European Society of Gynaecological Oncology position statement

Closing the Gap in Women’s Health: Building an EU-wide Ecosystem of Centres of Excellence

Executive summary

Women across Europe face persistent structural barriers in accessing quality, timely, and innovative healthcare, particularly in **gynaecological oncology**. With more than 40 years of experience, the European Society of Gynaecological Oncology (ESGO), together with ENGAGe, its patient advocacy network representing women affected by gynaecological cancers, demonstrate how **coordinated, evidence-based, and patient-centred approaches can reduce disparities and improve outcomes across cervical, ovarian, endometrial, vulvar and vaginal cancers.**

This paper provides a blueprint for EU-wide action, supporting gender equality, health equity, and innovation in women’s health policy. It argues that creating an EU-wide ecosystem of **Centres of Excellence for Women’s Health** could serve as a powerful and scalable solution. These centres would provide consistent, high-quality care, enable better research and data collection, and reduce inequalities by including all women, in their diversity, into national healthcare systems.

ESGO’s and ENGAGe’s holistic, science-based certification and education frameworks are built on multidisciplinary expertise, quality assurance, patient experience, and meaningful patient-organisation involvement. Supported by real-world data, these frameworks offer examples of how structured standards can help address the complex and evolving needs of women’s health across Europe. This approach also provides a foundation for future aims and collaboration, ensuring continued progress in improving outcomes for all women.

1. Context and rationale

Despite representing over half of the EU population, many women experience unmet medical needs, limited access to cutting-edge therapies, and underrepresentation in clinical research - challenges that are particularly evident in gynaecological cancers, which remain consistently under recognised and insufficiently addressed. This is especially true for women affected by intersecting socio-economic determinants of health, including age, ethnicity, sexual orientation, gender identity, income and geographic location (1).

In her political guidelines, European Commission President Ursula von der Leyen reaffirmed that gender equality remains a top priority for the EU’s current mandate. Building on this, the European Commission published a **Roadmap for Women’s Rights** (2) on the 7th of March 2025, outlining its commitment to gender equality and accelerating progress in this area. At the heart of this momentum is the upcoming **EU Gender Equality Strategy 2026-2030**, currently in development.

This strategy will set out concrete, cross-sectoral measures to close persistent gender gaps, including in healthcare. In support of this, the European Parliament SANT Committee published on the 24th of October 2025 a **Report on the Gender Equality Strategy** (3) calling for comprehensive, gender-responsive healthcare, with better disaggregated data to detect treatment gaps, and an EU strategy addressing women's specific health needs across the life course. These developments offer a powerful window of opportunity to address structural barriers in women's health, starting with those affecting women with gynaecological cancers.

2. The case of gynaecological oncology

Gynaecological cancers represent a clear and urgent case for change. Each year, an estimated 1.2 million women are diagnosed with cancer in the European Union (1). In 2022, in Europe more than 274,000 were diagnosed with gynaecological cancers, including endometrial, ovarian, cervical, vulvar, and vaginal cancers (4). Despite this significant burden, policy attention and resource allocation remain disproportionately focused on cervical cancer, leaving other malignancies critically underserved.

Recent EU-level action on cervical cancer shows that coordinated policy can deliver impact. Building on this progress, comparable focus is needed across all gynaecological cancers, not only on prevention and risk-reduction. Today, many women still face delayed diagnosis, limited treatment options, and fragmented follow-up. Barriers to innovation, uneven availability of genetic and molecular profiling, and insufficient access to clinical trials drive persistent outcome gaps between EU Member States.

Closing these gaps requires a coordinated, integrated approach that guarantees timely, equitable, high-quality care regardless of postcode; while strengthening research capacity, bringing innovation closer to patients, and embedding robust quality standards across health systems.

2.1 Disease burden in Europe

A growing number of women are living chronically with gynaecological cancers, which presents new challenges in long-term care, timely access to innovation, and survivorship support. **Endometrial cancer is now the most common gynaecological malignancy in Europe** and the fourth most common cancer among women overall, after breast, colorectal and lung. Its incidence is rising steadily, driven by ageing populations, obesity, diabetes, and other metabolic comorbidities (5). While less common, **ovarian cancer remains the most lethal gynaecological cancer** due to late-stage diagnosis and limited screening options (6). **Cervical cancer continues to impose a substantial and highly variable burden across Member States**, underscoring the importance of human papilloma virus (HPV) vaccination and organised screening. **Vulvar and vaginal cancers are rare in Europe**, with incidence rates below 5 per 100,000 women, but have a profound impact on quality of life. These patterns are reflected in **Table 1**.

Cancer site	Cases	ASR Incidence	Deaths	ASR Mortality
Cervix uteri	28,211	11.7	13,636	5.3
Corpus uteri (endometrium)	69,163	26.6	17,301	6.2
Ovary	40,714	15.7	27,677	10.2
Vagina	2,098	0.8	844	0.3
Vulva	12,700	4.6	4,458	1.5

Table 1: Incidence and mortality of Gynaecological cancers in EU-27 in 2022. Table summarises cervix uteri, corpus uteri (endometrium), ovarian, vulva, and vaginal cancers in the European Union (EU-27). Incidence and mortality are shown for calendar year 2022. Rates are age-standardised (ASR) per 100,000 using the European Standard Population 2013 (ESP2013). Hence, counts are adjusted to the ESP2013 age structure to enable fair comparisons across countries. Source: Joint Research Centre (JRC)'s European Cancer Information System (ECIS)(7).

Beyond clinical impacts, women's cancers place a significant **economic burden on society due to direct, indirect, and informal care costs**. Although global data are limited on gyneacological cancer, some studies illustrate the scale: for example, the World Ovarian Cancer Coalition estimated ovarian cancer costs at USD 70 billion across 11 countries in 2022 (8). Most notably, indirect and intangible costs, such as productivity losses and caregiver time, are often overlooked but substantial. In Sweden, for instance, indirect costs for breast and ovarian cancers accounted for more than half of total costs (9), emphasising the importance of adopting a broader societal perspective. Overall, these findings imply that investments in prevention, early detection, and timely access to care and innovation can not only improve patient outcomes but are also economically sustainable, as they help reducing the wider societal and financial impact.

