Fertility and Migrants' Integration: Social Norms Change after Forced Migration *

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Abstract

Migrants often exhibit different fertility patterns compared to natives but tend to converge toward native fertility levels over time. This paper examines the role of descriptive social norms in driving this convergence through a Randomized Controlled Trial (RCT) that delivers an information intervention to Syrian refugees in Türkiye. We survey 1,600 migrants about their fertility choices, intentions, and beliefs. Participants are divided into three groups: one-third receive information about the fertility choices and intentions of Syrian migrants in Türkiye (T1), one-third receive the same information about Turkish natives (T2), and one-third receive no information (control group). Both treatments lead to an immediate reduction in the perceived ideal number of children among Turkish natives, with T2 having a larger effect. Additionally, T2 reduces short- and medium-term intentions to have a child by between 1/3 and 1/5 of the control group's mean. Both treatments—especially T2—increase the likelihood of fearing social stigma for having too many children. The effects on fertility intentions are stronger among men and religious individuals, while the effects on perceived stigma are more pronounced among religious and highly conformist individuals.

1 Introduction

Fertility rates across continents have been diminishing in the last decades, but low-income countries still display substantially higher fertility rates than high-income ones. Migration is expected to mechanically level this gap over time, as flows typically occur from lower-income

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to higher-income countries. However, migrant's fertility rates in destination countries tend to converge to those of natives. This convergence has important policy implications for countries' economies and welfare system, and may, in part, reflect the cultural assimilation of migrants. A better understanding of this phenomenon is particularly important in countries hosting a large number of forced migrants, given the substantial implications for their health and education systems in both the short- and medium-run.

More broadly, examining how individuals adapt their fertility decisions when exposed to a different socio-economic context can shed light on the determinants of such choices, improving the accuracy of demographic forecasts and guiding the development of more effective public policies to shape population trajectories, a topic of increasing relevance for aging countries.

In this paper, we use a Randomized Controlled Trial (RCT) to examine the role of social norms in in shaping the convergence of migrants' fertility attitudes toward those prevalent in host countries. We present Syrian migrants under temporary protection in Türkiye with information about the fertility norms and attitudes of Turkish natives, and measure the impact of delivering this information on their fertility intentions, perceived stigma from their fertility decisions, and beliefs about natives. To identify the effects of our treatment, we compare the outcomes of migrants' receiving information about Turkish natives to those of a control group receiving no information, and to a second treatment group receiving information about the fertility of Syrians. The inclusion of the latter group allows us to disentangle misperceptions about overall fertility levels from those specifically related to the fertility gap between migrants and natives.

Our experiment investigates the fertility norms of Syrian migrants relocated in Türkiye due to the civil conflict that started in 2011. This groups provides an ideal sample to study the adaptation of fertility norms for several reasons. First, as we explain below, difference between natives' and migrants' fertility rates are very large. Second, given the forced nature of Syrian migration to Türkiye, Syrian refugees are not likely selected in terms of cultural similarity with Turkish natives. Third, Syrians obtained a legal right to stay in Türkiye, and migration to neighboring Europe almost stopped after the EU-Türkiye deal, suggesting that cultural integration in Türkiye is relevant for this population of migrants .

Our survey and information interventions involve a sample of 1,600 individuals across Türkiye. We assess belief updating by comparing treatment and control groups immediately following the provision of information during the baseline survey. To evaluate the medium-term effects of the information, we conduct a follow-up survey with the same individuals 7 to 8 months after the baseline.

Immediately after receiving the treatment providing information about Turkish natives

(T2), Syrian migrants are significantly less likely to report intentions to have a child within the next two and five years—by one-third and one-fifth, respectively—and report a lower ideal number of children. We show that these effects are driven by an increase in the perceived stigma associated with having many children and a decrease in the perceived ideal number of children among natives, both of which are influenced by exposure to the Turkish fertility information.

In contrast, the treatment delivering information about Syrians (T1) does not produce a statistically significant effect on Syrian migrants' fertility intentions. While it does lead to a reduction in the reported ideal number of children, this effect is smaller in magnitude than that observed under the treatment providing information about Turkish natives (T2). This treatment also increases perceived stigma associated with having many children, as well as the perceived number of ideal children among natives, though the latter effect is smaller than that of the T2 treatment. Effects of T1 on perceived natives' fertility intentions could be explained by T1 reducing perceived fertility of the overall population–for both migrants and natives. Nonetheless, our results show that exposure to information about natives has a more robust and stronger effect on fertility intentions, which could be due to different aspects of the dynamics of integration: scarcer information about natives compared to other individuals in the migrants' community or an intention to integrate in host society.

Effects of T2 on migration intentions are entirely localized among religious individuals and males. Religious individuals are more likely to report they want to have more children in the short term, and are more likely to perceive stigma for having too few children. The information provided in T2 helps to mitigate this source of stigma among migrants. Instead, T2 increases perceived stigma from having too many children in the males sample. While T2 reduces perceived stigma from having too few children among conformist individuals, this does not produce a differential impact on their fertility intentions.

In the follow-up, after 7-8 months, migrants' fertility intentions are not different, on average, across treatment arms. However, fertility intentions of groups that were most affected during the baseline (religious individuals and males) continue to be affected.

Our intervention mimics a key aspect of immigrant integration in destination countries—namely, the process of learning about the social norms of native populations. In particular, we inform migrants about the ideal number of children among Turkish couples, which might be different from the realized and observable number. This is an information that might be harder for migrants to discover in their environment. Our work can then inform policymakers about the dynamics of immigrants' fertility in host society.

The rest of this draft paper is organized as follows. In Section 3, we present the context of our intervention. In Section 4, we detail our intervention and experimental design. In

Section 5, we report our sample and data. Section 6 presents a brief conceptual framework. In Section 7 we report and discuss our empirical results.

2 Theoretical Framework

Our framework is grounded in a large body of literature across disciplines documenting the convergence of immigrants' fertility rates to host country levels (Farber and Lee, 1984; Kahn, 1988; Adserà et al., 2012). Immigrants' adaptation may be partially driven by the economic and institutional context of host countries (Andersson and Scott, 2005). However, cultural norms have been shown to influence fertility decisions of migrants in Europe and the US (Fernández and Fogli, 2006, 2009). Social norms diffusion, determining changes in such norms has been proven to be an important predictor of fertility decisions (Spolaore and Wacziarg, 2022), also affecting fertility rates among immigrants and their source-country communities (Beine et al., 2013).

Demography literature goes a long way conceptualizing the relationship between fertility behavior and migration. These efforts can be summarized under five main hypotheses; *socialization*, *adaptation*, *selection*, *disruption* and *interrelations* (Hervitz, 1985; Kulu, 2005; Schmid and Kohls, 2010). The *socialization* hypothesis assumes that the fertility behavior of migrant women reflects the fertility behavior of the place where they had spent their childhood and a convergence to the fertility behavior of the destination may occur in the next generation(s) (Goldberg, 1959; Rosenwaike, 1973; Stephen and Bean, 1992). In contrast, *adaptation* hypothesis suggests that the current context has a more important role and the fertility behavior of migrant women converges to that of the destination relatively soon (Myers and Morris, 1966; Goldstein, 1973). The *selection* hypothesis highlights the characteristics of those who migrate and claims that due to the selective nature of migration, the fertility behavior of migrants is already more similar to the destination than to the origin (Zarate and De Zárate, 1975; Courgeau, 1989). The *disruption* hypothesis assumes that the challenging conditions after migration lead to a period of low or no fertility for migrant women, but this is mainly for the short term (Goldstein, 1973; Hervitz, 1985). Last but not least, the *interrelations* hypothesis highlights that the fertility of migrants increases after migration, but this can be explained with the help of the factors behind the migration decision rather than migration alone (Schmid and Kohls, 2010; Lübke, 2015).

Building on the literature on immigrant fertility, it is important to recognize the difference between voluntary and forced migration and how this distinction may relate to the hypotheses on migrants' fertility. This approach especially challenges the validity of the arguments of the *selection* and *adaptation* hypotheses, underlining that forced migration does not involve

a selective process as voluntary migration does, and forced migrants may face more socio-economic and spatial isolation than voluntary migrants, respectively (Agadjanian, 2018). The lack of data on forced migrants is an important barrier for comparative research between voluntary and forced migrants with respect to demographic outcomes, yet the available studies support the existence of different patterns.

