ASGO
Australian Society of Gynaecologic Oncologists

15 June 2006

Mr E Humphery
Secretary
COMMUNITY AFFAIRS REFERENCES COMMITTEE
PARLIAMENT HOUSE
CANBERRA ACT 2600

Dear Mr. Humphery

I attach the submission from the Australian Society of Gynecologic Oncologists (ASGO) to the Senate Inquiry into Gynaecological Health in Australia.

ASGO represents the gynaecological oncologists of Australia and New Zealand. We believe that great inroads have been made in the diagnosis, care and treatment of women with gynaecological cancer. But we are strongly of the view that much more is needed. Our recommendations are made in the attached submission.

I, on behalf of ASGO, thank you and the Commonwealth Government for the opportunity to provide you with our views.

We look forward to a productive outcome and hopefully major advances in the care of women with gynaecological cancer.

Yours sincerely

Conjoint Associate Professor Anthony PROIETTO

PRESIDENT, ASGO

SENATE INQUIRY INTO GYNAECOLOGICAL CANCER SERVICES

AUSTRALIAN SOCIETY OF GYNAECOLOGIC ONCOLOGISTS (ASGO)

June 2006

Summary

In its submission to the Senate Inquiry into Gynaecological Health in Australia, the Australian Society of Gynaecologic Oncologists (ASGO) makes the following recommendations :

A National Gynaecological Cancer Centre

1. that the Commonwealth Government establish a National Centre for Gynaecological Cancer to co-ordinate all aspects of gynaecological cancer care, education and research.

Research Funding

2. that the Commonwealth Government substantially increase its funding contribution to research in the area of gynaecological cancers.

3. that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer.

Screening Tests Funding

4. that the Commonwealth Government continue to support and indeed substantially increase its funding of research into the development of a screening test for ovarian cancer.

5. that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre co-ordinate the research activities.

Treatment Services and Health Support Programs Funding

6. that the Commonwealth Government provide funding so that the number of medical and allied health professionals employed by the various gynaecological cancer centres can be increased to meet the clinical needs of the population.

7. that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre work with the various centres to determine and prioritise staff needs.

People with Special Needs

8. that the Commonwealth Government provide funding so that people with special needs (be they cultural background, remote location, etc) can have access to the same diagnostic, treatment, support, and educational services available to the rest of the population.

9. that funding be provided so that health care practitioners working with these communities or in remote and isolated areas can obtain the support they need to properly treat these women.

10. that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre determine and prioritise needs.

Medical Community's Educational Needs

11. that the Commonwealth Government provide funding so generalist medical practitioners can be better equipped to quickly diagnose and refer women who present with sometimes vague but potentially life-threatening symptoms.

12. that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre undertake all the associated tasks in consultation with the various gynaecological cancer centres.

Community's Educational Needs

13. that the Commonwealth Government provide funding so appropriate education programs and materials can be provided to the community and women in particular.

14. that the funding be provided to the proposed National Centre for Gynaecological Cancer and that the proposed Centre co-ordinate the tasks in consultation with the various gynaecological cancer centres and voluntary and other organisations.

Psychosocial / Psychosexual Support for Patients

15. that the Commonwealth Government provide funding so that women with gynaecological cancer can have access to appropriately qualified Psychologists and Counsellors.

16. that the funding be provided to the proposed National Centre for Gynaecological Cancer and that the proposed Centre co-ordinate the resources and act as a reference point for patients and their health carers.

About ASGO

ASGO is the organization of gynaecological oncologists in Australia and includes the New Zealand gynaecological oncologists. It was founded in the mid 1980s. The Executive has representatives from each of the States. The Executive elects a Chairman and a Secretary / Treasurer.

The objectives of ASGO, as noted in the organisation's Constitution are :

1. to promote and improve standards of care of patients with gynaecologic cancer.
2. to promote postgraduate, undergraduate and community education in the area of gynaecologic oncology.
3. to promote research into gynaecologic oncology.
4. to advise upon and assist in the training and teaching of gynaecologic oncologists.
5. to undertake other such activities as would support the achievement of the stated objectives.

