely diagnosis, access to specialist care, and overall health outcomes.

The broader impact of gynaecological cancer mortality is profound. Over the next ten years, it is estimated that more than 42,900 children in Australia will lose their mothers to these diseases. Beyond the immediate emotional toll, the social and economic consequences are far-reaching, affecting families, communities, and the health system. The ongoing loss of life from gynaecological cancers continues to impose a substantial and enduring burden on Australian society.

ON AVERAGE
SIX
women die each day from one of these cancers

MORE THAN
42,900
children in Australia will lose their mothers to these diseases

Gender bias

The pathway to timely and accurate diagnosis of gynaecological cancers is frequently impeded by a range of systemic and societal barriers.

Many women are unable to prioritise their own health needs, often due to caregiving responsibilities and entrenched cultural expectations. These factors, coupled with structural barriers within the healthcare system, can significantly delay accurate and timely diagnosis as well as access to appropriate treatment and care.

Evidence indicates that gender bias remains prevalent within Australia's healthcare system, particularly in the context of gynaecological cancers. Women's symptoms are frequently misattributed to benign or unrelated conditions, such as menstrual cramping, menopausal symptoms or are otherwise minimised and dismissed. Psychosomatic labelling—where women are told their pain is 'all in their head'—remains a common occurrence.

This pattern of dismissal and de-prioritisation of women's health concerns is well documented, including in the findings of the Inquiry into Women's Pain[1] and in research demonstrating that women are consistently diagnosed later than men across a range of medical conditions.

Such delays are concerning for patients and can have significant consequences for disease progression and overall outcomes[2].

While the cumulative effect of systemic barriers and gender bias has contributed to delayed diagnosis and treatment for many women with gynaecological cancers, there is substantial opportunity for change. Strengthening education within the medical workforce on the early signs and symptoms of gynaecological cancers, alongside empowering women with knowledge to advocate for their health, are pivotal steps forward.

Initiatives led by organisations such as ANZGOG's Survivors Teaching Students® program, have already begun to shift awareness and practice. With sustained commitment to education, improved communication, and a health system responsive to women's needs, Australia can be well placed to reduce diagnostic delays, improve outcomes, and ensure that all women receive timely care.

Diverse communities

Australia is internationally recognised for its leading cancer care and the significant improvements in survival rates achieved for selected cancer types over recent decades.

The country's pioneering introduction of the HPV vaccine and highly effective cervical cancer screening program have resulted in significant reduction of cervical cancer mortality. Additionally, over 80% of endometrial cancers are treated successfully with surgery alone, enabling the majority of women to survive.

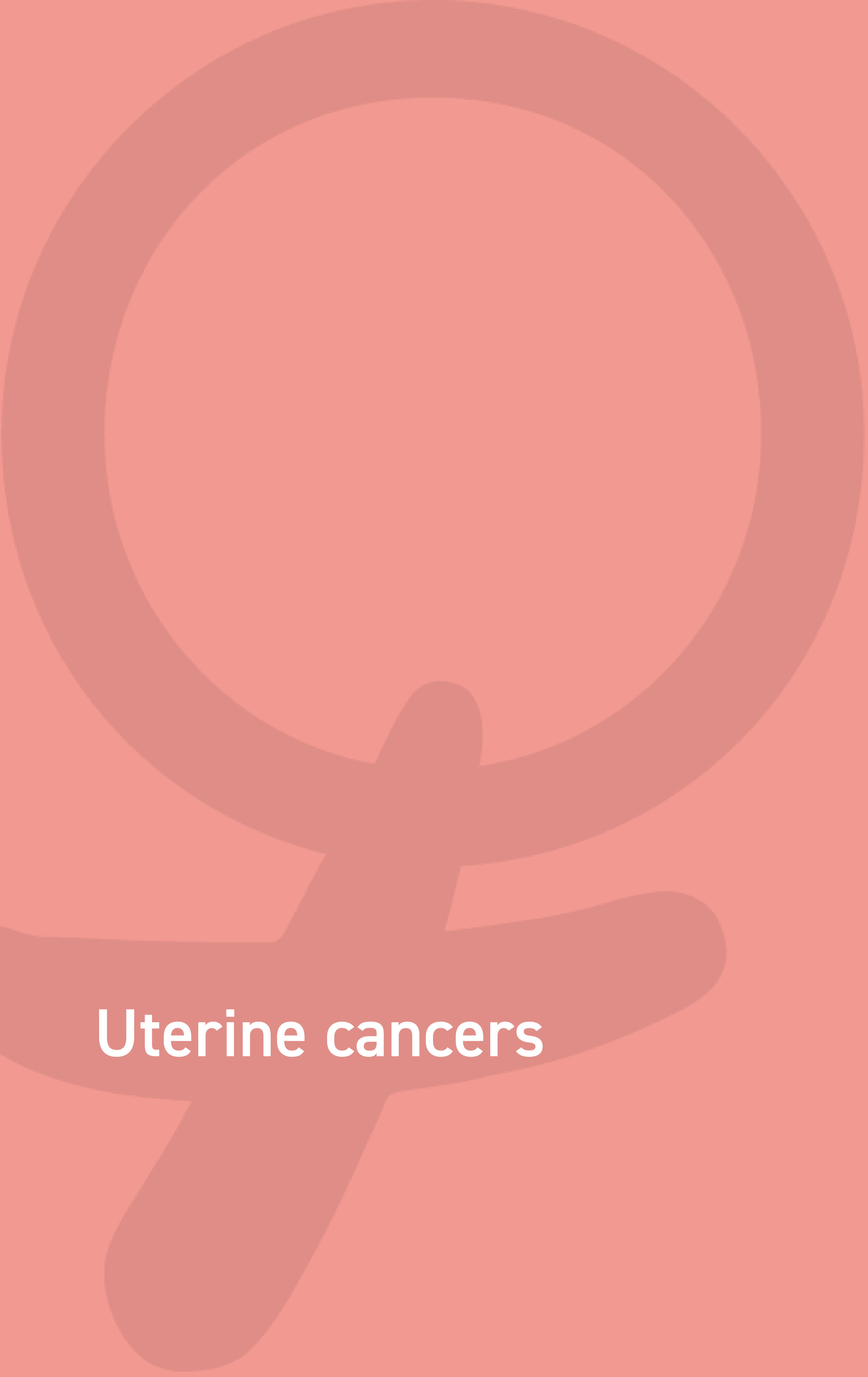
However, these successes have not benefitted all women equally: persistent inequities in outcomes remain for those diagnosed with gynaecological cancers, shaped by social, cultural, environmental and health system factors, including limited screening access (except cervical cancer), delays in diagnosis, insufficient provision of culturally safe care, and restricted access to advanced therapies.