Forced migration literature shows evidence for the *disruption* hypothesis, when the forced displacement involves spousal separation and/or in the presence of severe conditions that affect mental and physical health. If and when these conditions improve, the disruptive effect of forced migration on fertility can disappear (Holck and Cates Jr, 1982). There is also support for *interrelations* hypothesis, such that the fertility of forced migrants was found to be high after arrival (Avogo and Agadjanian, 2008; Andersen et al., 2023). However, the higher fertility observed among forced migrants compared to voluntary migrants can disappear in the long term, as voluntary migrants recover from the disruptive period and catch up with forced migrants at completed fertility (Avogo and Agadjanian, 2008). Last but not least, forced migration literature relying on the *adaptation* hypothesis shows evidence that forced migrants' fertility may converge with the destination fertility over time, when they learn the local language and can integrate into social and economic life (Rumbaut and Weeks, 1986; Williams et al., 2013), if refugee women do not already have children at the time of arrival (Andersen et al., 2023), and if displacement occurs in younger ages (Adserà et al., 2012).

Narrowing down our focus to the case of Syrian refugees, we recognize an effort in the literature to understand the Syrian refugees' family dynamics and fertility patterns in the host countries. Studies in host countries Türkiye, Jordan and Lebanon underline the pattern of early marriage among Syrians, which is a continuation of pre-war practices in Syria (Sieverding et al., 2020) as well as a reaction to conditions of uncertainty in the destination country and safety concerns (Cherri et al., 2017; Bozdag et al., 2022). The selectivity of Syrian refugees is also emphasized to avoid misleading interpretations by comparing their marriage and fertility patterns with the Syrian national averages (Sieverding et al., 2020; Çağatay et al., 2020). Past fertility estimates of Syrian migrants in Türkiye based on the available data suggest that their TFR was above 6 in 2004, reached the lowest values in the years after the war (approximately 4.5) and then increased again to a level above 5 (Çağatay et al., 2020). Although this increase in the last few years hints toward the *interrelations* hypothesis, there is also evidence of adaptation. Studies on Syrian migrants in Türkiye show that timing of reproductive events can be delayed if they start after migration (Saraç and Koç, 2020), and fertility preferences can change due to economic hardship or interactions with Turkish people (Bozdag et al., 2022). The decrease in desired fertility can also be

a temporary adjustment if it comes as a response to economic uncertainties, which is an opinion more prevalent among men (Bozdag et al., 2022). Last, and closely related to our study, it can also be a response to the stigma they face in the new society for higher fertility. Literature shows evidence of such stigma that Syrian migrants experience, both from the people they interact with in the host society and the medical staff, in the contexts of both Türkiye and Lebanon (Kabakian-Khasholian et al., 2017; Bozdag et al., 2022).

3 Context

3.1 Syrian refugees in Türkiye

Following the start of the civil conflict in Syria in 2011, Türkiye started receiving Syrian refugees fleeing the violence in 2012. The size of the refugee influx increased sharply after 2012, and according to statistics from the Presidency of Migration Management the stock of refugees reached its peak with 3.7 million in 2021. There was some decline in refugee stock after 2021 following the construction of safe zones in Northern Syria. However, a sizable refugee population of around 2.9 million resided in Türkiye by the end of 2024, around the time our surveys were conducted.

The Turkish Disaster and Emergency Management Authority (TDEMA) set up several camps for the refugees near the border, hosting the first wave of refugees. Starting in 2013 refugees began to to reside out of camps and spread to other regions in the country. In 2014 Syrian refugees were given "Temporary Protection" status by the Turkish Government, along with access to health and education services.

Figure 1 illustrates the distribution of Syrian refugees in Türkiye across the 81 provinces in 2024. Provinces bordering Syria have the highest fraction of refugees in their provinces. The highest levels of population are observed close to the Syrian border, as well as around the richer areas of Istanbul and Bursa. During our survey, focused on areas with higher presence of Syrians. We conducted interviews in: Adana, Ankara, Bursa, Istanbul, Izmir, Kocaeli, Konya, and Şanlıurfa, with ratio of Syrian refugees ranging between 2.5% and 11% of the overall population.

3.2 Fertility rates among Turkish and Syrian women

Türkiye has been going through a fertility transition over the past decades. Total fertility rate (TFR), defined as the average number of live births that a woman would have over the ages 15-49, was 2.38 in 2001, remained slightly above the replacement level (2.1) until 2018 and then further declined, reaching 1.5 by 2023 (TurkStat, 2024), which is very similar to

the TFR of EU member states.[1] A summary of the change of total fertility rates in the provinces included in our study is presented in Table 15 in the Appendix.

The TFR in Syria also underwent a decline over the past decades, passing from 4 in 2001 to 3.5 in 2010 (UNFPA and Syrian Commission for Family Affairs & Population, 2023), but it remained above the TFR in Türkiye, which was 2.1 in 2010. We show the overall evolution of both rates, based on World Bank data, in Figure 2 in Appendix. Differences in fertility between Turkish natives and Syrian migrants may be exacerbated by the composition of the Syrian migrant population, if high-fertility regions are over-represented among the Syrians in Türkiye. It should also be noted that there is significant regional divergence in the TFR in Syria. The limited information we have before the start of the civil war in 2011 shows that the TFR in As-Suwayda, a low fertility region, as slightly below the replacement rate (UNFPA and Syrian Commission for Family Affairs & Population, 2023). In contrast, pre-war estimates highlight four governorates as high fertility regions, where the TFR is well above the national level (3.5) that can be listed as Deir ez-Zor (6.8), Daraa (5.1), Raqqa (4.9) and Idlib (4.7) (Rashad and Zaky, 2013). This regional divergence in the TFR calls for a closer look at the province of origin in Syria for a better understanding of fertility patterns.

According to the Turkish Demographic and Health Survey (TDHS) Syrian Sample (HUIPS, 2019b), the total fertility rate of Syrian migrants in Türkiye is 5.3 while the total wanted fertility rate is 4.2, the median age at first birth is 21.4 and the peak of age-specific fertility rate (ASFR) is reached between the ages 20-24. The Syrian migrants included in the DHS are overwhelmingly from provinces close to the border. Past estimates of Syrian migrants in Türkiye suggest that their fertility evolved in the last years. Their TFR was above 6 in 2004, reached the lowest values in the years after the war (approximately 4.5) and then increased again to a level above 5 (Çağatay et al., 2020). This could be due to the compositional changes outlined above, as well as other more complex mechanisms of delayed fertility due to war (Saraç and Koç, 2020).

4 Intervention and experimental design

Participants assigned to Treatment 1 (T1) were presented with information about the fertility behavior and intentions of Syrian women aged 15–49 living in Turkey. Drawing on the Syrian Sample of the Turkish Demographic and Health Survey 2018 (HUIPS, 2019b), our information intervention reported that Syrian women in this age bracket have an average completed fertility of 5.3 children over their lifetime. To convey the substantial heterogeneity underlying this mean, participants were also informed that, among a hypothetical sample

[1]Syrians under temporary protection in Türkiye are not included in the general population statistics.

of 100 Syrian women, 25.8% would have no children at all, whereas 21.7% would have four or more children. The treatment then turned to fertility aspirations: Syrian women were reported to desire, on average, 3.9 children. All figures were displayed both in prose and via icon-array graphics, with an explicit note that these values represent group averages and that individual outcomes vary.

The presentation was strictly descriptive and neutral. No normative or policy-oriented language was employed; the sole aim was to inform respondents with the demographic characteristics and reproductive intentions of a key refugee subgroup. By standardizing both content and format, Treatment 1 isolates the effect of exposure to factual fertility information—absent any normative framing—on subsequent beliefs, attitudes, or policy preferences.

