

“Assessment of the participation of women volunteers in the palliative care system in Kazakhstan”

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ASSESSMENT OF THE PARTICIPATION OF WOMEN VOLUNTEERS IN THE PALLIATIVE CARE SYSTEM IN KAZAKHSTAN

Abstract

Women's participation and the nature of assistance in the provision of social policies, especially in healthcare related to socially significant diseases, is becoming more prominent. The aim of this study is to develop proposals for streamlining the palliative care system in Kazakhstan based on the analysis of the influence of women volunteers on the process of public administration. The paper interviewed two groups of respondents: volunteers and workers (medical institutions and charity organizations employees). Atlas.ti software was used to analyze and construct specific feedback on the data received. The coding results revealed that women volunteers act as an intermediary between the state administration and the palliative care system. In addition, it was determined that the prominent participants in developing the palliative care system are hospitals and charitable foundations. In general, the contribution of women volunteers to financial assistance, organization of training and master classes for doctors in the field of oncology, and provision of additional beds for patients and consultations was revealed. Further, the state's main shortcomings in organizing palliative care were identified: poor regional budgeting system, weak legislative system, and inadequate financing of hospitals. The findings imply that women volunteers should be given a higher status and included in the public administration structure, especially for different representations of the needs of minorities.

Keywords

management, public management, palliative, healthcare system, volunteer, social policy

JEL Classification

J16, J18, I18

INTRODUCTION

Government stands out as the leading actor in implementing and managing social policies. Nevertheless, in managing and implementing any social policies and healthcare, other agents participate as individual entrepreneurs, private businesses, non-governmental organizations (NGOs), and private individuals like volunteers. Women are primarily involved in promoting social issues such as pensions, medicine, and education, which could be observed through the early developments of women's clubs, where women were raising questions about education and community social support. One of the healthcare areas where women are actively engaged is palliative care. Palliative care has been regarded as a social issue, where the provision of social support by volunteers, in particular their support of patients who have been diagnosed with cancer or needed palliative care assistance, as well as bereavement. Social activities women pioneered in the mid-90s have become part of public administration functions.

Palliative care system development is especially urgent in developing countries that lack the basis for institutionalization. This is be-

cause the palliative care system is not regarded as a socially significant issue by governments; this is the reason women are actively involved in its development.

Most volunteers and essential actors in the delivery of palliative care are women. In Kazakhstan, the palliative care system is still undergoing changes, managed with assistance from medical institutions and volunteers. It must be mentioned that there are different levels of involvement in volunteering and the nature of volunteering. Thus, palliative care in Kazakhstan requires the development of effective management mechanisms with the involvement of interested ministries and departments and the participation of international organizations and NGOs. In developing these relationships, women volunteers play an essential role that has not yet been sufficiently explored. However, the palliative care system in developed countries is different than in developing countries, where palliative care is at an early stage of development. In developing countries, improvement of the legislative framework, healthcare system, and budgeting at the regional and national levels is required. In addition, there is a need to improve and streamline the process of organizing Kazakhstan's state policy in palliative care.

1. LITERATURE REVIEW

Today palliative care interventions in resource-limited settings are rare or poorly developed. Nevertheless, most women try to participate in this process of their own free will to preserve and improve their quality of life. Women's volunteering is a social activity aimed at helping people and alleviating suffering. Women's volunteers are more active in healthcare and intend to cooperate with public institutions and assist policymakers in improving and implementing social policies. However, their contribution has not been evaluated as an essential part of healthcare programs, as they are measured as extras (Roessler et al., 1999). Shortage of financial support is usually relevant in implementing social programs. Budget reduction of welfare benefits leads to the state's social service performance propensity. Therefore, the activity of volunteers in providing social help has an economically significant contribution to the implementation of social policies (Stadelmann-Steffen, 2011; Woitha et al., 2015).

Women are more active in volunteering; they are involved in the healthcare system and provide unpaid services. It was noted that in developing countries, women are more active in volunteering than men (Glenton et al., 2010; Wymer, 2011; Gil-Lacruz et al., 2019; Wiepking et al., 2022). However, there is no access to palliative care and treatment, which motivates local women to take measures in the management process – the development of palliative care services (Loth et al., 2020; Kaba, 2021). Therefore, volunteering related to the health

sector, especially palliative care provision, is dominated by women volunteers, which is provided as a personal will, requires more personal time, and is a non-paid job (Einolf, 2011; Zana et al., 2020; Vanderstichelen et al., 2022).

