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Keywords: Religiosity; Health behavior; Socioeconomic inequality; University students; Pakistan.

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Title

Religiosity, Socioeconomic Inequality, and Health Behavior among Pakistani University Students: A Sociological Analysis

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Contents

Abstract

This paper analyzes the sociological connection between religiosity, socioeconomic disparity, and health behaviors among Pakistani university students based on the sociological framework. The multistage stratified random sampling was used to obtain 384 students at the University of Sargodha to complete a quantitative cross-sectional survey. The results indicate that there is a statistically significant positive correlation between religiosity and health behaviors. Family income and perceived social status were also found to be important predictors and there was no statistically significant influence of age and education level. The paper will be a contribution to sociology of health because it will reveal the combined effects of culturally embedded religious norms and structural inequalities on health behavior among young adults in Pakistan and it will have a significant implication on culturally sensitive health promotion interventions and equity-based health promotion in higher education institutions.

Keywords:

Religiosity; Health behavior; Socioeconomic inequality; University students; Pakistan.

Introduction

The health behavior in young adulthood contributes a conclusive factor to both physical and mental well-being in the long term. During this life phase, the levels of autonomy, identity, and exposure to various social forces are at their highest most, which contributes to this stage being considered a critical time in defining health-related behaviors including diet, physical activity, substance use, stress management and health-seeking behavior (Rangan, 2025). The sociological studies have consistently shown that health behaviors are not only the result of either individual choice or biological predisposition but are also ingrained in the social systems, the cultural norms and the economic disparities (Short, & Mollborn, 2015).

The health behaviour in childhood and early adulthood has significance in the physical and mental wellbeing in the long-term. It is a stage in life which is characterized by elevated level of biological, psychological and social transitions and at this stage there is formation of habit when it comes to diet, physical exercise, substance use and adaptation to stress. Research has always shown that health behaviour are not only formed in vacuum but are also dictated by the more macro social determinants such as socioeconomic status, education and cultural context (Adler and Newman, 2002; Braveman et al., 2011; World Health Organization [WHO], 2008). It is therefore essential to know the determinants that direct the health related choices of the young populations so as to be able to promote good health and prevent diseases.

One of the most influential and consistent health behavior determinants has been the socioeconomic inequality. People who are placed in better socioeconomic standing tend to have more access to healthcare facilities, information about health and supportive conditions that contribute to preventive care and healthy living. Contrarily, economic disadvantage limits the ability to pursue health-promoting activities and in most cases leads to late seeking healthcare (Stephens., et al 2012). In developing countries such as Pakistan, where out-of-pocket expenditures dominate healthcare financing, economic constraints exert a particularly strong influence on health-seeking behavior.

Religiosity is one of the sociocultural factors that have been gaining more and more popularity in the study of behavioural health and behavioural research. Religiosity is expressed in beliefs, practices and engagement in organized or individual religious activities, which may be used to design values, norms and everyday behaviors (Hussain, S., et al. 2025). According to previous research, the idea of religiosity may be linked to healthier lifestyles, less risky behavior, and enhanced mental health due to such mechanisms as social support, moral guidance, and adaptive coping strategy (Chatters, 2000; Koenig et al., 2012; Levin, 2011). Such influences might be especially acute among the youths who use religion as a way of identity, meaning, emotional control in the periods of transition in their lives.

Health psychological theoretical viewpoints are helpful in exploring these relations. The Theory of Planned Behavior tends to focus more on the importance of attitudes, subjective norms, and perceived behavioral control as determinants of health behavior changes (Ajzen, 1991), whereas Social Cognitive Theory focuses on self-efficacy and social modeling as determinants of behavior changes (Bandura, 1986, 2004). These processes may be mediated by religion because it has the power to influence health-related norms, support positive attitudes, and increase perceived behavioral control.

Although evidence increasingly becomes global, little empirical studies have been conducted at the point of religiosity and health behaviors with respect to young population in developing and religiously oriented societies. The proposed exploratory research will examine the relationships between religiosity and health behaviors in young people and it will be added to a more contextually sensitive comprehension of how health behaviors are established and in a bid to inform culturally sensitive health promotion practices.