Treatment 2 (T2) mirrored the structure of Treatment 1 (T1) but focused on information on native Turkish women aged 15–49, based on the Turkish Demographic and Health Survey 2018 (HUIPS, 2019a) and the Turkish Statistical Institute (TurkStat, 2024). Participants first read that Turkish women have an average of 2.0 children, substantially lower than their Syrian counterparts. We also highlighted dispersion within the Turkish population: 35.4% of Turkish women are reported to be childless and only 5.2% are reported to bear four or more children. Turning to fertility desires, participants saw that Turkish women aspire to 2.8 children on average. As before, we conveyed information through both textual description and AI-generated visualizations, with clear disclaimers regarding within-group variability.

By employing identical framing, modality, and graphical style across both treatments, the design ensures that any differences in participants' reactions can be attributed solely to the content of the fertility profiles —Syrian versus Turkish— rather than to differences in presentation.

To ensure the randomization into different treatment arms, at the baseline, the enumerators selected the individuals' treatment arms based on a predetermined treatment status associated with the individual to be surveyed.

In the next section, we check for balance based on the following characteristics: location (Istanbul versus other locations), gender, age, birth location, duration length of stay in Türkiye, marital status, mother alive, father alive, religion (whether Muslim), religiosity, ever given birth, number of children, education, Turkish proficiency, unemployed, out of the labor force, type of work, social security, job before Türkiye, income less than expenses, aid index (as defined below), people living in the household, people working in the household, durables index (as defined below), number of siblings, presence of Turkish in the area, conformity scale.

5 Sample and data

The surveyed population was drawn from the Syrians under temporary protection residing in Türkiye and having a partner at the time of the survey implementation. The sampling procedure we pursued was stratified by sex and province.

Our survey and treatment was conducted by our partner, Istatistik Dünyası, in houses and public spaces. As we explain in Section, 3, survey regions were drawn among the ones with the largest proportion of migrant population. While the survey took place individuals were privately administered the questionnaire using a self-administered survey on tablet, in the presence of one enumerator. Only one person per couple was surveyed. We ran three surveys: a pilot with an expected sample size of 100 individuals, a baseline survey (including the treatment material), and follow-up survey both with an expected sample size of 1600 individuals.

We collected the survey data in three distinct phases. The first phase consisted of a pilot questionnaire aiming to ascertain the quality of responses to our planned survey.[2] The second phase was the baseline data collection, that took place late Winter and Spring 2024. This survey employed an updated version of the questionnaire used during the pilot survey, which was uploaded before starting to roll-out the baseline. The third phase, aiming to measure medium-term impacts of the treatment, took place in Fall 2024. The questionnaire consisted of a subset of the questions in the baseline survey: all questions included after the treatment in the baseline. We gave a monetary incentive of 100TL (approximately 3$) for completing the in the follow-up survey.

In the baseline survey, before delivering the treatment in control groups, we collected a comprehensive set of socio-demographic characteristics for use in balance checks and as controls in our analyses. We collected respondent location in Türkiye, as categorized as residing in Istanbul versus elsewhere, as well as province of birth in Syria. We measured educational attainment by the highest level of schooling completed. To summarize the respondents' financial status we asked them whether their income was larger, equal or smaller than their expensive. Then we aggregated this in a dummy reporting whether income was lower than expenditures due to low variation across other categories. We also computed an aid index based on PCA-aggregation of questions reporting whether the respondent receives aid in different forms from a wide range of sources. We collected the self-stated level of religiosity using a Likert scale. We use this in our analysis by aggregating answers in a dummy variable measuring 'above-median' religiosity. Finally, we assessed conformist tendencies with

[2]As we detail in our pre-registration material at `https://www.socialscienceregistry.org/trials/12925`, we conducted the pilot survey after submitting our pre-analysis plan.

a brief version of the Mehrabian and Stefl (1995) conformity questionnaire and aggregated those responses into a single conformity scale using the same PCA procedure. To use this variable in heterogeneity analysis we further aggregate it into a dummy for 'above-median conformity'. We construct a dummy for Turkish presence in one's area, taking the value 1 if the subject reports that their area is predominantly Turkish or mixed Turkish-Syrian, 0 if it's predominantly Syrian.

After delivering the treatment, we collected information on the main outcomes, including fertility intentions, perceived stigma, and beliefs about natives' and migrants' fertility. We measure intentions to have children in different time spans: in the next 2 years, in the next 5 years, and at some point. [3] We measure of perceived stigma based with a dummy reporting whether subjects believe that "[p]eople around me think I should have more" or "less" children. We measure beliefs by answers to on the average number of children among Turkish natives and Syrians, and on their ideal number of children of Turkish couples and of Syrian couples.[4]

6 Methods

We operationalize the notions from the literature of descriptive norms in a stylized model building on Akerlof (1997) and Brock and Durlauf (2001), to think more precisely about treatment effects, identification, and the evaluation of counterfactual scenarios. Suppose that individuals form fertility intentions based on the utility of having children, which is additively separable in two components. The first component is the utility that parents enjoy in giving birth and raising a child, we assume that this is given by the constant b, and a random, mean-zero component ε, iid type-1 Gumbel distributed.

The second component is the utility of conforming to the preferences of others. We suppose that migrants interact with other migrants or natives, with probability p_m and p_n, respectively, and such that $p_m + p_n = 1$. In this setting, allowing fertility intentions and shocks to change over time, an individual has children at time t if and only if:

$$b + p_m a_m(t) + p_n a_n(t) + \varepsilon_t \geq p_m(1 - a_m(t)) + p_n(1 - a_n(t))$$

Where $a_m(t)$ represents an indicator variable for intending to have (a high number of) children.

[3] We also check for potential effects on pregnancies, but we are underpowered for this analysis.

[4] We also asked a question about the perceived number of couples without children. However, the answers to this question are disproportionally located at 0% at 50%. We believe that this was due to a complex formulation with a double negative. Indeed, results show a negative impact of treatments on these variables.

We also assume that migrants are not perfectly informed about the fertility of natives. In particular, beliefs about native fertility evolve according to:

$$\bar{a}_n(t+1) = (1-\gamma)\bar{a}_n(t) + \gamma\bar{a}_n, \quad \gamma \in (0,1] \tag{1}$$

Where $\bar{a}_n$ represents the current steady-state of natives fertility.[5]

Taking as given the law of motion for beliefs of natives, fertility intentions in the host country then follow a logistic decision rule:

$$\bar{a}_m(t+1) = \sigma\left(b - p_m - p_n + 2p_m\bar{a}_m(t) + 2p_n\bar{a}_n(t)\right), \quad \text{where } \sigma(z) = \frac{1}{1+e^{-z}} \tag{2}$$

Expression 2 already suggests that the dynamics of convergence will be influenced by the relative value of conforming. If b is high, fertility preferences are mostly driven by the intrinsic value of having children, and other's people norms (native or migrants alike) have a lower impact on behavior. To think more generally about the dynamics of integration in the destination country, we can assume that migrants in the country of origin, before migrating, have no probability of interacting with natives of the destination country $p_n = 0$. Suppose also that initial beliefs about fertility of natives correspond to the fertility of migrants in the host country. Now define deviations from the initial migrant fertility level as:

$$x_t = \bar{a}_m(t) - \bar{a}_m(0).$$

Log-linearizing the expressions above and using Equation 1, we obtain:

$$x_t \approx \sum_{k=0}^{t-1} \lambda^{t-1-k}\mu\left[1-(1-\gamma)^k\right] = \mu\left[\frac{1-\lambda^t}{1-\lambda} - \frac{(1-\gamma)^t - \lambda^t}{1-\gamma-\lambda}\right] \tag{3}$$

where

$$\lambda = \sigma'(z_0)p_m, \quad \mu = \sigma'(z_0)p_n(\bar{a}_n - \bar{a}_m(0)).$$

It is instructive to assess the impact of γ, λ, and μ on the convergence to the new social norm in the destination country. Convergence speed is proportional to μ representing a scaled difference in the initial differences in norms between migrants and natives. If migrants have to cover a larger gap, they change their norms faster as they integrate.

The parameter $\lambda \in (0,1)$ represents a scaled version of the probability of interacting with migrants. Higher segregation in the destination country can be captured by higher p_m. If

[5] We are implicitly assuming that this steady-state does not change with the arrivals of migrants because, e.g., the migrants' population is not large enough to affect it.