Background

Gynaecological cancers comprise primary neoplasms of the ovary, fallopian tube, uterus, cervix, vagina and vulva. Data from the Australian Institute of Health and Welfare (AIHW) indicate that 3881 women were newly diagnosed with a gynaecological cancer in 2001. This represents almost 10% of all cancers in women. Table 1 shows the number of new cases of each gynaecological cancer diagnosed every year between 1998 and 2001 (*AIHW Interactive Cancer Data : Cancer Age Specific Data Cube*).

Table 1 : Number New Cases of each Gynaecological Cancer, 1998 - 2001

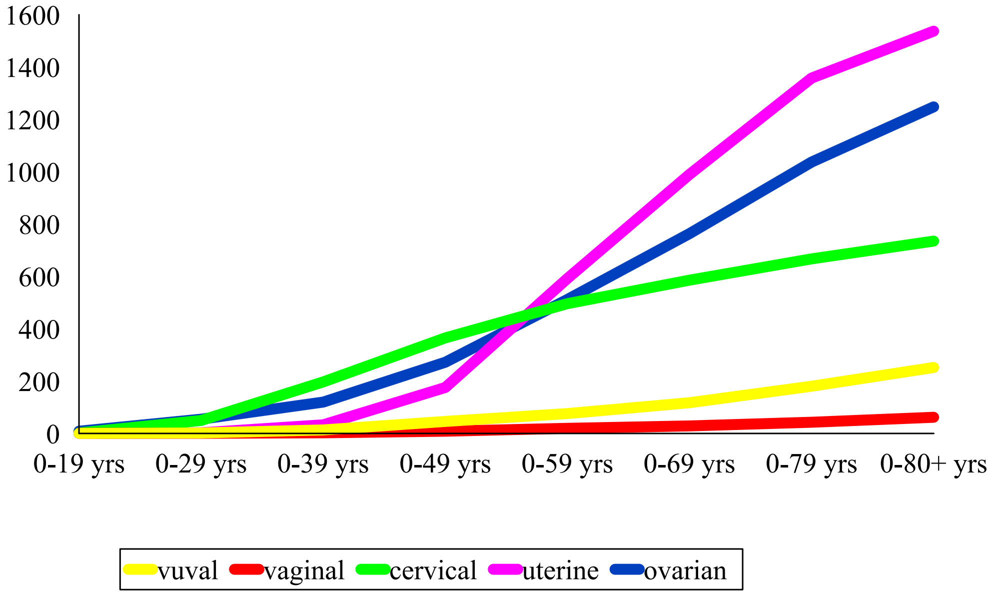
	1998	**1999**	**2000**	**2001**
Vulval	211	200	203	252
Vaginal	56	73	71	62
Cervical	855	794	754	735
Uterine	1397	1434	1580	1537
Ovarian	1232	1218	1263	1248
Other Gynaecological	50	67	58	52

The majority of gynaecological cancers occur in older women but a significant number are found in younger women. Table 2 shows the number of women diagnosed with each type of gynaecological cancer by age groups, in 2001 (*AIHW Interactive Cancer Data : Cancer Age Specific Data Cube*). Figure 1 clearly shows that the majority of gynaecological cancers occur in the older age groups.

Table 2 : Number New Cases of each Gynaecological Cancer x Age Groups, 2001

	Vulval	Vaginal	Cervical	Uterine	Ovarian
0 - 19 years	0	1	2	0	9
20 - 29 years	2	0	48	3	46
30 - 39 years	12	2	147	30	65
40 - 49 years	32	6	168	143	152
50 - 59 years	30	11	131	416	240
60 - 69 years	42	9	90	398	252
70 - 79 years	63	14	81	368	273
80^{+} years	71	19	68	179	211

Figure 1 : Cumulative Number New Cases of each Gynaecological Cancer x Age Groups, 2001



Current best practice worldwide is for patients with gynaecological cancers to be treated in dedicated gynaecological cancer centres by specialist teams of gynaecological, radiation and medical oncologists, specialist pathologists, specialised nursing staff, psychologists, social workers and palliative care services. Treatment is usually complex and prolonged and very taxing on both the patient and her family / friends.