Thus, volunteering is expected to contribute to social policy issues, especially in welfare states (Dahlberg, 2005). For instance, management of such standard costs as traveling, medicine, and accommodation when not regarded by local governments are covered by volunteers (Hopkins et al., 2013). In addition, previous studies on volunteering in palliative care and assistance to medical institutions investigated the influence of volunteers supporting patients (Weeks et al., 2008; Claxton-Oldfield et al., 2010; Claxton-Oldfield & Beaudette, 2021). For example, Candy et al. (2015) studied if families of cancer patients, those who needed palliative care, or patients themselves were satisfied with the help of volunteers.

While developing personal and professional skills through non-governmental organization (NGO) activities, volunteers can have more influence in terms of management of a social policy provision, better under the officially regarded social institution of palliative care (Haski-Leventhal et al., 2010; Haski-Leventhal et al., 2018). For instance, support of a political decision of an NGO member is better regarded than that of a single person. Volunteering could be provided regularly, which means being a member of an NGO. However, volunteering on a discontinuous basis is more often conducted due to such factors as lack of time, personal issues (e.g.,

financial or health), and negative attitude of support receivers. At the same time, negative is not only society's reaction but also consumption because recipients are not always satisfied with the help provided (Acus, 2018). In the case of institutionalized rules, public perception is more positive. This is because, within an institutionalized structure, these rules become a part of a social institution (Khadzhyradieva et al., 2019).

Unlike social workers, volunteers act as a link between social service receivers and the professional staff and become active when the government is more deliberate in solving the social crisis. Volunteering has a tremendous economic impact on implementing social policies, so-called "social volunteering," among which the most important is medicine (Stadelmann-Steffen, 2011). Although volunteering is not paid, it is important to accept their involvement as positive cooperation, especially in palliative care development, and put them in line with public bureaucrats of the 5th grade (Park, 2013). Moreover, women's NGOs, like voluntary and charity organizations, have led public administration development (Scheer, 2002). Women volunteers act as mediators providing people with general information on social benefits offered by the government, such as free treatment. They also provide another type of help depending on their skills (Cohen & Numa, 2011; Jack et al., 2012; Park, 2013; Foster et al., 2018). There is a list of essential functions like providing psychological support, teaching, and social assistance (Coleman et al., 2022).

For public policy, volunteer involvement has a beneficial role as well. This is reflected in saving additional funds, which is performed in inpatient service, mental help, and support of patients or their families (Burbeck et al., 2014; Scheer, 2002; Bloomer & Walshe, 2020). For instance, in the Netherlands, the national policy regards primary care settings as the place for receiving palliative care. In this regard, the leading roles of health service providers are attained to general practitioners and district nurses. However, psychologists and social workers are less involved in palliative care. Thus, the cooperation of general practitioners and district nurses with volunteers shows their importance (Koper et al., 2018).

The presence of good institutions based on public management ensures investment in human capi-

tal, which is a crucial welfare state. Consequently, it breeds trust-based relationships between government and society (Acemoglu et al., 2001). In the case of palliative care, volunteers act as pushers having a propensity for legitimacy. Thus, it influences the perception of hospices as legitimate institutions. This draws the tendency to apply the palliative care system in hospitals of regional importance. Hence, this leads to the widely occurring nature of palliative care practice consequences. In the interaction between official servants and volunteers as well as members of charity foundations, coercive and mimetic pressure could be observed (Rasche et al., 2020). The first condition leads to the development of an official policy or practice. This is usually preceded by a listing of existing issues, which is the consolidation of a roadmap. Second, organizations, particularly hospitals, are put into the condition of adopting well-established standards and practices. The interaction between the government, hospitals, and volunteers develops its structure through permanent practice. It is the development of the ways to exchange information and enhance its quality.

The government tries to pursue new social policies to support society. One of the key moments of social policy implementation is improving staff qualification. In particular, health policies talk about salary increases for further motivation of medical staff and improving their experience and knowledge by providing training and entitling educational grants (Inbadas et al., 2018). This could be a lop-sided social policy structure when service receivers fall behind the target of a social policy. As a result, the government does not always get sufficient policy implementation. Women make up most employees and entrepreneurs in health-care, education, and other areas of social welfare (Satpayeva et al., 2020; Kireyeva et al., 2022).

The systematic cooperation of hospices, charity organizations, and women volunteers with hospitals and the local government is observed through involvement in the implementation of palliative care or assistance to patients diagnosed with cancer. Khadzhyradieva et al. (2019) discussed the effects of "behavioral insights," where great attention is given to the nudging technologies used by public policy. The noble combination of ideal society behaviors of nudging governments has created the

conditions for creating public policy functioning areas. Thus, the palliative care system could be operated and promoted as a positive movement throughout the country by institutionalizing this system. The creation of specific rules led by the institutionalized structure prompts the actions to be taken and the expected behavior of the public in solving related issues. Therefore, local governments can better influence society through palliative care institutionalization. This is especially urgent in remote areas, rural settlements, and areas vulnerable to economic downturns and natural disasters.