$\lambda = 0$, migrants are only responsive to natives' norm. We have:

$$x_t = \mu \left(1 - \frac{(1-\gamma)^t}{1-\gamma}\right).$$

In this case, convergence speed is driven purely by belief updating γ. In other words, if migrants only interact with natives and want to conform to natives, convergence can only be slowed down by beliefs frictions. If, instead, migrants only care about migrants' norms, we have $\lambda \to 1$. In this case, we have:

$$x_t \to \mu \left(t - \frac{1-(1-\gamma)^t}{\gamma}\right),$$

implying slower, approximately linear convergence for large t.

The parameter $\gamma \in (0, 1)$ represents the speed of convergence of migrants to the right set of beliefs about the norms of natives. An increase in γ, consistent with our treatment delivering Turkish information, would decrease the term in square brackets in times t. Higher speed in the beliefs convergence translates in faster convergence of fertility norms. In the extreme, for no convergence in beliefs, $\gamma = 0$, fertility norms do not change over time. Instead, if belief adjustment is friction-less, $\gamma = 1$,

$$x_t = \mu \frac{1-\lambda^{t-1}}{1-\lambda}.$$

In this case, the speed in convergence of social norms only depends on the probability of interaction between migrants and natives. Higher probability of interacting with migrants reduces convergence speed. In other words, even without any frictions in the fertility update, segregation and the lack of interaction between migrants and native predict slows down convergence.

7 Analysis and Findings

We estimate the impact of the treatment on fertility outcomes with the following regression:

$$y_{i,t} = \beta_0 + \beta_1 T_{i,1} + \beta_2 T_{i,2} + \beta X_i' + \epsilon_{i,t} \tag{4}$$

where $y_{i,t}$ represents outcomes–fertility intentions, perceived stigma, and beliefs–measured at time t (0 for baseline and 1 for follow-up). The variables $T_{i,1}$ and $T_{i,2}$ are treatment dummies, X_i is a vector of controls, and $\epsilon_{i,t}$ is the error term. Controls include stratification variables,

demographic characteristics, religiosity, conformity, presence of Turkish natives in the area, location (Istanbul and Izmir vs others), and observables that display some unbalance in either treatment group T1 or T2 as suggested by Bruhn and McKenzie (2009). We are also interested in the differential impact of T1 and T2. To assess this, we compute the p-value for an F-test that they the two treatment effects are equal.

Assessing the impact of the treatments on beliefs and stigma requires estimating their effects on multiple variables. To handle multiple hypothesis testing, we compute family-wise error rates using the step-down procedure of Westfall and Young (1993). We also construct PCA indexes for each variable group and estimate the treatment impact on these indexes.

For follow-up outcomes, we check for selective attrition by assessing whether attrition is correlated with treatment dummies, controlling for stratification, unbalanced, and heterogeneity variables.

To study the mechanisms driving treatment effects, we estimate heterogeneous treatment effects across religiosity, gender, conformity, and measures of interaction with natives' heterogeneous treatment effects, we estimate:

$$y_{i,t} = \alpha_0 + \alpha_1 T_{i,1} + \alpha_2 T_{i,2} + \alpha_3 T_{i,1} W_i + \alpha_4 T_{i,2} W_i + \alpha_5 W_i + \alpha X_i' + \nu_{i,t} \tag{5}$$

where W_i is a dummy for key moderators of the treatment effect. We also report p-values for an F-test that sum of the effect for the treatment dummy and the same dummy interacted with W_i, representing the treatment effect for individuals with $W_i = 1$, is 0.

In Table 32, we report the balance table for the treatments and control groups on the main demographics, moderators, and outcomes of our treatment, comparing each treated group separately against the control group. Treatment 1 (T1) is the one in which we provided Syrian fertility information, while Treatment 2 (T2) is the treatment delivering information about Turkish natives, the focus of our experiment. Both treatment groups are balanced on gender composition, age, marital status, religiosity, share of tertiary educated, employment, unemployment, and type of neighborhood (predominantly migrants vs. not). On average, subjects in T2, are less likely to be secondary educated than the control group, and the difference is statistically significant at the 10% level. In addition, on average individuals in T2 arrived in Türkiye 4.5 months after individuals in the control group. This difference is statistically significant but small compared to the 93.5 months average for the control group. In both cases, these differences could potentially confound the effect of our treatment, but they should do so contrary to our treatment direction since they potentially introduce the integration of migrants or the knowledge about the local environment. In any case, we control for this and all other unbalanced variables in the our analyses. Subjects in T1 have

been in Türkiye for 4.5 more months, and are less likely to have given birth in the past. Again, we control for these variables in our analyses.

In Appendix Table 12, we report additional observables for balance. While the population in T1 is slightly less integrated according to language and and employment measures. More importantly, T2 is generally balanced, with only two observables characteristics out of fifteen (father alive, and employment before migration) being significantly different from the control group.

The main result of our paper is summarized in Table 2. In this table we report the results of the regression previously discussed on the dummies reporting intentions to have a child in the following 2 years (first two columns), in the following 5 years (third and fourth columns) or at some point in the future (last two columns). Odd columns report results without control and event columns report results with controls.

Our main treatment, T2, has a statistically significant negative effect on the fertility intention to have a child within 2 and 5 years from the interview date. The negative effects is about 1/3 and 1/5 of the mean in the control group mean, which are 15% and 25% respectively. The effect is negative but not significant for the more generic question regarding having a child at some point. The effect of T1, consisting of information about the fertility of Syrians in Türkiye, is not statistically significant. In addition, we tested for significance in the difference of the impact of T1 and T2. The p-values reported borders significance at 10% level for the probability of wanting children in the next 2 years and wanting children at some point. This provides suggestive evidence that our treatment mimicking the integration process of migrants, with the discovery of information about the attitudes and descriptive social norms in the receiving country has a stronger impact on their decisions.

In Table 17, we explore effects of our treatments on the ideal number of children declared by subjects. People exposed to both T1 and T2 significantly decreased their ideal number of children. This decrease is larger in T2–20% of the control mean–than T1– 8% of the control mean–and the difference is statistically significant at the 99% level.

Table 1: Balance table

	(1) Control Mean	(2) T1 - Control	(3) T2 - Control
Female	0.571	0.027	-0.048
	(0.495)	(0.030)	(0.030)
Age	33.749	0.437	0.258
	(9.208)	(0.562)	(0.579)
Months in Türkiye	93.451	4.507**	-4.515**
	(29.832)	(2.107)	(1.903)
Marital status	0.903	0.022	0.017
	(0.297)	(0.017)	(0.017)
Given birth	0.787	0.054**	-0.032
	(0.410)	(0.024)	(0.026)
Religiosity	0.487	-0.027	0.040
	(0.500)	(0.031)	(0.031)
Secondary Education	0.607	-0.050	-0.053*
	(0.489)	(0.030)	(0.030)
Tertiary Education	0.236	0.034	-0.001
	(0.425)	(0.027)	(0.026)
Currently Employed	0.331	-0.031	0.023
	(0.471)	(0.028)	(0.029)
Currently Unemployed	0.135	-0.017	-0.019
	(0.342)	(0.020)	(0.020)
Migrants' neighborhood	0.406	-0.001	0.021
	(0.492)	(0.030)	(0.030)
Expected Pregnancy	0.022	-0.011	0.006
	(0.148)	(0.008)	(0.010)
Observations	534	1,067	1,067

Notes: The first column reports the control mean of the variable and its standard deviation in parenthesis. The last two columns report differences between T1, T2 and the control group, with OLS estimates and standard errors (in parentheses). *, **, and *** denote significance at 10, 5 and 1 percent level, respectively. X, Y, Z are described in Section **??**.