Religiosity is a multidimensional social force which determines the values, identities and behavioral pattern of individuals beyond the realm of individual belief. The sociological interpretations understand religion as a moral control mechanism whereby norms, meanings and shared expectations are learned and internalized and direct every day behavior. With religious orientation, religious practices and social interaction, people gain moral orientations that affect decision-making and self-control in various aspects of life. Modern researchers still view religiosity as an origin of meaning, socialization, and normative direction, with references to lifestyle decisions and individual behaviour (Ellison and Levin, 1998; Koenig, 2012).

Health behavior, including preventive actions, avoidance of health threats, and reactions to illness, is now seen as socially embedded instead of individual. Empirical studies indicate that religiosity can affect health behaviors through moderation, discouragement of harmful practices, and conceptualizing care towards the body as a moral duty (George, Ellison, and Larson, 2002; Koenig, King and Carson, 2012). Moreover, involvement in religious groups may strengthen

health-related norms by social regulation and supportive contacts that influence the expectation of behavior.

Young adulthood is a crucial period where health behavior patterns are established and supported together with other more general identity process and wider autonomy. During this stage, individuals contend on individual beliefs, societal values, and way of lives with long term health effects. Through the examination of religiosity as a social determinant of health behavior in this age bracket, a more insightful point is made on how the moral structures and social regulation intersect with the day to day activities of the health behaviors. The research therefore examines the relationship between religiosity and health practices among young adults and therefore falls under sociological debate on religion, moral control, and the adoption of health-related behaviors.

Religion has dominated the social life in Pakistan and has continued to be among the determinants of the norms, values and day to day practices including those related to health and wellbeing. The existing literature shows that in Muslim cultures, religious beliefs and practices have moderating effects on perceptions of illness, preventive health, and health-seeking behavior because they frame health as a moral and social obligation (Koenig, 2012; Padela and Curlin, 2013). Pakistani studies have also emphasized how religious norms affect the attitudes toward medical treatment, lifestyle behaviors, and coping mechanisms, especially with regard to moral guidance and influences of the community (Ahmed et al., 2016). Nevertheless, much of the existing literature has been quite fragmented and tends to emphasize clinical or psychological aspects; providing few sociological details on how the issue of religiosity functions as a larger social determinant of health behavior.

The young adults in Pakistan, in particular, are of particular importance in studying this relationship since they are in the process of finding their identity amidst the swift social transformation, urbanization, and exposure to global living styles. According to the past literature, religious values might prevent risky behavior and encourage self-regulating; however, socioeconomic stressors and evolving social contexts might complicate the connection (Riaz et al., 2019). Nevertheless, there is limited empirical studies that mainly conduct a systematic study of religiosity and health behaviors among Pakistani youth through sociological lens. In bridging such a gap, the current research provides the context-specific data that adds to the current knowledge of the interaction of religious norms with the health practices in Pakistan and provides insights into both the sociological and culturally-competent health interventions.

Despite its social significance, religiosity has frequently been examined through psychological or clinical lenses, with limited sociological attention to the ways in which religious norms interact with socioeconomic inequality to shape health behavior. Addressing this gap, the present study examines the joint influence of religiosity and socioeconomic status on health behaviors among university students in Pakistan. The sociological approach allows the study to shift beyond individualistic explanations of health behavior and places health behavior in the context of more general processes of moral regulation, social control and class-based differentiation.

Significance of the Study

The study is important in that it has a gap that is critical in the research on how religiosity can be used to determine health behavior in the socio economic and healthcare context of Pakistan, which is a lower middle income nation with a huge health system challenge. The financing of health in Pakistan is greatly biased with out-of-pocket (OOP) expenses whereby over half of health costs are funded directly by households and not by the government, which limits access to basic services and increases disparities in health outcomes. According to the latest National Health Accounts statistics, 52.6 percent of the total health spending is in the private spending sector, of which approximately 89 percent of the sector is the OOP payments, which places an enormous financial burden on the individuals and families, and results in long delays or avoidance of healthcare services (Pakistan Bureau of Statistics, 2021,22). On this basis, it is necessary to determine the sociological results regarding non- economic determinants such as religiosity to secure effective and equitable

health interventions to complement structural health reforms.