The burden of gynaecological cancers falls disproportionately on:

- Aboriginal and Torres Strait Islander women
- Women living in rural and regional areas
- Women from lower socio-economic backgrounds

These groups experience higher incidence rates, lower survival outcomes, and reduced access to essential cancer services, including clinical trials and specialist care. The Australian Cancer Plan underscores the importance of recognising intersectionality in addressing these disparities. Many women belong to multiple priority populations, and the convergence of these factors further elevates their risk of adverse outcomes.

Achieving equity in cancer care requires the delivery of tailored, timely, and adequately resourced services that are accessible, inclusive, and person-centred. There is ongoing and dedicated work across Australia to address these disparities and ensure every woman has the opportunity for the best possible outcome.



Uterine cancers

Uterine cancers

Uterine cancer is the most commonly diagnosed gynaecological cancer in Australia.

There are two main types of uterine cancer:

1 **Endometrial cancer**, which occurs in the lining of the uterus (endometrium) and accounts for approximately 95 per cent of all uterine cancer cases.

2 **Uterine sarcomas**, rare subtypes originating in both the uterine lining (endometrium) and the muscle tissue layer of the uterus (myometrium), account for the remaining cases.

Because so many uterine cancers originate in the endometrium (roughly 95 per cent), it can be interchangeably referred to as endometrial cancer.

Rising incidence and mortality:

Uterine cancer presents a growing health challenge both globally and in Australia. Worldwide, incidence has increased by more than 15% over the past three decades, with cases projected to surpass 670,000 by 2050.

In Australia, this upward trend is even more pronounced: data from the Australian Institute of Health and Welfare show a 13.8% increase in uterine cancer incidence over just five years, from 2019 to 2024.

This rise is largely driven by population ageing, changing reproductive patterns including later pregnancies and declining birth rates and increasing rates of obesity and metabolic disorders (such as diabetes and hypertension)[345].

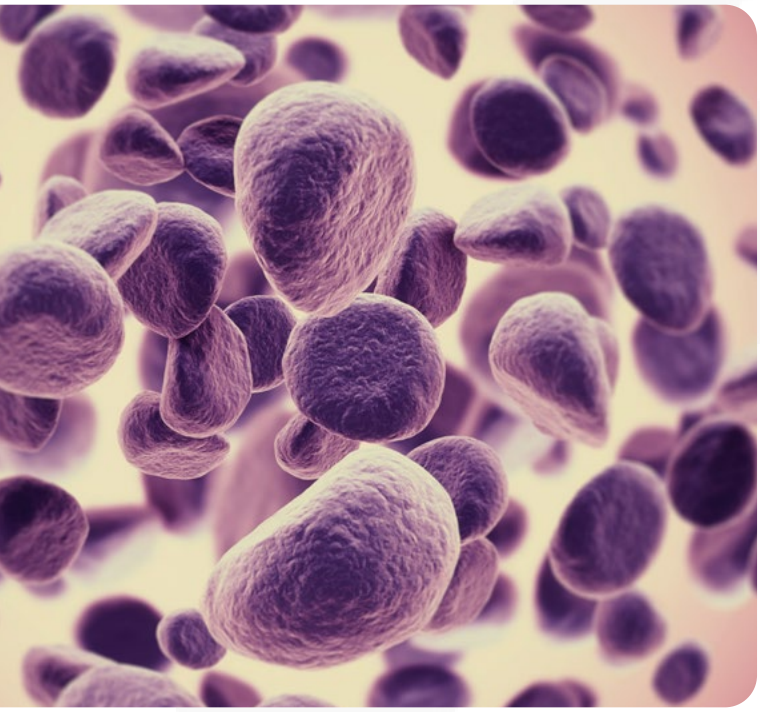
The impact of the rising prevalence of people overweight or living with obesity in particular has resulted in increasing incidence of uterine cancer among young adult women[6]. Each 5-unit increase in body mass index (BMI) is associated with a 50 per cent increase in uterine cancer risk, largely due to hormonal imbalances[7], specifically, excess estrogen or progesterone deficiency, linked to obesity. Furthermore, women with higher BMI not only face a greater risk of developing uterine cancer but also experience higher disease-specific mortality rates[8].

> **No words can describe the experience of that appointment and being told that this cancer is rare and incurable; the disbelief and devastation.**
>
> **Afterwards we talked, we cried, and we shared our determination and optimism in the face of it all.**
>
> **Alex — diagnosed with a uterine cancer.**

Between 1980 and 2013, the proportion of adult women globally with a BMI of 25 kg/m^2 or greater increased by nearly 10 per cent, with the most pronounced increases observed in high-income countries, including Australia. Nationally, the proportion of Australian women aged 18 years and over, who are overweight or obese, now exceeds the OECD average, with the prevalence nearly doubling between 1980 and 2022.

As a result, the incidence of uterine cancer in Australia is expected to rise sharply over the next decade. It is projected that more than 74,000 women in Australia will be diagnosed with uterine cancer over the next decade (2025 – 2035).

When uterine cancer is detected early, surgical treatment and appropriate therapies result in five-year survival rates exceeding 80%. However, for women diagnosed with advanced or recurrent uterine cancer, the prognosis is much poorer, with five-year overall survival rates falling below 20%. The anticipated increase in incidence over the coming decade will inevitably lead to a higher number of deaths. AIHW data show that uterine cancer mortality rates increased by 1.9 per cent per annum between 1971 and 2014. Over the next decade, more than 8,600 Australian women are expected to lose their life from uterine cancer.



PROJECTED MORE THAN

74,000

women in Australia will be diagnosed with uterine cancer over the next decade.