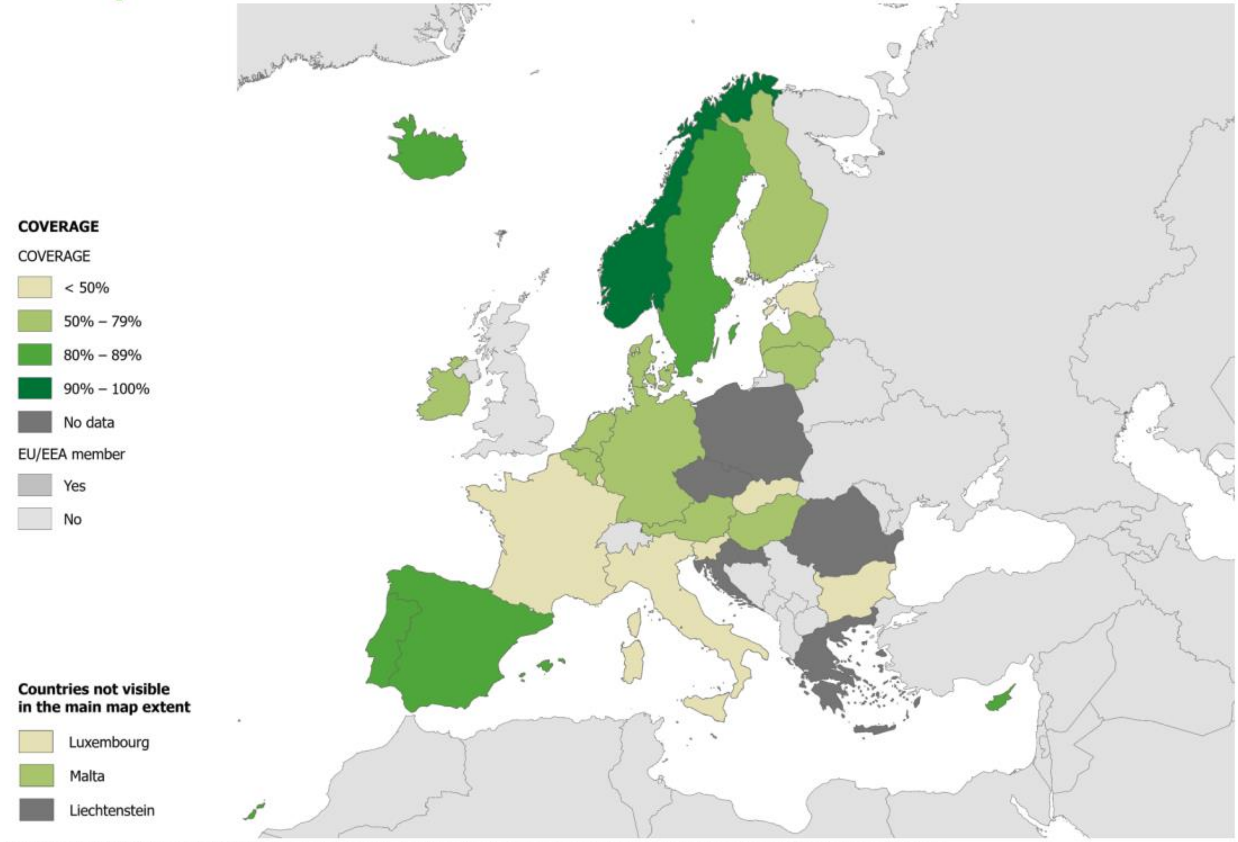
The prioritisation of women's health serves as a measurable indicator of the quality, maturity, and equity of healthcare systems and should be embedded as a central strategic objective.

2.2 Systemic Barriers in Gynaecological Oncology

2.2.1 Prevention and Early Diagnosis

Prevention and early diagnosis represent critical yet persistently underdeveloped stages of the gynaecological cancer pathway in Europe. Despite the availability of effective prevention measures such as HPV vaccination and organised cervical screening, coverage remains highly uneven(10). For example, the last dose of HPV vaccination in females varies from <50% to ≥90% across EU/EEA countries, with an EU average around 64% in 2022, reflecting stark geographical, socioeconomic, and cultural disparities, as indicated in **Figure 1** (11). Moreover, cervical screening participation among women 20–69 varies widely across the EU, from roughly 20% to about 80% across countries in 2023 (**Figure 2** (12)).

While cervical cancer benefits from established programmes, other gynaecological malignancies remain underserved: ovarian cancer continues to be diagnosed at advanced stages in more than two-thirds of the cases, as no validated population-based screening methods exist, and endometrial cancer, though often symptomatic at early stages, lacks systematic early prevention strategies and identification of high-risk groups (13).



Map produced on: 24 Jan 2024. Administrative boundaries: © EuroGeographics © UN–FAO © Turkstat.The boundaries and names shown on this map do not imply official endorsement or acceptance by the European Union.

Figure 1: HPV vaccination coverage among females in EU/EEA countries (2022). Map showing estimated coverage of the final dose of the HPV vaccination series among females in EU/EEA countries, classified into five coverage categories: <50%; 50–79%; 80–89%; and 90–100%, with "no data" indicated in dark grey.

Source: European Centre for Disease Prevention and Control (ECDC), Vaccine Preventable Diseases Monitoring System, data extracted 24 January 2024.