The religion in Pakistan, mostly Islam, is evident in various ways in how it shapes the worldviews, norms, and practices in daily life, the health-related ones being not an exception. The Islamic doctrine emphasizes cleanliness, moderation and body maintenance, which theoretically can inform healthy lifestyle practices and coping strategies in the times of stress, such as in the condition when health is at risk (Inhorn and Serour, 2011; Pargament et al., 2020). The sociological implications of the interplay of cultural and religious context and health behavior are furthered by the empirical investigation of these dynamics among young adults who are balancing between antique religious and the contemporary health problems. The study may guide culturally competent policy-making, including health education and community-based interventions that may use religious institutions and leaders to support health-enhancing health practices to reduce disparities and overall well-being of the Pakistani and the more diverse social environment by analyzing how religiosity supports or restricts health-enhancing health practices.

Objectives of the Study

1. To determine the level of religiosity among university students at the University of Sargodha.
2. To analyze the trend of health behaviors adopted by the young adults in terms of preventive measures and health seeking behaviors.
3. To examine the association between religiosity and health behavior among students in the university.
4. To examine the role of socioeconomic factors in shaping health behaviors.

Research Questions

1. What is the level religiosity of university students?
2. What are the common health behaviors among young adults in the university?
3. Does religiosity have any effect on health behaviors of university students?
4. How much role does a socioeconomic determinant play in influencing the health behavior of young adults?

Literature Review

Health behaviors are generally known to be patterned socially and are the result of complex interaction between an individual, cultural and structural factors. One of the central viewpoints of sociological studies is that socioeconomic status is a key determinant of better or worse health behavior and health outcomes because it affects access to health services, health-related knowledge, and material conditions that are required to lead to a healthy way of life. Empirical evidence always shows that people with high socioeconomic status are more involved in preventive care and healthier behavior than their less advantaged counterparts.

The interaction of the social, psychological and cultural factors is quite complex in that they affect the health behaviors of the young populations. As noted by the current literature, the socioeconomic status, education, and social contexts are important factors contributing to the participation of individuals in health-promoting or risky conducts (Adler and Newman, 2002; Braveman et al., 2011; World Health Organization [WHO], 2008). This is especially sensitive to young people especially in transitional life stages like adolescence or emerging adulthood where identity formation and socialization is going on.

Health psychological theories are a good foundation to explaining the health behaviors among young people. According to the Theory of Planned Behavior (TPB), health-related intentions and behavior are predicted by three factors, which are the attitudes, subjective norms, and the perceived control over behavior (Ajzen, 1991; Ajzen and Fishbein, 1980). TPP has been empirically tested to be relevant in explaining a broad spectrum of health behaviors, composite of substance use, physical activity, and help-seeking (Godin and Kok, 1996). Equally, the Social Cognitive Theory focuses on mutual relationships between individual, behavior and environment, as well as the contribution of self-efficacy and social modeling to health promotion (Bandura, 1986, 2004). These theories are especially applicable with the youthful populations, whose actions are highly

shaped by the peer group, family and cultural values.

The concept of religiosity has become a significant sociocultural determinant of health behaviors and outcomes. Generalized reviews show that religious participation has been linked to healthier living, reduced exposure to risky activities and improved mental health outcomes (Chatters, 2000; Koenig et al., 2012). Religiosity can work in health behavior because it can have moral guidelines, social support, coping and meaning-making (Levin, 2011). In adolescents and young adults, systematic evidence indicates that greater religiosity is related to better health attitude and lower rates of behavior including substance use (Dew and Wong, 2006).

Religiosity has increasingly been identified as a significant sociocultural determinant of health. These associations are commonly explained through mechanisms such as moral regulation, social support, coping resources, and collective norms that guide behavior. For young adults, religion may provide a sense of meaning, identity, and behavioral guidance during periods of social transition.

The mental health and coping are especially relevant to youth population. Survey of college students has demonstrated that stress, anxiety, and depression are high, and the help-seeking behaviors vary (Hunt and Eisenberg, 2010). Religious coping has emerged as one of the most prominent coping strategies that young people are using in their efforts to cope with the psychological distress, they provide emotional, perceived control, and community comfort (Holt et al., 2010). These processes can cause health behavior indirectly by minimizing risk behavior related to stress and promoting adaptive coping.

The context-specific study also presents the significance of religiosity in non-Western cultures. Research in Pakistan has established that religiosity is important in influencing mental health, coping, and health practices in young adults. As an example, religiosity was observed to mediate health anxiety in the period of the COVID-19 pandemic (Khalid et al., 2021) and perceived stress in emerging adults (Khan and Bashir, 2023). Other studies also suggest that there were positive correlations between religiosity, spiritual well-being, and health-promoting behavior among Pakistani university students (Mushtaq et al., 2021).

