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Content

Editorial

With the publication of this fourth volume of the International Journal of Buddhist Social Work, the journal reaches another important stage in its ongoing development. Each volume represents not only an academic output but also a collective effort to nurture and advance Buddhist social work as an emerging field of research and practice.

Compared with the previous year, this volume reflects clear growth and increasing scholarly engagement. We received a greater number of academic submissions than in Volume 3, and the diversity of contributing authors has expanded significantly. Manuscripts were submitted from India, Sri Lanka, Cambodia, Japan, as well as from other countries and regions. This growing variety of perspectives and contexts signals a strengthening international research community and suggests that the journal is steadily gaining wider recognition.

This progress would not have been possible without the dedication and cooperation of many individuals. I would like to express my sincere gratitude to the authors who entrusted their work to the journal, as well as to the reviewers and editors whose careful and thoughtful contributions ensured the academic quality of this volume. While academic publishing inevitably presents challenges, the experience gained over previous volumes has contributed to a more stable and confident editorial process, allowing the journal to continue its development with renewed momentum.

The journal also continues its tradition of connecting academic inquiry with artistic expression through the cover image. This year's front-page illustration is a traditional brush painting by the Japanese author Ayako Kimijima, depicting a horse and symbolically associated with the Year of the Horse. Following earlier volumes featuring original artworks by artists from Bhutan, Sri Lanka, and Mongolia, this contribution from Japan extends our visual journey across Asian cultures. These artworks serve not only as aesthetic elements but also as cultural reflections that resonate with the values and contexts of Buddhist social work.

As the International Journal of Buddhist Social Work moves forward, this fourth volume reaffirms our commitment to high-quality peer-reviewed scholarship, international diversity, and the continued exploration of Buddhist social work as a field grounded in Buddhist philosophy and responsive to contemporary social realities. We look forward to further collaboration, deeper dialogue, and continued growth in future volumes.

Josef Gohori,

Chief Editor

Academic Articles

The Role and Impact of Buddhist Social Work in Contemporary Society: A Comparative Study of Traditional and Modern Approaches

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Abstract:

Buddhist social work has deep roots in the teachings of the Buddha, emphasizing compassion, community support, and the alleviation of suffering. From the earliest days of Buddhism, social service was a key aspect of the monastic community's role, focusing on aiding the needy, promoting social justice, and fostering communal harmony. In contemporary society, Buddhist social work has adapted to address modern issues, including poverty, mental health, and environmental challenges. The primary objective of this study is to examine the points of convergence and divergence between traditional and modern forms of Buddhist social work, and to assess their respective contributions and overall impact on contemporary society. The study has examined historical texts and compared them with current social practices among Buddhist organizations and communities. The research methodology involved qualitative analysis, including literature reviews and case studies of contemporary Buddhist social programs.

Keywords: **Buddhist social work, contemporary society, traditional approaches, modern approaches**

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1. Introduction

Buddhist social work, as a form of applied ethics, is grounded in the Buddha's moral teachings, especially *karuṇā* (compassion) and *mettā* (loving-kindness). From the Sangha's earliest days, monks and laypersons have provided charitable services, from offering food to the hungry to mediating community disputes, as a direct extension of spiritual cultivation. This symbiotic relationship between spiritual practice and social service is enshrined in canonical texts such as the *Sigalovada Sutta*, which delineates responsibilities toward family, friends, teachers, workers, and society (DN.3. P.308).

In the 21st century, the scope of Buddhist social work has widened dramatically (Queen & King, 1996, p. 12). Practitioners today engage with global challenges such as climate change, urban poverty, refugee crises, gender inequality, and mental health problems. These issues demand organizational sophistication, partnerships with secular agencies, and the use of technology for outreach.

This paper aims to investigate how Buddhist social work has evolved by identifying both its enduring elements and its contemporary transformations. It contrasts traditional temple-based practices with modern institutional models, evaluates the distinctive strengths and limitations of each approach, and examines their broader implications for social welfare in the present day.

2. Literature Review

2.1 Historical Foundations of Buddhist Social Work

The origins of Buddhist social work are deeply embedded in the early teachings and organizational structures of the Buddhist *Sangha*. As stated in Rahula (1978), the *Sigalovada Sutta* has often been described as the "householder's code" and sets out a framework of mutual obligations between laypersons and the monastic community. Rahula Thero draws extensively from the Pali Canon to explain the ethical and social dimensions of Buddhist practice. He

emphasizes that generosity (*dāna*) and social harmony are not peripheral acts but integral components of the Buddhist path for both lay and monastic practitioners.

Similarly, Gethin (1998) situates Buddhist social engagement within the broader doctrinal and institutional framework of early Buddhism. He examines canonical sources such as the *Vinaya Pitaka* and *Sutta Pitaka*, focusing on the practical roles of the *Sangha*. Gethin notes that monks were frequently involved in education, the provision of healthcare (often through herbal medicine), and mediation in disputes. These activities were performed not as optional charity but as natural extensions of the *Sangha*'s moral authority and reciprocal relationship with lay supporters. By identifying these roles as inherent to the monastic vocation, Gethin's analysis supports the view that traditional Buddhist social work was community-centered, localized, and sustained by spiritual duty rather than by bureaucratic institutions.

Expanding on this perspective, Harvey (2013) addresses the symbiotic nature of the lay–monastic relationship in early Buddhist societies. Combining doctrinal analysis with socio-historical observation, he describes how monasteries functioned as centers for moral guidance, dispute resolution, and basic education, thereby fulfilling both religious and civic roles. This dual function is relevant to the current research as it illustrates how Buddhist social work was historically inseparable from religious life, as a sharp contrast to the more secularized, professionalized nature of many modern Buddhist aid organizations.

The historical record also indicates that the absence of centralized state welfare in pre-modern Asia heightened the *Sangha*'s role as a de facto social service provider. Queen (2000), writing on the evolution of Engaged Buddhism, acknowledges that early Buddhist communities were the primary agents of welfare in their locales. While his work is more contemporary in focus, Queen draws on historical precedent to trace the transformation of Buddhist service. He notes that the *Sangha*'s moral obligation to care for the sick, offer guidance to those lacking access to learning, and mediate disputes was viewed as a direct expression of the Buddha's teachings. This is consistent with scriptural sources such as the Vinaya's account in which the Buddha declares, "He who tends the sick tends me" (Mahāvagga 8.26). This historical continuity lays the groundwork for comparing how such roles have expanded, professionalized, and globalized in the modern era.

The compassionate ethos central to Buddhist social work is clearly articulated by Thich Nhat Hanh (1987) in his discussion of interbeing and mindful engagement. While Thich Nhat Hanh writes primarily on modern applications, he situates them firmly within the ethical lineage of early Buddhist practice. He argues that compassion is not merely an emotional state but an actionable commitment to alleviate suffering, a principle traceable to the earliest *Sangha* activities. This conceptual bridge highlights how traditional principles continue to inform modern Buddhist social activism, forming the philosophical foundation for the comparative analysis undertaken in this study.

The historical foundations of Buddhist social work, as discussed in the works of Rahula, Gethin, Harvey, Queen, and Thich Nhat Hanh, reveal a consistent pattern in which spiritual cultivation is inseparably linked with practical service to the community. Rahula (1974) highlights how early Buddhist monastic life was grounded in ethical responsibility and social obligation; Gethin (1998) explains that Buddhist doctrine has always emphasized compassion and communal welfare as essential aspects of practice; and Harvey (2000) similarly identifies generosity, care, and non-harm as central ethical imperatives. Queen (2000), writing on the development of Engaged Buddhism, demonstrates how historical forms of Buddhist service were relational, small-scale, and community-embedded. Thich Nhat Hanh (1998) further illustrates how mindfulness-based action emerged from these early precedents and later shaped modern social engagement movements. Together, these sources show that early Buddhist social involvement was primarily localized, morally grounded, and integrated with daily spiritual discipline, a foundation that contrasts with the more institutionalized, professionally structured, and globally networked models of contemporary Buddhist social work. Understanding these historical roots is therefore crucial for evaluating the points of alignment and divergence between traditional and modern approaches.

2.2 Traditional Approaches

Traditional Buddhist social work has long been rooted in temple-centered community life, where spiritual and social responsibilities intersect. Queen (2000) offers a detailed historical analysis of the Buddhist Sangha's social functions in pre-modern Asia, focusing on its role as the central provider of welfare in societies lacking formal state systems. He notes that monasteries served as

hubs for almsgiving *(dāna),* shelter for the needy, education, and conflict mediation, all motivated by the pursuit of religious merit. This aligns directly with the current study's framework, illustrating how traditional Buddhist social work blended moral obligation with community well-being in a holistic, locally grounded way.

Similarly, Harvey (2013) examines the doctrinal and practical foundations of Buddhist social engagement, emphasizing the Sangha's reliance on mutual support between monks and laypeople. Harvey describes almsgiving as a reciprocal act in which monks receive material support while offering spiritual guidance and moral instruction in return. He stresses that this exchange fostered communal cohesion, with temples functioning as both religious centers and civic institutions. This reinforces the present study's focus on traditional approaches as community-driven and trust-based, in contrast to the more formalized structures of modern Buddhist NGOs, which tend to be legally registered, professionally staffed, and project-based. In contrast, the traditional system was informal, relational, and woven into the daily social fabric. Modern organizations often emphasize bureaucratic structure, measurable outcomes, fundraising, and partnerships with international agencies, whereas traditional Buddhist social work relied on mutual obligation, ethical duty, and shared spiritual values. Traditional Buddhist social work was organically embedded within the community, while modern Buddhist social work increasingly operates through formal institutions shaped by global development frameworks.

Rahula (1978) further highlights the moral dimensions of these practices, drawing from the Sigalovada Sutta (Dīgha Nikāya 3. P.1), to show that charity, education, and moral teaching were integral to Buddhist life. He interprets these duties as spiritual imperatives embedded in everyday conduct. These activities were not optional or peripheral but central to fulfilling the Buddhist path. Rahula interprets these duties as spiritual obligations woven into everyday life, rather than optional, benevolent acts. In his view, these forms of service constitute a practical expression of the Buddhist path, demonstrating that social responsibility and moral cultivation are inseparable within Buddhist practice.

Taken together, the analyses of Rahula, Harvey, and Queen suggest that pre-modern Buddhist social work functioned largely as an organic, temple-centred welfare system sustained by reciprocal generosity *(dāna)*, religious motivation, and a shared sense of moral responsibility.

Rahula's account of lay monastic reciprocity emphasizes how almsgiving and moral obligation bound communities to temple institutions, producing dependable local relief in the absence of a centralized state apparatus (Rahula, 1954, p.17). Harvey's historical overview orients these practices within broader institutional and doctrinal frameworks, showing how their effectiveness depended on local social networks and normative expectations rather than bureaucratic scale (Harvey, 2013, p.33). Queen's work on socially engaged Buddhism highlights how these temple-based networks mobilized religious commitment into practical support while remaining inherently local in reach, a key point of contrast with the large-scale, bureaucratic welfare models addressed later in this study (Queen, 2000, p.42). Together, these sources indicate that traditional Buddhist social work was highly effective at the local level but not designed for centralized, nationwide redistribution, a central comparative hinge for the modern approaches examined below.

2.3 Modern Adaptations

Modern Buddhist social work refers to contemporary forms of Buddhist-inspired social action that go beyond the traditional, temple-centered model of charity found in many Buddhist cultures. It reflects an expansion from temple-centered community care to globally networked, professionalized service organizations. Thich Nhat Hanh (1987, p.65) is a central figure in articulating "Engaged Buddhism," which integrates meditation practice with active involvement in social, political, and environmental causes. He emphasizes mindfulness as both a personal and collective tool for transformation, arguing that addressing structural causes of suffering, such as war, inequality, and environmental degradation, is as essential as personal spiritual cultivation. Thích Nhất Hạnh discusses mindfulness not only as an internal spiritual discipline but as a collective, socially transformative practice. He argues that insight gained through meditation must naturally lead to compassionate action addressing the systemic sources of suffering, such as war, social injustice, and environmental destruction.

Queen (2000) traces the institutionalization of Buddhist service through the growth of professionalized NGOs and international networks. He documents the emergence of organizations that combine Buddhist ethics with secular humanitarian methods, often operating transnationally. These groups address disaster relief, refugee support, and human rights advocacy,

frequently in partnership with non-Buddhist agencies. This illustrates how modern approaches extend the reach of Buddhist compassion while adapting to the operational standards of global aid systems.

Modern Buddhist social work increasingly integrates mindfulness into mental health and counseling practices. Harvey (2013, pp. 218-220) examines how mindfulness, once primarily a religious practice, has been adapted into evidence-based therapeutic interventions addressing anxiety, trauma, and stress. Kabat-Zinn (1990, pp. 41-45) similarly demonstrates that secular mindfulness programs, such as Mindfulness-Based Stress Reduction (MBSR), are effective in clinical settings while preserving key ethical elements drawn from Buddhist teachings. Shapiro, Carlson, Astin, and Freedman (2006, pp. 377-380) further note that these interventions provide tools for cultivating self-regulation, emotional balance, and compassion, reflecting a continuity of Buddhist ethical principles in a modern, professionalized social context. Together, these sources illustrate a significant shift from strictly religious instruction to broadly accessible, health-oriented applications, showing that modern Buddhist social work can address contemporary social and mental health priorities while retaining its moral foundation.

Taken together, these sources reveal that modern Buddhist social work has evolved from localized, volunteer-driven efforts into a multifaceted, global movement. It retains its core motivation of compassion but operates within a professionalized, collaborative framework that enables large-scale impact. This transformation sets the stage for the comparative analysis of how traditional intimacy and modern scalability might be effectively integrated.

3. Methodology

This study adopts a qualitative, comparative case study design to examine the role and impact of Buddhist social work in contemporary society, with particular emphasis on the alignment and divergence between traditional and modern approaches. Qualitative methods were chosen to capture the depth of meaning, cultural context, and philosophical underpinnings that quantitative measures alone could not adequately convey. The study combines a literature review and case

study analysis, using thematic coding for data interpretation. Three case studies were selected to provide concrete examples of Buddhist social work in both traditional and modern forms:

- Tzu Chi Foundation (Taiwan): A large-scale Mahāyāna Buddhist humanitarian organization noted for its global reach and professionalized aid structure.
- International Network of Engaged Buddhists (INEB): A transnational network advocating for social justice, environmental sustainability, and peacebuilding, integrating Buddhist ethics with secular activism.
- Local Temple-Based Outreach Program in Sri Lanka: A Theravāda temple initiative offering free medical clinics, food distribution, and educational support within a rural community, relying entirely on volunteer labor and local donations.

4. Case Studies

4.1 Tzu Chi Foundation

Founded in Taiwan in 1966 by Dharma Master Cheng Yen, the Tzu Chi Foundation exemplifies the synthesis of Buddhist compassion and contemporary humanitarian systems. Its mission draws directly from the Mahāyāna principle of *karuṇā* (compassion) but expresses it through a global, modernized network of care.

Tzu Chi's work includes a wide range of services, operating general hospitals in Taiwan, providing free clinics in underserved regions, and maintaining a robust disaster relief program capable of rapid international deployment. For example, after the 2010 Haiti earthquake, Tzu Chi combined local volunteer mobilization with international supply chains to deliver food, medical services, and temporary housing. Their disaster operations employ modern logistics management, digital tracking systems, and partnerships with governmental and non-governmental organizations, reflecting a pragmatic approach to alleviating suffering.

Tzu Chi's educational initiatives, which include primary schools, vocational programs, and higher education, integrate academic training with moral education grounded in Buddhist ethics.

Students are encouraged to participate in community service, linking theory and practice. This dual emphasis reflects the organization's ability to adapt traditional Buddhist altruism to the demands of contemporary societies while maintaining its spiritual core.

The Tzu Chi case illustrates how Buddhist social work can transcend regional boundaries and adopt technological efficiencies without losing its ethical foundation. Its model shows that compassion, when paired with organizational discipline and modern tools, can achieve large-scale, sustained impact.

4.2 International Network of Engaged Buddhists (INEB)

Founded in 1989 by Thai activist and scholar Sulak Sivaraksa, the International Network of Engaged Buddhists focuses on integrating Buddhist values with global advocacy for social justice, environmental stewardship, and peacebuilding. INEB operates not as a centralized aid provider but as a decentralized network connecting monks, nuns, lay practitioners, academics, and activists from Asia, Europe, and the Americas.

INEB's approach reflects the Engaged Buddhism movement, which interprets Buddhist practice not as withdrawal from society but as active participation in transforming it. For instance, INEB has been involved in campaigns against human trafficking in Southeast Asia, peace education initiatives in conflict zones such as Myanmar, and ecological restoration projects in rural Thailand. Its work combines grassroots community engagement with international policy dialogues, ensuring that local concerns are represented in global forums.

Unlike Tzu Chi's structured, service-oriented model, INEB prioritizes advocacy, awareness-raising, and the empowerment of marginalized voices. It uses workshops, interfaith dialogues, and training programs to cultivate mindfulness-based leadership and ethical activism. This method emphasizes structural change over direct relief, seeking to address the root causes of suffering rather than only its immediate symptoms. The INEB case demonstrates how Buddhist principles can inform a modern, activist-oriented model of social work. Blending spiritual discipline with political engagement, it provides a template for addressing systemic issues in an interconnected, globalized society.

4.3 Temple-Based Outreach in Sri Lanka

In rural Sri Lanka, Buddhist temples have long served as vital centers for both spiritual practice and community welfare. Rooted in Theravāda Buddhist traditions, these temple-based outreach programs trace their origins to the ancient *vihāra* model, in which monastic institutions were expected to guide moral life while meeting social needs (Gombrich & Obeyesekere, 1988). Organized and led primarily by resident monks *(wiharadhipathi)* and nuns *(newasika bhikkshuni)*, these programs operate with the active involvement of lay volunteers, reflecting the Buddhist principle of Saṅgha-lay cooperation.

These outreach initiatives typically address three main areas of need. First, many temples run free medical clinics, providing basic healthcare services, including the distribution of herbal remedies derived from the island's long-standing Ayurvedic tradition (Hewage, 2015). Second, food security is supported through daily or weekly *dāna* programs, in which meals are prepared and distributed to low-income families. Third, educational support is offered in the form of after-school tutoring sessions, often focusing on language, mathematics, and moral instruction. This emphasis on education reflects the traditional Buddhist view that learning is both a practical and a spiritual pursuit (Gunawardana, 2000).