The system of palliative care in Kazakhstan requires significant changes in several aspects. First, Kazakhstan still lacks information, which prevents it from realizing the actual situation in terms of the urgent need for palliative care in the country. Second, the healthcare infrastructure is not ready to provide palliative care as there is a lack of beds and qualified staff. Third, the legal system still needs to be adequately developed to consider the current situation regarding palliative care provision. Nevertheless, the government showed that it is ready to develop a system of palliative care provision. Management of palliative care system development in Kazakhstan has been undergoing fast and significant changes with the cooperation of women volunteers and hospitals.

Most women volunteers in healthcare, especially in the palliative care system, demonstrate a high level of awareness and professional competence in the process and procedures of palliative care provision, as well as the social policy establishment. Women's volunteer activism is manifested in the cooperative form with government and state healthcare structures. Thus, it saves time and avoids extra costs. Participation of women volunteers in the management of palliative care system development plays a significant role and greatly impacts the process of palliative care institutionalization. Moreover, their participation in the management process of socially significant diseases shifted the provision of the state policy to another level.

The literature review has shown few studies in Kazakhstan regarding palliative care provision. There is still a gap in the studies in the way assistance was provided by volunteers and in the

process of volunteers' assistance to medical staff. Revealing current gaps in the process of assistance between volunteers and medical staff will allow for investigating the contribution of volunteers in the provision of palliative care management in Kazakhstan.

Thus, this study aims to investigate the impact of the participation of women volunteers in the development of the palliative care system on the process of public administration.

2. METHODOLOGY

The primary research method was the interview conducted on open-ended questions based on semi-formalized scenarios with the participation of two groups of respondents: volunteers and workers (medical institutions and charity organizations employees), lasting about 90 minutes. A total of 10 people participated in the interview.

The interview provided a preliminary analysis of the nature of the charity foundation's involvement in palliative care delivery. The selection procedure included two factors:

- 1) nature of the delivered help – based on the provided literature review, the foundations which assisted daily both for medical staff and patients with their families were chosen for the provision of the semi-structured interview;
- 2) location – Almaty city is the pioneer of hospices development and the center for palliative care delivery in Kazakhstan.

Half of the respondents were leaders of the volunteer movement in Kazakhstan. Some were medical staff members, two of them were in managing positions, and one was in a secondary position. Finally, two respondents were volunteers who assist charity foundations in organizational processes such as provision of master classes, organization of training sessions for doctors, and primary consultation of patients who intend to travel abroad or need assistance in raising funds for medical treatment. The number of volunteers interviewed is conditioned to the saturation point (Saunders et al., 2018).

Table 1. Description of research question groups

Source: Compiled by the authors.

No.	Question group	Description of question groups
1	1-2	Interviewees described the procedures they must go through when visiting patients (support receivers) or families. This group also collected information on the visiting rules, which also drew limitations to the interviewees, especially when providing support to patients or families.
2	3-4	The information about the issues faced by both interviewees and support receivers was covered. This question group sought information about the nature of assistance provided to patients and families.
3	5-7	The recommendations as well as current issues of the healthcare system were discussed. This part gives a better picture of the interviewees' qualifications and experience in their fields.
4	8	The challenges in cooperation were discussed. These challenges are mostly discussed between volunteers, charity foundation members, volunteers-staff, and medical staff.
5	9	The recommendations were collected. This will help if interviewees want to add more of their points of view to their questions.
6	10	The interviewees' visions of current or future development of health policy in Kazakhstan were collected.

The questions were divided into ten groups, where some groups included from 2 to 5 questions for better delivery of the issue. These groups were based on the “what is the problem represented to be” method. The interview questions description is given in Table 1.

This analysis primarily relies on the experience of volunteers or participants of this movement in the palliative care management. Furthermore, for the processing of primary data in this study, Atlas.ti was used, which offers functions for the centralization of all necessary information and has mechanisms that allow for qualitative data analysis. This software is focused on qualitative data analysis, which allows for studying large amounts of information, focusing on its content. Thus, the study identified connections, hierarchies, and existing networks between different topics and subtopics, established results, and systematized conclusions.

Data processing was carried out by step-by-step actions. First, data processing included coding operations. Throughout the interview analysis, 42 codes were developed. Second, the codes were grouped into three network groups. This allowed studying and analyzing the palliative care system development and the role of women volunteers in this process. Third, three networks were developed: palliative care system participants, contribution, and palliative care system.

The first network group presented the main participants of the palliative care system development and the nature of their communication. The network included 15 codes, of which three were the

principal codes. Thus, the palliative care system consists of two main participants: hospitals and women volunteers. Each participant code included the main functions. For example, women volunteers' code included two main functions, and hospitals had one main function.