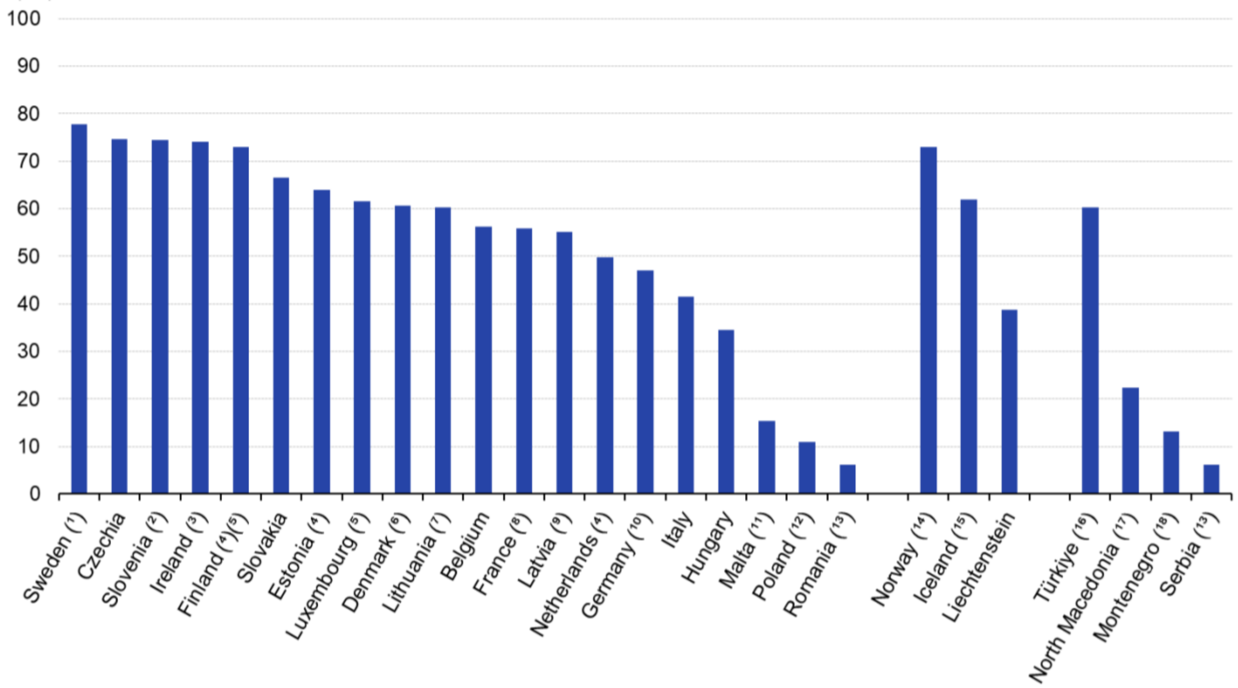


Figure 2: Cervical cancer screening rate among women in the EU. Proportion of women aged 20–69 years who were screened for cervical cancer within the previous three years (or according to the national screening frequency). Data refer to programme-based screening and represent the share of eligible women covered.
Source: Eurostat, *extracted 2024*

Patient-level barriers further undermine prevention, with many women reporting low awareness of gynaecological cancer symptoms and risk factors, limited knowledge of available screening options, and psychological obstacles such as fear, embarrassment, or stigma associated with gynaecological examinations (14). These gaps translate into low uptake of preventive measures: for example, **less than one third of women surveyed across ten European countries had ever participated in a cervical cancer screening programme before diagnosis**, **and awareness of hereditary or metabolic risk factors for ovarian and endometrial cancer remains critically low** (14). Structural barriers, including delays in follow-up after abnormal screening tests, inadequate access to genetic testing and counselling, and limited diagnostic capacity in rural or resource-constrained settings, exacerbate these inequities across Europe and globally (15,16).

In response to these persistent patient-level and structural barriers, a dual prevention strategy is needed. First, the availability and accessibility of evidence-based prevention tools must be strengthened, including screening programmes, follow-up pathways, and access to genetic testing and counselling. Second, preventive activities should be better integrated and, where possible, combined across the care pathway and over the life course.

Integrated prevention approaches have the potential to improve adherence, reduce the time burden and psychological barriers experienced by women, and limit fragmentation of care. By simplifying access and reducing duplication, such models can also help alleviate workload pressures on healthcare professionals. Over time, more coordinated prevention strategies are likely to contribute to improved equity in access, better health outcomes, and a more efficient use of healthcare resources.

2.2.2 Treatment

Despite significant therapeutic advances, **timely and equitable access to appropriate treatment for gynaecological cancers remains inconsistent across Europe**. Although international guidelines recommend treatment initiation within 30 days of diagnosis, surveys show that nearly one in five patients wait longer than two months before starting therapy, with delays most pronounced in Central and Eastern Europe (14). Such waiting times are linked to workforce shortages, limited radiotherapy and surgical capacity, and bureaucratic inefficiencies, as well as fragmented or absent clinical pathways across institutions and at the national level, all of which contribute to poorer survival outcomes (15). Beyond delays, access to innovative therapies is highly unequal: targeted treatments including immunotherapies, PARP inhibitors, and fertility-sparing approaches are not consistently integrated into national care pathways, and reimbursement decisions often lag behind EMA approvals, leaving patients in lower-income Member States particularly disadvantaged (17,18).

Surgical care also demonstrates disparities. While minimally invasive procedures are associated with improved recovery and outcomes in endometrial cancer, only 43% of European centres offer advanced laparoscopic training and fewer than one in four provide robotic training, with formal curricula available in less than one third of centres(19). Surgical skills and institutional facilities are also the main determinants of survival in ovarian cancer, yet a consistent proportion of women affected are treated inappropriately. The lack of structured training undermines the dissemination of surgical innovation and reinforces geographical inequalities. Furthermore, fragmentation of national clinical guidelines means that women with the same diagnosis may receive markedly different treatment depending on where they live (20).

In this context, the organisation of care plays a decisive role. The lack of specialised centres, uneven surgical expertise, limited training opportunities, and fragmented clinical pathways all point to the need for greater centralisation of women’s cancer care, with a clear focus on the entire patient journey, from diagnosis and treatment to survivorship and long-term follow-up.

Centralised care models have been shown to support higher quality standards, concentration of multidisciplinary expertise, and more consistent implementation of evidence-based treatment strategies, particularly for complex surgical procedures and rare tumour types. By reducing fragmentation across institutions and care interfaces, such models can help minimise delays, optimise resource use, and create the structural conditions needed to address inequities in access and outcomes across different healthcare settings.

Participation in clinical trials, a key driver to innovation, also remains low across many countries, particularly for women with rare tumour types, reducing opportunities for early access to promising therapies (21).