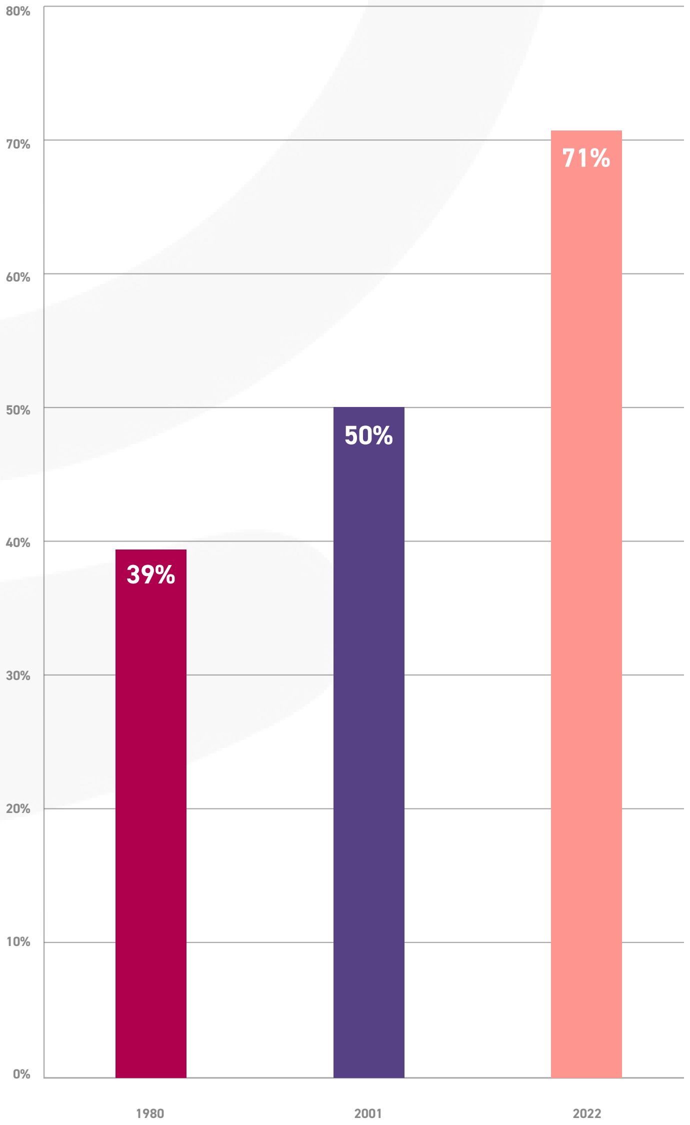


Figure 3:
Percentage of Australians that are obese or overweight (1980-2022).

KEY FACTS

AIHW data show that the underlying risk factors of overweight and obesity risk are disproportionately represented among these priority populations:

People from areas of low socioeconomic advantage are

1.6x

more likely to be living with obesity.

First Nations women are

1.18x

more likely to be overweight or obese.

Women in regional communities are

1.08x

more likely to be overweight or obese.

Elderly Australian women have among the highest risk for being overweight or obese, at

1.7x

more likely than the average Australian.

Disproportionate impact on priority populations:

The risks and impacts of uterine cancer are not evenly distributed across the population. Certain groups, identified as priority populations in the Australian Cancer Plan and the National Women's Health Strategy, are disproportionately affected.

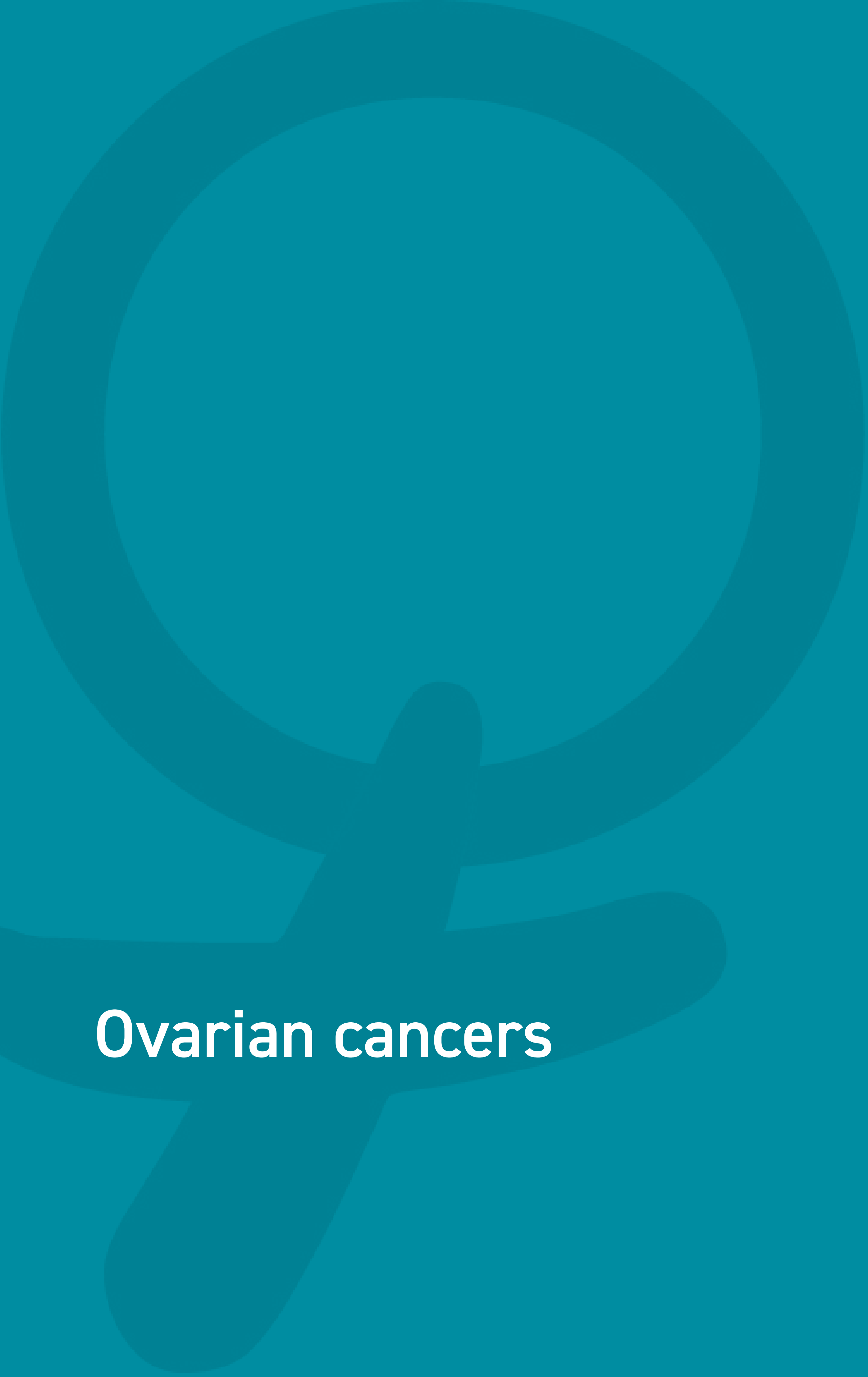
These include:

- Aboriginal and Torres Strait Islander women
- Women living in regional and remote areas
- Women from lower socioeconomic backgrounds

These populations often experience lower levels of health literacy and higher barriers to accessing care, which can result in increased risk of incidence, later stage of diagnosis, high levels of unmet need, and poorer survival outcomes.