4.3.1 Contemporary Society

In contemporary society, Buddhist social work has adapted to address a range of modern challenges, demonstrating both the resilience of its ethical foundations and the flexibility of its practical applications. While historically rooted in the Buddha's teachings on compassion (*karuṇā*), generosity (*dāna*), and the alleviation of suffering (*dukkha*), Buddhist social engagement has evolved to meet the shifting needs of the modern world (Queen, 2000). This evolution reflects an enduring capacity to remain relevant while responding to issues such as poverty, mental health, and environmental degradation.

Poverty alleviation has been a central focus of Buddhist social work since the earliest days of the monastic tradition, when monks and nuns offered food, shelter, and education to the underprivileged in exchange for lay support (Schmithausen, 1999). In the modern context, these

efforts have expanded into structured community development programs, including vocational training, microfinance initiatives, and health care services (Keown, 2013). Such projects aim not only to provide immediate relief but also to foster long-term economic stability, reflecting the Buddhist ideal of compassion in action (*karuṇā-upāya*), or the use of skilful means to address suffering.

Addressing mental health has emerged as another significant area of adaptation. Early Buddhist teachings emphasized the cultivation of mental well-being through meditation, ethical discipline, and mindfulness (Rahula, 1974). In recent decades, these practices have been integrated into modern psychological and therapeutic frameworks, producing programs such as mindfulness-based stress reduction (MBSR) and trauma recovery workshops (Kabat-Zinn, 2003). Many Buddhist organizations now provide counselling services, meditation retreats, and addiction recovery programs that blend traditional Dharma teachings with evidence-based therapeutic methods, thereby reaching a broader demographic that includes non-Buddhists (Baer, 2003).

Buddhist engagement with environmental challenges is a more recent but increasingly important development. The principle of interdependence (*paṭiccasamuppāda*) and the teaching of non-harm (*ahiṃsā*) have long underscored a harmonious relationship with the natural world (Harvey, 2000). In response to climate change, deforestation, and biodiversity loss, Buddhist communities have initiated projects such as tree planting, wildlife conservation, and advocacy for sustainable agricultural practices (Sivaraksa, 1992). The emergence of "eco-dharma" movements illustrates how environmental stewardship has been reframed as an extension of Buddhist compassion toward all sentient beings (Kaza, 2000).

These adaptations have been implemented within diverse organizational models. Some initiatives remain localized, centered around temples and monasteries that operate through volunteer labor and local donations, ensuring cultural relevance and deep community trust (Samaranayake, 2019). Others have formed partnerships with national and international NGOs, enabling the scaling of projects and the exchange of resources and expertise (Engel, 1999). Despite differences in scale, both models share a commitment to integrating traditional Buddhist ethics with practical responses to contemporary problems.

The impact of these contemporary adaptations has been multifaceted. In economic terms, Buddhist social programs have provided vulnerable populations with sustainable livelihoods and greater resilience to poverty. Psychologically, they have offered culturally sensitive mental health care rooted in ethical and meditative traditions. Ecologically, they have contributed to grassroots environmental activism and education, linking ecological well-being with spiritual practice. Collectively, these contributions demonstrate that Buddhist social work, while firmly anchored in ancient traditions, has the capacity to innovate and respond effectively to modern crises (Queen, 2000; Keown, 2013).

4.4 Community-Centered Approach

A distinctive feature of Sri Lankan temple outreach is its emphasis on personal engagement. Monks often maintain close relationships with beneficiaries, enabling aid to be tailored to individual or household circumstances. Such personal familiarity fosters trust and reinforces the temple's role as a moral and social anchor. Unlike large-scale humanitarian organizations, these programs do not rely on complex logistics or international funding networks. Instead, they function through local donations, both monetary and in-kind, and the voluntary labour of community members (Samaranayake, 2019).

4.5 Sustainability and Spiritual Motivation

The sustainability of temple-based social work is deeply rooted in the Buddhist ethic of *dāna* (generosity), understood not merely as charitable giving but as a core practice leading to merit (*puñña*). This reciprocal relationship where lay communities provide material support and monks offer spiritual guidance ensures a steady flow of resources and commitment (Bartholomeusz, 1994).

4.6 Role in the Contemporary Context

Although modest in scale compared to modern organizations such as the Tzu Chi Foundation, Sri Lankan temple outreach remains highly relevant. Its strength lies in preserving the intimate, relationship-centered nature of Buddhist social work, maintaining cultural continuity, and fostering community solidarity. These programs also fill critical gaps in rural social welfare

provision, particularly in areas where state services are limited (Abeysekera, 2016). In this sense, they represent a "traditional approach" to Buddhist social engagement—complementing, rather than competing with, modern, technology-driven humanitarian models.

By combining ancient ethical principles with a contextually grounded understanding of local needs, temple-based outreach in Sri Lanka demonstrates the enduring adaptability of Buddhist social work. It offers a sustainable, culturally resonant model capable of fostering both spiritual and material well-being in contemporary society.

5. Discussion

The findings of this comparative study indicate that while contemporary Buddhist social work has expanded its operational capacity and diversified its modes of engagement, it has largely preserved its ethical foundation rooted in Buddhist doctrines such as *dāna* (generosity), *karuṇā* (compassion), and *mettā* (loving-kindness). Whether manifested in the structured humanitarian networks of the Tzu Chi Foundation, the activist-oriented International Network of Engaged Buddhists (INEB), or the localized, relationship-based outreach of rural Sri Lankan temples, these initiatives share a commitment to alleviating suffering in accordance with the Buddhist path.

5.1 Balancing Ethical Continuity with Structural Adaptation

Modern Buddhist social work reflects a process of professionalization, integrating organizational management techniques, strategic partnerships, and technological tools to improve service delivery (Queen & King, 1996). This adaptation has facilitated rapid response to large-scale crises, increased transparency in resource allocation, and enhanced accountability to donors and stakeholders. However, the move toward institutional complexity also raises concerns about potential bureaucratization and the dilution of interpersonal connection qualities that have traditionally distinguished Buddhist community service (Jones, 2021).

Traditional, temple-centered outreach, by contrast, tends to preserve a strong sense of interpersonal connection. Close contact between monks and community members enables more tailored forms of assistance, moral guidance, and a shared spiritual ethos that reinforces communal bonds (Bartholomeusz, 1994). However, the very local orientation that nurtures trust can also restrict the breadth and scalability of such efforts, especially when addressing wider structural challenges like entrenched poverty or environmental decline.

5.2 Complementary Strengths and Tensions

The comparative analysis suggests that traditional and modern models should not be viewed as mutually exclusive but rather as potentially complementary. Modern organizations, with their global reach and logistical capacity, are well-positioned to address emergencies and advocate for policy change. Meanwhile, traditional methods excel in fostering durable, trust-based relationships that support community resilience and moral development (Abeysekera, 2016).

Nonetheless, tensions remain. Modern organizations may face the challenge of maintaining a distinctly Buddhist identity while engaging in secular humanitarian partnerships. Similarly, traditional institutions risk marginalization if they do not adapt to shifting socio-economic conditions, including urbanization, declining monastic vocations, and generational changes in volunteerism (Deegalle, 2006).

5.3 Implications for the Future of Buddhist Social Engagement

To sustain relevance in the 21st century, Buddhist social work may benefit from hybrid approaches that combine the scalability of modern systems with the relational strengths of traditional models. These could include:

- Embedding community-based volunteer programs within large organizations to preserve interpersonal bonds.
- Integrating modern management and fundraising practices into temple outreach without compromising spiritual focus.
- Encouraging collaboration between global Buddhist networks and local monastic communities to ensure both breadth and depth of service.

Such integrative strategies would not only preserve the ethical and cultural heritage of Buddhist social work but also enhance its capacity to address both immediate humanitarian needs and long-term structural challenges.

Ultimately, the evolution of Buddhist social work reflects the adaptability of Buddhist ethics to diverse contexts and scales of operation. As globalization, environmental crises, and social inequalities continue to shape the humanitarian landscape, Buddhist social engagement, whether traditional or modern, offers a unique moral and practical framework for promoting both individual and collective well-being.

While both traditional and modern approaches share a foundation in compassion and ethical responsibility, their operational frameworks diverge significantly:

Table 1: Aspects of traditional and modern approaches

Aspect	Traditional	Modern
Motivation	Primarily spiritual merit-making	Combination of ethical values and measurable social impact
Leadership	Monastic-centered	Professionalized teams (monks, lay experts, secular professionals)
Scope	Localized	Global or multi-regional
Methods	Informal, ritual-based giving	Programmatic, data-driven, policy-oriented
Impact Focus	Immediate relief	Sustainable, systemic change

The evolution reflects a shift from primarily *charity-based relief* to *advocacy and empowerment*, without losing the philosophical grounding in compassion.

Buddhist social work, whether in its traditional or modern form, remains a potent force for alleviating suffering and promoting human dignity. Traditional models preserve the moral and spiritual essence of service, while modern adaptations expand reach, professionalize interventions, and tackle systemic problems. The comparative study underscores that the future of Buddhist social work lies in the synergy between the timeless wisdom of compassion and the practical tools of contemporary social service frameworks.

6. Conclusion

Buddhist social work in contemporary society demonstrates both the enduring relevance of ancient ethical principles and the adaptive capacity of Buddhist communities to address evolving social challenges. Across diverse contexts ranging from the structured, globally networked humanitarianism of the Tzu Chi Foundation, to the advocacy-driven activism of the International Network of Engaged Buddhists (INEB), to the deeply localized, relationship-centered outreach of Sri Lankan temples, the guiding force remains the same: the alleviation of suffering in accordance with the Dharma.

The differences between these approaches lie primarily in their operational scale, organizational structure, and methods of engagement. Modern Buddhist NGOs often employ advanced logistical systems, international partnerships, and professional management practices to achieve large-scale impact. In contrast, traditional models rely on personal familiarity, community trust, and culturally embedded rituals of generosity (*dāna*). Both approaches offer unique strengths: modern institutions excel in efficiency and reach, while traditional forms preserve intimacy, cultural continuity, and a strong sense of local identity.

In an increasingly interconnected world, these distinctions should not be seen as competing paradigms but as complementary resources for holistic social engagement. Future efforts in Buddhist social work may benefit from hybrid models that combine the technological and organizational capacities of modern NGOs with the trust-based, spiritually integrated methods of traditional welfare. Such integration could ensure that compassion is delivered both effectively and authentically, meeting urgent material needs while nurturing the moral and spiritual dimensions of human well-being.

In essence, Buddhist social work in contemporary society represents a synthesis of tradition and innovation. By adapting to issues such as poverty, mental health, and environmental degradation, it continues to serve as a vital force for social cohesion, moral guidance, and holistic well-being. This adaptability not only preserves the cultural heritage of Buddhist ethics but also ensures its enduring relevance in a rapidly changing global context. Ultimately, Buddhist social work, whether traditional or modern, remains a vital moral and social force, offering not only relief

from suffering but also pathways toward greater community resilience, ethical awareness, and shared humanity.

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Buddhism and Palliative Care: How Buddhist Practice Provides Alternative Care

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Abstract

Palliative care seeks to relieve suffering and improve quality of life for patients and their families facing serious illnesses. In Sri Lanka, where Buddhism shapes much of cultural life, spiritual practices often play a role as significant as medical treatment. This study explores how Buddhist philosophy and rituals function as alternative forms of care within palliative contexts. Drawing on interviews with Buddhist monks, bereaved family members, and a sample of forty cancer patients, this study examines the ways religion intersects with end-of-life care. The analysis revealed that Buddhist philosophy does not merely provide emotional comfort but reframes illness itself: teachings on karma and impermanence shifted patients' and families' experience of fear and grief into a moral, spiritual narrative that made suffering intelligible. Rituals such as Pirith chanting, Bodhi Pooja, and merit-making practices functioned therapeutically, offering emotional stability, spiritual reassurance, and continuity of care beyond death. Care was often collective, involving family, community, and monastic support, challenging biomedical models focused solely on the individual. These findings highlight that Buddhist practices are central to holistic palliative care, addressing physical, emotional, and spiritual dimensions of suffering.

Keywords: **Buddhism, palliative care, rituals, family coping, Sri Lanka**

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1. Introduction

Death is an inevitable part of the human experience, a universal reality that transcends culture, religion, and geographical contexts, despite the differences in belief and practices around it. Regardless of how life ends, whether peacefully or through suffering, most individuals share a common desire for a calm, dignified, and meaningful death. However, in reality, the final stage of life is often shaped by a range of external factors, including medical, emotional, social, cultural and economic circumstances. As global health challenges continue to grow, particularly with the rise of chronic and terminal illnesses, healthcare systems around the world have developed specialized approaches to support individuals during the dying process. Among these, palliative care has emerged as a vital field, designed not only to alleviate physical pain but also to uphold patients' dignity, comfort, and holistic well-being as they approach the end of life.

The term palliate is derived from the Latin word *pallium* meaning "cloak," referring to covering or masking symptoms without curing the disease (Saunders, 1987). This connotation evolved into the notion of easing or lessening suffering. Palliative care began as hospice care, which was frequently provided by caregivers in religious and faith-based organizations (Bradford, 2023). Due to the rapidly aging population and non-communicable chronic illnesses, the demand for palliative care has significantly expanded within formal orthodox medicine and conventional biomedical healthcare systems

According to the World Health Organization (WHO) palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness (World Health Organization, 2020). Palliative care is typically provided to patients with chronic illnesses that cannot be treated or cured through curative interventions, and who have reached the end stage of life. Importantly, palliative care is that this care aims neither to hasten nor to postpone the death of individuals, but to provide them with the opportunity to live their final stage of life with the highest possible quality and dignity.[1]

In 1948, Dame Cicely Saunders, a British physician, established the first professional hospice to care for patients with terminal illnesses (Clark, 2007). Her success in improving the quality of

[1]

life of her patients inspired her to bring the concept of hospice care to other physicians, who immediately saw the importance of honoring people's desires and requirements at the end of life (Clark, 2007). Saunders's work not only transformed how terminally ill patients were treated, but also laid the foundation for the development of palliative care, which expanded the focus beyond hospice to address the physical, emotional, and spiritual needs of people facing serious illness at any stage of the disease trajectory (Redwine & Ganti, 2024). This broader understanding of care naturally connects with long-standing cultural and religious perspectives on death and dying.

Buddhism, one of the world's oldest living religions, offers a coherent set of teachings and practices to help people understand and navigate the reality of mortality. Its major branches, such as Theravāda, Mahāyāna, and Vajrayāna, provide distinct perspectives on how individuals can meet the end of life with awareness, acceptance, and compassion.

Buddhism has shaped a wide range of teachings and practices that frame death as a natural transition rather than an abrupt end. The Theravāda branch, dominant in Sri Lanka, Thailand, Myanmar, Laos, and Cambodia, preserves the earliest teachings of the Buddha in the Pāli Canon and strongly influences how people in these regions understand illness, decline, and dying. In many Asian and South Asian contexts, including Sri Lanka, Buddhism functions not only as a religious tradition but also as a social institution that shapes political, moral, and communal life. These beliefs naturally extend into attitudes toward end-of-life care. As a result, Buddhist perspectives offer an important and culturally grounded framework for palliative care, giving patients and families philosophical tools to cope with suffering, impermanence, and loss.

Beyond Theravāda communities, Mahāyāna and Vajrayāna traditions also offer perspectives relevant to palliative care. In Tibetan Vajrayāna Buddhism, for example, the *Bardo Thödol* (popularly known as the Tibetan Book of the Dead) provides guidance for the dying and the dead through recitation and visualization practices (Cuevas, 2008). In East Asian Mahāyāna contexts, Pure Land practices such as reciting the name of Amitābha Buddha aim to focus the mind on rebirth in a realm free from suffering.

This heavy philosophical foundation plays a significant role in shaping how medical professionals and policymakers should approach the development of structured palliative care systems in the Asian context. In many parts of Asia, collective approaches often deeply rooted in

cultural and religious traditions such as Buddhism function as alternative care systems that meet many of the needs that formal palliative care would address. While these informal and community-driven systems can provide meaningful emotional, spiritual, and practical support, they can also act as barriers to establishing standardized, systemic palliative care models. The challenge lies in determining whether religiously informed, community-based approaches can continue to adequately meet the needs of individuals as societies move toward greater individualism. This shift raises important questions about the sustainability of collective care traditions and whether they can adapt to fill the gaps that emerge when social structures and values change.

2. Buddhist Perspective on Death, Dying and Sickness

Pavāta dīpa tulyāya – sāyu santatiyākkhayaṁ

Parūpamāya samphassaṁ – bhāvaye maraṇassatiṁ

"Life passes towards its end like the flame of a lamp goes out by the wind. Seeing how others die applying it to one's own life, one should develop mindfulness of death (*Maranasati: Verses of Mindfulness of Death*, n.d.)."

From the Buddhist perspective, the inevitability of death is inseparable from the broader reality of existence. The Buddha repeatedly taught that jāti (birth), jarā (aging), vyādhi (sickness), and maraṇa (death) are universal experiences shared by all human beings (Harvey, 2013). To be born is to be subject to these stages, and each is accompanied by a degree of dukkha (suffering), which is both unavoidable and intrinsic to the human condition. Within the Buddhist philosophical framework, these stages form part of the samsāric cycle, a continual process of birth, decay, and death binding beings to the realm of suffering. The path to liberation lies in breaking free from this cycle, culminating in Nibbāna (Nirvana), the state of ultimate peace and freedom from suffering.

In the context of palliative care, these teachings offer more than metaphysical reflection; they provide a framework for understanding life's impermanence and for preparing the mind to face death with clarity and acceptance. By integrating *Maranasati* and related Buddhist practices,

patients and caregivers may approach dying not as an isolated sudden life event, but rather as part of a natural process within a broader existential journey.

With the understanding of how Buddhist philosophy has placed death and process of dying within the journey of life, the following Sections review the existing literature on Buddhism and Palliative care, how it has been integrated into orthodox medical systems and practice.

1. Buddhist Doctrine on Death, Dying and Sickness

As outlined in the introductory paragraphs, death, dying and sickness are not peripheral teachings but the central realities and core doctrines of Buddhism, where the teachings focus on the search for eternal peace for humankind.

In the Buddhist tradition, the teaching corpus is often described as comprising eighty-four thousand Dhamma elements, a symbolic expression of the breadth of the Buddha's guidance (Buswell and Lopez, 2014). Across this vast body of teachings, many discourses address death, illness, and the nature of human existence either directly or indirectly. As scholars point out, the teachings of Buddhism are centered on *anicca* (impermanence), *dukkha* (unsatisfactoriness), and *anatta* (non-self), which form the philosophical basis for approaching mortality (Harvey, 2013; Keown, 2018).