Economic disparities increase these gaps, as access to high-cost medicines and genetic testing and biomarker analysis are often unavailable outside of wealthier healthcare systems, and early-access or compassionate-use programmes are unevenly implemented across Member States (22,23). For instance, recent ESGO-affiliated data show that comprehensive molecular profiling for endometrial cancer is fully available in only 29.4% of Eastern European countries, with lack of public reimbursement and limited access to accredited laboratories identified as the main barriers (24). Altogether, these systemic barriers in treatment prevent scientific progress from being translated into equitable and improved outcomes for gynaecological cancer patients across Europe.

2.2.3 Patient Management and Follow-up care

In the following years, many more people in the EU will be living with cancer, as a consequence of the rising burden and morbidity of chronic diseases. Half of them will be women. Following treatment, comprehensive survivorship care and follow-up management are essential to address full spectrum of ongoing needs patients face, including gynaecological problems related to previous or ongoing treatments (25).

Patients often continue to experience significant psychological distress, including anxiety, depression, and fear of recurrence, which necessitates integrated mental health support and psychosocial assessments during follow-up visits, with access to counselling and peer support services (26). Furthermore, many survivors experience late and long-term physical effects, which include lymphedema (27), peripheral neuropathy (28), early menopause with its related side-effects andsecondary cancers. Informational needs remain high as survivors require clear guidance on self-care, lifestyle modifications, and understanding symptoms to watch for, alongside with individualised survivorship care plans that provide structure and clarity during the transition from active treatment to long-term health management (25). Notably, substantial disparities across Europe are also evident in the availability of gynaecological cancer support services. For instance, only 31.1% of patients received printed information from their healthcare providers, with distribution rates varying widely, ranging from 62.4% in Denmark to just 4.6% in Greece (14). As an increasing number of women become long-term cancer survivors, existing follow-up programmes need to be critically reassessed and adapted, as they typically end after five years. This time-limited approach no longer reflects the complex and often lifelong medical, psychosocial, and functional needs of many survivors.

In this context, a prospective study initiated by an ESGO Centre of Excellence demonstrated a significant and clinically relevant improvement in quality of life among women participating in a structured follow-up programme within a cancer survivorship framework (29). These findings highlight the added value of systematic, interdisciplinary, and long-term survivorship care.

Taken together, these findings point to the need for dedicated cancer survivorship services. Such clinics should address not only long-term and late treatment-related morbidities, but also implement structured secondary prevention strategies, including the promotion of bone health, cardiovascular health, mental and psychosocial well-being, and the surveillance and prevention of second malignancies.

Cancer during pregnancy, pregnancy after cancer treatment and sexual health management are critical components of aftercare. Early fertility counselling is ideal, but follow-up care should also allow for reproductive consultations and support for sexual well-being and body image restoration that often remain unaddressed in routine care (25,29). **Survivorship care extends to addressing social isolation and relationship disruptions, and job reintegration with multidisciplinary approaches** that include patient advocacy groups, peer support groups and psychosocial rehabilitation to rebuild survivors' social roles and emotional resilience (25).

It is estimated that financial toxicity affects between 48% and 73% of cancer survivors (30), with some subgroups of patients, such as young adults (31) and women in rural areas (32), being particularly vulnerable. These challenges require a tight collaboration between oncologists, gynaecologists, primary care doctors, and allied health professionals to provide holistic, individualised care tailored to cancer type, recurrence risk, and personal needs.

Caregivers of women with gynaecological cancers face distinct emotional and practical burdens that are often underrecognised. Women frequently hold central roles within their families, and their temporary absence or reduced capacities can create significant strain on household functioning and caregiver well-being. Partners and family members may struggle with anxiety about recurrence, treatment-related side effects, sexual and relationship changes, and a lack of clear information. Moreover, particularly among unpaid caregivers, significant gender imbalances persist, with the majority of caregiving responsibilities disproportionately falling on women. For instance, a 2023 European Institute for Gender Equality study indicates that 49% of partnered women take primary responsibility for essential childcare, versus just 6% of men (33). This is also reflected among cancer; consequently, women caring for cancer patients often have to reduce their hours, modify their work patterns, or leave their jobs altogether, resulting in immediate income loss and long-term pension penalties, heightening their vulnerability to poverty (1). The financial toll on caregivers has been well documented. For example, Eurofound's European Quality of Life Survey shows that 42% of non-working carers are in the lowest income quartile (compared with 24% of non-carers), and 59% struggle to make ends meet (compared with 46% of non-carers) (34). Integrating caregiver support into survivorship care — including counselling, relationship guidance, and access to peer networks — is essential to improve patient outcomes, reduce isolation, and strengthen long-term resilience for the whole family, with active involvement from patient organisations and the care centre.

3. ESGO's holistic response

The field of gynaecological oncology is increasingly moving towards coordinated, science-based, and patient-centred approaches. **Alongside integrated surgical and medical treatment, achieving equitable access requires prevention, education, psychological support, and structured pathways to adopt and scale innovation**. Only by aligning scientific progress with efficient clinical pathways, structured training, quality assurance, and close collaboration with patient organisations can these advances translate into real-world improvements for all patients – reducing disparities and improving outcomes.

Several concrete examples from the ESGO ecosystem:

- **ESGO has developed an hospital-based accreditation framework,** which integrates clinical standards, scientific evidence, prevention strategies, and specialist training. In 2025, ESGO has accredited 77 hospitals in training, 69 in ovarian cancer surgery, 32 in endometrial cancer surgery and 4 in cervical cancer management, aiming for 1 centre per 10 millions of inhabitants. **Figure 3** shows the geographical distribution of these centres, that apply evidence-based guidelines, conduct regular tumour board reviews, and undergo structured audits, showing how coordinated standards at tertiary level of healthcare system led to more consistent care and better patient outcomes.

- **ESGO has established Quality Indicators (QIs) for ovarian, endometrial, and cervical cancers** through multidisciplinary panels and has published these QIs as disease-specific, measurable process and outcome standards (i.e. time-to-treatment targets, optimal surgical staging, complete cytoreduction rates, and audit requirements). ESGO uses QIs for accreditation schemes, external peer-review audits, and centre-level benchmarking dashboards, that translate QIs into continuous improvement plans (35).