Comment and Recommendations

In this submission it will be argued that although significant advances have been made in the area of gynaecological cancer, there is much work to be done. We have made great advances in treating *some* women with *some* gynaecological cancer. Unfortunately, progress has been uneven and not all women have benefited to the same extent.

It will be further argued that currently the work is fragmented and under-funded and that the Commonwealth Government needs to consider making an immediate and substantial increase to the funding provided to this area and to the establishment of a nation-wide umbrella organization.

The submission will argue that because gynaecological cancers mainly affect older women and because Australia's population is ageing at a rapid rate, the incidence of gynaecological cancers will increase over the next several years. The AIHW estimates that there will be 4 488 gynaecological cancers by 2011, an increase of 15% since 2001. Ovarian, uterine, vaginal and vulval caners are each expected to increase by 25%. The number of cervical cancers is expected to decrease by 34%. (*AIHW Cancer Incidence Projections Australia 2002 to 2011; Cancer Series 30*) Such an increase in the incidence of most gynaecological cancers will bring with it not only emotional trauma to the women involved but also major funding implications for the Commonwealth and State Governments. However, it will be argued, that the morbidity and mortality associated with gynaecological cancer can, without doubt, be substantially reduced by improvements in diagnosis and treatment but that those advances require funding and co-ordination to achieve their maximum benefits for the community and the Government.

A National Gynaecological Cancer Centre (NGCC)

There are a large number of organizations involved in the various aspects of providing care and support to women diagnosed with gynaecological cancer, their carers / families, and their health team. Each of them performs a valuable service.

Heffernan provides a good summary of the community-based organisations. It is given in Appendix 2.

In addition to all the community organizations, there are a number of Government-based organizations such as the various Cancer Councils which also provide patient support and education materials and undertake some statistical analysis of data collected through the health system. With the exception of the Northern Territory and the ACT, each state has gynaecological cancer centres attached to some of the major hospitals. ASGO represents the gynaecological oncologists practicing in Australia.

Communication between these various bodies does occur but is necessarily ad-hoc. Many of them are run by volunteers or else on very limited resources by people with a large number of commitments, and each organization has a different and sometimes specific focus. There is no national body able to act as a resource and coordinating centre for gynaecological cancer. Resources vary within and between states and development of guidelines, educational materials and other resources occurs unevenly on an ad-hoc basis with no coordination or pooling of knowledge or resources.

It could be argued that because ASGO is a national body it could take on at least some of the co-ordination required. To some extent, ASGO has taken on this role. However, it does not have the resources (human or financial) to undertake such a role effectively. It also is run by volunteer specialist medical practitioners whose main focus must remain patient care and treatment.

ASGO is strongly of the view that a national dedicated body will minimise duplication of effort and resources, provide strategic direction and leadership, develop and standardise protocols and guidelines, co-ordinate research and education programs, serve as a focus for women diagnosed with cancer, and act as a resource for medical and allied health professionals involved in their care.

At the moment, each state works more or less independently though the medical specialists make every effort to communicate with each other. The communication is ad-hoc, on a needs basis and inefficient. There is no central reference point. Each medical practitioner therefore wastes valuable time, which could be spent in patient contact and patient care, obtaining details which could easily be centralised in an organization such as the proposed NGCC.

In addition, each state has a Cancer Registry which collects and distributes data and the Australian Institute of Health and Welfare collates these data nationally. The timeliness of these data is not always optimal (for example, the AIHW is now publishing incidence data for 2001). These data are vital to allow the various gynaecological centres and other organizations to plan their services and, to some extent, to monitor the effectiveness of the service they provide.