Table 2: Treatment effects: Intention to have a child

	(1)	(2)	(3)	(4)	(5)	(6)
	Child within 2 years		Child within 5 years		Child at some point	
T1	-0.0260	-0.0150	-0.0352	-0.0204	0.0121	0.0305
	(0.0204)	(0.0203)	(0.0254)	(0.0242)	(0.0304)	(0.0277)
T2	-0.0522**	-0.0463**	-0.0521**	-0.0624**	-0.0198	-0.0159
	(0.0204)	(0.0203)	(0.0254)	(0.0242)	(0.0304)	(0.0277)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1 = T2	0.198	0.122	0.506	0.082	0.295	0.093
N	1600	1600	1600	1600	1600	1600
Control mean	0.15	0.15	0.25	0.25	0.45	0.45

Table 3: Treatment effects: Ideal number of Children

	(1)	(2)
	Ideal Number of Children	
T1	-0.305***	-0.358***
	(0.100)	(0.0859)
T2	-0.896***	-0.945***
	(0.100)	(0.0861)
Controls	No	Yes
p-value: T1 = T2	0.000	0.000
N	1600	1600
Control mean	4.46	4.46

Notes: This table reports OLS estimates of the effects of the treatments on the ideal number of children participants would choose. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

To investigate the mechanism driving treatment effects on fertility intentions and the ideal number of children, we explore the impact of our treatment on perceived stigma of having too few or too many children. In Table 4, the dependent variable in first and last two columns are dummies reporting whether the individual believes that "[p]eople around them think I should have more" or "less" children, respectively.

Neither T1 nor T2 have statistically significant effect on the perceived stigma from having too few children, although the effect of T2 is negative. Instead, both treatments increase the perceived stigma from having too many children. The effect of T2 is larger in magnitude, but the difference with T1 is only significant in the specifications without controls. For T2, the fraction perceiving that people around them think they should have less children increases from 15% to 24%. These results suggest that our treatments, and especially T2 affected fertility intentions through the social norms channel.

To further explore our proposed mechanism related to descriptive social norms, we assess the impact of our treatment in Table 13. The first two columns two and four show the effects of our treatments on the beliefs about the average number of children for a Turkish couple in their neighborhood, and the last two columns show the effect on the beliefs about the ideal number of children of Turkish couples. Neither T1 or T2 have a statistically significant effect on the perceived average number of children of Turkish couples. It is worth noticing that on average individuals in the control group only slightly overestimate the number of

Table 4: Treatment effects: Stigma

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	-0.00113	0.000492	0.0678***	0.0454*
	(0.0299)	(0.0298)	(0.0246)	(0.0236)
T2	-0.0311	-0.0374	0.113***	0.0815***
	(0.0299)	(0.0299)	(0.0246)	(0.0237)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.315	0.203	0.068	0.126
N	1600	1600	1600	1600
Control mean	0.40	0.40	0.15	0.15

Notes: This table reports OLS estimates of the effects of the treatments on the stigmatization variables. In the first two columns, the outcome is perceived higher stigmatization about having children, and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

children of Turkish natives–the number given in the information session was 2.0 and the average perceived is 2.3. This suggests a general good ability to observe Turkish fertility outcomes. However, both T1 and T2 have a negative, statistically significant effect on the perceived ideal number of children in Turkish couples. Such effect is larger in magnitude for T2 than T1, 17% vs. 12% of the control mean, respectively, and the difference is statistically significant.[6] This effects are consistent with the higher overestimation of average perceived ideal number of children–3.3 vs 2.8 given in the information session. Subjects have not been knowledgeable about non observable preferences of the Turkish society, which requires a more advanced level of social network and conversations with Turkish people.

The ordering of the variables shown in our information intervention may provide a reason why effects are only statistically significant for the perceived ideal number of children. Indeed, this was the last written information item given to treated subjects, and it was the last vignette shown, which represented a woman thinking about a certain number of children. Subjects may have retained this piece information more clearly and for longer given that it was the last thing shown in the treatment.

In Appendix Tables 16 to 19, we replicate the analysis restricting the sample to women

[6]We also asked a question about the perceived number of couples without children. However, the answers to this question are disproportionally located at 0% at 50%. We believe that this was due to a complex formulation with a double negative. Indeed, results show a negative impact of treatments on these variables.

Table 5: Treatment effects: Beliefs about Turkish Couples

	(1)	(2)	(3)	(4)
	Beliefs: n. children		Beliefs: ideal children	
T1	0.0607	0.0576	-0.341***	-0.425***
	(0.0679)	(0.0642)	(0.0768)	(0.0759)
T2	-0.0369	-0.0387	-0.590***	-0.580***
	(0.0679)	(0.0644)	(0.0768)	(0.0761)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.151	0.133	0.001	0.040
N	1600	1600	1600	1600
Control mean	2.34	2.34	3.32	3.32

Notes: This table reports OLS estimates of the effects of the treatments on the beliefs about Turkish couples' number of children variables. In the first two columns, the outcome is the belief about the average number of children Turkish couples have, in the second two columns, the outcome is the belief about the ideal number of children Turkish couples have if they could choose. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

or partners of women below 45 years, i.e. reproductive ages. Results are qualitatively unchanged and quantitatively very similar.

7.1 Heterogeneity Analysis

To further explore the moderating effects of the impact of social norms of fertility, we show how the treatment varies across some theoretically relevant observable characteristics.

In Table 7, we show heterogeneous effects on fertility intentions across people who declare to be more religious than median (religious) versus below. We interact both treatment dummies with a dummy variable for being religious. Baseline coefficients for T1 and T2, reporting effects for non-religious people, positive, and even marginally statistically significant for the dummy reporting the intention to have children at some point. Interaction with the religiosity dummy are negative, and always significant for T2. Comparing the baseline coefficient for T2 and its interaction with the religiosity dummy, we observe that the effect of T2 is only significant for T2. In Appendix Table 21, reporting the heterogeneous treatment effects on perceived stigma. Indeed, religious individuals are more likely to suffer stigma from having too few children, and T2 reduces the probability of reporting such stigma for them.

In Table 6, we report heterogeneous effects on fertility intentions across gender. We interact treatment dummies with a dummy for being female. The baseline coefficient for treatment dummies, reporting the effect for males, is negative and significant for T2, for all treatments except for the outcome reporting the intention to have a child at some point, in the specification without controls. The interaction coefficient is always positive and significant in the specifications including controls. The impact of T2 is only significant for males in our sample. Again, we turn to analyzing heterogeneous effects on perceived stigma in Appendix Table 22, showing that males are the only category for which T2 significantly increase the perceived stigma of having too many children.

As we pre-specify, we checked for the presence of heterogeneous effects due to differential probability of interacting with natives, proxied by Turkish presence in the neighborhood. We constructed a dummy which indicates if the neighborhood in which they live is predominantly Syrian or not and we interacted this dummy with our treatment dummies. We did not find any evidence of differential effects, as it can be seen in Appendix Tables 25-26.

Moreover, we checked for differential treatment effects in accordance to the degree of conformism of the subjects. As we previously explained, we measured conformist tendencies with a short version of the Mehrabian and Stefl (1995) conformity questionnaire, from which we built a single conformity scale using the same PCA procedure. Finally, we interact the treatment dummies with a dummy indicating if the subject was above the median conformity level in our sample. The results can be seen in Table 24. We find that more conformist people are the ones that react to our treatments increasing stigma perceptions. Namely, we observe an increase in the share who believe that people around them think they have too many children. The treatments also decrease the share of them who believe other people think they should have more children. These results may indicate that our conformist scale is indeed capturing higher concerns about other people's opinions. However, we do not notice a direct effect of conformism on our main outcomes, maybe due to interactions with other characteristics, like gender and religiosity which seems more prominent in those choices.