In the *Satipaṭṭhāna Sutta* (MN 10), which teaches the four foundations of mindfulness in the contemplation of the body, monks are instructed to engage in nine cemetery contemplations. These are to help understand the changes of the body (stages of decomposition), to internalize and understand the inevitable changes and weakening of the physical form.

Similarly, the *Anattalakkhaṇa Sutta* (SN 22.59) frames the aggregates of body, feeling, perception, mental formations, and consciousness as "not mine, not I, not myself," challenging the notion of a permanent self that could be destroyed at death. This doctrinal foundation positions death as a natural transformation within the continuum of conditioned existence rather than an absolute end.

A distinctive feature of Buddhist preparation for death is the practice of *maraṇasati*, or "mindfulness of death." The *Maraṇasati Sutta* (AN 6.19–6.20) urges practitioners to reflect on the inevitability of death not occasionally, but as a daily practice. This repeated contemplation is

meant to generate urgency in the spiritual path, reducing complacency and increasing readiness for the moment of dying. Importantly, mindfulness of death is framed not as a morbid fixation, but as a source of mental clarity and perspective. The tradition also treats illness as an opportunity for insight. In the *Girimananda Sutta* (AN 10.60), when Monk Girimananda falls ill, the Buddha prescribes ten contemplations including impermanence, dispassion, cessation, and non-self as a means to alleviate mental distress and deepen understanding of the Dharma. These teachings reveal a consistent approach: physical decline and death are inevitable, but suffering in relation to them is optional and can be lessened through cultivated awareness (*sati*). Ethical conduct (*sīla*), meditative stability (*samādhi*), and wisdom (*paññā*) form the foundational practices that enable a mind to meet death without fear or regret. This provides guidance to the sick on how to navigate through the pain and suffering, while keeping clarity and understanding of their causes and alleviation.

Narratives of the Lord Buddha's own death, preserved in the *Mahāparinibbāna Sutta* (DN 16), provide a model for dying with calmness and composure, especially in difficult situations. Even during his final illness, the Buddha remained composed, continuing to guide his disciples and emphasizing the impermanent nature of all things with his last words: "All conditioned things are impermanent. Strive on with diligence." Such accounts highlight the Buddhist ideal of meeting death as a culmination of practice rather than as a defeat.

In Mahayana sources, this theme is extended in the *Vimalakīrti Nirdeśa Sūtra*, where the lay bodhisattva Vimalakirti uses his own sickness as a teaching tool, explaining the illusory nature of the body and encouraging compassion for all who suffer, viewing sickness not as an unfortunate circumstance, but as an opportunity for insight and understanding of reality. Vajrayana traditions, particularly in the *Bardo Thödol* (Tibetan Book of the Dead), provide explicit guidance for navigating the intermediate states between death and rebirth. This text trains practitioners to recognize the true nature of mind during the dying process, using meditative familiarity to transcend fear and confusion. Across these traditions, a coherent picture emerges: Buddhist teaching does not seek to avoid or deny death but instead cultivates the mental and spiritual qualities needed to approach it with awareness, compassion, and liberation from attachment.

2. *Utilization of Buddhist Practices in Sri Lankan Orthodox Medicine and the Development of Palliative Care*

In Sri Lanka, the incorporation of Buddhist rituals and monastic interactions into orthodox medical contexts reflects a culturally sensitive approach to supportive end-of-life care. While palliative care is increasingly recognized within national health frameworks, traditional Buddhist spiritual practices continue to play a critical role in comforting the sick, reconciling families with the dying process, and preserving cultural integrity. Monastics, particularly bhikkhus, are routinely invited into hospital and home settings to chant protective suttas such as the *Ratana Sutta* and *Metta Sutta*, which offer emotional steadiness and invoke awareness of impermanence and refuge in the Triple Gem. Though formal studies on this integration are limited, this ritual inclusion aligns with findings highlighting the importance of spiritual care as part of holistic healing, particularly when it alleviates emotional and spiritual distress beyond physical symptoms (Quinn & Connolly, 2023).

Palliative care in Sri Lanka has gradually evolved into a structured component of the national health agenda. The Ministry of Health has embedded palliative care within the National Health Policy, the National Strategic Framework for Palliative Care Development (2019–2023), and the National Strategic Plan for Cancer Prevention and Control (Perera et al., 2019b). The Sri Lanka Medical Association's Palliative and End-of-Life Care Task Force and the National Cancer Control Program have also produced locally tailored, dual-purpose guidelines aligned with cultural and resource realities (Perera et al., 2019b). Furthermore, palliative care primarily focuses on patients with chronic and life-limiting illnesses, including those in the final stage of cancers and chronic kidney disease (CKD) and selected long-term conditions. However, many non-communicable and communicable diseases may become chronic depending on patients' conditions, age and disease progression. Additionally, palliative care has been introduced as a pilot project in selected hospitals across the country. Examples include Apeksha Cancer Hospital, Nuwaraeliya District Hospital (Oncology Unit), Anuradhapura Teaching Hospital (CKD care), among others. Although the demand for palliative care is widely recognized, service provision

continues to receive comparatively low priority within the national health system. Despite its broad relevance, palliative care service delivery remains under-prioritized in Sri Lanka's mainstream healthcare planning and resource allocation.

Within the palliative care framework in Sri Lanka, key areas of support include pain and symptom management, psychological and emotional support, social and spiritual support, as well as assistance for families and caregivers during the patient's illness and the bereavement period (National Strategic Framework for Palliative Care Development in Sri Lanka, 2018).

Taken together, these doctrines and narratives form a comprehensive framework for understanding dying, death, and sickness in Buddhism. Death is acknowledged as certain, its timing uncertain, and the process of dying is recognized as an opportunity for profound realization. Sickness is not viewed solely as misfortune but as a potential catalyst for insight into impermanence and non-self. The preparatory practices from mindfulness of death to ethical conduct and meditative training are aimed at ensuring that when death comes, the mind is steady and untroubled. In the Buddhist view, a "good death" is not measured by external conditions, but by the internal readiness of the mind to let go. This reframing shifts the focus from prolonging life at all costs to living, aging, and dying in ways that are in harmony with the truths of impermanence, suffering, and non-self. Such teachings remain deeply relevant, offering both philosophical guidance and practical methods for anyone confronting illness, caring for the dying, or preparing for their own final moments.

Death and dying are subjects that evoke such deep and disturbing emotions that we usually try to live in denial of death. Yet we could die tomorrow- completely unprepared and helpless. The time of death is uncertain, but the truth of death is not. All who are born will certainly die.

Chagdud Tulku Rinpoche (1930e - 2002)

3. Research Problem

While orthodox medical systems in Sri Lanka have made progress in establishing palliative services primarily targeting pain relief and symptom management, the cultural and spiritual

dimensions of care remain underdeveloped. Families and communities frequently turn to Buddhist rituals, chanting, and the presence of monastics to find comfort and meaning at the end of life. However, these practices are not systematically integrated into formal healthcare delivery. Although monastics hold a central role in Buddhist care traditions, they are rarely trained in clinical palliative care, resulting in support that is largely ritualistic rather than interdisciplinary or clinically informed. This creates an ongoing tension between Sri Lanka's cultural reliance on Buddhism and the predominantly biomedical model of palliative care, leaving patients and families without fully holistic support. Existing palliative care initiatives strongly emphasize clinical management while spiritual needs are addressed informally by families or delegated to religious institutions. Consequently, care delivery becomes fragmented, and the physical, psychological, and spiritual needs of patients are not equally prioritized. To date, few studies have systematically explored how patients with chronic and life-limiting illnesses express religious and spiritual inclinations, how Buddhist care practices have been adapted, overlooked, or excluded in formal palliative systems, and how families navigate and negotiate the interface between medical treatment and religious practice.

This study investigates Buddhist practices as complementary care strategies in palliative settings, beyond their traditional ritual functions. Practices such as chanting, meditation, merit transfer, and monastic guidance demonstrate potential in addressing psychosocial and spiritual needs that are often insufficiently supported within conventional biomedical models. By examining their current application in Sri Lanka, identifying existing gaps, and exploring pathways for systematic integration into formal healthcare structures, the study demonstrates how culturally-grounded care resources can strengthen holistic support. Such integration has the potential to enhance physical, emotional, social, and spiritual well-being, ensuring that palliative services are both culturally responsive and aligned with international standards of holistic palliative care.

4. Research Objectives

Building on the problem identified, the primary objective of this study is to explore how Buddhist practices can function as alternative care strategies that complement biomedical palliative services in Sri Lanka. In line with this overarching aim, the study has the following sub-objectives:

- To examine how Buddhist practices such as chanting, meditation, merit transfer, and monastic guidance are currently applied in end-of-life care.
- To identify the limitations of these practices and explore how they can be systematically integrated into healthcare delivery to support holistic palliative care.

These objectives aim to provide a structured framework for understanding the potential role of Buddhist practices in enhancing palliative care, addressing both spiritual and psychosocial needs alongside medical treatment.

5. Methodology

Research Design

This study employed a mixed-methods design, combining quantitative and qualitative approaches to examine the role of Buddhist practices as alternative care strategies within palliative settings in Sri Lanka. The quantitative component involved a structured questionnaire survey administered to cancer patients at Ratnapura Teaching Hospital, capturing their religious orientation, engagement with Buddhist practice, and reliance on spirituality during illness. This component provided breadth by identifying patterns across the study sample. The qualitative component consisted of in-depth interviews with Buddhist monks and family members of patients who had died from serious illnesses, offering deep insights into the lived experience of Buddhist-informed end-of-life care and practices. Qualitative data provided depth by exploring meaning, emotions, and contextual factors. The integration of these two methods allowed for triangulation of findings, demonstrating how the practices described by Buddhist monks are enacted by patients with serious illnesses, and how these practices contribute to patients' spiritual reliance and coping during the end-of-life process.

Study area

As the study adopted a mixed-methods design to generate broader insight into the subject matter, data collection was structured across both quantitative and qualitative domains. Quantitative data were collected at Rathnapura Teaching Hospital, which serves an extensive catchment area

spanning urban and rural communities, thereby enabling access to a socioeconomically and culturally diverse patient population.

The inclusion of temples and community-based contexts was necessary, as palliative care in Sri Lanka frequently extends beyond the clinical settings and into socio-religious environments. Buddhist monks commonly engage in non-clinical care roles offering spiritual guidance, chanting, meditation, and ritual support that cannot always be accommodated within the structural and operational constraints of hospital wards. Conducting interviews with monks in temples or community settings enabled the study to capture the doctrinal, pastoral, and caregiving dimensions of their role beyond institutional limitations. Similarly, psychosocial experiences of family members, including anticipatory grief, caregiving during the dying process, and post-death bereavement, primarily unfold in home and ritual spaces rather than in hospital wards. Interviewing family members within their community settings allowed deeper, more personal reflection in familiar and emotionally supportive environments. By examining both quantitative and qualitative study sites, the research accounted for the interplay between institutional healthcare and culturally embedded Buddhist care practices, allowing for a more holistic understanding of end-of-life care in the Sri Lankan context

Sampling

Patients with Cancer (Survey)

Convenience sampling was used to choose 40 cancer patients undergoing palliative care from the hospital wards. This approach minimized participant burden, which was ethically justified given their heightened vulnerability due to the illness. The survey questionnaire included demographic questions on age, gender, socioeconomic status, and religious affiliation, followed by questions on engagement in Buddhist practices such as chanting, meditation, temple visits, and perceived reliance on monastic guidance during the illness.

Religious Leaders (Qualitative Interviews)

Purposive sampling was used to select four Buddhist monks with a documented history of providing spiritual and psychosocial support to patients and families in health care and community contexts. Participants included monks affiliated with Apeksha Hospital Temple, Dambuwa Temple, and Colombo North Hospital, where one of the monks also worked as a

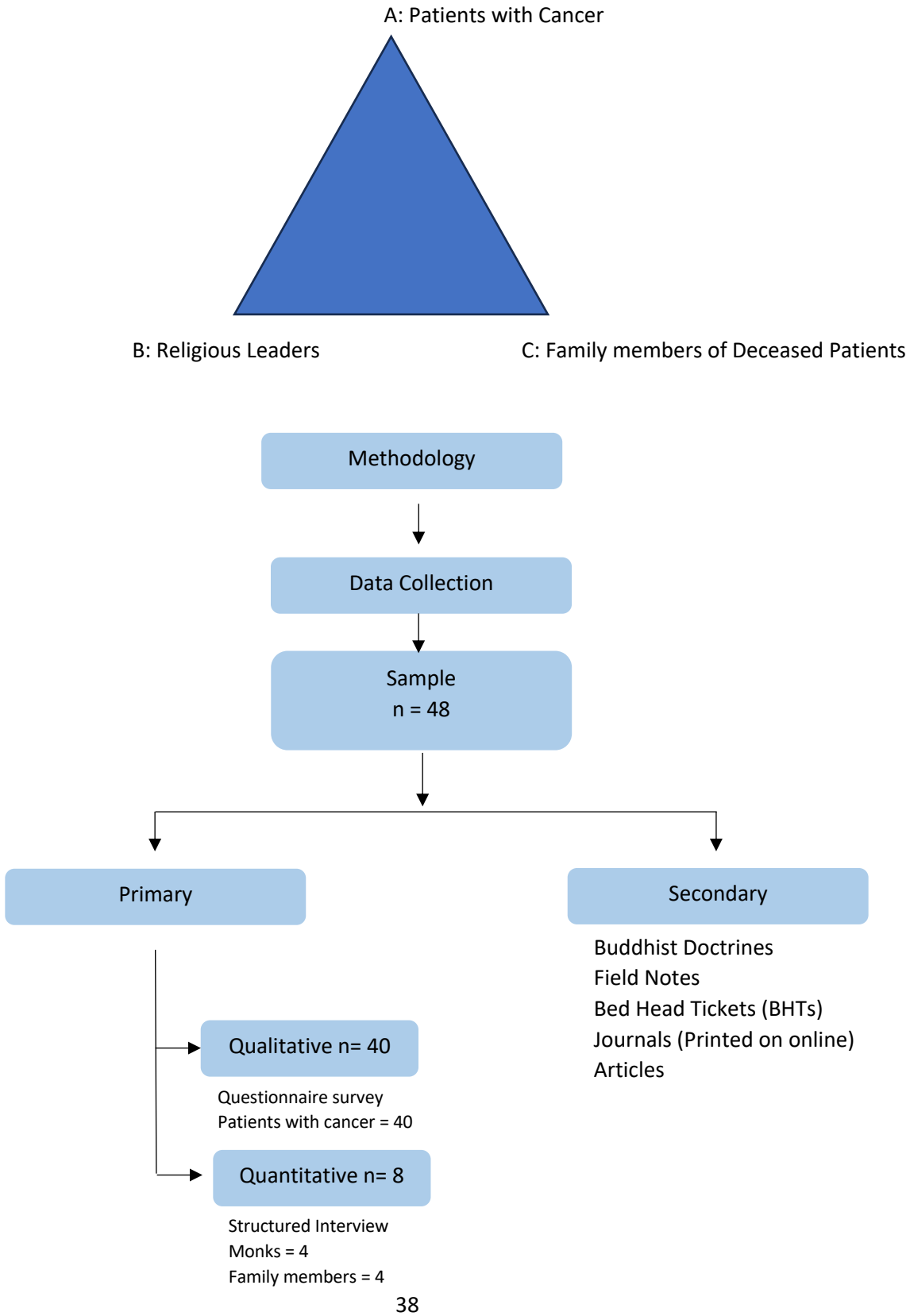
clinical psychologist. Their inclusion was essential for capturing the therapeutic, pastoral, and doctrinal dimensions of Buddhist end-of-life care. Interviews explored both practice-based contributions including chanting, meditation facilitation, and ritual administration, as well as doctrinal frameworks such as impermanence (*anicca*) and compassion (*karuṇā*). These narratives provided contextual depth to understand the monastic caregiving beyond institutional constraints.

Families of Deceased Patients (Qualitative Interviews)

Purposive sampling and snowball sampling were employed to select four family members of patients who had previously received palliative care. Initial participants were identified through hospital networks and subsequent participants were recruited via snowball sampling. Interviews examined three core domains: coping strategies during the dying trajectory, the use of Buddhist rituals and spiritual practices in supporting the patient at the end of life, and experiences of anticipatory grief prior to death. The stories from this group offered a critical viewpoint on the ways in which religious rituals supported both the acceptance of death, the continuation of caring following a loss and emotional transition.

While ethically appropriate, this sampling strategy may limit the generalizability of findings, as the sample may not be fully representative of the broader population, and this is addressed in the study's limitation section.

Figure 01: Triangulation of data set



6. Data Analysis

This study used a mixed-methods approach. Quantitative survey data were first examined descriptively to identify patterns in patients' engagement with Buddhist practices and their self-reported influence on acceptance, mental tranquility and spiritual coping. These findings were then integrated with themes generated from qualitative interviews, which were analyzed using thematic analysis to examine dimensions of spiritual care, ritual importance, and coping strategies. Field notes further supported contextual interpretation by capturing observed behaviors and practice settings, ensuring that both narrated experiences and enacted practices informed the analysis. Triangulation was made possible by the merging of multiple data sources, offering a more thorough and complex understanding of the role of Buddhism in palliative care in Sri Lanka.

7. Ethical Considerations

Ethical considerations were integrated throughout the study. All participants provided informed consent, and verbal consent was obtained when written consent was not feasible. Interview transcripts were de-identified to ensure anonymity and confidentiality. Participants were made aware of their right to withdraw at any time. Given the sensitivity of the topic, especially for bereaved family members, interviews could be paused or terminated based on participants' needs. Coordination with medical personnel in hospital settings ensured that data collection did not disrupt patient care or contribute to distress. Ethical approval was obtained from the relevant Institutional Review Boards.

8. Results

Palliative care worldwide is guided by the principle that the final stage of life should focus less on cure and more on relief from suffering, dignity, and quality of life. This care model addresses not only physical pain but also the psychological, social, and spiritual dimensions of the patient's experience. In doing so, it recognizes that the last moments of life are not just medical events but

deeply human experiences that shape how families cope with grief and transition through bereavement.