Although growing evidence is available, the interaction between religiosity and more general social and psychological health behavior determinants in youthful populations has a gap. The decisions made on the issue of health behavior are still influenced by education and socioeconomic factors (Cutler and Lleras-Muney, 2010; Glanz et al., 2008), and thus integrative models that take into account religiosity and the well-known models should be used. The exploratory study of the religiosity and health behaviour among the young people can thus help in giving a more elaborate explanation of health promotion in the culturally and religiously diverse settings (Hussain, S., et al. 2025).

The interdisciplinary research evidence demonstrates that religiosity and spirituality are continuously correlated with the health attitudes and behaviour of diverse groups in the population such as the young adults. In systematic quantitative research reviews, it is found that the majority of the studies indicate a positive association between religiosity and spiritual involvement as well as psychological wellbeing and reduced participation in health-risk behaviour such as unsafe sex, substance abuse, and stress disorders (Koenig et al., 2012). The religiously active are also more likely to benefit during preventive health behaviour such as physical exercise and medical advice follow-up, which explains the importance of religion as a lifestyle determinant (Koenig et al., 2012). The theories elucidating these associations are the presence of moral norms, community support systems and the organized coping solutions enhancing the resilience and self-regulatory behaviour in high religious participants. The applicability of religiosity in culturally specific health behaviour shaping is also supported by empirical evidence in Muslim-majority and South Asian settings. As an example, in Pakistan, religion has been demonstrated to affect the religious coping to deal with health anxiety-related crises, including the COVID-19 pandemic, indicating that religious engagement is an adaptive response to health-related stress and emotional control (Khalid et al., 2021). A study of the relationship between religious orientation and mental health in Pakistani university students also reveals that there are

inverse correlations between religiosity and depression, anxiety, and stress symptoms, which provide evidence of protective impacts of religious participation in psychological health outcomes. This literature highlights the role of religiosity as not solely making behavioural responses but also a process of social support and cultural meaning-making which influence how young adults react to health issues.

Although most of the positive correlations are prevalent, the literature also shows inconsistency in the religiosity-health relationship, and context-sensitive models should be applied. Other studies indicate that religious norms and beliefs can be inconsistent with contemporary healthcare practices, including vaccine acceptance or formal medical treatment, implying that religiosity is at times a barrier to prompt healthcare use without sufficient supporting information (e.g., the studies on the pandemic vaccines). Additionally, the inconsistency of measurements across studies with regard to how religiosity is measured (in terms of attendance, belief, or coping) implies the conceptual complexity of the field and the relevance of rigorous and multidimensional methods (Koenig et al., 2012).

Importantly, existing literature reveals gaps in sociological theorization, as many studies treat religiosity as an individual-level psychological variable rather than a socially embedded system of norms and practices. Furthermore, the existing research that scrutinizes the combination of religiosity and socioeconomic disparity to determine the health behavior of young adults is limited. This paper addresses these gaps by taking the sociological approach to understanding religiosity in a space of inequality and social stratification.

Theoretical Framework

This paper theorizes religiosity as a socially situated morally controlling mechanism and symbolic capital as opposed to an individual religion. Based on Durkheimian theory, religion has been identified as a source of collective norms that govern acceptable behavior and bring about self-control including behavior that relates to health. Socialization inculcates religious expectations that explain body care, moderation and responsibility in a way that it becomes a moral requirement.

Bourdieusian approach views religiosity as a constituent of habitus of an individual, which interacts with socioeconomic position to create dispositions towards health practices. Religion norms can serve as a kind of moral capital or symbolic capital, especially among people with weak economic capabilities, as they promote self-regulation and health-protecting practices in the situations when the material access to the healthcare is limited.

Religious groups are considered a location of social control and social support, which re-enforcement of health norms by means of collective expectations, observation, and shared accountability. These are the sociological processes, which can be used to explain the interplay between religiosity and socioeconomic inequality to create differentiated health behaviors by young adults in Pakistan.