At another level, each of the gynaecological oncology centres has its own database which is used to supplement the information available nationally and at a state level. These centres do share data for specific projects and research. However, for a number of reasons (lack of resources, incompatible data bases, etc) there is no national collation or analysis of data collected by each centre.

Therefore, the current position is that each centre in each state is producing and analysing statistics for use in enhancing the treatment of patients with gynaecological cancer. Not only is this extremely wasteful of valuable resources but it also fragments the data providing less statistically robust information. A body, such as the proposed NGCC, could collect the data from all centres across the country, pool it and analyse the complete set.

Educational resources have a similar fate, with each state, and sometimes each centre, developing its own materials (eg information booklets, databases, protocols etc).

Psychological support is vital to women facing diagnosis and treatment for gynaecological cancer. This support can sometimes be obtained from community bodies, sometimes from the state-based cancer bodies, or from the gynaecological oncology centres. In other words, it is very difficult for women who are already distressed to quickly ascertain where they can get the help they need.

A national body would act as a coordinating centre to ensure that best practice guidelines are established at a national level. It would ensure the best use of funding and resources by avoiding the duplication inherent in the current more fragmented approach. It would act as a reference centre for clinicians and others to seek advice/information. It could liase with bodies such as ANZGOG to facilitate the conduct of clinical trials. The proposed NGCC could also act as a fundholder. The most important function of the proposed NGCC would be to support gynaecological cancer centres nationally and so help achieve the best possible outcomes for patients.

It is recommended that the Commonwealth Government establish a National Centre for Gynaecological Cancer to co-ordinate all aspects of gynaecological cancer care, education and research.

Research Funding

Each of the country's gynaecological cancer centres is involved in a number of crucial research projects, both at a national and an international level. But there is little co-ordination and precious little funding. In many cases, the funding comes from the private sector, usually drug companies. It can be argued that funding from such sources is not always appropriate and that the integrity of any research findings is at its highest when the funding source is an independent party.

Increase in government funding will result in greater and more time-efficient progress and greater integrity in the research findings. The flow-on benefit to patient care and treatment outcomes cannot be underestimated.

It is recommended that the Commonwealth Government substantially increase its funding contribution to research in the area of gynaecological cancers.

It is further recommended that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer.

Screening Tests Funding

We have made important advances in the screening, diagnosis and treatment of cervical cancers. Pap screening has been used to screen for cervical cancer since the 1950s. In the 10 years from 1993 to 2002, the age standardization incidence rate for cervical cancer has declined by 48% and mortality has declined by 49%. It is widely accepted that screening has played a major role. To ensure continued decline in cervical cancer incidence and mortality it is vital that the national pap smear screening program continues to receive adequate funding. Indeed, the program needs to make even greater efforts to screen a greater proportion of women especially indigenous women and women of non-English speaking background.

The recent development of a vaccine against the human papilloma virus (HPV) will undoubtedly reduce the incidence of cervical cancer *eventually*. But it will be many years before the vaccine can have a measurable impact. In the meantime, any reduction in the pap smear screening program will be extremely short-sighted and undoubtedly reverse the downward trend in the incidence and mortality of this disease.

The advances made in the diagnosis and treatment of cervical cancer show us what is possible. They also remind us that we have a long way to go.

While none of the other gynaecological cancers has an associated screening test, there have been breakthroughs in developing a screening test for ovarian cancer. As noted by Professor Hacker at the Roundtable discussion on Gynaecological Health Issues *(Community Affairs Reference Committee, Response to the Petition on Gynaecological Health Issues, March 2006):*

> " It should be possible, with a concentrated effort, to find a test for this disease. It may not be a single test, because there are several different types of epithelial ovarian cancer, but the commonest is the so-called serous type of cancer, and we are concentrating our efforts on looking at those serous cancers. So, unlike the situation five years ago, where this was like looking for a needle in a haystack, we now have the wherewithal to come up with a test, but obviously it takes a lot of time, effort and money."