- **ESGO has developed a structured training programme,** namely the Fellow Certification (EBCOG recognised subspecialty in gynaecologic oncology) that has certified 112 fellows since 2020, with 115 currently in training (36), providing a concrete example of how international initiatives can help fill these gaps in skills and education.

- In collaboration with numerous European professional medical and scientific associations, **ESGO has developed a wide range of practical guidelines** for the management of gynaecological cancers. These guidelines undergo rigorous methodological evaluation, extensive external peer review, and continuous updating. Published in the most prestigious oncology journals, they serve as a key benchmark for clinicians across multiple specialties, including medical oncology, radiation oncology, and gynaecology.

- Building on tailored prevention strategies – such as the success of HPV vaccination and cervical screening, which have demonstrated how coordinated European action can deliver measurable improvements in outcomes – similar approaches could bring comparable benefits for other gynaecological cancers. **ESGO's 2025 consensus statements** provide a concrete example: they recommend age-specific risk-reducing surgery for BRCA and other pathogenic gene carriers (including Lynch syndrome), discourages ineffective screening methods, and support informed use of oral contraceptives and hormone therapy. These measures illustrate how risk-adapted approaches can be translated into practice.

- Aligning with Parliament's call for more and better-quality sex- and gender-disaggregated health data to identify subgroup disparities, **ESGO's Ovarian Cancer Database** collects data from over 12,000 patient records across 86 centres in 26 countries. This initiative demonstrates the value of pooling real-world data to improve understanding, inform policy, and support EU-level monitoring of outcomes in gynaecological oncology (37).

- In parallel with real-world data, translational collaboration helps discoveries reach patients faster. **ESGO TransLink** connects laboratories and clinics, enables data and resource sharing, and supports large-scale studies; by bridging basic research and clinical practice, it helps accelerate advances in risk prediction, early detection, and personalised therapy - a model that Europe can support and scale.

- **ESGO networks** create a full pipeline from evidence to practice and back. **ENGOT** coordinates pan-European phase II–III trials and translational sub-studies that change clinical practice; **ENYGO** builds the workforce of young (less than 40 y.o.) clinicians, via structured fellowships, mentoring, exchanges, and regular case-based learning across Member States; and **ENGAGe** integrates the patient voice by co-developing guidelines and endpoints, embedding patient-reported outcomes, and producing plain-language resources. Together, they accelerate uptake of innovation while strengthening quality, equity, and trust.

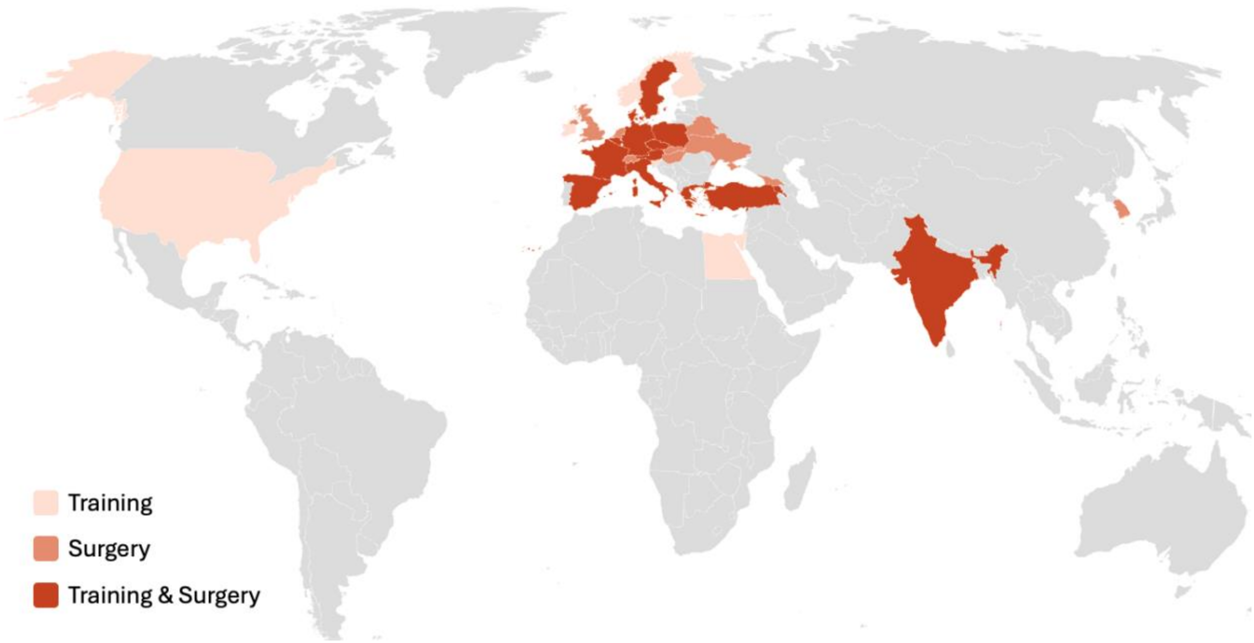


Figure 3: Geographic distribution of ESGO-accredited centres (2025). The map displays countries hosting ESGO-accredited centres for gynaecological oncology. Countries shaded in light pink host centres accredited for training only; orange indicates countries with centres accredited for ovarian and endometrial cancer surgery only; and dark red marks countries with centres accredited for both training and surgery. Data were obtained from the official ESGO list of accredited centres (accessed November 2025).

Together, these experiences and successes point to a positive way forward: Europe can build on existing successes to develop prevention strategies and care models that are evidence-based, data-driven, and holistic, ensuring better outcomes and quality of life for women at every stage of their cancer pathway. Yet, **the widespread absence of formal subspecialty recognition for gynaecological oncology across Europe highlights a persistent unmet need**, that demands a structural change to close this gap.

Progress in gynaecological oncology depends on embedding quality indicators in routine care, expanding structured training, and using real-world data to steer policy and practice. ESGO shows how this works in practice: link standards to accreditation, audit performance, and benchmark centres for continuous improvement; but lasting impact requires making these models part of national infrastructure. **Institutionalising coordinated, multidisciplinary, evidence-based practice is essential to deliver durable equity in women's health across Europe**.