Table 6: Intention to have a child: gender heterogeneity

	(1)	(2)	(3)	(4)	(5)	(6)
	Within 2 years		Within 5 years		At some point	
T1	-0.0566*	-0.0452	-0.0612	-0.0333	0.0324	0.0465
	(0.0316)	(0.0312)	(0.0391)	(0.0372)	(0.0469)	(0.0426)
T2	-0.0977***	-0.102***	-0.0913**	-0.116***	-0.0599	-0.0841**
	(0.0303)	(0.0299)	(0.0375)	(0.0357)	(0.0449)	(0.0408)
Female	-0.0675**	-0.0389	-0.137***	-0.0398	-0.141***	-0.0745
	(0.0291)	(0.0343)	(0.0360)	(0.0409)	(0.0431)	(0.0468)
T1×Female	0.0543	0.0524	0.0497	0.0230	-0.0274	-0.0256
	(0.0414)	(0.0405)	(0.0511)	(0.0483)	(0.0613)	(0.0552)
T2×Female	0.0806**	0.102**	0.0624	0.0980**	0.0637	0.127**
	(0.0410)	(0.0402)	(0.0506)	(0.0480)	(0.0607)	(0.0548)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1+ T1xFemale = 0	0.930	0.784	0.727	0.742	0.900	0.560
p-value: T2+ T2xFemale = 0	0.536	0.993	0.397	0.587	0.926	0.252
N	1600	1600	1600	1600	1600	1600
Control mean	0.15	0.15	0.25	0.25	0.45	0.45

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with gender on the intention to have a child. In the first two columns, the outcome is intention to have a child in two 2 years, in the second two, it is intention to have a child in 5 years; and in the third two, it is intention to have a child at some point. Odd columns report the estimates obtained without controls in the regression, and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 7: Intention to have a child: religiosity heterogeneity

	(1)	(2)	(3)	(4)	(5)	(6)
	Within 2 years		Within 5 years		At some point	
T1	0.0190	0.0174	0.0104	0.00528	0.0798*	0.0704*
	(0.0280)	(0.0277)	(0.0348)	(0.0330)	(0.0417)	(0.0378)
T2	0.00559	0.0154	0.0347	0.0192	0.0773*	0.0806**
	(0.0290)	(0.0288)	(0.0360)	(0.0343)	(0.0432)	(0.0393)
Religious	0.0905***	0.0744***	0.0693*	0.0410	0.0347	0.0130
	(0.0288)	(0.0285)	(0.0357)	(0.0339)	(0.0428)	(0.0388)
T1×Religious	-0.0925**	-0.0673*	-0.0950*	-0.0526	-0.145**	-0.0824
	(0.0408)	(0.0401)	(0.0507)	(0.0478)	(0.0607)	(0.0547)
T2×Religious	-0.117***	-0.121***	-0.170***	-0.160***	-0.187***	-0.189***
	(0.0407)	(0.0402)	(0.0506)	(0.0479)	(0.0606)	(0.0548)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1+ T1xReligious = 0	0.013	0.088	0.021	0.174	0.138	0.763
p-value: T2+ T2xReligious = 0	0.000	0.000	0.000	0.000	0.010	0.005
N	1600	1600	1600	1600	1600	1600
Control mean	0.15	0.15	0.25	0.25	0.45	0.45

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with religiosity on the intention to have child. In the first two columns, the outcome is intention to have a child in two 2 years, in the second two, it is intention to have a child in 5 years; and in the third two, it is intention to have a child at some point. Odd columns report the estimates obtained without controls in the regression, and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

7.2 Second Wave

The second wave of surveys were conducted between 7-8 months after the first one. The participants were called on their individual phone which they consented to provide to the firm in the first round of interviews.

However, the attrition rate was limited to less than 15% of the sample (234 out of 1600). We performed a regression of a dummy for not having being interviewed in the second wave on the treatment received, in order to check to possible unbalanced attrition that could bias our results. The participation in the second wave is not correlated to having receive either treatment, as it can be seen in table 8.

Table 8: Attrition and Treatments

	y = 1 if subject attrited at F.U.		
T1	-0.0297	-0.0243	-0.0221
	(0.0216)	(0.0214)	(0.0216)
T2	-0.00908	-0.00685	-0.00718
	(0.0216)	(0.0216)	(0.0217)
Controls (heterogeneity variables)	No	Yes	Yes
Controls (unbalanced observables)	No	No	Yes
N	1600	1600	1600

Notes: This table reports OLS estimates of the effects of the treatments on the Attrition dummy variable which takes 1 if the subject did not participate in the second wave of the survey. In the first column, we do not control for any other variable. In the second column we control for the variables relevant for our heterogeneity analysis, while in the third we controls for additional variables that were unbalanced in our sample. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

The main results on fertility intentions from the second wave are reported in tables 9 , 10 and 11. From the first table, we can see that under the assumption of homogeneous treatment effect, the no treatment had a statistically significant impact on any of the fertility intention measures.

When we replicate the analysis allowing for heterogeneity across the dimensions that were relevant at baseline, we observe persistence in some of our results. If we allow for heterogeneous effects across gender or religion, the treatment with Turkish information (T2) maintains a statistically significant negative effect on the intention of having a child within 2 years in the male population (table 10). Further, T2 had a significant negative effect on the intentions to have a child within 2 and 5 years among more religious participants, in line with the result of the first wave.

Overall, the results indicate that the effect of the treatment is persistent in the medium

term among the population more sensible to the information. [7] Given such heterogeneity, the overall results for the second wave are also consistent with ha significantly higher attrition rate among women in the sample, as reported in Appendix Table 20.

Table 9: Treatment effects 2nd Wave: Intention to have a child

	(1)	(2)	(3)	(4)	(5)	(6)
	Child within 2 years		Child within 5 years		Child at some point	
T1	0.00811	0.0122	-0.00332	0.00421	0.0423	0.0536*
	(0.0177)	(0.0179)	(0.0244)	(0.0241)	(0.0321)	(0.0305)
T2	-0.0228	-0.0164	-0.0214	-0.0261	0.00566	0.0156
	(0.0178)	(0.0181)	(0.0245)	(0.0243)	(0.0322)	(0.0307)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1 = T2	0.080	0.107	0.458	0.204	0.252	0.209
N	1366	1366	1366	1366	1366	1366
Control mean	0.08	0.08	0.17	0.17	0.36	0.36

Notes: This table reports OLS estimates of the effects of the treatments on the intention to have children variables. In the first two columns, the outcome is intention to have child in two 2 years, in the second two, it is intention to have child in 5 years; and in the third two, it is intention to have child at some point. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

[7] Unfortunately,due to miscommunication with the survey firm, the ideal number of children was only collected for a subsample in the follow-up and we cannot use it in the analysis.

Table 10: Intention to have a child: gender heterogeneity second wave

	(1)	(2)	(3)	(4)	(5)	(6)
	Within 2 years		Within 5 years		At some point	
T1	0.00689	0.0111	0.0377	0.0533	0.119**	0.121**
	(0.0277)	(0.0278)	(0.0380)	(0.0373)	(0.0501)	(0.0472)
T2	-0.0592**	-0.0608**	-0.0238	-0.0373	0.00675	-0.00843
	(0.0267)	(0.0268)	(0.0366)	(0.0360)	(0.0483)	(0.0455)
Female	-0.00996	-0.00933	-0.0485	0.0113	-0.0254	0.00122
	(0.0255)	(0.0309)	(0.0349)	(0.0415)	(0.0460)	(0.0525)
T1×Female	0.00271	0.00369	-0.0634	-0.0815*	-0.122*	-0.112*
	(0.0360)	(0.0358)	(0.0494)	(0.0481)	(0.0651)	(0.0608)
T2×Female	0.0668*	0.0802**	0.00191	0.0208	-0.00339	0.0442
	(0.0358)	(0.0356)	(0.0491)	(0.0479)	(0.0647)	(0.0605)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1+ T1xFemale = 0	0.677	0.523	0.417	0.364	0.927	0.809
p-value: T2+ T2xFemale = 0	0.751	0.420	0.504	0.608	0.938	0.381
N	1366	1366	1366	1366	1366	1366
Control mean	0.08	0.08	0.17	0.17	0.36	0.36

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with gender on the intention to have child variables. In the first two columns, the outcome is intention to have child in two 2 years, in the second two, it is intention to have child in 5 years; and in the third two, it is intention to have child at some point. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 11: Intention to have a child: religiosity heterogeneity second wave