Of all the gynaecological cancers, ovarian cancer presents the greatest clinical challenge. It requires intensive and complex treatment, and it is very demanding for both patients and the health care team. It has the highest fatality-to-case ratio of all the gynaecological malignancies. The incidence of ovarian cancer in the Australian population is 10.7 per 100 000 women. The lifetime risk of developing ovarian cancer between the ages of 0 and 74 years is 1:124. The mortality is very high, over 60% of the women diagnosed with ovarian cancer will die of their disease.

A reliable screening test for ovarian cancer would be a major achievement. Early stage ovarian cancer has a generally good prognosis. Patients with stage 1A or 1B disease with well or moderately well differentiated tumours have a 5-year survival rate of more than 90%. For patients with more advanced disease the prognosis is very much poorer.

An ovarian cancer screening test has the potential to decrease the incidence of the disease and improve the prognosis through early detection and treatment. The development of such a test is extremely resource intensive. The $15 million provided by the Commonwealth Government has gone a long way but further substantial funds are needed if a screening test is to be developed.

It is recommended that the Commonwealth Government continue to support and indeed substantially increase its funding of research into the development of a screening test for ovarian cancer.

It is further recommended that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre co-ordinate the research activities.

Treatment Services and Health Support Programs Funding

Australia has a highly-trained, world-recognised and dedicated group of medical practitioners. Unfortunately, not all women have received the benefit of their care and treatment. *Some* women with gynaecological cancers are treated in a timely manner by a team of highly qualified specialists in hospitals with top-class facilities, usually in the metropolitan areas. Unfortunately, many women receive too little treatment too late.

Some hospitals (particularly those in regional areas of Australia) do not have the number of qualified staff or the number of operating sessions required to properly treat women with gynaecological cancers. Women with gynaecological cancers who live in these areas are required to travel hundreds of kilometres to receive treatment. These women not only have a life-threatening illness, they also have to leave their support networks behind and travel to an unfamiliar location to receive major treatment. Moreover, many women do not have the financial resources to travel to another location in order to undergo treatment.

The provision of high quality clinical services requires adequate funding and resources. On a national level there is considerable variation in the level of resources available to gynaecological oncology centres. Centres in capital cities are generally better staffed than those in regional areas and waiting times for consultations and treatment tend to be shorter. However, ***all*** centres have deficiencies in their clinical service levels which need addressing.

Currently, Australia has 34 Gynaecological Oncologists. The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) states that one Gynaecological Oncologist is needed per 400 000 population. Australia should, therefore, have 48 Gynaecological Oncologists in order to adequately service the needs of the Australian community. Even on the current numbers of gynaecological cancers (setting aside the predicted increase in incidence, see above), Australia is 14 Gynaecological Oncologists short. It is well documented in the literature that patients treated by specialist doctors have a better outcome. The shortfall in the number of specialist doctors will have enormous implications for the community.

Enhanced funding, and perhaps allocation of funding by the proposed national centre on the basis of need and cost-effectiveness, would significantly improve service provision. It is especially critical that resources are made available to allow women from regional and remote areas to access equitably services that residents of major population centres are more readily able to use. This may require improvements in travel and accommodation assistance to allow patients to attend referral units, but it also requires investment in the staffing and training of smaller local hospitals and health centres to enable as much care (especially monitoring and follow up) as possible to occur in the patient's own environment.

It is recommended that the Commonwealth Government provide funding so that the number of medical and allied health professionals employed by the various gynaecological cancer centres can be increased to meet the clinical needs of the population.

It is further recommended that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre work with the various centres to determine and prioritise staff needs.

People with Special Needs

Women in remote areas and indigenous women diagnosed with gynaecological cancers have a poorer prognosis, usually because they are diagnosed when their disease is more advanced.