4. Structural change through infrastructure: Centres of Excellence for Women's Health

4.1 EU policy levers and initiatives

Europe already offers successful models of collaborative, cross-border infrastructure that can serve as a foundation for structural change in women's health. The Coordination and Resource Centre on Comprehensive Cancer Centres and Networks of Excellence (**CRANE) project**, launched in 2023 and funded under the EU4Health Programme, is supporting Member States in **establishing or strengthening Comprehensive Cancer Centres (CCCs)**, combining clinical excellence with research, innovation, and education. These centres, and the networks they create, could become a natural partner in the development of women's health centres, particularly in advancing gynaecological oncology, data collection and adding comprehensive care of gynaecologic oncology patients, including taking care of reproductive health and obstetrics outcomes. Similarly, the **1+ Million Genomes Initiative** shows how federated, cross-border data platforms can support personalised medicine and research, providing a precedent for how women's health centres could generate and use real-world evidence to inform care and policy.

Further lessons can come from ongoing European initiatives on structured networking, informing how to achieve innovation, sustainability, and stronger integration between research and healthcare. The **European Reference Networks (ERNs)**, now comprising over 1,600 specialised centres in 382 hospitals across 27 Member States and Norway, demonstrate the power of cross-border expertise in managing rare and complex diseases. They provide a template for how collaboration and knowledge-sharing can directly benefit patients. At the same time, the **Joint Action on Networks of Expertise on Cancer (JANE) 2** is preparing the launch of seven new EU Networks in domains such as personalised prevention, survivorship, palliative care, high-tech medical resources, and cancers with poor prognosis.

4.2 Good practice from Member States

To date, CCCs networks cover six Member States (38). **Finland**'s CCCs, such as *Helsinki University Hospital Cancer Centre*, are embedded in regional health systems and lead on HPV-based screening and standardised gynaecological cancer care pathways. In **France**, the *Unicancer network* of 18 regional CCCs includes institutions like *Gustave Roussy* and *Institut Curie*, which are European leaders in gynaecological cancer research and treatment. **Germany**'s system includes over 15 CCCs such as the *Charité Comprehensive Cancer Center*, complemented by more than 200 gynaecological cancer centres which provide specialised services such as high-volume gynaecological oncology surgery and multidisciplinary teams focused on ovarian, cervical, and endometrial cancers. **Italy** hosts CCCs such as the *Istituto Nazionale dei Tumori* and *Istituto Europeo di Oncologia Milan*, offering robotic and minimally invasive gynaecologic surgery and participating in international clinical trials. The **Netherlands** centralises complex gynaecological procedures in centres like the *Netherlands Cancer Institute*, and **Portugal**'s *Instituto Português de Oncologia* ensures national coverage of gynaecological oncology care through its Lisbon, Porto, and Coimbra branches.

In parallel, several leading oncology institutes – commonly referred to as **Centres of Excellence (CoEs)** in cancer – have strong expertise in gynaecological oncology. These include, to name just a few, institutions like **Spain**'s *VHIO*, specialized in precision oncology and translational research including gynaecological trials; **Sweden**'s *Karolinska Institute*, a key EU-level research partner in molecular gynaecology and women's health; **Belgium**'s *Institut Jules Bordet* and **UZ Leuven**, leading hospitals with ESGO-accredited services in gynaecological oncology; **Czechia**'s *Masaryk Memorial Cancer Institute*, also ESGO-accredited, acting as a de facto CoE with national leadership in gynaecological care and EU-funded research.

While CCCs offer integrated, multidisciplinary services, CoEs typically focus on specialist expertise and innovation. CoEs complement CCCs by offering deep specialisation, clinical innovation, and educational leadership. However, both types of centres are predominantly concentrated in urban areas, and the fact that most Member States are not yet part of structured CCC networks **continues to limit equitable access, particularly for underserved populations**. This persistent disparity in coverage undermines the goals of the Europe's Beating Cancer Plan, which aims for 90% of eligible cancer patients to have access to CCCs by 2030 (39). A coordinated call to action is urgently needed to address this inequity, ensuring that all women can benefit from timely, high-quality screening, diagnosis, and treatment.

5. Policy Recommendations

Building on the evidence and examples presented in this paper – including existing models of multidisciplinary care, quality assurance, training, accreditation and patient involvement – we propose the following policy recommendations to support a more equitable and sustainable approach to women's health and gynaecological cancer care across Europe. These recommendations are designed to be implementable through existing EU and national policy levers, and to bring together institutions, Member States, healthcare providers, patient organisations and innovators around a shared objective: translating proven standards and innovation into consistent real-world access and outcomes for women, irrespective of geography or socio-economic background.

5.1 Recommendation 1

Establish an integrated EU-wide ecosystem of Centres of Excellence for Women's Health

EU institutions. Support the development of a shared, EU-wide framework for Women's Health Centres by building on existing EU initiatives and infrastructures (e.g., Comprehensive Cancer Centres, Networks of Excellence, relevant Joint Actions), and promote common standards for prevention, diagnosis, treatment and survivorship. Finance through future EU programmes, on research and innovation and health, specific projects to define scope, governance, structure and collaboration of the Centres of Excellence.

Member States. Support the development of national networks of Women's Health Centres with clear catchment areas, referral pathways and responsibilities across the care continuum, and embed multidisciplinary and quality standards in national cancer plans, clinical pathways and accreditation/quality-improvement processes.

Healthcare sector and professional community. Organise care around multidisciplinary specialised centres that cover prevention, diagnostics, surgery, systemic therapy, psycho-oncology, fertility/sexual health and survivorship in a coordinated way. Use recognised clinical standards, quality indicators and accreditation frameworks to support continuous quality improvement and reduce unwarranted variation.

Patient advocates and patient organisations. Co-design the scope and governance of Women's Health Centres, ensuring patient representatives are involved in advisory boards and evaluation. Develop and disseminate accessible information so women know where these centres are and what services they provide.

Industry and innovators. Collaborate with Women's Health Centres to co-develop diagnostics, therapies and digital tools that respond to clearly identified clinical needs and quality standards, avoiding parallel or fragmented service pathways. Partnerships should respect centre governance and clinical independence, with safeguards on promotion and influence agreed at EU and national level.