Data from the Queensland Cancer Registry further demonstrate that these risk factors, combined with systemic inequities in healthcare access, result in higher incidence and mortality rates for Aboriginal and Torres Strait Islander women, regional women, and women from socioeconomically disadvantaged backgrounds.

For example, a woman from a low socioeconomic background is 1.7 times more likely to be diagnosed with uterine cancer than a woman from the highest socioeconomic background, and her risk of death is 2.1 times higher.



Ovarian cancers

Ovarian cancers

Ovarian cancer is not a single disease but an umbrella term encompassing a wide range of sub-types, that differ in their biology, behaviour, and response to treatment. Ovarian cancer has many recognised morphological subtypes.

The ovaries are made up of three main types of cells. Each of these cell types can give rise to distinct forms of ovarian cancer.

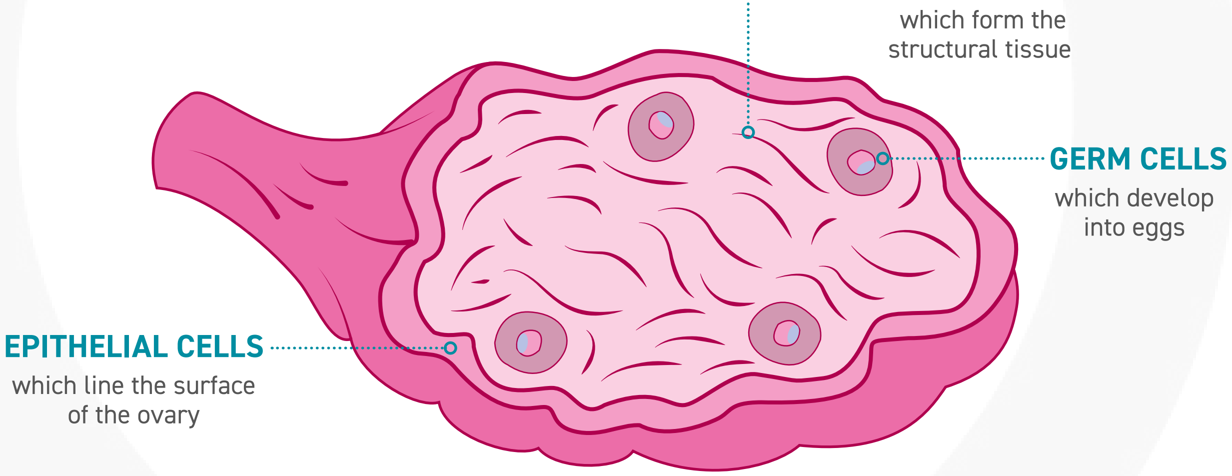


Figure 4:
Diagram of an ovary showcasing three main type of cells.

Epithelial ovarian cancer is the most common form, accounting for approximately 90% of all ovarian cancer diagnoses. It begins in the surface epithelial cells and includes several subtypes, such as:

- High-grade serous (the most common)
- Endometrioid
- Low-grade serous
- Mucinous
- Clear cell
- Undifferentiated or unclassifiable types

Other less common, non-epithelial ovarian cancers include:

- Primary peritoneal cancer
- Fallopian tube cancer
- Germ cell tumours
- Sex cord-stromal tumours
- Small cell carcinoma

KEY FACTS

EVERYDAY

5

women are diagnosed with ovarian cancer.

EVERYDAY

3

women lose their lives to ovarian cancer.

Ovarian cancer as the most lethal of all gynaecological cancers and ranks among the deadliest cancers affecting Australian women.

67%

of ovarian cancers are identified at Stage III or IV.

The five-year survival rate drops further to a combined

29%

Incidence and mortality:

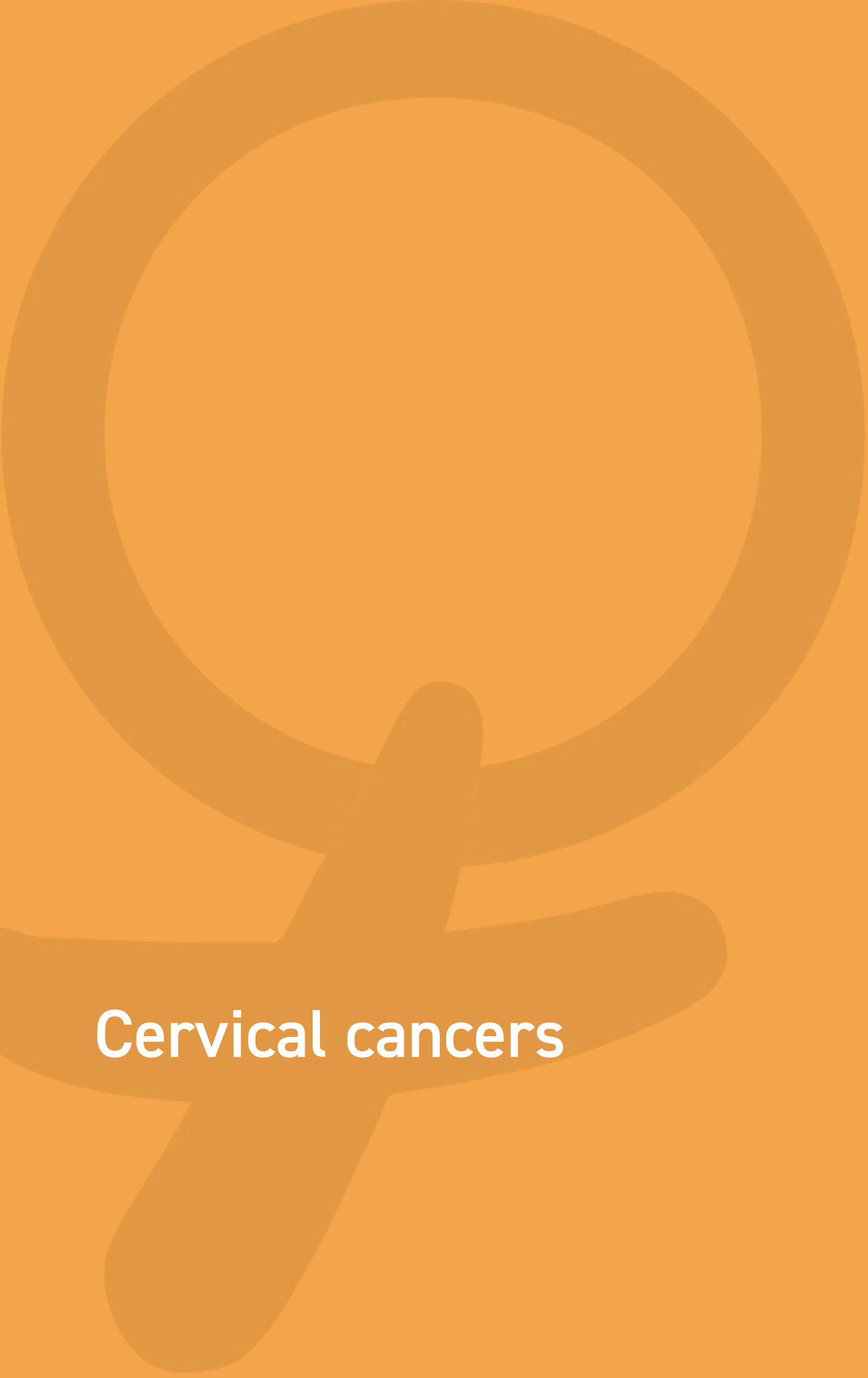
Every day in Australia, five women are diagnosed with ovarian cancer, amounting to around 1,825 new cases each year. It is projected that 24,000 Australian women will be diagnosed with ovarian cancer over the next decade.