The second network group analyzed the moderating role of charity foundations. It included 11 codes, of which three were the primary codes: contribution, which included main participants: hospitals and charity foundations. While for hospitals, two main contributions were revealed in the system of palliative care development; charity foundations provided six codes.

The third network group revealed the main issues of palliative care system development at the state and regional levels. In total, the network included 15 codes, of which three were considered the primary: palliative care system development, which included recommendations and public policy issues.

3. RESULTS

The interview was provided to identify hidden factors and reveal region-specific experiences. The developed codes were divided into three major groups: palliative care system participants, palliative care system, and contribution. Figure 1 shows the structure of palliative care system participants.

Figure 1 revealed that women volunteers perform-moderating roles between public adminis-

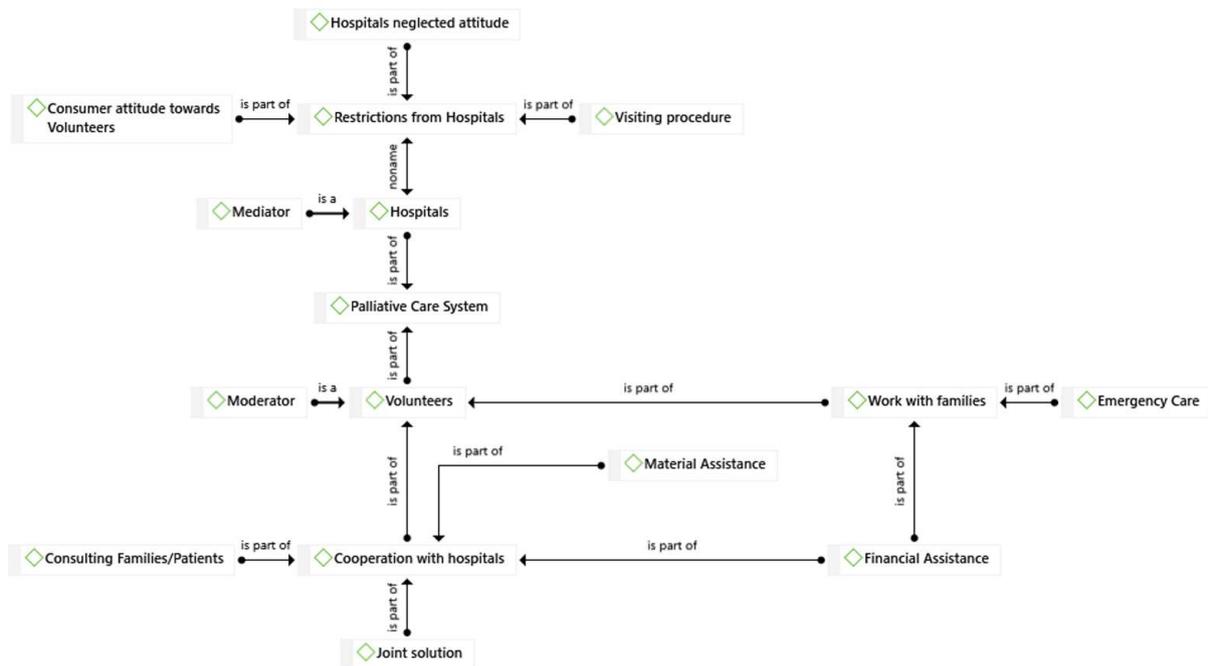


Figure 1. Participants of palliative care system

tration and the palliative care system. The moderating effect of women volunteers is provided in the delivery of several necessary actions in terms of palliative care provision. First, they establish cooperation with hospitals, which includes financial assistance, joint solutions, material assistance, and consulting patients. Financial assistance is usually provided to cover such expenses as conveniences for families who come from the regions and usually stay in hospitals. Another group of expenses is purchasing new machines and equipment for medical examinations or treatments. Usually, such items are unaffordable for hospitals; therefore, volunteers assist in finding investors or collecting funds. Second, most interviewees stated that women volunteers often take joint actions with hospitals in consulting patients when families are against health treatment due to home issues. Such cases are very characteristic of families from other regions. The medical staff and volunteers have noticed that people from the regions depend on cultural habits. For instance, parents would prefer to take their child to a local healer based on religious restrictions such as a prohibition of surgeries. Third, material assistance differs from financial, as it can require parts of emergency care items such as diapers, clothes, or food.

On the part of hospitals, the interviews showed that they usually take the function of a mediator

between volunteers and the government in questions associated with palliative care policy delivery. However, there are restrictions for volunteers during natural visits. There is a strict rule that any visitor has to follow, but as volunteers deal with patients and families regularly, they need to provide a medical record book and pass some medical examinations. This is done to ensure the safety of patients, but the relationship with hospitals sometimes has some adverse outcomes. For example, hospitals sometimes prefer large companies to provide events for children. The issue in such situations, people not involved in palliative care organizations are unaware of patients' diets and health conditions. Organizations usually bring soda drinks or sweets, which are not allowed for patients, especially those who have just had surgeries.