5.2 Recommendation 2

Secure sustainable financing and governance for women's health services

EU institutions. Use and further optimise existing EU funding instruments (e.g. EU4Health, Cancer Mission, cohesion/structural funds) to Women's Health Centres and related services, and research activities, ensuring that women's health and gynaecological cancers are consistently reflected in funding priorities, including in less-resourced regions.

Member States. Establish stable reimbursement and budgeting mechanisms that cover multidisciplinary teams, diagnostics, survivorship, psycho-social support and participation in registries and trials. Ensure that women's health is integrated into mainstream health and cancer budgets, with explicit lines for gynaecological oncology and survivorship care.

Healthcare sector and professional community. Work with payers to design funding models that reward integrated, guideline-based care (e.g. bundled payments or centre-based contracts) rather than fragmented fee-for-service. Document cost-effectiveness and system benefits to support sustained investment in centres and multidisciplinary teams.

Patient advocates and patient organisations. Advocate for dedicated, long-term funding for women's health services, highlighting the costs of late diagnosis, avoidable complications and unmet survivorship needs. Contribute to budget and policy debates by bringing evidence and lived experience to hearings and consultations.

Industry and innovators. Align pricing, market-access and managed-entry agreements with the objective of sustaining comprehensive women's health services, including in less-resourced regions. Any financial contributions to infrastructure or training should be transparent, arm's-length and complementary to – rather than a substitute for – stable public funding.

5.3 Recommendation 3

Embed equity and gender sensitivity as core principles of cancer and women's health policy

EU institutions. Strengthen and operationalise equity and gender sensitivity across EU cancer and gender-equality initiatives, guidance and funding programmes by promoting clear objectives, measurable indicators and consistent implementation related to women's health, and by systematically monitoring their impact on vulnerable and underserved groups.

Member States. Make equity and gender sensitivity explicit pillars of national cancer plans and women's health strategies, with measurable targets to reduce geographic, socioeconomic and other disparities in access, quality and outcomes. Use disaggregated data to identify gaps and prioritise resources for under-served regions and groups, including tailored outreach and support.

Healthcare sector and professional community. Incorporate gender and equity perspectives into clinical guidelines, care pathways and quality standards, ensuring that symptom recognition, diagnostic work-up, treatment and survivorship reflect women's specific needs and contexts. Provide training on gender bias, communication and cultural competence for all professionals involved in women's cancer care.

Patient advocates and patient organisations. Advocate for policies and services that recognise intersecting inequalities affecting women with, or at risk of, gynaecological cancers. Co-design information and support that are accessible and acceptable to diverse groups and monitor whether reforms reduce inequities in practice.

Industry and innovators. Design trials, post-authorisation studies and launch strategies that include women in all their diversity and do not systematically disadvantage smaller markets or public systems. Eligibility criteria, site selection and pricing policies should be reviewed for their equity impact and adjusted where they risk widening existing gaps in access or outcomes.

5.4 Recommendation 4

Strengthen workforce capacity and formal recognition of gynaecological oncology

EU institutions. Support the recognition of gynaecological oncology as a subspecialty through common EU-level training standards and mutual recognition of qualifications. Facilitate cross-border training and exchanges via scholarships, fellowships and mobility schemes.

Member States. Include gynaecological oncology in national workforce strategies, with protected time and resources for specialised training and continuous professional development. Create clear career pathways and staffing norms for multidisciplinary teams, including nursing, psycho-oncology and allied professionals.

Healthcare sector and professional community. Expand structured training and mentorship programmes in gynaecological oncology, including through cross-centre exchanges and recognised curricula. Ensure that specialised centres have sufficient trained staff to deliver guideline-based surgery, systemic therapy and survivorship care.

Patient experts, advocates and patient organisations. Call for access to specialists with recognised training in gynaecological oncology and for adequate staffing levels in centres. Participate in training activities (e.g. patient speakers, co-developed materials) to ensure education reflects real needs and experiences.

Industry and innovators. Provide independent educational grants to support multidisciplinary skills development in gynaecological oncology, especially in under-served settings, channelled through transparent mechanisms and aligned with recognised curricula – without influencing product choices or guidelines.

5.5 Recommendation 5

Build robust data, research and learning systems centred on women's needs

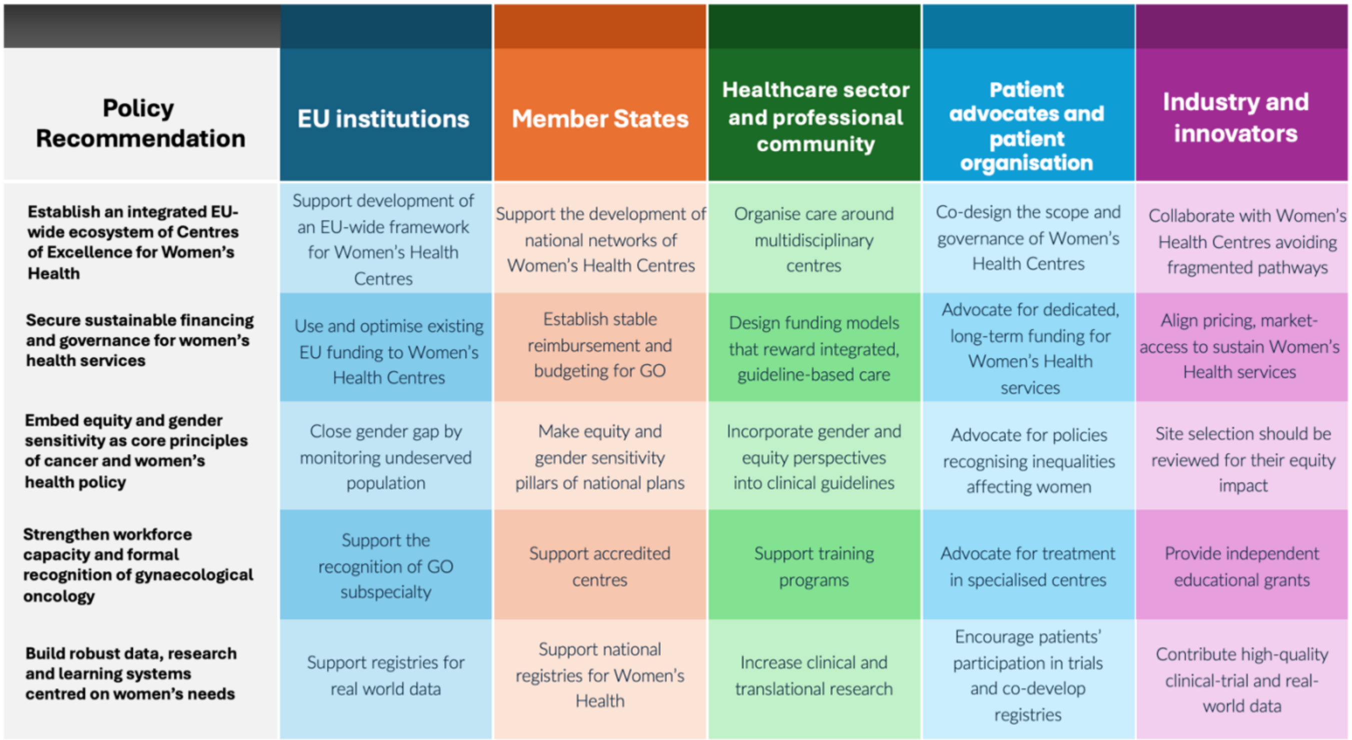
EU institutions. Support and align EU-level infrastructures and programmes in the health fields (e.g., registries, biobanks, genomic and real-world data platforms), to ensure they consistently capture and use gender-disaggregated data and include women's health priorities, gynaecological cancers and survivorship outcomes.