	(1)	(2)	(3)	(4)	(5)	(6)
	Within 2 years		Within 5 years		At some point	
T1	0.0339	0.0263	0.00920	-0.00492	0.0761*	0.0497
	(0.0241)	(0.0243)	(0.0332)	(0.0326)	(0.0437)	(0.0414)
T2	0.0282	0.0331	0.0419	0.0249	0.0325	0.0274
	(0.0252)	(0.0254)	(0.0347)	(0.0342)	(0.0457)	(0.0434)
Religious	0.0561**	0.0495*	0.0233	0.00262	-0.0187	-0.0440
	(0.0252)	(0.0254)	(0.0347)	(0.0341)	(0.0457)	(0.0433)
T1×Religious	-0.0538	-0.0291	-0.0263	0.0215	-0.0771	0.00889
	(0.0355)	(0.0355)	(0.0488)	(0.0477)	(0.0642)	(0.0606)
T2×Religious	-0.102***	-0.0978***	-0.122**	-0.0990**	-0.0494	-0.0226
	(0.0356)	(0.0357)	(0.0489)	(0.0480)	(0.0645)	(0.0608)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1+ T1xReligious = 0	0.446	0.916	0.632	0.637	0.983	0.189
p-value: T2+ T2xReligious = 0	0.003	0.011	0.020	0.030	0.710	0.913
N	1366	1366	1366	1366	1366	1366
Control mean	0.08	0.08	0.17	0.17	0.36	0.36

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with religiosity on the intention to have child variables. In the first two columns, the outcome is intention to have child in two 2 years, in the second two, it is intention to have child in 5 years; and in the third two, it is intention to have child at some point. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

References

Adserà, A., A. M. Ferrer, W. Sigle-Rushton, and B. Wilson (2012). Fertility patterns of child migrants: Age at migration and ancestry in comparative perspective. *The Annals of the American Academy of Political and Social Science 643*(1), 160–189.

Agadjanian, V. (2018). Interrelationships of forced migration, fertility and reproductive health. In G. Hugo, M. J. Abbasi-Shavazi, and E. Percy Kraly (Eds.), *Demography of refugee and forced migration*, pp. 113–124. Springer.

Akerlof, G. A. (1997). Social distance and social decisions. *Econometrica: Journal of the Econometric Society*, 1005–1027.

Andersen, S., A. Adserà, and M. Tønnessen (2023). Municipality characteristics and the fertility of refugees in Norway. *Journal of International Migration and Integration*, 1–44.

Andersson, G. and K. Scott (2005). Labour-market status and first-time parenthood: The experience of immigrant women in Sweden, 1981–97. *Population studies 59*(1), 21–38.

Avogo, W. and V. Agadjanian (2008). Childbearing in crisis: War, migration and fertility in angola. *Journal of Biosocial Science 40*(5), 725–742.

Beine, M., F. Docquier, and M. Schiff (2013). International migration, transfer of norms and home country fertility. *Canadian Journal of Economics/Revue canadienne d'économique 46*(4), 1406–1430.

Bozdag, I., C. Sierra-Paycha, and A. Andro (2022). Temporary adjustment or normative change? fertility and marriage preferences of Syrian refugees in Turkey in the context of forced migration. *Frontiers in Human Dynamics 3*, 778385.

Brock, W. A. and S. N. Durlauf (2001). Discrete choice with social interactions. *The Review of Economic Studies 68*(2), 235–260.

Bruhn, M. and D. McKenzie (2009). In pursuit of balance: Randomization in practice in development field experiments. *American economic journal: applied economics 1*(4), 200–232.

Çağatay, P., F. Keskin, and B. Ergöçmen (2020). Fertility behavior of Syrian women in Turkey: The crosscut of intention and regulation. In *Syrian refugees in Turkey*, pp. 86–102. Routledge.

Cherri, Z., J. Gil Cuesta, J. M. Rodriguez-Llanes, and D. Guha-Sapir (2017). Early marriage and barriers to contraception among Syrian refugee women in Lebanon: a qualitative study. *International journal of environmental research and public health 14*(8), 836.

Courgeau, D. (1989). Family formation and urbanization. *Population* (ES1), 123–146.

Farber, S. C. and B. S. Lee (1984). Fertility adaptation of rural-to-urban migrant women: A method of estimation applied to Korean women. *Demography 21*(3), 339–345.

Fernández, R. and A. Fogli (2006). Fertility: The role of culture and family experience. *Journal of the European economic association 4*(2-3), 552–561.

Fernández, R. and A. Fogli (2009). Culture: An empirical investigation of beliefs, work, and fertility. *American economic journal: Macroeconomics 1*(1), 146–177.

Goldberg, D. (1959). The fertility of two-generation urbanites. *Population Studies 12*(3), 214–222.

Goldstein, S. (1973). Interrelations between migration and fertility in Thailand. *Demography 10*(2), 225–241.

Hacettepe University Institute of Population Studies (HUIPS) (2019a). 2018 Turkey demographic and health survey.

Hacettepe University Institute of Population Studies (HUIPS) (2019b). 2018 Turkey demographic and health survey - Syrian migrant sample.

Hervitz, H. M. (1985). Selectivity, adaptation, or disruption? a comparison of alternative hypotheses on the effects of migration on fertility: The case of Brazil. *International Migration Review 19*(2), 293–317.

Holck, S. E. and W. Cates Jr (1982). Fertility and population dynamics in two Kampuchean refugee camps. *Studies in Family Planning*, 118–124.

Kabakian-Khasholian, T., R. Mourtada, H. Bashour, F. E. Kak, and H. Zurayk (2017). Perspectives of displaced syrian women and service providers on fertility behaviour and available services in west bekaa, lebanon. *Reproductive Health Matters 25*(sup1), 75–86.

Kahn, J. R. (1988). Immigrant selectivity and fertility adaptation in the United States. *Social Forces 67*(1), 108–128.

Kulu, H. (2005). Migration and fertility: Competing hypotheses re-examined. *European Journal of Population/Revue européenne de Démographie 21*(1), 51–87.

Lübke, C. (2015). How migration affects the timing of childbearing: The transition to a first birth among Polish women in Britain. *European Journal of Population 31*(1), 1–20.

Mehrabian, A. and C. A. Stefl (1995). Basic temperament components of loneliness, shyness, and conformity. *Social Behavior and Personality: an international journal 23*(3), 253–263.

Myers, G. C. and E. W. Morris (1966). Migration and fertility in Puerto Rico. *Population Studies 20*(1), 85–96.

Rashad, H. and H. Zaky (2013). A comparative analysis of fertility plateau in Egypt, Syria and Jordan: policy implications. *Policy Implications*, 1.

Rosenwaike, I. (1973). Two generations of Italians in America: their fertility experience. *International Migration Review 7*(3), 271–280.

Rumbaut, R. G. and J. R. Weeks (1986). Fertility and adaptation: Indochinese refugees in the United States. *International Migration Review 20*(2), 428–466.

Saraç, M. and İ. Koç (2020). Timing of reproductive events among host community and syrian refugee women in turkey: An event history analysis from menarche to menopause. In *Syrian Refugees in Turkey*, pp. 49–67. Routledge.

Schmid, S. and M. Kohls (2010). Fertility of female immigrants in Germany. In *Demographic aspects of migration*, pp. 179–207. Springer.

Sieverding, M., C. Krafft, N. Berri, and C. Keo (2020). Persistence and change in marriage practices among Syrian refugees in Jordan. *Studies in Family Planning 51*(3), 225–249.

Spolaore, E. and R. Wacziarg (2022). Fertility and modernity. *The Economic Journal 132*(642), 796–833.

Stephen, E. H. and F. D. Bean (1992). Assimilation, disruption and the fertility of Mexican-origin women in the United States. *International Migration Review 26*(1), 67–88.

(TurkStat), T. S. I. (2024, May). Basic fertility indicators, 2001-2023. URL: `https://data.tuik.gov.tr/Bulten/Index?p=Birth-Statistics-2023-53708`. Online; accessed February 2025.

UNFPA and Syrian Commission for Family Affairs & Population (2023, January). Fourth report on the state of Syria's population 2020. URL: `https://syria.unfpa.org/ar/publications/%D8%A7%D9%84%D8%AA%D9%82%D8%B1%D9%8A%D8%B1-%D8%A7%D9%84%D8%B1%D8%A7%D8%A8%D8%B9-%D8%AD%D9%88%D9%84-%D8%AD%D8%A7%`

D9%84%D8%A9-%D8%B3%D9%83%D8%A7%D9%86-%D8%B3%D9%88%D8%B1%D9%8A%D8%A9-2020. Online; accessed February 2025. Original title in Arabic:.