Figure 2 illustrates the encoding results that describe the contribution of charitable foundations, which are managed by women volunteers and hospitals.

As a result of the interviews, the following contributions provided by charity foundations were revealed. Charity foundations contributed to five directions: private hospice institutions funding, medical training of the medical staff in palliative care delivery, management and development of healthcare projects, consultation of patients, and financial aid provision. In addition, they provide financial assis-

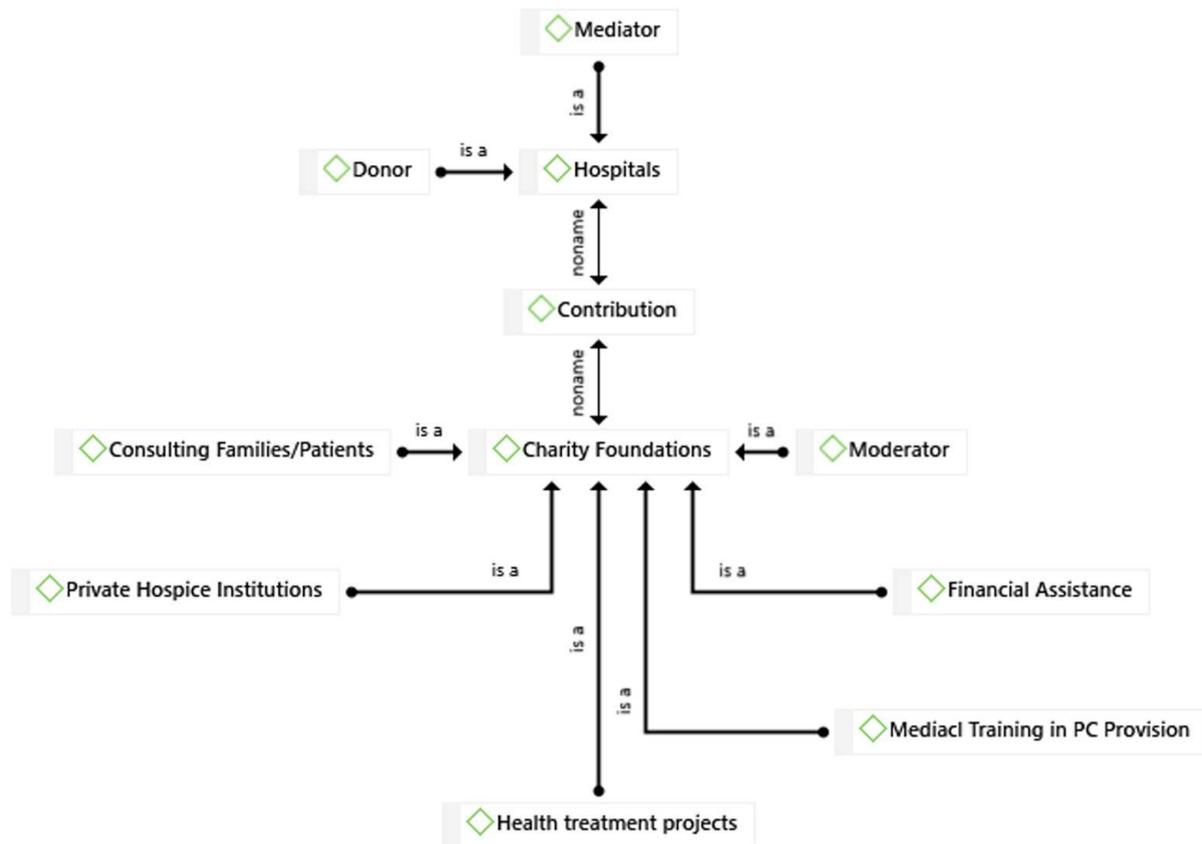


Figure 2. Contribution of charity foundations and hospitals to the palliative care system

tance to patients in raising funds. There are charity foundations in palliative care, which are supported by donations of volunteers, with different programs to support one patient or a program to provide necessary things to people in need.

Volunteers have introduced the palliative care roadmap by establishing private hospices, providing training for first psychologists in oncological issues, and organizing health treatment projects. Moreover, they are constantly working on improving the palliative care delivery system. Charity foundations have launched training programs for medical staff by providing master-class surgeries in Kazakhstan. For instance, master classes are provided by international doctors in oncology. At the same time, the price for surgeries provided during the master class is reduced, and there are free-of-charge surgeries. Local doctors assist during surgeries, allowing them to practice immediately and improve their skills. The government is not expected to cover such expenses as accommodation or travel costs for patients and their families, as surgeries are provided in the country. Thus, they save the budget.