Moreover, the multicultural nature of Australia adds another layer of complexity which needs to be addressed. We need to increase their understanding of the role and importance of screening, where it exists, and of the need to investigate any symptoms, and their accessibility to appropriate services.

Medical practitioners working in these areas also have special needs. Their geographical isolation results in limited access to education and support / advice from medical specialist teams.

It is recommended that the Commonwealth Government provide funding so that people with special needs (be they cultural background, remote location, etc) can have access to the same diagnostic, treatment, support, and educational services available to the rest of the population.

It is recommended that funding be provided so that health care practitioners working with these communities or working in remote and isolated areas can obtain the support they need to properly treat these women.

It is further recommended that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre can determine and prioritise needs.

Medical Community's Educational Needs

Generalist medical practitioners have limited exposure to women with gynaecological cancers. Women often present to their GP with vague and ill-defined symptoms and they often present after several months. This combination (limited exposure, vague symptoms, delayed presentation) can make it very difficult for generalist medical practitioners to firstly diagnose and then appropriately refer the patient.

Most centres run education programs for the GPs in their catchment area. Indeed, the GMCT provides funding for the centres in NSW to hold annual seminars. The programs are usually extremely well attended and very successful. However, they are run on an ad-hoc basis and in addition to the other work of the centres. They are, without doubt, duplicated across the country so the scarce resources are used very inefficiently.

These programs need to be better co-ordinated, better advertised, and more frequent. The Commonwealth Government needs to provide funds to ensure that the medical practitioner who first comes into contact with a women with gynaecological cancer has sufficient up-to-date knowledge of the disease, has access to a referral system which will maximise the health outcome for the patient, has access to educational material for himself / herself and the patient, and has the support (s)he needs to continue to care for that patient over the many years she will have the disease. The proposed Centre is best placed to undertake these tasks.

It is recommended that the Commonwealth Government provide funding so generalist medical practitioners can be better equipped to quickly diagnose and refer women who present with sometimes vague but potentially life-threatening symptoms.

It is further recommended that the funding be provided to, and co-ordinated by, the proposed National Centre for Gynaecological Cancer and that the proposed Centre undertake all the associated tasks in consultation with the various gynaecological cancer centres.

Community's Educational Needs

As noted several times in this submission, symptoms of some gynaecological cancers are very vague and easily misinterpreted. Sometimes the symptoms can be embarrassing for the women concerned. Usually, the women do not feel so unwell that they feel they need to take early action. Sometimes, the women may recognise the symptoms but are too frightened to have them investigated. The community needs to be made aware that they do need to have the symptoms investigated and that they should not delay their visit to their doctor.

A number of community education forums exist (for example, the Cancer Councils of each state, the OvCa and affiliated organizations, etc). These organisations admirably perform a much-needed function with little or no support.

Most, if not all, the gynaecological cancer centres have developed pamphlets and information packages. Many involve themselves in media events to increase the community's awareness of gynaecological cancers.

There are a number of internet sites which provide some information to the community.

These sources of information are disparate, ad-hoc and under-funded but they are crucial. The current model, with all its duplication, is a simple waste of resources. The mortality and morbidity associated with gynaecological cancers can only be decreased if the community, women in particular, are made aware of the symptoms and encouraged to seek immediate medical attention.

The Commonwealth Government needs to provide funding so that the education can be better co-ordinated, cater for the diverse cultures and have a higher audience reach, and the organizations providing this valuable service are supported.

It is recommended that the Commonwealth Government provide funding so appropriate education programs and materials can be provided to the community and women in particular.

It is further recommended that the funding be provided to the proposed National Centre for Gynaecological Cancer and that the proposed Centre co-ordinate the tasks in consultation with the various gynaecological cancer centres and voluntary and other organisations.

Psychosocial / Psychosexual Support for Patients

There is ample evidence in the literature that gynaecological cancer and its treatment is associated with a high incidence of psychological and sexual dysfunction which, in turn has a major negative impact on the patient's recovery, return to normal function and quality of life. It is also extremely stressful for their partners and family.