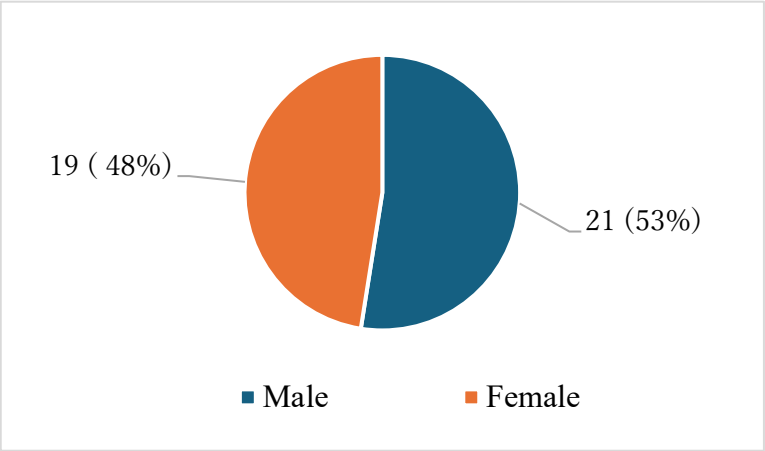
Within this holistic approach, spirituality and religion emerge as central elements. Decades of research, summarized by Koenig (2012) in the *Handbook of Religion and Health*, show that serious illness and dying often intensify religious or spiritual engagement. While not all individuals become more religious at the deathbed, many do turn toward faith as a way to find meaning, cope with uncertainty, and reconcile with mortality. This pattern is not limited to Western settings; it resonates across cultures, including South Asia.

In Sri Lanka, recent work, including the validation of the Sinhala S-SNAP tool (2024) has demonstrated that spiritual needs are both significant and measurable among patients with cancer. These findings show that spiritual care is not an optional addition, but an essential dimension of end-of-life support.

With this background, the analysis now turns to the specific ways Buddhist practices function within palliative care and in the wider community. By situating these practices within both global and local understandings of spirituality at the end of life, the discussion highlights how religion operates not only as ritual but also as a psychosocial and existential support system.

In discussions of the final stages of life, the general assumption is that individuals should remain calm, mindful, and free from sadness or self-directed anxiety. However, according to Buddhist perspectives, the Buddha acknowledged that all sentient beings experience fear of death and suffer in the phase of mortality. This raises an important question in the real-life context: whether individuals truly experience death, sadness and future-related anxiety in the ways described doctrinally. Do individuals experience anxiety about the future in the final stage of life? Do they feel sadness or emotional distress? The following data patterns were collected from forty cancer patients at Ratnapura Teaching Hospital. The figures first present the demographic characteristics of the sample before providing deeper insight into the overall religious tendencies of the group.

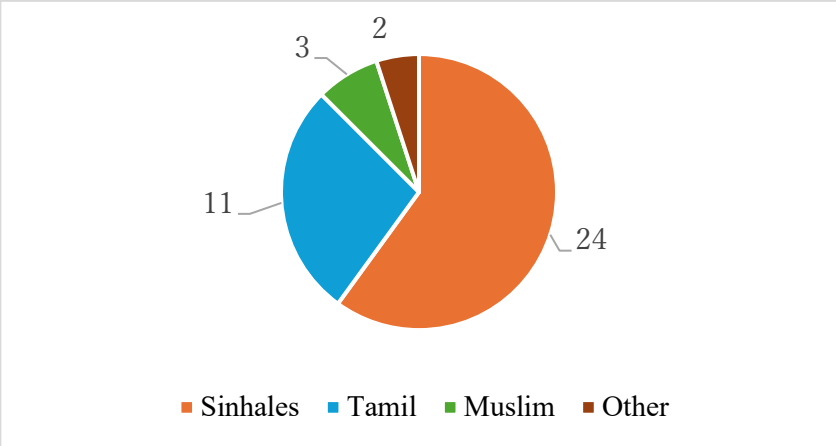
Figure 02: Gender distribution of participants (n=40)



(Source: Field data, 2025)

As shown in Figure 02, the survey included 21 males (53%) and 19 females (48%), indicating a slight male predominance within the study sample. Figure 03: Ethnic Background of participants.

Figure 03: Ethnic Background of the participants



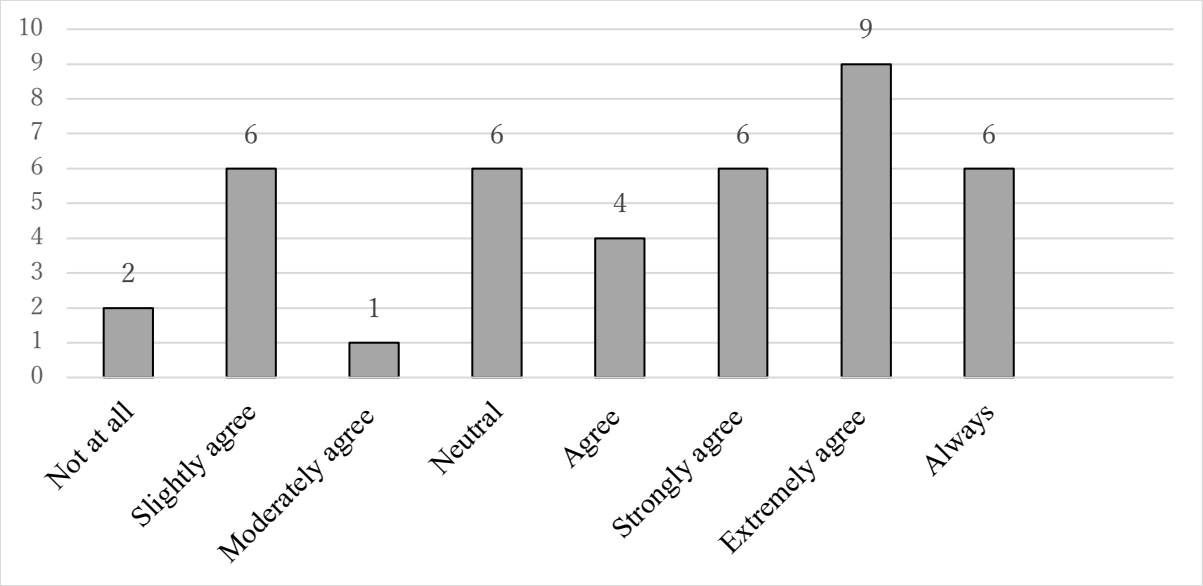
(Source: Field data, 2025)

As illustrated in Figure 03, most participants were Sinhalese (60%), followed by Tamils (27.5%) and other ethnicities comprising a small minority. This indicates that the sample is predominantly Sinhalese, with smaller but notable representation from Tamil participants, and very limited representation from Muslims and other groups.

Regarding marital status, most participants were married (62.5%). Widowed individuals comprised the second largest group (22.5%), while singles (12.5%) and divorced participants (2.5%) accounted for the remainder. This demonstrates that majority of the sample were married.

Taken together, the demographic distributions indicate a slight male predominance, strong representation of Sinhala Buddhist participants, and a majority who were married. Although gender representation was relatively balanced, diversity in both ethnicity and marital status was limited, with smaller proportions of Tamil, Muslim and other participants, as well as widowed, single, and divorced individuals. With this understanding of the sample characteristics, the analysis now turns to the religious and spiritual orientation of the study participants.

Figure 04: Level of sadness among patients



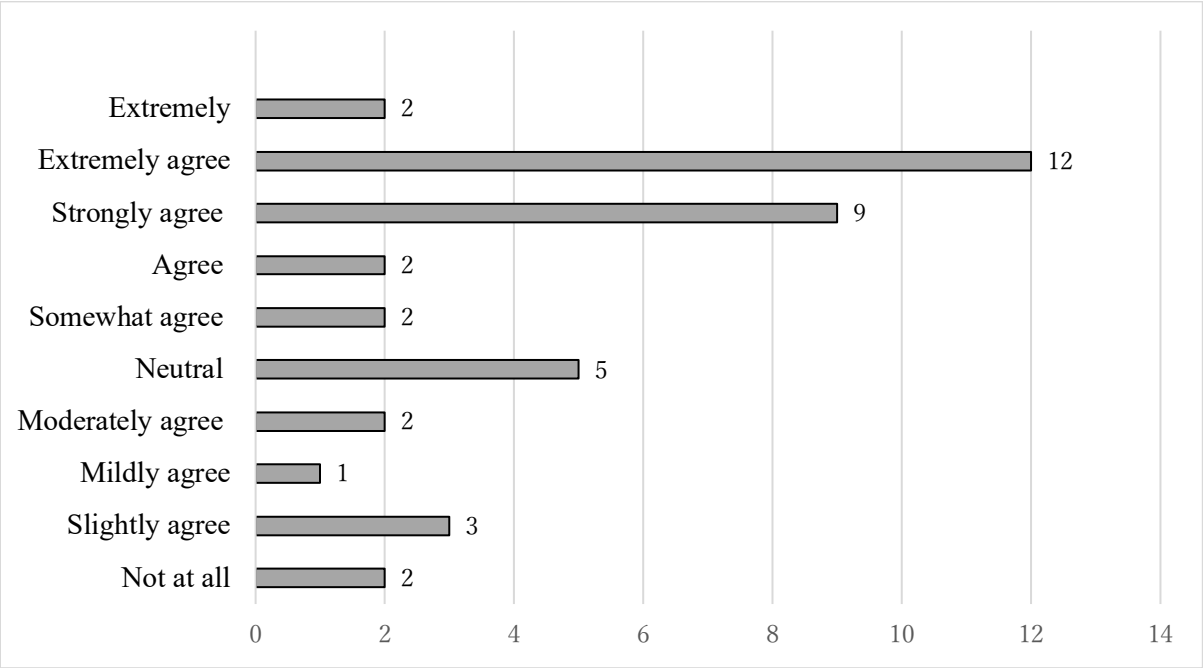
(Source: Field data, 2025)

According to Figure 04, 5% of surveyed patients reported not feeling sad at all, suggesting emotional resilience or effective coping strategies. 15% experienced only slight sadness, indicating the presence of mild manageable distress. One participant (2.5%) identified sadness as a moderate problem, reflecting noticeable but not overwhelming emotional struggle. Another 15% reported a neutral response, potentially reflecting ambivalence or emotional detachment. Conversely, a significant portion of patients reported higher levels of sadness. 10% experienced considerable sadness, and 15% stated they felt sad very often, indicating recurring emotional

distress. The largest group (23%) described severe sadness, while 15% reported extreme and persistent sadness, reflecting overwhelming emotional suffering.

When faced with pain, uncertainty, and the approach of death, it is natural for patients to struggle with overwhelming emotions. In this context, sadness emerges as a common and deeply human response in palliative care, underscoring the need for care that addresses more than the physical symptoms alone.

Figure 05: Level of nervousness and worry

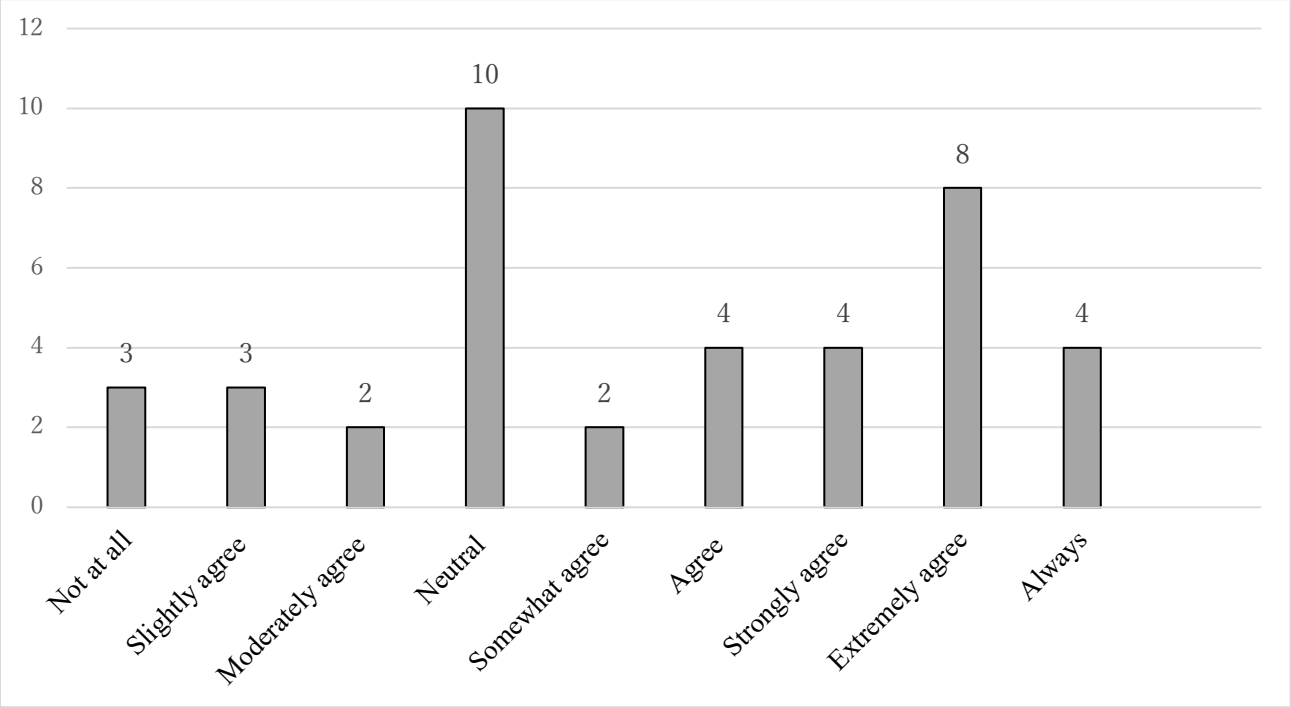


(Source: Field data, 2025)

Analysis of self-reported nervousness and worry revealed substantial variation among participants. A small proportion of respondents reported minimal emotional distress: 5% (n=2) indicated that they did not feel nervous or worried at all, while 8% reported feeling this way rarely, and 3% sometimes. Additionally, 5% reported occasional worry, and 13% selected a neutral response, which may reflect ambivalence or emotional detachment. Higher levels of nervousness were more prevalent. Five percent of participants reported feeling nervous frequently, another 5% often, and 23% very often. Notably, 30% of respondents indicated that they were always nervous or worried, and a further 5% reported feeling worried all the time.

Overall, 58% of participants experienced persistent or near-constant nervousness or worry, indicating that nervousness and worry constitute a significant and enduring psychological burden for a majority of patients in the palliative care context.

Figure 06: Level of fear about the future



(Source: Field data, 2025)

In the survey, 10% of patients reported not feeling scared about their future at all, while another 10% (n=8) indicated only slight fear, suggesting a small group was able to maintain relative calm despite uncertainty. Five percent of respondents reported moderate fear, indicating some unease without overwhelming distress.

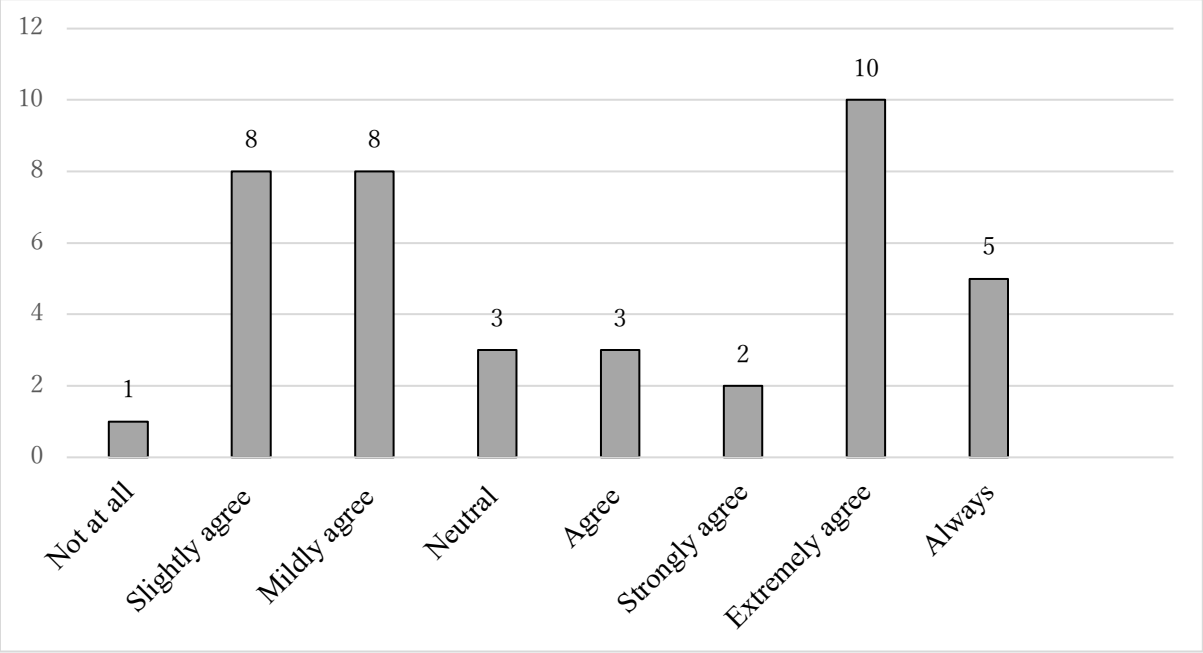
A significant proportion, 25%, described themselves as neutral, which may reflect emotional detachment, denial, or ambivalence about confronting their prognosis. At the higher end of the spectrum, 5% somewhat agreed that they were scared, 10 % identified their fear as considerable, and another 10% rated it as severe, highlighting a significant segment of patients struggling with real anxiety about the future. The largest proportion of participants (20% , n=16), reported severe

fear, while 5% described themselves as extremely scared, indicating that a substantial group (50%) reported high levels of fear when contemplating what lies ahead.

These findings suggest that, while some patients are able to face the future with relative calm, the majority struggle with significant fear and uncertainty. In the context of palliative care, this is particularly important: it shows that beyond physical pain, existential fear of death and the unknown weighs heavily on patients.

Overall, sadness, anxiety, and fear are common emotional challenges affecting the mental and overall wellbeing of people living with serious illnesses. Many patients experience high levels of stress and emotional distress; however, their care often remains confined to standard medical practices, which do not adequately address these aspects of suffering. In this context, religious practices appear to function as complementary forms of care, contributing to greater psychological stability and inner strength. Such practices provide a spiritual framework that enables patients to confront the prospect of death with greater acceptance and resilience. Figure 07 illustrates the overall levels of religiosity reported by the sample.