Tragically, three women lose their lives to ovarian cancer every day, with more than 14,000 deaths projected in the next 10 years alone, positioning ovarian cancer as the most lethal of all gynaecological cancers and ranks among the deadliest cancers affecting Australian women.

Despite advances in cancer care, the five-year survival rate for ovarian cancer remains low at just 49 per cent and represents the same level as all cancer survival in 1975. The prognosis is particularly poor due to the high proportion of cases diagnosed at an advanced stage; 67 per cent of ovarian cancers are identified at Stage III or IV, at which point the five-year survival rate drops further to only 29 per cent combined. As a result, the majority of women are diagnosed too late for curative treatment.

While the average age at diagnosis is 66 years, ovarian cancer does not discriminate by age and can affect girls and women in their teens, 20s, 30s, and 40s. The impact of ovarian cancer is therefore felt across the lifespan, with significant consequences for individuals, families, and communities.

> **My doctor was amazing. She was empathetic; she went through it all slowly and made me call my mum. I tried not to cry, but I did.**
>
> Alisha — diagnosed with low grade, serous ovarian cancer.



Cervical cancers

Cervical Cancers

Cervical cancer is one of Australia's public health success stories, with prevention achieved through both HPV vaccination and the National Cervical Screening Program (NCSP).

Despite these advances, around 1,030 women are diagnosed, and 269 women die from the disease each year. Unlike most other cancers where 10year outcomes are often reported, annual incidence and mortality remain key measures for cervical cancer due to its preventable nature.

HPV and Vaccine Development

In the 1980s, Australian researchers Professors Ian Frazer and Jian Zhou were instrumental in establishing the causal link of human papillomavirus (HPV) in cervical cancer (>95% of cases), paving the way for the development of a preventive vaccine in the 1990s. The national HPV vaccination program was introduced in 2007 and now achieves coverage of more than 80% of adolescents. Vaccination is a powerful primary prevention strategy, blocking HPV infection before it can initiate cancer. It also reduces the risk of other HPV-related cancers, including vulvar and vaginal cancers, though it has no effect on ovarian or uterine cancers, which are not HPV-related.

National Cervical Screening Program

The National Cervical Screening Program was launched in 1991 to detect pre-cancerous changes before progression to invasive disease. Originally based on 2yearly Pap smears for those aged 20–69, the program transitioned on 1 December 2017 to a more sensitive test: a 5yearly HPV screening test for people aged 25–74, incorporating partial HPV genotyping with reflex cytology triage. This shift to HPV testing reflects its causal role in nearly all cervical cancers and has contributed to significant declines in incidence and mortality.

A Complementary Approach

Cervical cancer remains the only gynaecological cancer with a population screening program. Prevention relies on two complementary strategies:

- HPV vaccination - Primary prevention (halting HPV infection, the cause of cervical cancer)
- Cervical screening - Secondary prevention (detecting and treating precancerous changes before invasive cancer develops)

KEY FACTS

ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN:

3.4x

more likely than non-Indigenous women to die from cervical cancer.

1.5x

more likely to be diagnosed with the disease.

Towards Elimination

Australia continues to lead the world in cervical cancer prevention. With high vaccine coverage and participation in screening, significant progress is being made towards the national goal of eliminating cervical cancer as a public health problem within the coming decades...

Disparities

Disparities remain for women from diverse backgrounds. Aboriginal and Torres Strait Islander women, women living in rural and remote areas, as well as women from lower socioeconomic backgrounds or all tend to have higher rates of cervical cancer, as they may have less access to screening and healthcare services, and lower rates of vaccination rates, and significantly higher probabilities of death.

The increase in the discrepancy between incidence and mortality underlines that challenges faced by other women arising from the rareness of the cancer and barriers to accessing service are amplified for women from diverse backgrounds.

For example, Aboriginal and Torres Strait Islander women are 3.4 times more likely than non-Indigenous women to die from cervical cancer and 1.5 times more likely to be diagnosed with the disease.

These discrepancies are driven by systemic barriers to healthcare access, lower health literacy, and reduced engagement with preventive services.

Addressing these inequities is essential to realising the vision of cervical cancer elimination in Australia. Achieving this goal will require sustained commitment to improving access, culturally safe care, and targeted interventions for priority populations, particularly Aboriginal and Torres Strait Islander women.

Vulvar (or Vulval) cancers

Vulvar (or Vulval) cancers

KEY FACTS

EVERY YEAR

427

women are diagnosed.

When found at an advanced stage, survival decreases substantially to around

19%

EVERY YEAR

126

women lose their life to vulvar cancer.

Women with vulvar cancer face a lack of dedicated patient support, public awareness, and research attention.

Vulvar cancer is a rare and often misunderstood disease that affects the external genitalia of women.

Although it is less common than other gynaecological cancers, seeing 427 women diagnosed every year, its impact is profound, particularly because it is often diagnosed late due to embarrassment, stigma or lack of awareness about symptoms such as itching, irritation, or pain.