Hospitals participated as donors and mediators in the process of palliative care development. First, they provide financial aid for medical staff training and act as mediators between government and charity foundations by supporting them. Hospitals, apart from their professional duties, provide massive assistance to the health-care system. Most of the doctors and nurses in Kazakhstan are on the list for blood donation, as there is a significant lack of blood donors in Kazakhstan. Second, in terms of palliative care roadmap provision, hospitals stand out as mediators in the dialogue between volunteers and the government. Such cooperation is provided in cases of emergency, new laws (such as drugs distribution system) promotion as well. Finally, problems and recommendations are presented in Figure 3.

Thus, the palliative care system consists of the following categories:

- 1) palliative care has become a social issue that was not regarded as one at the governmental level earlier;

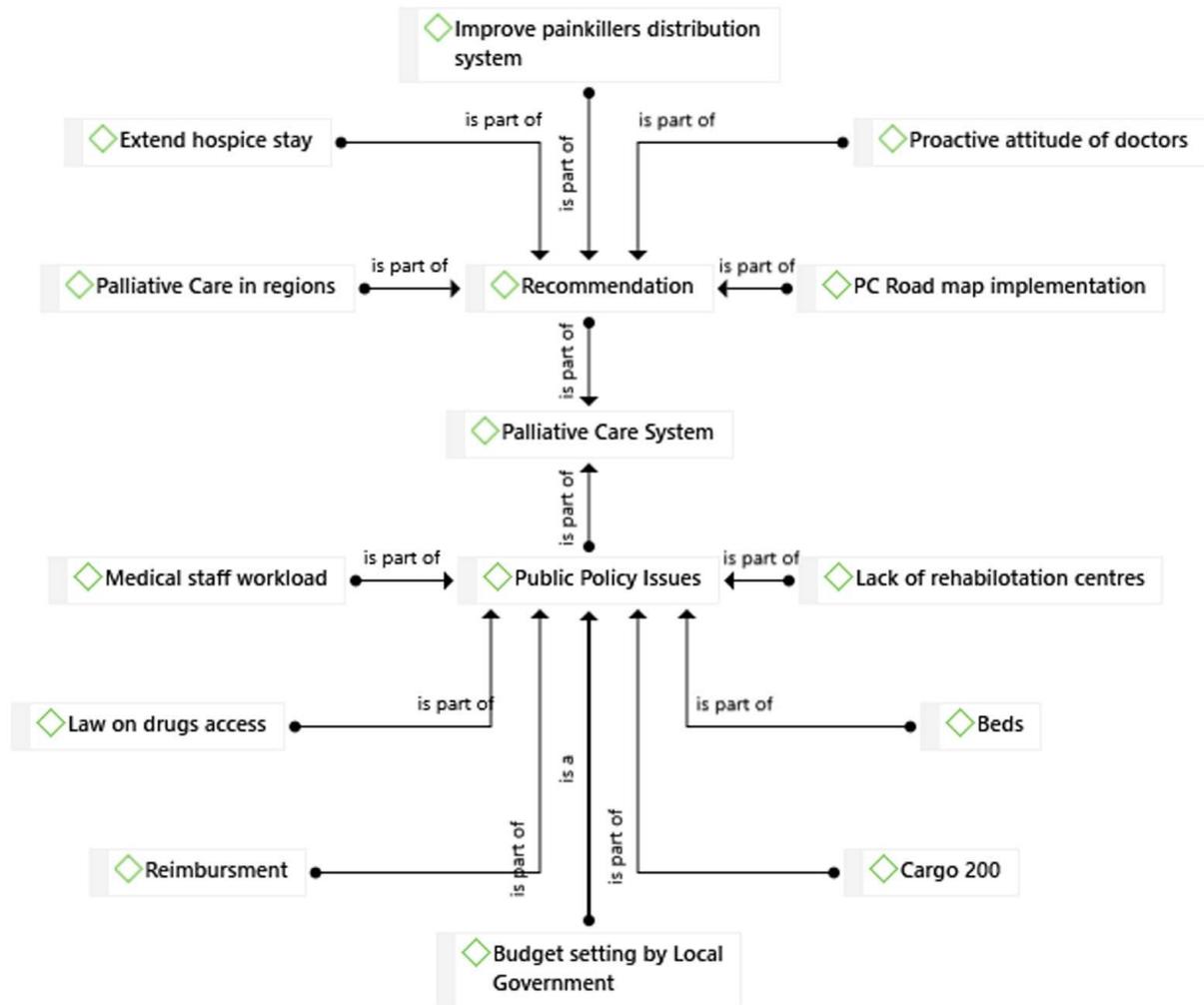


Figure 3. Public policy issues and recommendations

- 2) volunteers started repeating the international experience of volunteers in palliative care;
- 3) volunteers started establishing charity foundations;
- 4) the government started developing a legislations system for palliative care provision;
- 5) a roadmap for palliative care implementation was developed;
- 6) volunteers started cooperation with hospitals establishing the etiquette of communication;
- 7) development of private hospices is a coercive pressure, as there is a significant lack of beds at hospitals and medical staff who have passed training in palliative care.