Methodology

The research design was quantitative cross-sectional survey study by which the researcher investigated how religiosity, socioeconomic status, and health behaviors were related among students in universities. Multistage stratified random sampling was used in selecting 384 students of the University of Sargodha to represent across the faculties and gender. A 95% level of confidence and 5% margin of error was used to determine the sample size. The structured questionnaire included demographic variables, religiosity measures and health behavior indicators as data were collected using this. Analysis of reliability showed good internal consistency of all scales. Data analysis was conducted using SPSS, employing descriptive statistics, Pearson correlation analysis, analysis of variance (ANOVA), and multivariate regression techniques. Ethical considerations, including informed consent, anonymity, and voluntary participation, were strictly observed.

Results

Table 1

Demographic Information of the Respondents

Variables	Categories	Frequency	Valid percentage
Age	18–20	119	31%
	21–23	223	58.1%
	24–26	35	9.1%
	27 and above	7	1.8%
Gender	Male	192	50%
	Female	192	50%
Education level	BS/MSc	347	90.4%
	M. Phil	33	8.6%
	PhD	4	1.0%
Socioeconomic Status	Lower Class	7	1.8%
	Middle Class	356	92.7%
	Upper Class	21	5.5%
Residency Status	Day Scholar	228	59.4
	Hostelize	156	40.6

The table shows that there was equal representation of both sexes in that, there were equal gender representation (50-50) i.e. there were male and female participants. Most respondents are young adults between the age of 21 and 23 (58.1%), and have a BS/MSc degree (90.4%), which indicates the common academic level of the sample. The majority of the participants are middle-class (92.7) and day scholars (59.4%), which indicates a socioeconomically and residentially heterogeneous student body that can be studied in the context of religiosity.

Table 2

H1=Higher levels of religiosity among young adults positively correlate with increased health behaviors

		Religiosity	Health Behavior
Religiosity	Pearson Correlation	1	.435**
	Sig. (2-tailed)		.000
	N	384	384
Health Behavior	Pearson Correlation	.435**	1
	Sig. (2-tailed)	.000	
	N	384	384

Correlation is significant at the 0.01 level (2-tailed).

The findings indicate that there is a moderate positive relationship between religiosity and health behaviors ($r = 0.435$, $p < 0.01$), with more religious students practicing healthy behavior. This is not a chance relationship and is statistically significant. Thus, Hypothesis 1 is accepted, implying that religiosity has a positive impact on health behaviors among university students.

Table 3

H2 = Socio-economic and demographic factors significantly influence health behaviors and promote health equity among young people

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	794.098	4	198.525	2.486	.043
Within Groups	30264.087	379	79.852		
Total	31058.185	383			

The ANOVA (F = 2.486, p = 0.043) results indicate the family income has an important influence on the health behaviors of young adults. The null hypothesis is dropped because p = 0.05, which implies that the differences in the income level affect health-seeking behaviors. Therefore, the socioeconomic factors have a strong impact on the health behaviors of young adults.

Table 4

Age significantly affects the health behaviors of young people thereby affecting their attitude and practice of preventive healthcare measures

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	282.907	2	141.454	1.420	.243
Within Groups	36962.678	371	99.630		
Total	37245.586	373			

The result of the ANOVA (F = 1.420, p = 0.243) indicates that the age does not influence health behaviors of young adults significantly. The null hypothesis has not been rejected as p is more than 0.05. This is to mean that age is not a determining factor in the process of defining preventive health practices in this population.

Table 5

Perceived higher social status has a positive influence on the health behaviors by increasing the confidence in access to healthcare and taking initiatives to visit the doctor

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	631.037	2	315.518	3.197	.042
Within Groups	36614.549	371	98.692		
Total	37245.586	373			

The outcome of ANOVA (F = 3.197, p = 0.042) means that the perceived social status has a significant impact on health behaviors. The individuals with higher perceptions of status are more likely to adopt good health practices. This implies that social self-perception is a significant factor in health decision-making.

Table 6

Higher levels of education correlate positively with increased health literacy and proactive health behaviors among young adults

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	282.907	2	141.454	1.420	.243
Within Groups	36962.678	371	99.630		

The results of ANOVA (F = 1.420, p = 0.243) reveal that education level does not have any significant effect on health behaviors. In this sample, education does not seem to affect health practices among young adults. Health behaviors are probably more significantly shaped by other factors.