Figure 07: Levels of religiosity



(Source: Field data, 2025)

The main findings indicate that emotional distress is prominent among patients, with fear, anxiety and despair emerging as the most common experience. Religiosity was widespread within the sample, with 38% of participants reporting very high-level religiosity (extremely or strongly agreeing). In addition, 40% reported low to moderate religiosity (20% slightly religious and 20% mildly religious), while 8% indicated a neutral position and another 8% reported a moderate level of religious commitment. Only a very small number of participants reported no religious affiliation or practice. Overall, these findings indicate that a substantial majority of patients demonstrate moderate to high levels of religiosity, highlighting religion as an important coping resource. Qualitative interviews with Buddhist monks further contextualized these results, showing that Buddhist teaching and practice support patients and families in managing emotional suffering and end-of-life concerns, through an understanding of impermanence and ritual practices, family and community support, and engagement with healthcare settings.

Theme 1: Suffering, Karma, and Impermanence

According to Buddhist doctrine, the one thing that is inevitable in the world is death. Pain and suffering are understood as common facts of life that everybody must go through. Unlike medical definitions of stress, the Buddhist philosophy and doctrine present suffering as inherent to existence, shaped by the impermanence and the natural law of karma.

> *"Buddhism describes illness and disease as a common phenomenon and a dharma for everyone in this world. Buddhism sees it as a dharma that is common, inherited, and common to all beings who have been born."*
>
> (Interview 1: Buddhist monk serving as a national schoolteacher)

Above idea shows a direct connection to the doctrine of karma, which teaches that the actions of people in previous lives eventually lead to the conditions in the present (Buddhanet.net, 2024). So, even in a non-medical circumstance, it provides a belief framework or explanation for understanding why unfortunate or fortunate events occur. Particularly in a medical context, this belief offers an explanation for illness even in the absence of clear biomedical causes. The notion that illness arises from past deeds helps individuals and families make sense of suffering, reducing the sense of randomness that often intensifies fear. One monk explained this perspective:

"Life is already determined; it can be for weeks, days, or from today to tomorrow. Then you have to think that the merits and sins done in the past will bear fruit."

(Interview 2: Buddhist Monk)

However, karma is a moral system that recognizes the power of merit and extends beyond a simplistic framework of reward and punishment. It is believed that good acts will benefit patients and their families, either through recovery or a positive rebirth. Even in the face of terminal diagnoses, this worldview offers hope. One family member, for instance, explained how she attempted to remind her dying mother of her good deeds:

"I recited Pirith, I recited the good deeds… if my mother is angry with someone or something at this time, I want her to let it go. When I recite the good deeds, my mother has done, I want my mother to be happy."

(Interview 3: Daughter of a deceased patient)

The emotional turmoil of watching a loved one die is reframed through a karmic lens: recalling past merits provides comfort and nurtures the final state of mind (*cuticitta*), which determines the quality of rebirth. Although death is an emotionally tragic moment, attention shifts toward thoughts of rebirth, offering greater comfort. Patient discomfort is further contextualized through the Buddhist concept of impermanence. Impermanence operates across various aspects of life, including bodily health, physical strength, social status, and material wealth.

"The person with money loses money; a person without money loses everything. Only the clothes they are wearing remain."

(Interview 02: Buddhist monk)

Illness reminds patients and their families that death is the great equalizer, removing social indicators of income or status. This understanding aligns with Kellehear's (2007) sociological description of death as a "leveler," in which economic and cultural differences diminish as life comes to an end. Buddhism's emphasis on impermanence encourages acceptance among patients experiencing fear or depression, as it emphasizes that just as pain is temporary, so too are wealth or health.

Theme 2: Rituals as Sources of Healing and Resilience

Patients in the sample often turned to religion to alleviate fear and anxiety. .Buddhist rituals such as *Pirith* chanting, *Bodhi Pooja*, meditation, and merit-making served precisely this purpose, offering psychological calm and spiritual protection. These practices not only provide comfort to individuals on their deathbeds but also offer great strength to their families.

> *"What is expected… is to receive physical treatment and to heal them through mental treatment. Bodhi Pooja rituals, Pirith, meditation… all of these things give the patient great mental strength."*
>
> (Interview 01: Buddhist monk)

For families, rituals also provide comfort. A bereaved daughter recalled chanting *Pirith* for her dying mother:

> *"I recited Pirith, I recited the good deeds… If my mother is angry with someone or something at this time, I want her to let it go. When I recite the good deeds my mother has done, I want my mother to be happy."*
>
> (Interview 3: Daughter of a deceased patient)

Even as her voice "*was shaking with tears,"* she found relief in the act:

> *"It was a relief to me to be able to recite Pirith and to be able to tell her what a good thing she had done."*
>
> (Interview No 3: Daughter of deceased patient)

This illustrates the bidirectional nature of ritual. While rituals are primarily intended to provide comfort to the dying person or the individual experiencing illness, they simultaneously soothe and comfort caregivers and family members. This process directly helps establish post-death care for the family by allowing them to begin processing grief while still in the presence of their loved one. Rituals also mark the very moment of death. As one monk stated:

> *"I have seen people die while reciting Pirith."*
>
> (Interview 2: Buddhist monk)

This transforms the act of dying from a purely medical event into a spiritual passage, protected by the presence of sacred sound. For families, this is deeply significant as it signals that their loved one has passed away in a spiritually protected state, surrounded by wholesome words and blessings. Beyond the moment of death, rituals such as the seven-day alms giving, the three-month post-death almsgiving ritual, and the one-year death anniversary memorial sermon and almsgiving provide structured ways for families to sustain bonds with the deceased. The bereaved daughter explained:

> *"After that, what we did was give our mother alms… then we did the seven-day ritual, then we recited the bhana, then we did it for three months, and then we gave the annual ritual."*
>
> (Interview 3: Daughter of deceased patient)

These acts extend care beyond the life span, allowing families to continue expressing love and responsibility. In this way, families are not only able to cope with sadness of losing their loved ones but also experience these rituals as therapeutic practices. These are not merely acts of transferring merits; they function as meaningful ways for families to feel that they are still doing good for their loved ones. Additionally, these rituals affirm community solidarity, as neighbors and acquaintances often participate in organizing and performing these rituals. Notably, rituals are inclusive. A monk stated that: *"even Tamil, Muslim, and Christian families request Pirith threads and blessings,"* underscoring the universal appeal of ritual as a therapeutic resource. He recounted:

> *"One evening, while we were in the office, a Muslim father came. He came to me and said, 'Hamuduruwane, you went to the children's ward today to bless them, right? My child is also three beds away. There are some eggs in his lunch box. Hamuduruwane, take these eggs and bless our child too.'"*
>
> *(Interview 4: Buddhist monk)*

In palliative contexts, rituals therefore act as bridges between medicine and spirituality, offering resilience for patients, relief for families, and solidarity for communities.

Theme 3: Family and Community in Coping

Serious illness affects not only individual well-being but also the broader family system, reshaping roles, responsibilities, and emotional dynamics. In Buddhist contexts, however, this disruption of family life is met with a rich set of cultural and religious practices that mobilize both family and community in coping. Illness and death ripple beyond the individual, reshaping entire family systems.

> *"If someone in your family gets into this kind of situation, the entire family collapses."* (Interview 4: Buddhist monk)

A bereaved daughter confirmed this experience, describing the profound loneliness that followed her mother's death. The collapse is evident in the way families shift abruptly from daily routines to emergency caregiving, often at the expense of their own stability.

> *"After the loss, I felt a great sense of loneliness… I remember my sister and I sitting on the edge of a ditch in front of the hospital… Even then, we felt a great sense of loneliness."*
>
> (Interview 3: Daughter of a deceased patient)

Grief is not only sadness but also an existential loneliness or emptiness that affects surviving family members' sense of place and belonging. At this moment, communal assistance becomes a crucial support network, ensuring that families do not grieve alone.

> *"While we were in the hospital, the relatives and neighbors told the monk that our mother had passed away. Since then, everything has been done with the help of the neighbors…."*
>
> (Interview 4: Daughter of deceased patient)

> *"Within our Buddhist culture… when someone is in trouble, people look at it with a sympathetic perspective… No one is marginalized."*
>
> (Interview 1: Buddhist monk)

These practices reflect a collective model of coping, where suffering is shared rather than borne in isolation. Even families from other religious traditions turn to Buddhist rituals in times of crisis, recognizing their comforting power.

Through ritual and community support, grief is gradually transformed into gratitude and remembrance. Post-death rituals express humility and recognition of the life lived, affirming enduring bonds between the deceased and the living. In this way, Buddhist practices sustain both emotional and social resilience in the face of loss.

Theme 4: Integration and Challenges in Care Settings

While Buddhist practices offer profound resources for coping, their integration into medical settings remains inconsistent. The hospital setting itself emerged as an important context in which emotions were either intensified or alleviated. Interview participants provided valuable insights into how Buddhist practices are incorporated into medical environments, and the challenges involved in doing so. Their accounts indicate that although spiritual care is often welcomed in Sri Lanka's hospitals, its delivery is uneven, shaped by institutional structures, resource limitations, and external pressures such as the COVID-19 pandemic.

> *"In many hospitals, nowadays, there is usually a Buddha statue in a building, or in a ward of a hospital… I believe that it is really necessary for a patient to go there and heal his or her mind."*
>
> (Interview 2: Buddhist monk)

This reflects recognition by hospital authorities that psychological and spiritual well-being are part of holistic care. Such spaces offer patients and families the opportunity to engage in prayer, meditation, or ritual, even amidst clinical treatment. For patients in the sample who expressed fear or sadness, the presence of a sacred space may serve as an emotioinal anchor, reminding them of their spiritual resources and cultural traditions.

Openness to complementary care is essential in this context, where religious rituals are not viewed as competing with biomedicine but as augmenting it. In such settings, patients' religious expressions are respected and encouraged rather than suppressed, helping to address emotional

distress, anxiety, and fear. However, to realize the full benefits of these practices, orthodox medical systems and practitioners must actively support and accomodate religious engagement.

In contrast, some monks highlighted the obstacles posed by noisy, crowded wards and the limited cooperation of medical staff:

> *"Chanting Pirith in hospitals is challenging… children scream in pain; the environment is very busy. One day, when I was chanting Pirith in a children's ward, my attention was more focused on the sound of one person screaming in pain than the sound of my Pirith."*
>
> (Interview 3: Buddhist monk)

Moreover, while medical staff acknowledged the presence of monks, they offered little active support:

> *"In a situation like this, you can't expect much support from doctors and nurses. They know that we chant Pirith, but they don't give much support."*
>
> (Interview 4: Buddhist monk)

The bereaved daughter also described how institutional restrictions, particularly during the COVID-19 pandemic, limited religious practices:

> *"During the COVID period… those things cannot be done legally, but they are done humanely."*
>
> (Interview 3: Daughter of deceased patient)

This illustrates the tension between institutional regulations and humanitarian allowances. Families often improvised rituals themselves, sometimes under stressful conditions, reflecting both their resilience and the lack of formalized spiritual care within hospital settings. On the one hand, medical systems prioritize safety, efficiency, and standardized protocols; on the other, patients and families require spiritual care that cannot always be neatly codified. The family's experience demonstrates that even in restrictive environments, staff occasionally made compassionate exceptions, recognizing the deep significance of religious rituals at the end of life.

Families also reported having to improvise because there were no designated spaces for ritual practice. One participant recalled feeling morally obligated to recite Pirith for her dying mother as part of her responsibility, even without explicit guidance or support:

> *"As Buddhists, we understand that placing Pirith in such manner is... we don't know how she feels, but we performed Pirith, read books of merit (Pin Potha), etc. and made her aware of her actions. "*
>
> (Interview 4: Niece of a deceased patient)

This highlights a weakness in institutionalized spiritual care: families are frequently left to manage religious practices on their own, sometimes in unfamiliar and distressing environments. While this may strengthen family involvement, it can also intensify feelings of isolation and perceived lack of support from the medical system. To realize the full potential of holistic care, palliative systems in Sri Lanka must integrate Buddhist practices more consistently by providing appropriate spaces, clear institutional policies, and staff training that support spiritual needs alongside medical care.

9. Discussion

This study explored how Buddhist practices provide alternative forms of care within palliative contexts in Sri Lanka, drawing on interviews with Buddhist monks, bereaved family members, and insights from a patient sample. Overall, the findings demonstrate how Buddhist philosophy and ritual practices address sadness, anxiety, and fear, dominant experiences in serious illness and provide resources for resilience among patients, families, and communities.

The first theme showed that Buddhist teachings on karma and impermanence shaped how patients and families interpreted suffering. Illness was not viewed as random but as a karmic consequence of past actions, echoing the *Cūlakammavibhanga Sutta* (MN 135). This perspective provided meaning for patients who might otherwise have experienced their suffering as arbitrary or unjust. Similar findings appear in Keown's (2005) work, which notes that Buddhist patients often interpret illness through the lens of moral causality. This interpretation also offers a framework for moral reflection, guiding individuals in how they understand and live their present lives.

Impermanence (*anicca*) further reframed experiences of grief. Patients and families, confronted with the decline of loved ones, recognize death as a natural process rather than an avoidable tragedy. This understanding aligns with survey data: sixteen patients reported very severe fear about their future, while four described extreme fear, and many others expressed moderate to severe concern. These findings align with Harvey's (2013) observation that awareness of impermanence helps Buddhists accept life transitions with less resistance. Death, whether anticipated through illness or understood as an inevitable part of life, is rarely something individuals or families feel prepared to face. This suggests that spiritual frameworks can help palliative care providers shift the focus from extending life at all costs toward promoting dignity, serenity, and quality of life at the end of life by transforming dread and grief into acceptance.

The second theme emphasized the role of rituals such as *Pirith* chanting, *Bodhi Pooja*, and merit-making. These were not experienced merely as religious obligations but as therapeutic interventions. Monks described rituals as healing both the body and mind, an understanding consistent with Jayasinghe's (2021) finding that Buddhist chanting reduces anxiety and induces calm. Quantitative data further highlighted the importance of such interventions: 23% of patients reported *very severe* sadness, 15% described their sadness as *extreme*, and several others experienced considerable or frequent sadness. Worry followed a similar pattern, with 23% feeling worried often, 30% almost always worried, and 5% worried all the time. In total, 58% of the participants lived with persistent or near-constant worry, highlighting the heavy psychological burden faced by patients in palliative care. Testimony from bereaved family members illustrated the dual function of ritual. While chanting *Pirith* was intended to comfort the dying person, it also provided emotional relief for the relatives and loved ones. This reflects Turner's (1969) concept of ritual as a structured response to chaos, offering form and meaning in moments of emotional overwhelm.

Post-death rituals, such as almsgivings and annual commemorations, allow families to maintain bonds with the deceased while transferring merit to them, a practice grounded in the Buddhist teachings of the *Tirokudda Kanda* (*Khuddakapāṭha*, 7). This finding resonates with Klass et al.'s (1996) theory of continuing bonds, but adds a distinctively Buddhist dimension: bonds are understood not only psychologically but also karmically, with merit believed to influence the

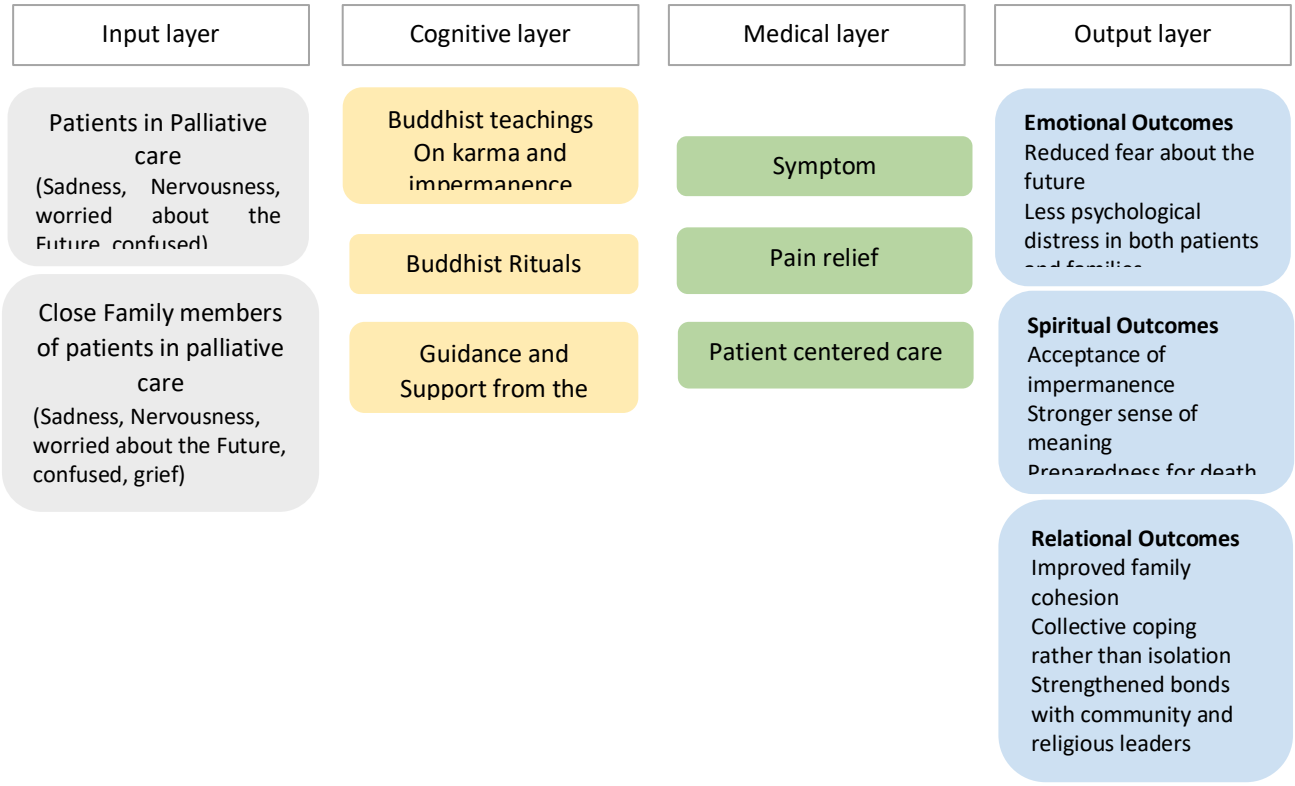
deceased's next rebirth. In this way, rituals extend palliative care beyond the clinical sphere, offering structured means to manage fear, grief, and meaning.