As a result of the analysis of the interviews, problems of the development of palliative care were identified: lack of rehabilitation centers and beds, medical staff workload, reimbursement, and budget set by local authorities. The palliative care system is currently facing issues that can be solved by the government and with women volunteers' assistance. Moreover, most interviewees talked about current issues in the management process of the palliative care system. There are direct issues as a great need for rehabilitation centers for those patients who are dying and who are in remission. Therefore, there is a need for an extended stay. This question needs to be improved through the improvement of palliative care policy. At the same time, the workload for medical staff, who deal with patients with socially significant diseases, must also be revised.

Interestingly, all respondents talked about the workload of nurses and the necessity of extra medical staff. It was stated that financial issues often become a barrier for patients to receive medical treatment. Apart from the free-of-charge medicines the government provides, those not on the list are very expensive. As most of the patients are below the average income (of large cities), as they are from regions, villages, or remote areas, they cannot afford the drugs needed. Even though government sets a budget for healthcare delivery, funds allocation is done by regional authorities. Moreover, another issue is that the local government does not specify the budget for palliative care delivery, such as Cargo 200. As a result, the patient's families address charity foundations to help collect money to transfer the body to Kazakhstan. Another urgent issue, which was mentioned by most respondents, is that the law on drug distribution, such as morphine and other painkillers, does not consider the cases of patients from regions, especially when they leave hospitals to return to their hometowns.

The study developed recommendations to revealed issues, including four main topics. First, palliative care roadmap implementation must be provided in full, considering several hospital beds for palliative care, especially in regions. Therefore, hospitals must hire more medical staffs, who mostly spend time with patients and are in regular contact with volunteers and patients. Consequently, the policy must be provided in regions (in local hospitals or new state hospitals needs to be opened). Third, the system of painkillers distribution and drug supply must be improved. However, as mentioned above, there must be a proactive attitude of doctors who want to enhance their experience in treating socially significant diseases. Fourth, until the question of new hospitals and hospices is established, the duration of hospital stays for patients, especially from regions, must be extended.

Therefore, recommendations show the need to develop the palliative care system roadmap and encourage a proactive attitude among medical staff. In addition, it is shown that there is a need for palliative care in regions, extended stay in hospices, and improvement in the distribution of painkillers.

Moreover, based on the provided coding of the interviews, a triangle of palliative care partici-

pants was developed, where hospitals stand out as mediators in the dialogue between the government and volunteers. Volunteers contribute to policymakers' objectives, making it easier to build further steps in palliative care delivery. It must be mentioned that according to the analysis, volunteers are the main pushers of the palliative care system institutionalization in Kazakhstan.

Depending on the theory of institutionalization, it is known as a (1) process of embedding a system, rules, or ideas (Acemoglu et al., 2001). Simply speaking, this is a (2) repetition of action by many people. Throughout (3) consistency, the actors (4) start setting rules or limitations for this action's performance. This is when (5) negative effects or outcomes, along with positive ones, are figured out. At this point (6), values and standard behavior, are the structure of a social institution being developed. The next stage is when (7) workers of this current social institution appear with a hierarchal structure.

The interviews provided showed consistency in the actions of volunteers with different patient situations. In addition, the scope and scale of appearing issues affect the performance of different actions. For example, there is usually a group of volunteers who offer routine assistance by providing patients with a homemade meal (for instance, if a patient is in a remote hospital and needs additional help, such as liquid food (e.g., soup)). Special meal plan for patients sometimes does not fit into the system of meal plans in hospitals. Another group of volunteers assists in managing issues related to purchasing drugs and consulting families and patients. Sometimes families come from remote regions, and many are not familiar with the social benefits they can account for. When patients are collecting documents for treatment abroad, volunteers assist in this process as well.

4. DISCUSSION

This paper shows that volunteers affect the implementation of social policies, which was not discussed in previous studies. Previous studies described the operational actions of volunteers

as providing physical help and assistance in the provision of palliative care assistance as coming nurses (Weeks et al., 2008; Candy et al., 2015; Loth et al., 2020; Claxton-Oldfield & Beaudette, 2021) or emphasized the impact of volunteering on the lives of volunteers (Claxton-Oldfield et al., 2010; Scott et al., 2021; Coleman et al., 2022). However, they did not consider all the hidden work volunteers did. For instance, finding the necessary drugs for treatment is sometimes a challenge. Therefore, even hospitals must address volunteers for assistance in finding the right medicine or covering financial expenses.