Discussion

The results of this research illustrate that religiosity has significant positive relationship with health behaviors that are compatible with the current empirical evidence that revealed that the more an individual engages in religion, the more they engage in healthier lifestyles and minimize risky behaviors. Studies indicate that religiosity is associated with improved preventive health behavior and lifestyle including reduced smoking, healthier diet, and increased physical activity and may be mediated by the influence of moral standards and social support networks in religious groups (Koenig et al., 2012). This study found that religiosity and economic situation are some of the factors that influence and interact to influence the responses of the university students and young adults to the health behaviors. Religiosity appears to influence health behaviors in terms of offering a moral norm, self-discipline, social support and psychological resilience all of which lead to healthier lifestyles and proactive health-seeking behaviors. In the meantime, the economic determinants particularly the income level contribute to the ratio of individuals using healthcare services and following healthcare behaviour greatly as the economic stability enables individuals to access regular medical care, preventive care and healthier lifestyles (Stephens, N. M., et al 2012).

The socio-economic analyses also highlight that family income and perceived social status are important determinants of health behaviors, which is reflective of well-established patterns in the literature on the socio-economic determinants of health behavior in the sense that higher socioeconomic status is linked to better health behavior outcomes, access to resources, and lower exposure to health-risks (Front Public Health, 2023; Adler and Ostrove, 2002; Socioeconomic Disparities in Health Behaviors, 2011). On the other hand, the insignificance of the age and education factors can be viewed as an indication, that in this young-adult group, economic and social status has a stronger impact on health behaviors compared to time of life and educational level independently. These subtle results indicate that although religiosity is always a predictor of healthier behaviors, the relationship between socioeconomic factors and health behaviors is complicated, and it is necessary to combine both cultural and economic aspects in the public health policies to increase healthy populations among youth.

Conclusion

Meanwhile, it is also important to take into consideration socioeconomic differences particularly income and perceived social status distinctions as a way of improving equal access to healthcare services. The structuring, engagement, and contextual and socially sensitive interventions can be strengthened by contextualizing the interventions and making them socially responsive to the lived lives of the young population by integrating culturally sensitive and faith-based health promotion programs to the community and university-based interventions. Combining all these findings, it is important to note that health behaviors are not determined by one determinant but are a result of the interaction of cultural, social,

and economic environments, which is why it is crucial to consider both value-based and structural factors when interpreting health behavior patterns in young populations.

Recommendation

Policy recommendations highlight the importance of health promotion strategies are culturally sensitive and inequality-aware in the context of higher education. University-health authority and religious institution partnerships can aid in universalizing preventive health measures at the same time eliminating structural hindrances to health care.

Limitations of Study

There are some limitations to this research. The cross-sectional nature also limits the ability to give a causal interpretation of the relationship between religiosity, socioeconomic factors, and health behaviors, as correlations were only found at one point in time. Self-reported data can also lead to social desirability and recall bias (especially in religiosity and health behavior measurement). Furthermore, the sample was restricted to students and young adults in universities, and this may limit the ability to generalize results to other age groups or non-student's groups. The future studies will adopt longitudinal or mixed approaches to capture the cause and effect relationships and underlying mechanisms, represent more varieties of people, and add objective health outcomes to enhance the rigor and generalizability of the results.

References

Adler, N. E., & Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. Health Affairs, 21(2), 60–76. https://doi.org/10.1377/hlthaff.21.2.60

Google Scholar Worldcat Fulltext

Ahmed, S., Ahmad, M., Swami, B. L., & Ikram, S. (2016). A review on plants extract mediated synthesis of silver nanoparticles for antimicrobial applications: a green expertise. *Journal of advanced research*, *7*(1), 17-28.

Google Scholar Worldcat Fulltext

Ajzen, I. (1991). The theory of planned behavior. Organizational Behavior and Human Decision Processes, 50(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Google Scholar Worldcat Fulltext

Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. Prentice-Hall

Google Scholar Worldcat Fulltext

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Prentice-Hall.