The third theme emphasized how serious illness and death disrupt entire family systems, often leading to isolation and disintegration. In Buddhist contexts, however, families and communities mobilize collectively in response. A bereaved daughter described how neighbors, monks, and family members provided ritual support and physical presence, ensuring that her family did not grieve alone. This reflects Kapferer's (1983) analysis of Sri Lankan healing rituals as collective practices that bind communities together. In contrast to Western models of bereavement, which are often highly individualistic (Kellehear, 2007), the Sri Lankan Buddhist approach frames grief as a shared social experience. This pattern can also be understood through Hofstede's Cultural Dimensions Theory, which characterizes Sri Lanka as a predominantly collectivist society, where individuals are embedded within strong social networks, and shared responsibility for suffering and care makes communal grieving a culturally expected and supported response (Hofstede, 1980). Families also emerged as active participants rather than passive observers. By reciting *Pirith* and recalling good deeds, they managed their own suffering while simultaneously offering spiritual support for the dying. This interactive role positions families as active co-providers of spiritual care, rather than mere recipients of medical information, within Buddhist palliative care contexts

The final theme revealed both integration and challenges in hospital settings. Some institutions supported spiritual practices, creating spaces for worship and encouraging monks' involvement consistent with Ariyaratne's (2014) observations that Sri Lankan hospitals often blend biomedical and religious care informally. However, significant obstacles remained. Noisy wards, lack of staff cooperation, and legal restrictions imposed due to COVID-19 limited ritual practice. Families frequently improvised rituals under stressful conditions, exposing gaps in institutionalized spiritual care. Survey data indicate that 42% of patients felt their spiritual needs were insufficiently supported in clinical settings, suggesting that even highly religious patients may experience unmet spiritual needs. This finding aligns with Sinclair et al.'s (2016) argument that while spirituality is acknowledged in palliative care, its delivery is often inconsistent and dependent on circumstances rather than systematic policy. For patients already experiencing sadness and fear, such inconsistency can be consequential: when rituals are smoothly integrated,

they provide peace; when obstructed, they may deepen feelings of abandonment. Overall, these findings underscore the need for stronger institutional frameworks that intentionally integrate spiritual care into palliative services in Sri Lanka, recognizing Buddhist practices not as supplementary but as central components of holistic end-of-life care.

Figure 08: Integrated conceptual model of Buddhist-informed palliative care



(Source: Developed by authors, 2025)

By demonstrating how Buddhist practices function as alternative forms of care in hospice settings rather than merely symbolic acts, this study advances our understanding of holistic care. These practices address social needs, by mobilizing family and community support, spiritual needs, by fostering wholesome states of mind at the time of death, and psychological needs by reducing grief, fear, and anxiety. Practically, the findings suggest that palliative care in Sri Lanka should:

- Provide dedicated spaces in hospitals for rituals and reflection guided by the teachings of respective religions.

- Train medical staff to collaborate with monks and families in delivering spiritual support.
- Recognize rituals as therapeutic interventions rather than peripheral additions to care.
- Strengthen community-hospital partnerships to ensure the continuity of spiritual care beyond clinical settings.

These recommendations align with the World Health Organization's (2020) call to integrate cultural and spiritual dimensions into primary palliative care.

10. Limitations

This study has several limitations. The sample was relatively small (n = 40) and drawn from a single hospital in Ratnapura, which may limit the generalizability of the findings to other regions or more diverse populations. Data were cross-sectional and relied on self-reported measures of emotions and religiosity, which may be influenced by social desirability or difficulties in articulating inner experiences near the end of life. The quantitative analysis remains descriptive in nature: although the figures reveal meaningful patterns, no statistical tests or inferential analyses were performed, which limits the depth of quantitative interpretation. Additionally, the study's focus on Buddhist-informed practices means that the proposed model may not fully capture the experiences of patients from other religious or cultural backgrounds.

11. Conclusion

This study demonstrates that Buddhist practice offers far more than religious comfort at the margins of serious illness. It provides an alternative system of care that addresses the emotional, spiritual, and social dimensions of suffering in ways that biomedical models alone cannot. For patients experiencing sadness, anxiety, and fear, Buddhist philosophy reinterprets suffering through the lenses of karma and impermanence, transforming fear into acceptance, and grief into understanding. For families, rituals such as *Pirith* chanting and merit-making are not merely symbolic but therapeutic, sustaining both the dying and the bereaved. For communities, these practices mobilize collective compassion, ensuring that illness and loss are never endured in isolation.

The significance of these findings is twofold. First, they affirm that Buddhism can play a central role in shaping palliative care in Sri Lanka, not as an optional cultural addition, but as a core dimension of care. Second, they highlight the need for healthcare systems to recognize spirituality as integral to human dignity at the end of life. To neglect these dimensions is to reduce palliative care to symptom management alone, overlooking the fears and sorrows that weigh most heavily on patients and families.

The way forward is clear. Palliative care in Sri Lanka, and in other Buddhist-majority contexts, must actively integrate spiritual practices into its care frameworks. This requires creating dedicated spaces within hospitals for ritual and reflection, equipping healthcare staff to collaborate respectfully with monks and families, and embedding compassion as a guiding principle alongside clinical competence. Doing so would not only enhance the cultural relevance of palliative care but also fulfill its deepest mission: to relieve suffering in all of its forms—physical, emotional, social, and spiritual.

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Research Notes

The Social Contribution of Buddhist Temples in Japan's Healthcare System

: The Perspective of SDG3 and Social Capital in "Health Japan 21"

Ayari Ogasawara

Abstract

This paper provides an overview of the recent "health" trends in Japan, policies centered on SDG3 (Good Health and Well-Being) in response to the revision to the third "Health Japan 21" initiative, and the role of Buddhist temples as stakeholders in the development of social capital (SC) within Japan's healthcare system. It analyzes the potential of Buddhist temples based on the findings of the Sustainable Development Solutions Network (SDSN) reports, large-scale surveys conducted by the Japan Buddhist Federation (JBF) , and current temple activities.

The results show that recent "health" trends in Japan have called for all stakeholders to contribute to the formation of "connections" and SC while responding to a changing society and international health issues, temples being no exception. Globally, research on loneliness and happiness is thriving. While similar research is being conducted in Japan, studies on the role of temples are also gradually increasing. Temple social activities contribute to the achievement of the SDGs and function as spaces for "loose connections," as sought by the JBF survey, significantly promoting "Health Japan 21." Additionally, temples provide relief to those who do not fit into existing social welfare systems through religiously motivated systems, which is an advantage of temple social activities which address diverse needs.

Keywords: **Social Contribution of Buddhist Temples, "Health Japan 21", SDGs (SDG3), Social Capital, Subjective Well-being**

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1. Introduction

"Health" Trends in Japan and SDGs

In recent years, Japan has implemented a series of administrative reforms related to "health promotion" in the medical field, including revisions to guidelines for new health promotion systems and updates to medical training curricula at universities. In 2024, the new "National Health Promotion Movement for the 21st Century" (the third "Health Japan 21" [HJ21]) was launched. HJ21 is a national policy that began in 2001 to promote the health of all citizens from a primary prevention perspective. It does so by establishing support systems for individual health promotion, with the overall target of extending healthy life expectancy[2]. In Japan, the Health Promotion Act was enforced in 2003; however HJ21 is a specific plan, of which the third phase was enacted in 2024.

The third HJ21 initiative aims to create a sustainable society where all citizens can lead healthy and fulfilling lives. It has adopted "inclusion" (promoting health for all, leaving no one behind) and "implementation" (taking effective measures). The plan builds on past efforts, addresses new health challenges, and aligns with international trends, including the Sustainable Development Goals (SDGs). Furthermore, it emphasizes the importance of improving the quality of the social environment. While the second HJ21 initiative included measures to improve the social environment, the third phase explicitly states the goal of fostering social capital (SC). This involves creating environments that support "creating a place to belong and participating in society," "environments that enable connections, including flexible relationships," and "environments that protect mental health" to maintain and improve social connections and mental health. Human health is greatly influenced by the social environment. Therefore, under the policy of "leaving no one behind," it is necessary to create an environment where all stakeholders, regardless of life stage, can engage in health promotion. This revision, in addition to reducing the risk of non-communicable diseases (NCDs)[3] and improving individual behavior and health status, focused on fostering SC within society "connections."

[2] https://www.mhlw.go.jp/content/001102728.pdf

[3] Non-Communicable Diseases (NCDs), a term used by the World Health Organization (WHO) to refer to non-infectious diseases, such as cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes.

Simultaneously, revisions to the curriculum for training medical professionals have been implemented. In line with the launch of the third HJ21, the "Medical Education Model Core Curriculum" for physician training was revised and implemented in 2024. The stated goal for this revised curriculum, "to nurture medical professionals who can play an active role in future society and local communities by looking ahead and connecting diverse environments and people," emphasizes "connections" in society.

Within the curriculum, the "generalism" component emphasizes a comprehensive approach to patients and their lifestyles. This involves an organ-based understanding grounded in physiological and anatomical principles, and a flexible clinical practice that accounts for patients' psychological and sociocultural backgrounds as well as their relationships with their family and the community. Hence, it seeks to cultivate the ability to achieve the well-being of individuals and society. Furthermore, within this "generalism," the "societal perspective" is particularly emphasized, requiring an understanding of "health perceptions and people's behaviors and relationships that emerge within cultural and social contexts." This calls for a humanistic scientific knowledge from the fields of cultural anthropology (medical anthropology) and medical sociology. In 2025, the "Nursing Education Model Core Curriculum" was revised to emphasize "generalism," and focus on comprehensively understanding patients in society while supporting them as professionals, with content that focuses on "healthcare in society."

Hence, the recent revisions to the medical technologist training curriculum are designed to foster "connections" with society and promote SC, while responding to an ever-changing society and international health issues, aligning with the objectives of HJ21. Based on the above, the future "health" trends in Japan, including healthcare, are expected to take a comprehensive direction that builds on the extension of healthy life expectancy, with two new trends:

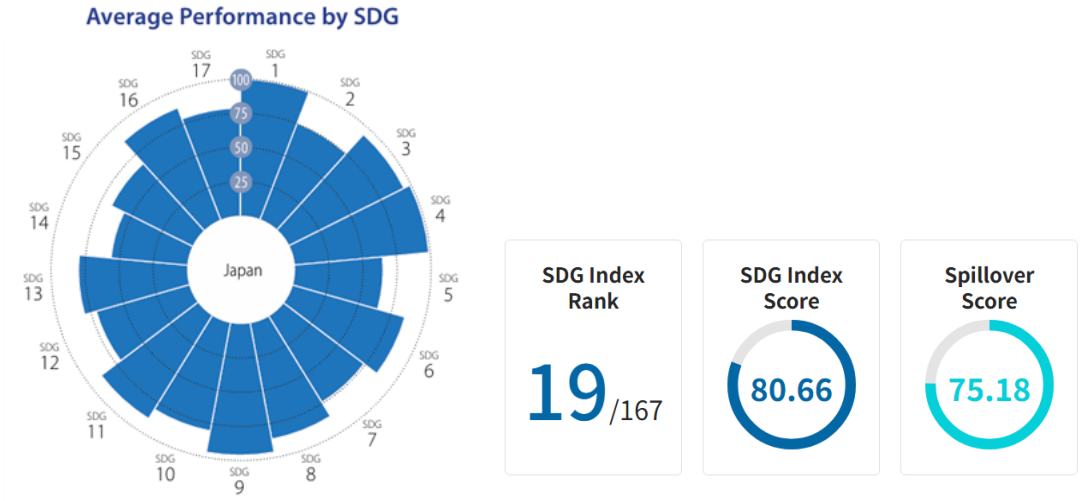
1) An international approach to health, specifically aligning with the SDGs.

2) Maintaining and improving social connections and mental health, emphasizing "connections" that take into account cultural and social backgrounds.

2. Expectations for SDG3 and Social Capital

The healthcare systems and administrative measures related to “health” are based on the SDGs, which are international standards that include “leaving no one behind” and “sustainability.” Therefore, this study confirms the relationship between SDG3 (good health and well-being), which is central to international health promotion, and SC (social capital), which is an important concept in “connections.”

Based on the Sustainable Development Report, June 2025, published by the Sustainable Development Solutions Network (SDSN)[4], renowned for its SDG-related data analysis and indicators, this study will summarize the current status of SDG achievement in Japan, focusing on SDG3.



Source: Country Profiles, Sustainable Development Report 2025

Figure 01.

[4] Sustainable Development Solutions Network (SDSN) https://www.unsdsn.org/.

SDG Dashboard and Trends in Japan

Major challenges

Significant challenges

Remaining challenges

Achieved

Source: Country Profiles, Sustainable Development Report 2025

Figure 02.

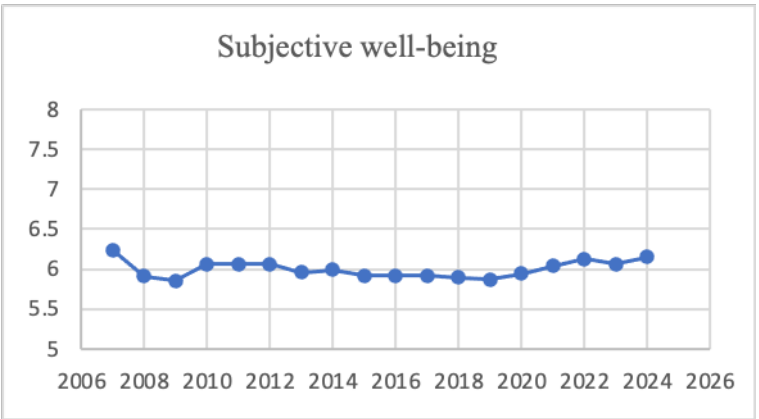
According to the 2025 report, Japan's SDG achievement ranking is 19th out of 167 countries (score: 80.66), with a spillover score of 75.18. SDG3 is the only goal to receive an "achieved" evaluation during this period, with indicators including subjective well-being being evaluated as achieved.

SDG3 – Good Health and Well-Being				
Maternal mortality ratio (per 100,000 live births)	3.1	2023	●	↑
Neonatal mortality rate (per 1,000 live births)	0.8	2023	●	↑
Mortality rate, under-5 (per 1,000 live births)	2.4	2023	●	↑
Incidence of tuberculosis (per 100,000 population)	9.3	2023	●	↑
New HIV infections (per 1,000 uninfected population, all ages)	NA	NA	●	●
Age-standardized death rate due to cardiovascular disease, cancer, diabetes, or chronic respiratory disease in adults aged 30 to 70 years (%)	8.0	2021	●	↑
Age-standardized death rate attributable to household air pollution and ambient air pollution (per 100,000 population)	12.0	2019	●	●
Traffic deaths (per 100,000 population)	2.7	2021	●	↑
Life expectancy at birth (years)	84.7	2023	●	↑
Adolescent fertility rate (births per 1,000 females aged 15 to 19)	2.0	2021	●	↑
Births attended by skilled health personnel (%)	99.8	2022	●	→
Surviving infants who received 2 WHO-recommended vaccines (%)	94.0	2023	●	→
Universal health coverage (UHC) index of service coverage (worst 0–100 best)	83.5	2021	●	↑
Subjective well-being (average ladder score, worst 0–10 best)	6.1	2024	●	↑
Gap in life expectancy at birth among regions (years)	2.5	2020	●	●
Gap in self-reported health status by income (percentage points)	16.5	2022	●	→
Daily smokers (% of population aged 15 and over)	16.7	2019	●	●

Source: Country Profiles, Sustainable Development Report 2025

Figure 03.

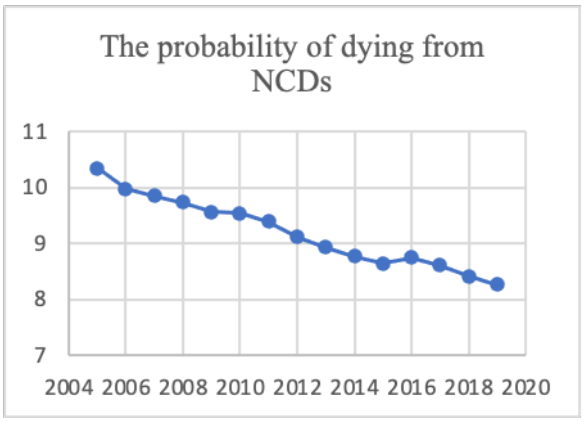
Furthermore, according to the SDSN report, the indicators of subjective well-being in Japan have followed the trends shown in Figure 04.



Source: Created by the author based on the Sustainable Development Report 2024,2025

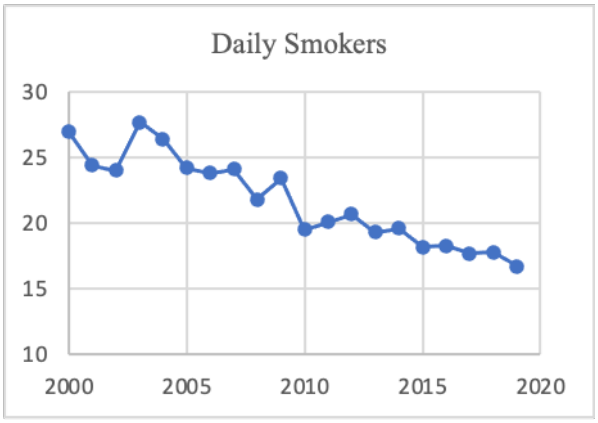
Figure 04. worst =0, 10=best.

Subjective well-being, one of the targets of SDG3, showed a decline when the survey began in 2007 but has remained stable since 2010. However, other indicators under SDG3, such as "mortality rate from non-communicable diseases (NCDs)" and "number of daily smokers," show an improving trend (Figure 05 and Figure 06).



Source: Created by the author based on Sustainable Development Report 2024

Figure 05. Age-standardized death rate due to non-communicable diseases (NCDs) such as cardiovascular disease, cancer, diabetes, or chronic respiratory disease in adults aged 30 to 70 years.



Source: Created by the author based on Sustainable Development Report 2024

Figure 06. The percentage of the population aged 15 years and older who are reported to smoke daily.

These goals, which Japan has been working on since 2001, overlap with those of HJ21, demonstrating that Japan's health promotion efforts are reflected in the evaluation of SDG achievement. Therefore, the third HJ21 continues to focus on improving subjective well-being, which remains at the same level as SDG3.

Regarding the improvement of subjective well-being, various studies have been published in Japan in recent years. Furthermore, several point to the relationship between happiness and loneliness. Internationally, Meta and Gallup's report, The Global State of Social Connections (2023),[5] conducted an international survey on social connections, happiness, and loneliness, and pointed out the impact of loneliness on mental and physical health. Furthermore, the World Happiness Report (2024) by SDSN[6] pointed out that loneliness was influenced by social connections and support; that is, across generations, people who received more social support experienced less loneliness and engaged in more social activities and interactions.