Member States. Strengthen national cancer registries and data systems to capture women's health indicators across the care pathway, including quality metrics and patient-reported outcomes. Use these data routinely to monitor disparities, guide resource allocation and update guidelines.

Healthcare sector and professional community. Develop interoperable registries and quality-monitoring systems at centre and network level, aligned with recognised indicators and EU data initiatives. Increase participation in clinical and translational research, especially for underserved tumour types and populations, and feed results back into practice.

Patient experts and patient organisations. Co-develop data collection tools and consent processes that respect privacy while enabling meaningful use of data for quality improvement and research. Encourage patient participation in registries and ensure equitable access to clinical trials for all patients across the EU, irrespective of geography, while ensuring that findings are communicated back in accessible formats.

Industry and innovators. Contribute high-quality clinical-trial and real-world data to interoperable, public-interest infrastructures governed by independent bodies, rather than creating proprietary silos. Study designs and evidence-generation plans should be co-developed with academic centres and patient organisations, with full, transparent reporting of results.



Policy Recommendation	EU institutions	Member States	Healthcare sector and professional community	Patient advocates and patient organisation	Industry and innovators
Establish an integrated EU-wide ecosystem of Centres of Excellence for Women's Health	Support development of an EU-wide framework for Women's Health Centres	Support the development of national networks of Women's Health Centres	Organise care around multidisciplinary centres	Co-design the scope and governance of Women's Health Centres	Collaborate with Women's Health Centres avoiding fragmented pathways
Secure sustainable financing and governance for women's health services	Use and optimise existing EU funding to Women's Health Centres	Establish stable reimbursement and budgeting for GO	Design funding models that reward integrated, guideline-based care	Advocate for dedicated, long-term funding for Women's Health services	Align pricing, market-access to sustain Women's Health services
Embed equity and gender sensitivity as core principles of cancer and women's health policy	Close gender gap by monitoring undeserved population	Make equity and gender sensitivity pillars of national plans	Incorporate gender and equity perspectives into clinical guidelines	Advocate for policies recognising inequalities affecting women	Site selection should be reviewed for their equity impact
Strengthen workforce capacity and formal recognition of gynaecological oncology	Support the recognition of GO subspecialty	Support accredited centres	Support training programs	Advocate for treatment in specialised centres	Provide independent educational grants
Build robust data, research and learning systems centred on women's needs	Support registries for real world data	Support national registries for Women's Health	Increase clinical and translational research	Encourage patients' participation in trials and co-develop registries	Contribute high-quality clinical-trial and real-world data

6. Conclusion

Advancing women's health across Europe requires a systemic reform. The disparities described in this paper are not isolated or circumstantial; they are the result of structural shortcomings in how care is organised, funded, and prioritised. Reversing them calls for an ambitious yet pragmatic approach: the establishment of an **EU-wide ecosystem of Centres of Excellence for Women's Health**, underpinned by sustainable financing, a recognised and adequately staffed specialist workforce, robust data and research systems, and policies that explicitly embed equity and gender sensitivity.

Such a framework would bring together certified, high-performing institutions with a clear mandate to deliver multidisciplinary, evidence-based, and equitable care. It would align standards and care pathways, enable interoperable data use, and support shared training and research agendas. According to ESGO's established quality indicators, clinical guidelines, and accreditation standards, developing a network of ESGO-accredited centres – with the objective of covering populations of approximately 1–2 million inhabitants per centre – each would help secure sufficient case volume and expertise while ensuring that women with gynaecological cancers receive rapid diagnosis, equitable, accessible high-quality care as close to home as possible. **The aim is not to "own" expertise but to mobilise it across borders** so that innovation moves faster into practice, funding is channelled more strategically, and fragmentation is reduced, thereby ensuring that women's health becomes a central and sustainable priority for Europe's healthcare systems.

ESGO's experience brings clear leadership, offering a clear path forward. Together with the active involvement of patient experts and advocates, its accreditation and training programs show how cross-border standards, multidisciplinary care, and investment in clinical excellence can be scaled across Europe. ESGO's success in harmonising quality indicators and supporting specialist education, and its commitment in improving prevention, makes it a key partner in building this future**. It stands ready to guide the design and expansion of a European infrastructure that delivers high-quality, equitable care**.

Now is the time for the EU, Member States, healthcare providers and patient organisations, to connect and coordinate existing efforts into a unified, quality-assured infrastructure. By implementing the reforms outlined in this paper, Europe can ensure that **every woman, regardless of geography or background, benefits from timely prevention, diagnosis, treatment, and survivorship support**.

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