Google Scholar Worldcat Fulltext

Bandura, A. (2004). Health promotion by social cognitive means. Health Education & Behavior, 31(2), 143–164. https://doi.org/10.1177/1090198104263660

Google Scholar Worldcat Fulltext

Braveman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2011). Socioeconomic disparities in health in the United States. American Journal of Public Health, 100(S1), S186–S196. https://doi.org/10.2105/AJPH.2009.166082

Google Scholar Worldcat Fulltext

Chatters, L. M. (2000). Religion and health: Public health research and practice. Annual Review of Public Health, 21, 335–367. https://doi.org/10.1146/annurev.publhealth.21.1.335

Google Scholar Worldcat Fulltext

Cutler, D. M., & Lleras-Muney, A. (2010). Understanding differences in health behaviors by education. Journal of Health Economics, 29(1), 1–28. https://doi.org/10.1016/j.jhealeco.2009.10.003

Google Scholar Worldcat Fulltext

Dew, R. E., & Wong, Y. J. (2006). A systematic review of associations among religiosity/spirituality and adolescent health attitudes and behaviors. Journal of Adolescent Health, 38(4), 433–442. https://doi.org/10.1016/j.jadohealth.2005.01.010

Google Scholar Worldcat Fulltext

Ellison, C. G., & Levin, J. S. (1998). The religion-health connection: Evidence, theory, and future directions. *Health education & behavior*, *25*(6), 700-720.

Google Scholar Worldcat Fulltext

Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2008). Health behavior and health education. Jossey-Bass.

Google Scholar Worldcat Fulltext

Godin, G., & Kok, G. (1996). The theory of planned behavior: A review. American Journal of Health Promotion, 11(2), 87–98. https://doi.org/10.4278/0890-1171-11.2.87

Google Scholar Worldcat Fulltext

Holt, C. L., Caplan, L., Schulz, E., et al. (2010). Role of religion in cancer coping among African Americans. Journal of Psychosocial Oncology, 28(3), 248–267. https://doi.org/10.1080/07347331003678328

Google Scholar Worldcat Fulltext

Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking among college students. Journal of Adolescent Health, 46(1), 3–10. https://doi.org/10.1016/j.jadohealth.2009.08.008

Google Scholar Worldcat Fulltext

Hussain, S., Yunus, A., & Mushtaq, S. K. (2025). Exploring the Psychological and Socio-Economic Impacts of Vandalism among Religious Minorities: A Post-Incident Analysis. *Pakistan Social Sciences Review*, *9*(2), 444-455. https://doi.org/10.35484/pssr.2025(9-II)34

Google Scholar Worldcat Fulltext

Khalid, Q., Jafree, S. R., Sohail, M. S., & Akram, M. B. (2021). A cross-sectional survey of Pakistani Muslims coping with health anxiety through religiosity during the COVID-19 pandemic. Journal of Religion and Health, 60(3), 1462–1474. https://doi.org/10.1007/s10943-021-01247-z

Google Scholar Worldcat Fulltext

Khan, A., & Bashir, K. (2023). Perceived stress and religious coping among Pakistani-origin emerging adults. Journal of Mind and Medical Sciences, 10(2), 267–275. https://doi.org/10.22543/7674.102.P267275

Google Scholar Worldcat Fulltext

Koenig, H. G., King, D. E., & Carson, V. B. (2012). Handbook of religion and health (2nd ed.). Oxford University Press.

Google Scholar Worldcat Fulltext

Levin, J. (2011). Religion and mental health: Theory and research. International Journal of Applied Psychoanalytic Studies, 8(1), 29–49. https://doi.org/10.1002/aps.251

Google Scholar Worldcat Fulltext

Mushtaq, R., Shoib, S., Shah, T., & Mushtaq, S. (2021). Religiosity, spiritual well-being, and health behaviors among university students in Pakistan. Journal of Religion and Health, 60, 2022–2038. https://doi.org/10.1007/s10943-021-01217-5

Google Scholar Worldcat Fulltext

Rangan, V. (2025). Influence of social factors on health behavior. In *Behavioral economics and neuroeconomics of health and healthcare* (pp. 153-180). IGI Global.

Google Scholar Worldcat Fulltext

Riaz, S., Xu, Y., & Hussain, S. (2019). Workplace ostracism and knowledge hiding: the mediating role of job tension. *Sustainability*, *11*(20), 5547.

Google Scholar Worldcat Fulltext

Short, S. E., & Mollborn, S. (2015). Social determinants and health behaviors: conceptual frames and empirical advances. *Current opinion in psychology*, *5*, 78-84.

Google Scholar Worldcat Fulltext

Stephens, N. M., Markus, H. R., & Fryberg, S. A. (2012). Social class disparities in health and education: reducing inequality by applying a sociocultural self model of behavior. *Psychological review*, *119*(4), 723.

Google Scholar Worldcat Fulltext

World Health Organization. (2008). Closing the gap in a generation. WHO. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

Google Scholar Worldcat Fulltext