As mentioned, Japan's third HJ21 promotes the creation of a social environment that fosters SC to strengthen people's connections, reduce loneliness, and provide social support. This is based on the results of empirical research conducted globally. SC values connections and relationships with other people. As stated by Putnam (2000), participation in religious activities is an important form of SC, along with political participation, civic activities, workplace connections, and charitable activities. Therefore, to respond to the government's HJ21 policy and social demands, it is necessary to reconsider the role of religion and religious organizations in Japan in fostering human connections.

3. Religious Leaders and Temples as Stakeholders

This section will provide an overview of the potential contributions that religious organizations, particularly Buddhist temples, can make to society as stakeholders in SDG3 and SC. Currently, within Japan's Buddhist community, some sects, related organizations, and Buddhist-affiliated

[5] https://www.gallup.com/analytics/509675/state-of-social-connections.aspx.

[6] https://www.worldhappiness.report/ed/2024/. Chapter 2: Happiness of the Younger, the Older, and Those In Between.

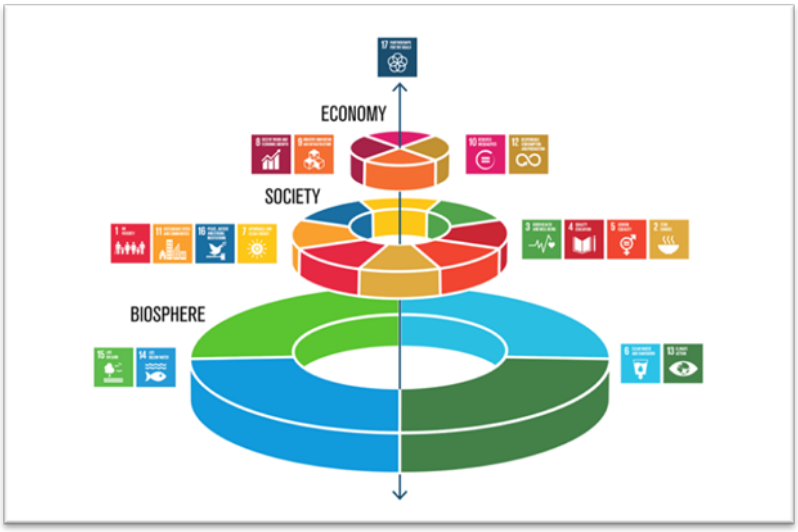
universities are actively engaged in SDG initiatives. The Japan Buddhist Federation (JBF) held symposia from 2020 to 2022. However, the main initiatives or research are conducted by individual sects within the country.

It is difficult to evaluate the relevance and contribution of such activities to the SDGs. However, among the social activities conducted by individual temples, initiatives such as the Otera Oyatsu Club, Children's Cafeteria, and Temple School Activities are common. These activities belong to the welfare field, which Buddhist organizations have focused on in modern times, and reflect traditional activities. In recent years, temples have begun offering a variety of social services, such as temple cafés, listening activities, mental health support, cultural exchange through music and exhibitions, and elderly services following administrative law. This has noticeable diversified and revitalized the temple social activities.

These activities are aimed at contributing to society by utilizing the unique resources of temples concerning the needs and circumstances of the local community. They serve as places for people of all ages to gather and receive services, contributing to the promotion of SDG3 and fostering SDG17 (partnership). Furthermore, such activities rely on collaboration and partnerships with diverse stakeholders, including local governments, and are distinct from closed-off or profit-driven social activities conducted by religious organizations alone. This is an important aspect of the "public interest" characteristic of religious organizations.[7]

When examining the activities of such temples through the Wedding Cake Model for SDGs (Figure 07), it becomes evident that their contributions are centered on society and are interconnected to the biosphere and the economy. The Wedding Cake Model was originally developed to illustrate that "all SDGs are directly or indirectly linked to sustainable and healthy food." For example, the contributions of food banks and waste reduction efforts seen in initiatives such as the Otera Oyatsu Club and Children's Cafeteria, as well as the use of locally grown crops, connect social activities to the biosphere and the economy.

[7] This paper, from the perspective of the "public interest of religious corporations," takes the position that religious corporations conduct activities that fulfill their basic functions and roles, such as proselytizing, rituals, and ceremonies, and activities that respond to social demands based on these functions. The view that "fulfilling the original functions and roles of religion is the basis of public interest" is common among researchers in multiple fields, such as law, religious sociology, and religious studies.



Source: Stockholm Resilience Centre

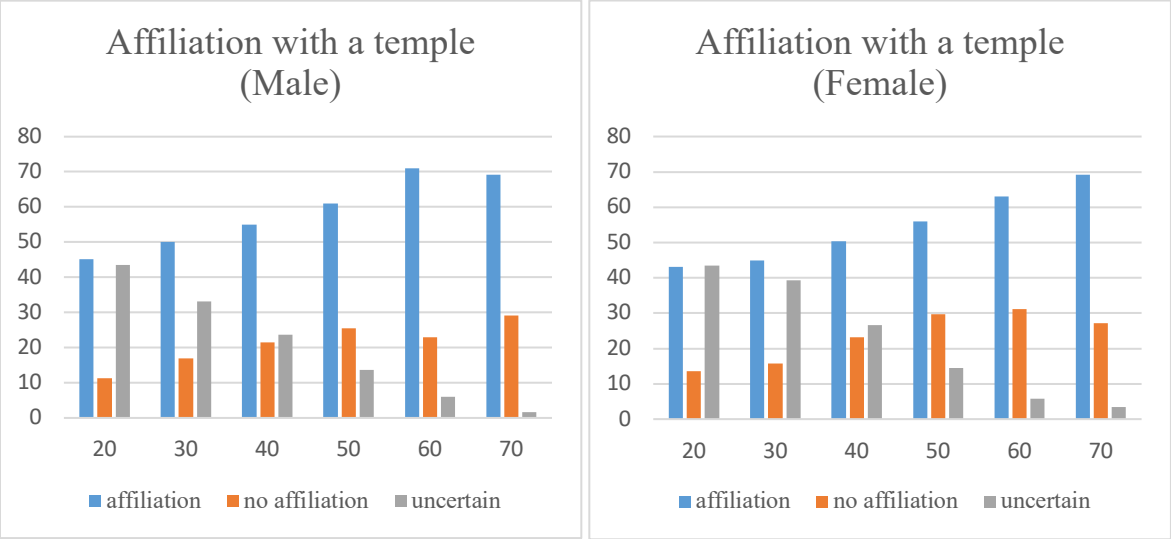
Figure 07. The SDGs wedding cake model

Social contribution activities by temples can often result in contributing to the achievement of SDGs. Hence, being mindful of SDGs as a global issue is meaningful for all stakeholders, including temples. However, SDGs can also be used as superficial PR tools, such as in corporate "SDG washing." As mentioned earlier, temple activities, including social contributions, are evaluated socially in terms of the "public interest of religious corporations." For this reason, the relationship with the SDGs must be understood in terms of social contributions and activities that grow from the primary activities of religious facilities in the community, such as legal affairs and missionary work, and not as a goal in itself.

4. Potential as a "Place of Loose Connections"

The contributions of temples' social activities to health are noteworthy from the perspective of the SDGs, especially SDG3. Furthermore, they can potentially contribute to SC, which is closely related to SDG3, such as alleviating loneliness and fostering "connections," based on empirical data. Regarding the social contributions of Japanese temples, the results of a nationwide large-

scale survey conducted in 2021 by the JBF and Daiwa Securities can be a reference indicator. [8] This survey analyzed the current relationship between Buddhist temples in Japan and society. The data is available on the JBF website and contains interesting findings. This study focuses on the section titled "Relationship with temples by age group." The following results were from a preliminary survey that asked men and women, aged 20 to 70 years, living in urban areas, whether they belonged to a temple (Figure 08).



Source: Created by the author based on the JFB "Survey on the Current State of Buddhism (FY 2021) Report: Temples'SDGs 'Social Contribution Activities' and 'DX,' etc."

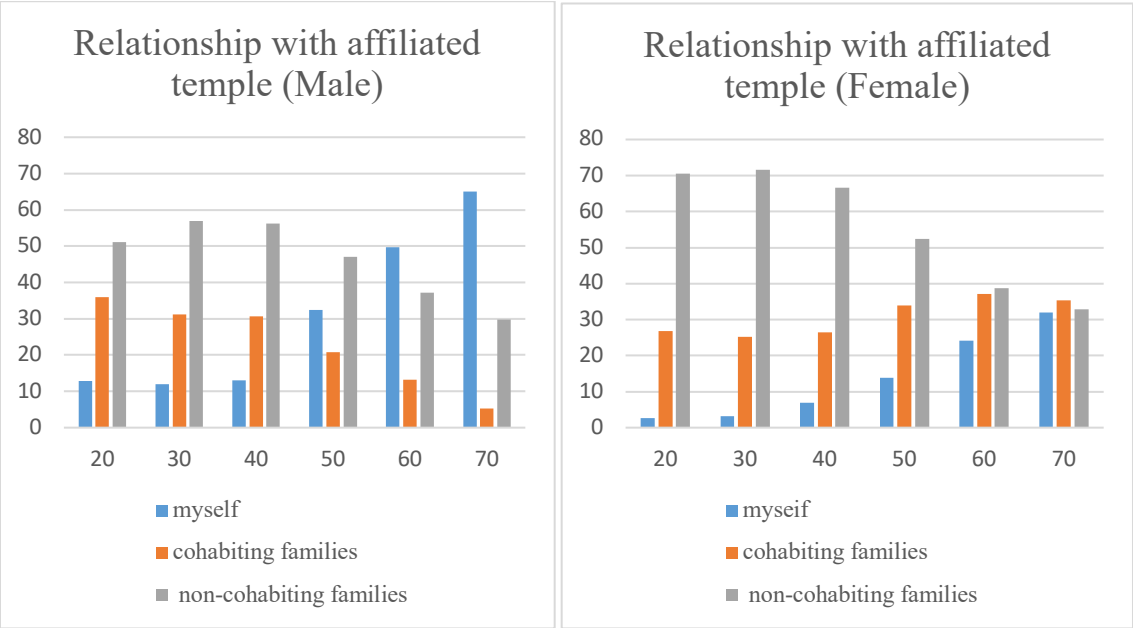
Figure 08.

According to the survey, the percentage of people who were aware of their affiliation with a temple increased with age, exceeding 50% among both men and women of Generation X and approximately 70% among Baby Boomers. Women showed a gradual increase, while men exceeded 50% in the latter half of the Millennial generation and increased rapidly from their 50s. This could be due to life events, such as inheritance and participation in funerals following the death of relatives. The changing relationships with religion and religious organizations at different stages of life are not unique to Japan. However, in Japanese society, the patriarchal

[8] "Survey on the Current Status of Buddhism (2021)" — Temples and SDGs: Social Contribution Activities and DX, etc. https://www.jbf.ne.jp/wp-content/uploads/site211/files/pdf/bukkyoureport2021.pdf.

family structure, a remnant of the traditional "family system," persists, and it can be inferred that men have more opportunities to take on or be aware of "inheriting funeral rites based on custom" at an early age.

Figure 09 shows the results of a survey of people who were aware of their affiliation with a temple. People in their 60s or younger, although aware of the temples they belonged to, were rarely actively involved. This generation recognized the existence of their affiliated temples as a connection to their families and ancestors; however, they regarded it as a "loosely connected group" that did not actively participate.



Source: Created by the author based on JFB "Survey on the Current State of Buddhism (2021) Report: Temples' SDGs 'Social Contribution Activities' and 'DX,' etc."

Figure 09.

In recent years, several individuals have maintained a "loose connection" with temples or religion through ancestral worship or religious beliefs, even if they were not formally affiliated with a religious organization such as by being registered as a temple parishioner. This "loose connection" is not limited to ancestral worship or rituals, and is also maintained through temple social activities.

For example, temples in urban areas that open their terraces to the public attract people of all ages, including Generation Y and X, who make up the majority of the workforce, seeking relaxation and a connection with nature. Additionally, temples hosting relatively large-scale Children's Cafeterias attract children and their mothers (Generation Y), along with teenagers, student volunteers in their 20s (post-millennials, Generation Z), and residents of all ages from the surrounding area, resulting in temples functioning as "gathering places" for people of all ages (Ogasawara 2026) .

Regarding SC, temple social activities maintain bonding, or "connections within the religious community centered on faith through religious activities," and bridge the "layers loosely connected to temples" or "layers distant from temples" with society, fostering "connections" and nurturing them. This role in fostering SC, as envisioned by HJ21, has long been recognized and practiced by temples in Japan.

5. Review and Outlook

This paper has reviewed the recent trends in Japan's "health" initiatives, focusing on the promotion of SDG3 in line with the revision of the third HJ21. Furthermore, it has examined the role of SC in fostering connections between society and individuals, which significantly influences health. Additionally, the paper has discussed the potential of Buddhist temples as stakeholders in fostering SC.

Japan's healthy life expectancy is increasing steadily and ranks among the top in the world. The incidence of lifestyle-related diseases, including NCDs, is declining. Hence, subjective well-being, social connections, and mental health are at the forefront. However, humans living within social connections must transcend those connections through "social death." To value social connections as an element of "health," a comprehensive view of health, which encompasses areas beyond the secular realm, is required. Hence, the psychological aspects of individuals and their "health perceptions shaped by cultural and social contexts" become increasingly important.

To ensure that "no one is left behind," it is necessary to be pluralistic; that is, multiple systems must coexist and function simultaneously. Social activities and support systems based on religious motives function as a part of social (cultural) systems while adhering to universal

principles distinct from secular principles. It is noteworthy that these systems serve as a safety net capable of accommodating individuals who, for various reasons, fall through the cracks of administrative or other support systems, or who choose not to utilize them.

Note: This paper is based in part on research conducted with funding from the Jodo Shinshu Hongwanji Buddhist Education Research Foundation.

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Temple-Based Buddhist Social Work in Post-Disaster Japan: Japanese Interfaith Chaplaincy and the Reconfiguration of Public Care

Yugaku Ikawa

Abstract

This research note examines the characteristics of care practices conducted by contemporary Buddhist priests in Japan, both within temple settings and in public spaces. In the post-war period, the caregiving activities of Buddhist priests have been regarded mainly as private and ritualistic duties. However, since the 2011 Great East Japan Earthquake, religious professionals have increasingly been recognized for their spiritual care work in disaster-stricken areas, hospitals, and welfare institutions. A significant development in this context is the emergence of Rinshō Shūkyōshi (臨床宗教師, Japanese interfaith chaplains). Originating from post-disaster recovery efforts, the Rinshō Shūkyōshi program was later institutionalized at Tohoku University as a professional certification that provides non-proselytizing, interfaith forms of spiritual care. At the same time, most Rinshō Shūkyōshi continue to serve as priests within temples and other religious institutions. Drawing on their experiences in public caregiving spaces, they are increasingly transforming temple-based activities into welfare-oriented forms of Buddhist social work that are open to local communities beyond traditional parishioners. This study focuses on a Buddhist priest trained as a Rinshō Shūkyōshi. It explores how practical engagement in public care fosters the transformation of traditional religious practices and redefines temples as centers of community-based public care.

Keywords: **Buddhist social work; community-based integrated care; Japanese interfaith chaplaincy; spiritual care; public religion**

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1. Introduction

Theoretical Background

This research note seeks to elucidate the characteristics of spiritual care and community-based support within temple-centered Buddhist social work in contemporary Japan. Historically, Japanese Buddhism has fulfilled multiple social roles, including education, welfare, and disaster relief (Ikawa, 2023). However, under the post-war constitutional regime that emphasized the separation of religion and state, Buddhism gradually withdrew from the public spheres of welfare and caregiving. As Japan's welfare state expanded and economic growth accelerated, social services increasingly transformed into a domain of governmental and professional sectors. Consequently, temples were primarily used for private religious functions such as funerals, memorial rites, and ancestor veneration.

Since the 1990s, however, a combination of social and demographic shifts—including population aging, community decline, and recurrent large-scale natural disasters—has prompted renewed attention to the public role of religion. The 1995 Hanshin-Awaji Earthquake revealed the limitations of state-centered disaster relief and underscored the importance of civil society and volunteer networks. At the same time, the Aum Shinrikyō (オウム真理教) incident deeply eroded public trust in religion, rendering its involvement in public life both problematic and contested. Buddhist temples were often derisively described as being merely "part of the landscape" during the disaster (Kurosaki, 2019).

Nevertheless, this tension also catalyzed critical reflection on the relationship between religion and society. The 2011 Great East Japan Earthquake, particularly, marked a decisive turning point: the compassionate activities of Buddhist priests and other religious professionals in disaster-affected areas led to a significant re-evaluation of the ethical and public functions of religion in Japan.

Institutional Developments

Within this shifting social environment, one of the most symbolic institutional developments was the emergence of the Rinshō Shūkyōshi (臨床宗教師, Japanese interfaith chaplains). Established in 2011 within the Practical Religious Studies Program at Tohoku University, this initiative

adapted Western chaplaincy models to Japan's unique religious and cultural context. Unlike conventional clerical activities such as preaching, ritual performance, or sutra chanting, Rinshō Shūkyōshi were professionalized as providers of non-proselytizing spiritual care in public settings beyond temple boundaries. The Japan Association of Clinical Religious Professionals was founded in 2016, followed by the introduction of a national certification system in 2018. As of March 2025, 211 chaplains have been certified, of whom approximately 40% work in medical and welfare institutions, particularly in palliative care units (Ikawa, 2023b).

The spiritual care offered by these chaplains involves deep, attentive listening to individuals' emotional and other concerns, helping them discover or reaffirm their own "sources of support" (Taniyama & Ikawa, 2021). These sources often include interpersonal relationships and familiar environments. For example, terminally ill patients may find a sense of peace and resilience in the presence of family members or in the emotional comfort of their own homes. This approach aligns with the World Health Organization's expanded concept of health and with recent international developments in social work that emphasize the spiritual and existential dimensions of holistic care.

Notably, Buddhist monks trained in this public form of spiritual care have begun to reconfigure temple-based Buddhist social work. Through this process, temples—once regarded primarily as private spaces for memorial and ritual practices—are being transformed into open, community-oriented centers of care that integrate spiritual and social dimensions of well-being.