Although centres treating patients with gynaecological cancer are well aware of the psychological and psychosexual cost, very few centres have sufficient resources to optimally deal with their patient's needs in these areas. Not even those centres in metropolitan areas have access to these health professionals. The situation in regional and remote areas is far worse with a critical shortage of appropriate health professionals so that some women have no access at all these services.

All centres treating patients with gynaecological cancer need to have access to a clinical psychologist and psychosexual counsellor and have appropriate social support mechanisms in place. These support services need to be available to patients not only during their stay in hospital but for a very extended period after their discharge and during the term of their treatment and beyond. It is especially critical for patients who suffer recurrence.

The proposed NGCC would be best placed to co-ordinate the resources, develop any programs required, and act as a reference centre for patients and their health teams.

It is recommended that the Commonwealth Government provide funding so that women with gynaecological cancer can have access to appropriately qualified Psychologists and Counsellors.

It is further recommended that the funding be provided to the proposed National Centre for Gynaecological Cancer and that the proposed Centre co-ordinate the resources and act as a reference point for patients and their health carers.

Membership of ASGO

Practising in Australia as CGO

New South Wales

Ken Atkinson, Alison Brand, Jonathan Carter, Felix Chan, Chris Dalrymple, Alan Ferrier, Greg Gard, Neville Hacker, Russell Hogg, Donald Marsden, Geoff Otton, Selvyn Pather, Tony Proietto, Greg Robertson, Gerard Wain,

Victoria

David Allen, Arthur Day, Peter Grant, Simon Hyde, Tom Jobling, Tom Manolitsas, Deborah Neesham, Michael Quinn, Robert Rome

Queensland

Alex Crandon, James Nicklin, Andreas Obermair, Lewis Perrin, Bruce Ward

Western Australia

Ian Hammond, Yee Leung, Tony McCartney

South Australia

Margaret Davy, John Miller

Tasmania

Penny Blomfield

Practising in New Zealand as CGO

Peter Sykes, Ai Ling Tan, John Whitaker

Practising Overseas

As CGO: Danny Cheng (Hong Kong), Peter Larsen-Disney (UK), Maurice Webb (USA)
As DGO: John Coulter (Ireland), Fred Kridelka (Austria), Eng Hseon Tay (Singapore)

Not in Active Practice as CGO

William Channen, Peter Elliott, Roger Houghton, Robert Planner, Robin Sander

APPENDIX 2

Community Organisations involved in Gynaecological Cancer

(Heffernan, Submission to Senate Inquiry into Gynaecological Health in Australia; June 2006)

ORGANISATION	LOCATION	ACTIVITY	$$ SOURCE
AOCS Australian Ovarian Cancer Study	Australia wide	Ovarian cancer research	USA Department of Defence
ASGO Australian Society of Gynaecological Oncologists	Australia wide	Scientific meeting	Professional fees
ANZGOG Australian and New Zealand Gynaecological Oncology Group	Australia and New Zealand	Gynaecological oncology research	USAGOG, Aventis
GAIN Gynaecological Information Awareness Network	WA	Consumer awareness and education	Community
GCRC Gynaecological Cancer Research Centre	VIC	Gynaecological oncology research	Community, Corporate
GMCT Gynaecological Malignancies' Clinical Taskforce	NSW	Psychosocial care, research, patient support	
GO FUND Gynaecological Oncology Fund	NSW	Research, patient support awareness	Community
GCS Gynaecological Cancer Society	QU	Patient support and resources, psychosocial	Community, Corporate
OvCa National Ovarian Cancer Network	VIC	Ovarian cancer research and patient support	Community, Corporate
Ovcare	VIC	Ovarian cancer	Community
OCRF Ovarian Cancer Research Foundation	VIC	Ovarian cancer research and awareness	Corporate, community
NBCC (Ovarian Cancer)	NSW	Ovarian cancer research	Government