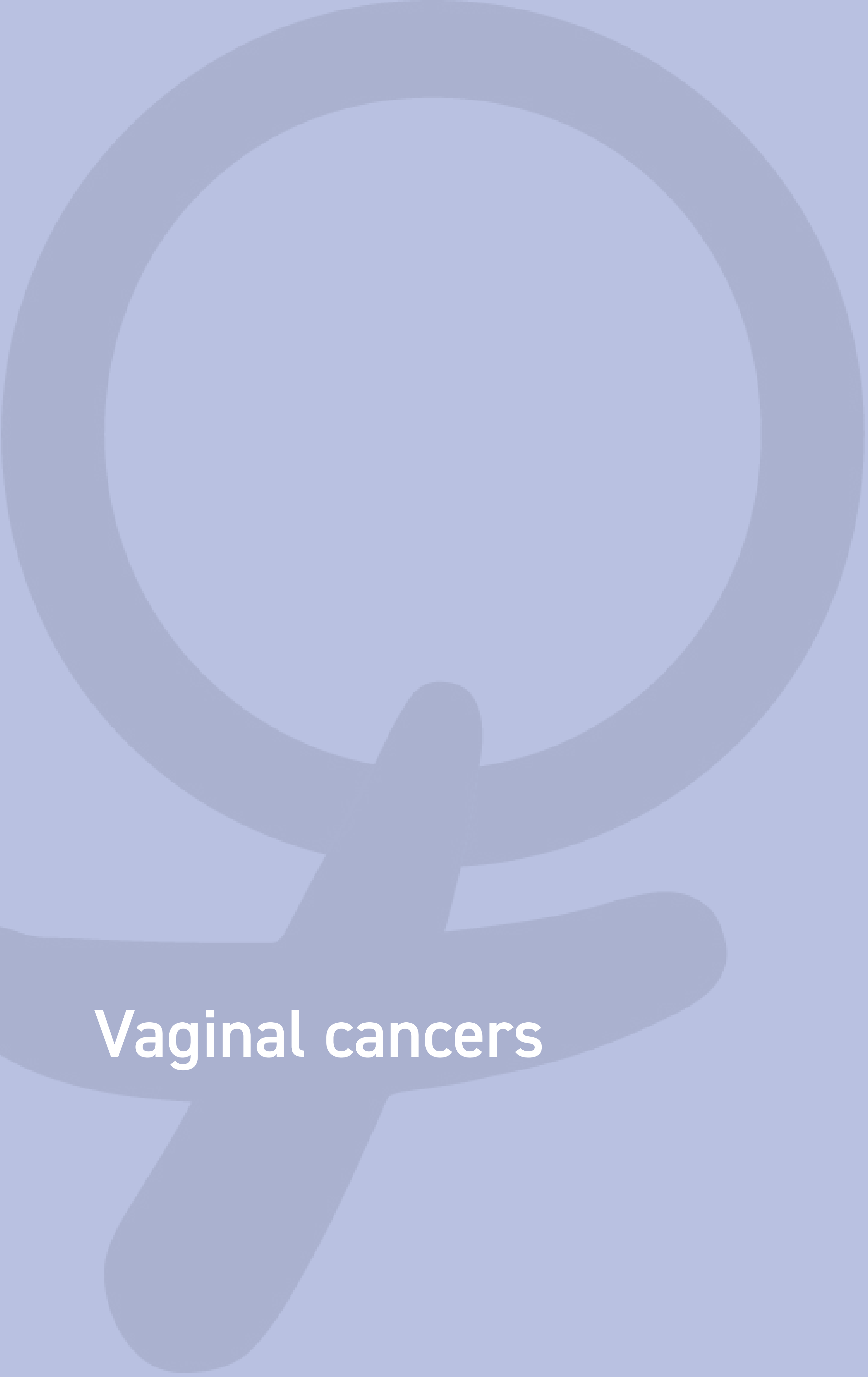
Types of vulvar cancer

- **Squamous cell carcinoma:** Most vulvar cancers (approx. 90 per cent) develop from squamous cells, the skin cells of the vulva. These cancers usually grow very slowly over a few years.
- **Vulval melanoma:** Vulval melanomas develop from melanin, the cells that produce pigment and give skin its colour. Only about 2 to 4 per cent of vulvar cancers are melanoma.
- **Adenocarcinoma:** These are very rare. They develop from cells that line glands in the vulval skin. Paget's disease of the vulva is a pre-malignant condition where glandular cells spread outwards and across the vulval skin.
- **Verrucous carcinoma:** This rare, very slow-growing type of cancer looks like a large wart.
- **Sarcomas:** These are extremely rare. Sarcomas develop from cells in tissue, such as muscle or fat under the skin, and tend to grow more quickly than other types of cancer.

When detected early, vulvar cancer has a five-year survival rate of approximately 74.7%. However, when found at an advanced stage, survival decreases substantially to around 19%. Many women delay seeking medical advice because of the sensitive nature of symptoms or fear of being dismissed. 126 women lose their life to vulvar cancer every year.

In addition to late diagnosis, women with vulvar cancer face a lack of dedicated patient support, public awareness, and research attention. There are no mainstream campaigns or specialised services to support women through diagnosis, treatment, or recovery.

Vulvar cancer can affect body image, sexuality, intimacy, and psychological wellbeing. This makes the need for holistic, compassionate care even more urgent.



Vaginal cancers

Vaginal cancers

Vaginal cancer is one of the rarest gynaecological cancers and is often underrepresented in national statistics

Each year, approximately 117 women are diagnosed with vaginal cancer in Australia, and around 35 women die from the disease. While it most commonly affects older women, however it can occur at any age.

Vaginal cancer can develop in anyone with a vagina, including women, transgender men, non-binary, and intersex individuals.

The two primary types of vaginal cancer are:

Squamous cell carcinoma (SCC): Arising from the thin, flat squamous cells lining the vagina, and representing the most common form.

Adenocarcinoma (including clear cell carcinoma): Originating from mucus-producing glandular cells, which is less common.

The five-year survival rate for vaginal cancer is approximately 54%.

Reflecting the challenges of earlier diagnosis. Similar to vulvar cancer, vaginal cancer is often detected late due to non-specific symptoms, stigma, and limited awareness among both the public and healthcare providers.

Currently, there are no targeted awareness campaigns, dedicated support groups, or specific care pathways for vaginal cancer patients. This gap means many affected individuals face their treatment journey without access to specialised care, psychosocial support, or peer networks, underlining the need for increased attention, education and resources in this area.