International Comparison

Comparable developments in Buddhist spiritual care have also emerged in other parts of Asia. In Taiwan, the introduction of Christian-style hospices in the 1990s prompted efforts to integrate Buddhist values into palliative medicine. The Lotus Foundation, established in 1994, initiated research on "Clinical Buddhist Chaplaincy," led by medical professionals in collaboration with Buddhist monastics (Fang, 2022). By 2006, Taiwan had established a national training program consisting of 65.5 hours of classroom instruction and 80 hours of hospice-based clinical practice (Bhikushu, 2016). These initiatives exemplify ongoing attempts to indigenize Western chaplaincy models within Buddhist cultural and ethical frameworks.

Japan's case, however, is distinctive in that its chaplaincy movement emerged within a society where religion had long been separated from public welfare institutions. Operating under a strict secular framework, Japanese chaplains formulated ethical codes that explicitly prohibit proselytization, thereby enabling the institutionalization of spiritual care within the parameters of constitutional secularism. In this respect, the Japanese model stands in contrast to Taiwan's hospital-based Buddhist chaplaincy and other Asian contexts—such as Thailand, Sri Lanka, Myanmar, and Nepal—where monasteries have historically engaged in education, welfare, and disaster relief.

The Japanese experience, therefore, presents a distinctive framework for reconfiguring the relationship between religion and public welfare. It demonstrates how Buddhist social work can emerge as a form of community-based care within a secularized society, thereby offering new insights into the evolving role of religion in the public sphere.

Case Overview

This study focuses on the Kōōji Temple(高応寺), a Nichiren Buddhist temple located in Misato City, Saitama Prefecture. Founded in the early seventeenth century, Kōōji is a typical mid-sized urban temple that has long maintained intimate, enduring ties with its surrounding community. In recent years, the temple has become a symbolic example of how Buddhist institutions in Japan are redefining their roles as community-based centers of care and engagement.

The current abbot, Rev. Nahō Sakai, is both a Nichiren Buddhist priest and a certified Rinshō Shūkyōshi trained at Tohoku University. Drawing on her experience providing spiritual care in medical settings—particularly in palliative care—she has sought to integrate the same ethical and reflective approaches into temple-based practices. Under her leadership, Kōōji has developed a range of programs that link Buddhist spiritual practice with community welfare initiatives, including shakyō (写経, sutra-copying) gatherings and the Waseda Kodomo Shokudō(わせだ子ども食堂, Children's Cafeteria).

These activities exemplify how Buddhist temples can reconfigure traditional religious practices into forms of public and relational care. While modest in scale, Kōōji embodies a broader post-

disaster trend in which small and medium-sized temples are being repositioned as open, inclusive spaces that foster both spiritual well-being and social connectedness within local communities.

Methodology

The findings presented in this article are based on the preliminary fieldwork conducted at Kōōji in May 2025. The author participated in one shakyō session and one cafeteria event, observing the preparation, implementation, and post-event processes. During these activities, unstructured interviews and informal conversations were conducted with the head priest, temple staff, and participants to explore the background, intentions, and perceived challenges of each initiative. A total of 11 individuals attended the shakyō session, while 20 participants—including both children and adults—participated in the children's cafeteria. Although the scope of observation was limited, this exploratory fieldwork offers a symbolic and instructive case illustrating how temples in contemporary Japan are integrating spiritual care with social work activities. Future research will include longitudinal participant observation and semi-structured interviews to collect more systematic and comparative data.

This study is theoretically informed by José Casanova's concept of Public Religion, which examines how religions engage with civil society beyond the domains of both state authority and private belief. Building upon this framework, the study investigates how Japanese Buddhist priests reconfigure traditional religious practices into forms of public and relational care, thereby expanding the social and ethical functions of temples in a secularized society.

2. Research Site: Kōōji Temple and Its Orientation Toward Public Care

Kōōji, the focus of this study, is a mid-sized Nichiren Buddhist temple located in Misato City, Saitama Prefecture. Founded in 1624 (the first year of the Kan'ei era), the temple has maintained intimate connections with the surrounding community for nearly four centuries. Misato is a suburban residential city approximately 30 minutes by train from central Tokyo. The city rapidly developed during the post-war period owing to significant urbanization. Within this environment, Kōōji has preserved daily interactions with residents while maintaining its traditional relationships with parishioners. Several of its former abbots were also Buddhist scholars,

affording the temple a dual character as both a community-based and an academically oriented "scholarly temple." Although modest in scale, Kōōji exemplifies the characteristics of a typical urban temple and serves as a valuable case for understanding localized forms of religious practice in contemporary Japanese Buddhism.

The current abbot, Rev. Nahō Sakai, succeeded her father in 2015 and completed the Clinical Religious Chaplaincy Training Program offered by the Practical Religious Studies Course at Tohoku University in the same year. She subsequently engaged in spiritual care activities in a general hospital in Saitama Prefecture, working in a palliative care ward. This professional experience provides an essential foundation for bridging traditional Buddhist practices with contemporary approaches to spiritual care in medical and welfare contexts. Drawing on her chaplaincy experience, Rev. Sakai has sought to bring the ethics and methods of public spiritual care back into the temple, thereby expanding the social role of Buddhist clergy.

Figure 1: Kōōji Temple, view of the main grounds (photograph by the author).

The guiding principle of Kōōji is "to help every visitor encounter their own Buddha." This phrase articulates an inclusive orientation that opens Buddhist values to all people, rather than restricting them to specific doctrinal followers or parish members. Rev. Sakai describes her understanding of the priest's role as follows:

> When I first became a monk, I felt I had to provide answers to the problems that people shared with me. However, over time, I realized that a monk is like a bridge—someone through whom the Buddha listens to people's worries and aspirations. The stories people share with me always reach the Buddha. Many visitors, through their encounter with the Buddha, find their own answers.

This perspective reframes the role of the priest not as a provider of answers but as a mediator who bridges "the Buddha" and "the people." Such an understanding intimately resonates with the foundational principles of spiritual care in Clinical Religious Chaplaincy—especially, attentive listening and the facilitation of self-reflection. For Rev. Sakai, the temple functions as a space where people can encounter and reaffirm their own sources of support, and where the priest serves as a compassionate bridge that supports that process.

Kōōji's philosophy is embodied in its community programs and ritual activities. The temple continues to hold a variety of traditional Buddhist ceremonies throughout the year, including the Setsubun purification ritual, the Nirvana Ceremony, the Founding Day of Nichiren Buddhism, the Segaki (a memorial rite for ancestors and hungry spirits) held during the Obon season, and the Hōonkō (a memorial service of gratitude). In addition, Kōōji actively organizes public social and cultural programs, including temple yoga, calligraphy classes, a mobile bookshop, and the annual music event "Fireflies' Evening." These initiatives transform the temple space into a hub of welfare-oriented and cultural practices, connecting religious tradition with community engagement.

Through these efforts, Kōōji has reconfigured traditional religious practice into a form of public care grounded in the principles of spiritual chaplaincy. Rev. Sakai's approach—viewing herself as a bridge between the Buddha and people—represents a conscious attempt to extend religious resources beyond the circle of parishioners and to render them available to the broader community. This approach reflects a wider trend in contemporary Japanese Buddhism, in which small and medium-sized temples are being repositioned as local centers for spiritual support, welfare, and social inclusion.

Within this broader context, this study focuses on two representative initiatives at Kōōji:

(1) the Shakyō program, and

(2) the Waseda Children's Cafeteria.

These practices illustrate how temple-based religious activities are being reconstituted as expressions of public care in contemporary Japan.

3. Buddhist Rituals and Public Care Practices at Kōōji Temple

This section analyzes the Buddhist rituals and social practices developed at the Kōōji. It examines how a Buddhist priest, trained as a Rinshō Shūkyōshi, has re-contextualized traditional religious roles to transform the temple into a hub of public care. At Kōōji, traditional Buddhist rituals derived from the teachings of Śākyamuni (釈迦) and Nichiren (日蓮) remain central. In addition to daily practices such as zazen (坐禅, sitting meditation), sutra chanting, and Dharma talks, the temple holds annual events including the Segaki (施餓鬼) memorial service during the Obon season (お盆, August 13–16), the Setsubun (節分) purification ritual, and the Joya-no-kane (除夜の鐘) bell ringing on New Year's Eve. Kōōji also hosts life-cycle ceremonies such as hatsumairi (初参り, infant blessing), shichi-go-san (七五三, children's rites of passage), coming-of-age celebrations, and weddings. Furthermore, beyond its parish community, the temple actively opens its doors to the public through cultural and social programs such as temple yoga, calligraphy classes, a mobile bookstore, and the music event Hotaru no Yūbe (ホタルの夕べ, "Evening of Fireflies").

These practices reflect an intentional effort not only to preserve traditional religious functions but also to reconfigure the temple as an open, community-oriented site of public and spiritual care. Particularly significant is how the perspectives on spiritual care—cultivated through the Rinshō Shūkyōshi training program—have been integrated into the temple's everyday activities. The following sections focus on two representative initiatives at Kōōji: (1) gankake shakyō (votive sutra copying) and (2) the Waseda Children's Cafeteria, to explore how religious practice and public care intersect to generate new relational spaces of Buddhist social work.

Reconfiguration of Spiritual Care: Votive Sutra Copying as a Form of Healing Practice

Shakyō is a Buddhist discipline involving the transcription of sacred texts with a brush, traditionally regarded as a meritorious act performed to accumulate virtue and receive blessings. At Kōōji, while this practice continues to draw on its traditional religious meaning, it has been reinterpreted as a contemporary form of spiritual care that promotes psychological and emotional well-being.

The shakyō session at Kōōji proceeds as follows: (1) a Dharma talk explaining the meaning of the sutra, (2) silent meditation and chanting to prepare the mind, (3) the act of copying the sutra, (4) time for participants to write personal wishes or concerns, (5) drawing an omikuji (traditional fortune slip), (6) dialogue with the abbot, and (7) a concluding prayer. Participants, surrounded by the fragrance of incense before the Buddha statue, calmly write at their own pace. The beauty of the characters is not emphasized; instead, handwriting is viewed as an authentic expression of one's present state of mind and body. At the end, each participant adds their name and date, writes a personal wish "to be delivered to the Buddha," and receives the omikuji message as a symbolic response from the sacred.

A distinctive feature of this practice is the personal dialogue that follows the copying session. The abbot reads the participants' written wishes and fortune messages as starting points for gentle, open-ended conversations. Through attentive listening, she sensitively addresses unspoken emotions and life contexts. For instance, when a participant writes "good health," the abbot might ask, "Have you been overworking lately?" or "Are you getting enough rest while caring for your mother?" Such dialogues help reveal latent stress and caregiving needs, enabling participants to reinterpret their experiences.

This dialogical process intimately aligns with the ethos of the Rinshō Shūkyōshi training program, which emphasizes "listening attentively to help individuals rediscover their own sources of support." Rather than instructing or advising, the abbot offers a safe and reflective space in which individuals can recognize diverse inner supports—spiritual beliefs, relationships, nature, or memories.

During the COVID-19 pandemic, participation reached nearly 100 people, prompting the temple to organize monthly sessions divided into morning, afternoon, and evening groups of 10 to 20

participants each. Most attendees are not parishioners but members of the general public, including those who travel from outside the prefecture or join with elderly family members. This trend suggests that the temple has come to be recognized as a "public space for self-reflection and spiritual care." What was once a devotional practice aimed at accumulating merit has evolved into a dialogical, person-centered form of care. This transformation—rooted in the abbot's professional experience as a Rinshō Shūkyōshi in healthcare settings—illustrates how public care practices can reshape and "publicize" religious activities.

In this sense, Kōōji's shakyō sessions function not merely as religious rituals but as a form of Buddhist social work, in which spiritual care is reinterpreted as a process of empowerment and the reworking of meaning embedded in everyday community life.

Creating a "Third Place" within the Temple: The Waseda Children's Cafeteria

While the votive sutra-copying practice reconfigures traditional ritual into a space for personal reflection, Kōōji has also developed another mode of public engagement that emphasizes social connection and community-based support. A representative example is the Waseda Children's Cafeteria, operated in collaboration with a local citizens' group. This section analyzes the temple's background and activities to illustrate how it responds to community welfare needs and serves as a center of public care.

Figure 2: Entrance to the main hall where the event is held (photographs by the author).

The Kodomo Shokudō (children's cafeteria) movement emerged in Japan in the mid-2010s as a community-based initiative to address food insecurity and social isolation. It not only supports children and single-parent families experiencing economic hardship but also includes elderly residents and young adults, serving as a local safety net. An increasing number of Buddhist temples across Japan have joined this movement, rendering it an important dimension of contemporary Buddhist social work.

Figure 3: Meals provided during the Waseda Children's Cafeteria program (photographs by the author).

At Kōōji, the Children's Cafeteria was launched in 2020 through collaboration with a local volunteer group. The event is held once a month in the temple's main hall, which is officially certified by the public health center for food handling and hygiene. During each session, approximately 30 boxed meals are prepared—free for children and 300 yen for adults. Although primarily designed for takeout, participants may also eat together in a tatami room adjacent to the main hall. In partnership with local businesses, the temple additionally distributes cosmetics and daily necessity items through a "cosmetic pantry." These activities have transformed the temple from a purely ritual space into a welcoming, safe environment for diverse members of the community.

Notably, the organizing group's mission statement explicitly extends beyond children and parents, aiming to foster inclusivity and new relationships across generations:

> Waseda Kodomo Shokudō is not only for single parents or children.University students and adults living alone are also welcome.When people of all ages gather, new communities emerge.Please think of this place as your "third place," different from home, school, or workplace (Waseda Kodomo Shokudō, 2021).

As this message suggests, the Cafeteria aspires to become a shared space of public care, mediated by the temple's religious environment. Participants include not only families in need but also students, young adults, residents, and temple members. Many first encounter the temple through this program and later join other activities such as sutra-copying sessions, yoga classes, or cancer support cafés. The cafeteria thus functions as a "third place" that transcends fixed roles of "helper" and "recipient," fostering intergenerational interaction and mutual support. This inclusive orientation exemplifies a form of public religion in practice, where temples—traditionally private religious institutions—become mediating spaces of relational welfare and community solidarity beyond institutional boundaries.

Although the abbot serves as the project's representative, she deliberately entrusts daily operations to volunteers, minimizing hierarchical control and respecting each person's agency. This flexible and supportive approach reflects the ethics of care nurtured through her Rinshō Shūkyōshi experience, revealing an ongoing process in which the temple is being reimagined as a site of public, relational care.

Summary

The case of Kōōji demonstrates how a Buddhist temple can dynamically integrate two complementary dimensions of care: inner-oriented spiritual care and community-based public care. The shakyō sessions invite participants into self-reflective dialogue through prayer and writing, while the Cafeteria fosters relational healing and social inclusion through food and

shared space. Despite their differing modalities, both practices are grounded in the abbot's professional training as a Rinshō Shūkyōshi and collectively reconfigure the temple as a site for restoring psychological stability and social connectedness. In this sense, Kōōji exemplifies how contemporary Buddhist temples in Japan can evolve from ritual institutions into active agents of public religion and Buddhist social work, bridging the realms of religion, community, and well-being.

4. Conclusion

This research note has examined the activities of clinical religious chaplains, whose social visibility has grown in Japan since the 2011 Great East Japan Earthquake. These activities represent not merely an expansion of religious presence into the public sphere but a cyclical process of transformation and return, in which engagement in public practice reshapes the self-understanding of religious practitioners, and, in turn, promotes the reconfiguration of temples as spaces of public care.

At the Kōōji Temple of the Nichiren sect, the traditional Buddhist practice of shakyō has been reinterpreted as a form of spiritual care through dialogue and self-reflection with participants. In collaboration with the Cafeteria, the temple has been transformed from a symbolically sacred space of religious authority into a "third place" offering safety and inclusivity. What unites these practices is their shared commitment to creating spaces where people—regardless of social background—can engage in conversation, mutual support, and the rebuilding of human connections.

Such initiatives embody not only the ethics of care developed within Japan's clinical chaplaincy movement—namely, "not preaching, not judging, and supporting individuals as they rediscover their own sources of meaning and strength"—but also the reorganization of Buddhist resources (such as sutra copying, prayer, and symbolic space) into concrete practices of public care. In other words, the experiences of clinical religious chaplains have transformed the perspectives and practices of Buddhist clergy, providing an opportunity to redefine temples—once regarded primarily as private religious institutions—as community-based sites of public engagement and

care. This transformation transcends the framework of “social contribution” and can be interpreted as an expansion of the public functions of Buddhist temples.

Furthermore, this case-based analysis offers both methodological and empirical insights for the emerging field of Buddhist Social Work in Japan, where detailed case studies of temple-based care practices have remained relatively scarce. Future research should compare similar initiatives across Buddhist denominations and regions, analyzing differences in doctrinal orientation, local context, and collaboration with governmental or welfare institutions. Integrating both qualitative and quantitative approaches will be essential to clarify how temples function as bases of public care and to evaluate their broader social impact.

More broadly, this study suggests that temple-centered practices of Buddhist social work in Japan may offer important insights into emerging forms of community-based integrated care in rapidly aging societies across Asia.

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Scope of Buddhist Social Work

Buddhist social work may be understood as an extension of Buddhist social welfare services. Buddhist social welfare can be traced back to the time of the Buddha in sixth-century BCE India and has a long-standing historical and cultural tradition. In contrast, Buddhist social work has emerged relatively recently as a distinct field of study and practice, making it both new and challenging. Despite this recent development, its foundational principles remain consistent with those of Buddhist social welfare.

Both Buddhist social welfare and Buddhist social work are grounded in Buddhist philosophy. The Buddha emphasized philanthropy, charity, mutual support, compassion, and other ethical virtues that are widely shared across Buddhist cultures. Although the conceptual systematization of Buddhist social work is still ongoing, the Asian Buddhist Social Work Research Network, supported by ARIISW, has proposed the following working definition:

"Buddhist social work refers to human activities aimed at helping individuals solve or alleviate life difficulties and problems based on the concept of Buddha nature. Buddhist social work seeks to identify and address causes of suffering in both the material and social realms, as well as in the human or inner realm, working on these dimensions in tandem. Its fundamental principles include compassion, loving-kindness, mutual help, interdependence, and self-reliance. Its central ethical foundation is the Five Precepts. The ultimate goal is to promote the well-being of all sentient beings and the realization of peace." Ven. Dr. Omalpe Somananda, editor

(For more details see: Akimoto, T., Hattori, M. (eds.) (2018). *Working Definition and Current Curricula of Buddhist Social Work.* Faculty of Sociology VNU University of Social Sciences & Humanities, Vietnam, and Asian Research Institute for International Social Work, Shukutoku University, Japan.)

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