Previous studies considered volunteers regardless of gender, although some included gender statistics; women's contribution was not considered a unique experience (Koper et al., 2018; McCall et al., 2020). This paper describes volunteers who participate in the management of social policy development. In addition, according to interviews in Kazakhstan, women represent the majority of volunteers actively involved in developing social policy in the field of palliative care.

The significant contribution is that women volunteers assist regardless of distance and quickly establish and develop networks and connections in remote areas. According to previous studies, volunteers were assigned by hospitals or social care workers within one region (Claxton-Oldfield et al., 2010; Candy et al., 2015; Woitha et al., 2015; Bloomer & Walshe, 2020; Vanderstichelen et al., 2022).

The current study represents volunteers as active participants of state policy provisions. At the same time, research predominantly shows that volunteers are regarded as nurses by doctors or the head of a hospital. However, volunteers try to cooperate with the government. First, they are well-educated in terms of laws and regulations regarding palliative care and are aware of different kinds of cancer diagnoses, treatment structures, and medicines.

The interviews have revealed a striking difference in how medical staff sees families and patients' issues. The medical staff does not usu-

ally discuss the need for a psychologist's help. Instead, they usually consider patients' physical needs. Volunteers and charity foundation workers underline the necessity of psychological help not only to patients but to their family members as well. Interestingly, when visiting patients at hospitals, volunteers have stressed that they usually do not contact families. All requests about material needs are passed through nurses (mostly). Thus, research results illustrated that although volunteers have less communication with patients or their families, they are more aware of their needs (such as psychological help) than medical staff (Burbeck et al., 2014; Scheer, 2002; Bloomer & Walshe, 2020; Claxton-Oldfield & Beaudette, 2021).

Volunteers and charity foundation members are more concerned with social policy implementation. These are questions of mandatory support delivery for patients and families, improvement of public health policies, and the delivery of them. As volunteers become members of staff, they limit their engagement with families. In this regard, they accept all issues addressed to them as complaints. At the same time, volunteers for their information assistance to families are limited in access by medical staff. As major expenses, volunteers support hospitals by providing them with expensive machines for the provision of medical examinations. Based on recent research, experience in developed countries with volunteers' participation in palliative care is different and limited to essential assistance (Cohen & Numa, 2011; Jack et al., 2012; Park, 2013; Foster et al., 2018; Coleman et al., 2022).

Volunteers have a significant impact on health-care policy provision. Volunteers should be included in the public administration structure. For the further representation of the needs of minorities, palliative care should be institutionalized officially. Doing so will help to create new workplaces and achieve sustainable development goals. Society will trust the palliative care system and develop a sense of oncological awareness, which can help reduce the morbidity rate.

CONCLUSION

This study aims to develop proposals for streamlining the palliative care system in Kazakhstan based on the study of the influence of women volunteers on the process of public administration. The results indicate that women volunteers prevail in the management process and provision of palliative care. Men's involvement in volunteering is more of a technical nature, as they receive salaries. On the other hand, women volunteers establish cooperation with medical institutions and patients. It includes financial assistance (or finding investors), medical staff training (master classes with the participation of foreign surgeons, free-of-charge surgeries, or training of psychologists socialized in oncological issues), or joint solutions (health treatment projects, events for children patients, transport issues, or transfer the body to Kazakhstan).

Moreover, there is material assistance (medical equipment, medicines, diapers, clothes, or food) and patient consultation (treatment program, preparation of documents for surgery abroad, or social benefits). Women reduced the time the government would have spent on developing the environment for palliative care system management in Kazakhstan. Moreover, volunteers have established a way of communication and objectives delivery to the government, where hospitals play the role of a mediator. Consequently, the government recognized the significance of palliative care system development.

However, the system of palliative care in Kazakhstan still requires significant changes. There are some problems with the public management of palliative care (lack of beds and information in terms of the urgent need for palliative care in the country, low level of healthcare infrastructure, especially in regions, poor regional budget management, deficiencies in organizational management, etc.). Palliative care roadmap implementation must be provided in full (medical staff, monitoring system, the system of painkillers distribution and drug supply). Consequently, the policy must be provided in regions. It is recommended that women volunteers should be given a higher status and included in the public administration structure. They should be accepted as official policymakers of palliative care system development in Kazakhstan regularly because women volunteers know about not only existing problems but also hidden ones. The level of their decision-making regarding palliative care roadmap development must be equal to policymakers.

The findings, recommendations, and suggestions developed during the study can serve as a theoretical and methodological basis for implementing Kazakhstan's state policy in palliative care. Further research could involve policymakers in the interview to study the significance of the involvement of women volunteers in palliative care system development or any related issue in social policy delivery.

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