EVERY YEAR

~117

women are diagnosed with vaginal cancer in Australia, and around 35 women die from the disease.

The five-year survival rate for vaginal cancer is approximately

54%

Impact of gynaecological cancers

Impact of gynaecological cancers

The impact of gynaecological cancers extends far beyond the physical effects of the disease and its treatment.

Women diagnosed face a complex interplay of physical, psychological, social, and financial challenges, with profound consequences that ripple through families and communities. Understanding and addressing this broad impact underscores the importance and urgency to catalyse innovative and practice-changing cancer research.

Physical impacts:

Gynaecological cancers are often diagnosed at advanced stages, necessitating aggressive treatments such as surgery, radiation, and chemotherapy. These treatments can result in significant physical discomfort, prolonged recovery periods, and permanent bodily changes, including disfigurement and loss of sexual function.

Surgery often involves the removal of part or all of the reproductive organs, which can lead to complications such as infections, chronic pain, impaired healing, or long-term changes in urinary or bowel function. Additionally, treatment can cause sexual dysfunction, loss of fertility, induce medical menopause, pain, and other symptoms that may deeply affect intimate relationships and self-esteem. Lymph node removal can result in lymphoedema (swelling of the legs), which can be painful and difficult to manage.

> **Emotionally I struggled and still struggle to this day with the trauma of it all. Sometimes it feels like it couldn't possibly have happened to me.**
>
> Kristy — diagnosed with cervical cancer.

Psychosocial and emotional impacts:

Beyond the physical toll, gynaecological cancers carry a heavy psychological burden such as scarring, loss of reproductive organs, and sexual dysfunction, can contribute to significant body image concerns and diminished self-esteem. Many women experience depression, anxiety, fatigue, and a persistent fear of recurrence.

Data from Ovarian Cancer Australia (OCA) reveal that[9]:

- 55 per cent of women diagnosed with ovarian cancer experienced anxiety
- 36 per cent experienced depression
- 66 per cent experienced fatigue
- 51 per cent experienced insomnia
- 48 per cent experience fears of recurrence.

This is significantly higher than for the average cancer patient and for the broader population[10]. This means that women with ovarian cancer:

- Experience depression at more than twice the rate of the average cancer patient and 10 times the rate of the average Australian
- Experience anxiety at nearly four times the rate of the average cancer patient and five times the rate of the average Australian.

These impacts often extend to family relationships. Partners, children, and loved ones may struggle to comprehend the emotional toll, leaving women feeling isolated and lonely. Expanding the reach and impact of research to include psychosocial care is therefore essential.

Gynaecological cancers can be a sometimes stigmatising form of cancer, which can make it hard for women to find support or even understand their own diagnosis. The genital location of the cancer can make discussing it uncomfortable, leading to social isolation or shame. Unlike other major cancers, like breast or prostate cancers, gynaecological cancers are often not widely discussed, and there is often a lack of public awareness of the disease and its effect. This can make it harder for women to receive timely diagnoses and appropriate care, and leave a woman feeling invisible, isolated and alone.

Financial hardship:

The cost of medical treatments, including surgery, radiation, and therapy, can place an overwhelming financial burden on women and their families, especially if they require extended care or rehabilitation. Added to this, the physical and emotional toll of treatment can interfere with a woman's ability to work or care for herself and her family.

This disruption can lead to financial instability and added stress. Women living in regional or remote areas may face further challenges, including the need to travel long distances for specialist care, compounding both physical and financial hardship.

Impact on a woman's family:

The loss of a woman to gynaecological cancer extends far beyond her own life. The death of a mother, daughter, partner, or friend leaves long-lasting emotional, social, and psychological impacts on families and communities.

Children: Over the next decade, an estimated 42,900 children will lose their mother to a gynaecological cancer. These children are at significantly higher risk of depression (23.9%) and anxiety (18.5%)[11] in the years following bereavement. Adult children are also deeply affected, with nearly one-third (30.2%) experiencing depression after the loss of their mother[12].

Partners: Approximately 16,300 partners will be directly impacted over the next decade. Studies show that 34.9% of bereaved partners experience depression, and many live with long-term psychological distress[13].

These figures underscore the far-reaching consequences of gynaecological cancers—not only for women themselves, but for the next generation and wider society.

> **I had a ticking time bomb in my pelvis, meanwhile, my children were 11, 13 and 14. And I was determined to fight for more time with them.**
>
> Ali — diagnosed with a gynaecological cancer.

Gynaecological cancer research

Gynaecological cancer research

Unquestionably, Investment in cancer research has consistently translated into significant improvements in survival outcomes.

Across all cancers, survival rates have improved by 43 per cent between 1975 and 2021, these advances realised through significant and sustained funding in high-impact research during the same period.

However, these improvements have not been shared across all cancer types. Most women diagnosed with gynaecological cancer are diagnosed with a rare cancer, and survival rates and treatment options for rare cancers remain poor.

Despite their complexity and poor outcomes, gynaecological cancers have historically received significantly less funding than other cancer types. Between 2003 and 2020, breast cancer research received $442 million, bowel cancer $191 million, prostate cancer $185 million, and melanoma $176 million. In comparison, all gynaecological cancers combined received just $137 million (broken down into ovarian cancer $94 million, uterine cancer $18 million, cervical cancer $20 million and other gynaecological cancers $5 million)[14].

While investment in ovarian cancer has increased over the past decade, it remains modest relative to the long-standing underinvestment and significant level of unmet need. Between 2003 and 2020, gynaecological cancers were the poorest research funded cancers in aggregate of all major cancer groups.

For example, only 35 per cent of women with ovarian cancer are currently eligible for precision medicine, and that eligibility is limited to a single investigation type linked to one treatment. For the majority, there is no molecular information to guide therapy once drug resistance develops, a common challenge, with 70–80 per cent of women with advanced ovarian cancer experiencing recurrence.

> **Expanding access to systematic molecular profiling would not only transform care for thousands of women but also open the door to more clinical trials. The absence of systematic molecular profiling also impacts the number of clinical trials available in Australia.**
>
> **The lack of pre-screened patients increases the cost and complexity of clinical trial recruitment, resulting in fewer trials for gynaecological cancers compared to other cancer types.**
>
> Professor Clare Scott — AM, ANZGOG Chair

Yet, there is enormous potential to change this trajectory. Research into precision medicine and molecular profiling is already demonstrating the power to personalise treatment and improve survival outcomes. Cancer is as unique as a fingerprint, and molecular profiling allows clinicians to identify the genetic features driving a tumour's growth. With this knowledge, oncologists can match women to therapies that directly target their cancer's characteristics. Data from Omico confirm that women who receive comprehensive molecular profiling and matched therapies achieve improved outcomes.

Each year in Australia, it is estimated that between 400 and 600 women diagnosed with gynaecological cancers undergo comprehensive molecular testing to inform a precision medicine approach to their care.

This accounts for only six to eight per cent of all women diagnosed with a gynaecological cancer annually, and less than 20 per cent of those diagnosed with advanced, rare, or recurrent disease.

Less than 10% of women receive access to comprehensive precision medicine to guide their treatment.

Figure 5:
Inconsistent, inequitable and inadequate access to comprehensive genomics medicine in gynaecological cancer care.

KEY FACTS

Between 2003 and 2020, breast cancer research received $442 million, bowel cancer $191 million, prostate cancer $185 million, and melanoma $176 million.

In comparison, all gynaecological cancers combined received just $137 million (broken down into ovarian cancer $94 million, uterine cancer $18 million, cervical cancer $20 million and other gynaecological cancers $5 million).

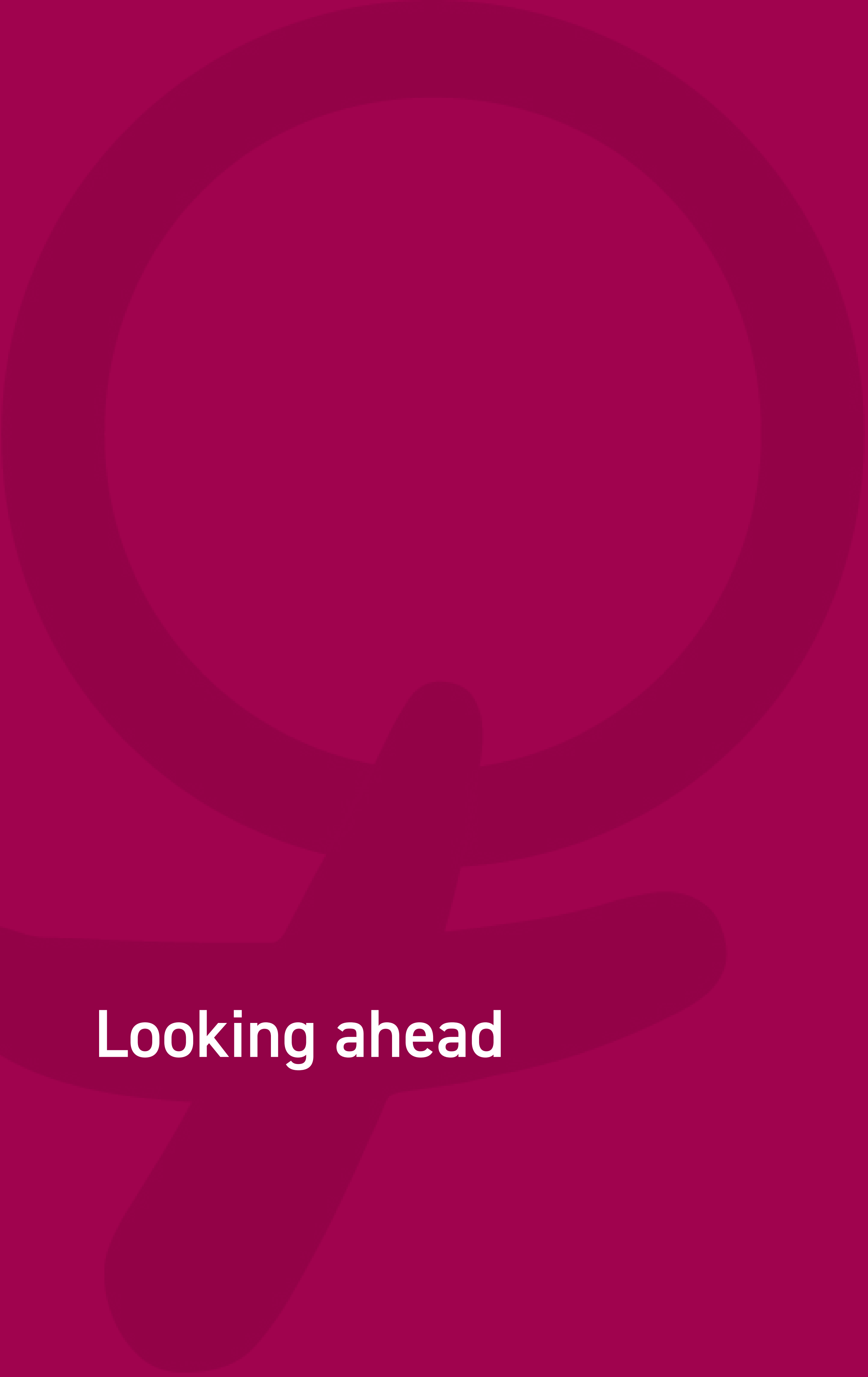
Cancer is as unique as a fingerprint, and molecular profiling allows clinicians to identify the genetic features driving a tumour's growth

Data from Omico confirm that women who receive comprehensive molecular profiling and matched therapies achieve improved outcomes

ONLY

6-7%

of all women diagnosed with a gynaecological cancer annually currently undergo molecular testing to inform precision medicine



Looking ahead

Looking ahead

While the impacts of gynaecological cancers are profound, there is genuine hope for change.

ANZGOG's Strategic Plan 2023–2028 sets a bold vision: to accelerate discovery, ensure equity of access, and transform outcomes for all women affected by these cancers. Achieving this requires urgent and sustained investment in research.

By filling these critical research gaps, Australia has the opportunity to deliver a step-change in survival outcomes, offering real hope to women and their families. With targeted investment and collaborative action, we can catalyse innovative, practice-changing research and expand its reach and impact—ensuring that advances in science translate into tangible improvements in care.

The future we seek is one where no woman dies prematurely from a gynaecological cancer, and where every woman, regardless of where she lives or her circumstances, has access to the latest, most effective treatments. Through commitment, collaboration, and innovation, this future is within reach.

> **The only way this will change is through scientific research. For me and other women in my situation, we are holding out for new treatments through clinical trials. My hope lies in advancements with new drug developments. Beyond my own experience, my hope is that things are different for women in the future.**
>
> **This will happen through raising awareness, prevention, earlier detection, and better treatments. Research is central to all of this, and so funding is crucial.**
>
> Alex — diagnosed with uterine cancer

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