Westfall, P. H. and S. S. Young (1993). *Resampling-based multiple testing: Examples and methods for p-value adjustment*, Volume 279. John Wiley & Sons.

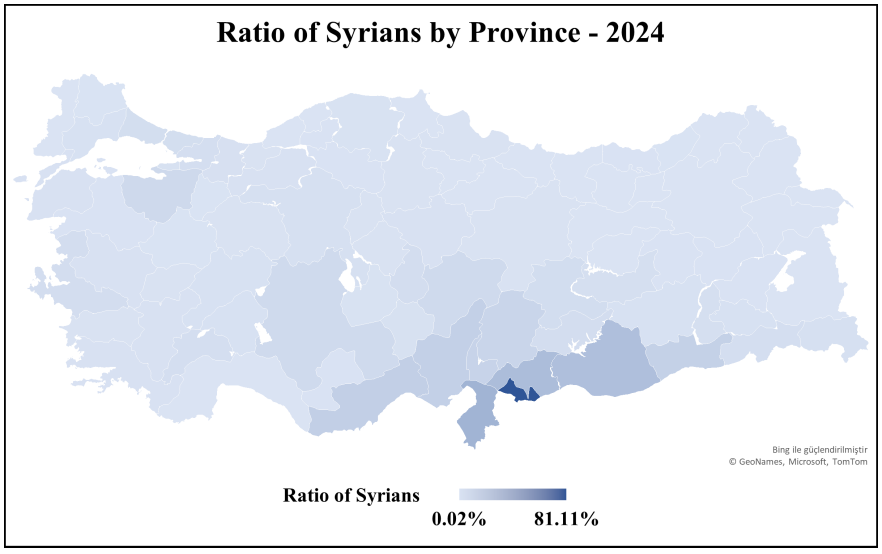
Williams, J., L. Ibisomi, B. Sartorius, K. Kahn, M. Collinson, S. Tollman, and M. Garenne (2013). Convergence in fertility of South Africans and Mozambicans in rural South Africa, 1993–2009. *Global Health Action 6*(1), 19236.

Zarate, A. and A. U. De Zárate (1975). On the reconciliation of research findings of migrant-nonmigrant fertility differentials in urban areas. *International migration review 9*(2), 115–156.

Appendix

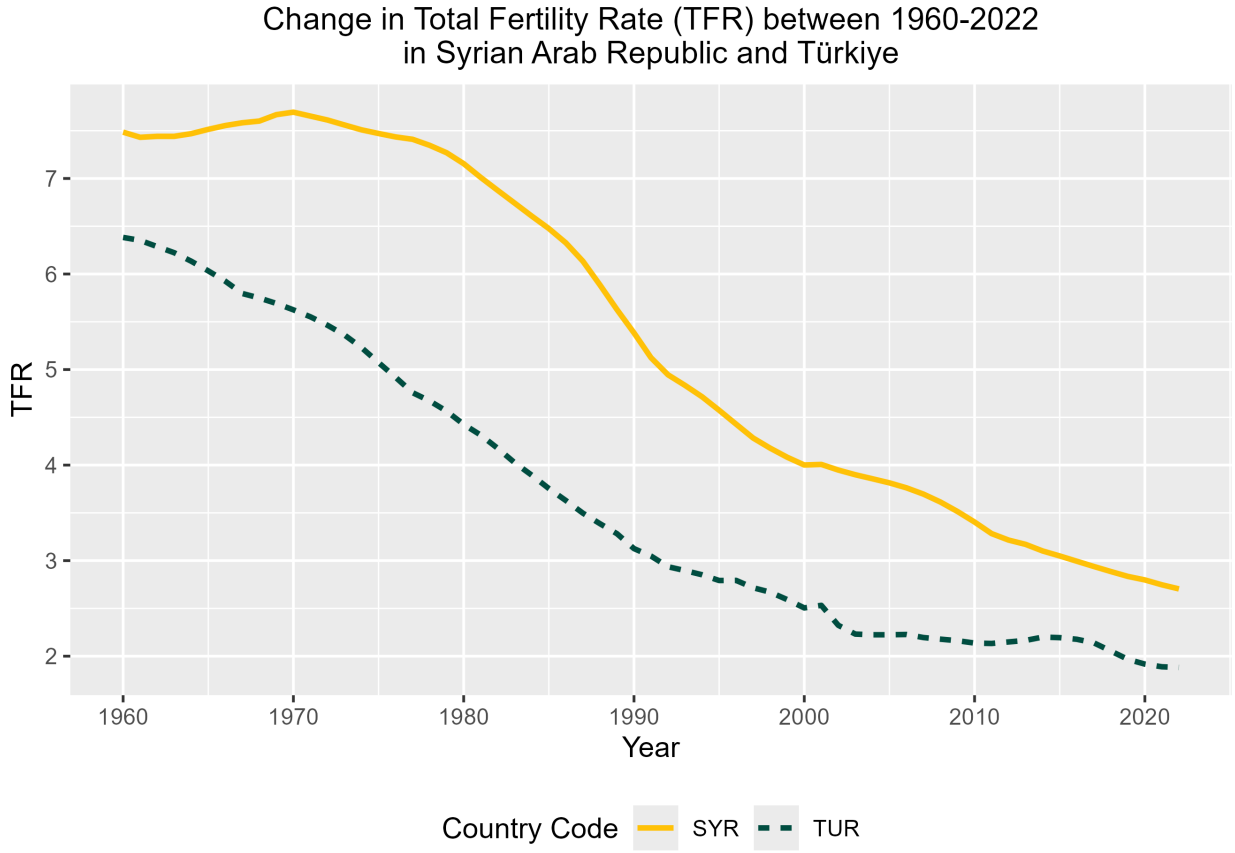
Figures and Tables

Figure 1: The Ratio of Syrians to the Province Population



Source: Directorate General of Migration Management

Figure 2: Comparison of the Change in Total Fertility Rates in Syria and Türkiye



Source: World Bank Group.
Please note that the World Bank data come from a combination of United Nations Population Division, World Population Prospects: 2022 Revision and national statistical offices. While there may be slight differences with the data from Turkish Statistical Institute, we used World Bank data for both countries in this figure to maintain consistency.

Table 12: Balance table

	(1) Control Mean	(2) T1 - Control	(3) T2 - Control
Whether mother alive	0.801	-0.051**	-0.034
	(0.399)	(0.026)	(0.025)
Whether father alive	0.646	-0.031	-0.049*
	(0.479)	(0.030)	(0.030)
N. of children	2.809	0.180	-0.029
	(2.249)	(0.140)	(0.143)

Table 32 (continued)

	(1) Control Mean	(2) T1 - Control	(3) T2 - Control
Turkish Speaking Proficiency	2.440	-0.112*	-0.014
	(1.092)	(0.066)	(0.067)
Turkish Reading Proficiency	2.279	-0.195***	-0.101
	(1.146)	(0.070)	(0.071)
Employed in last week	0.404	-0.069**	-0.001
	(0.491)	(0.030)	(0.030)
Student before migration	0.131	0.006	0.008
	(0.338)	(0.021)	(0.021)
Employed before migration	0.358	0.016	0.076**
	(0.480)	(0.030)	(0.030)
Financial distress	0.710	-0.032	-0.046
	(0.454)	(0.028)	(0.028)
N. of people living in household	5.551	-0.160	-0.053
	(2.120)	(0.128)	(0.131)
N. of people working in household	1.262	-0.120***	-0.026
	(0.721)	(0.043)	(0.045)
N. of single siblings	1.292	-0.086	-0.005
	(1.516)	(0.091)	(0.099)
N. of married siblings	4.335	-0.001	-0.176
	(3.133)	(0.204)	(0.195)
East Turkey	0.506	-0.012	-0.005
	(0.500)	(0.031)	(0.031)
Aid index	-0.069	-0.086	0.294**
	(1.982)	(0.118)	(0.134)
Collar type	0.296	0.011	0.015
	(0.458)	(0.046)	(0.044)
Observations	534	1,067	1,067

Notes: The first column reports the control mean of the variable and its standard deviation in parenthesis. The last two columns report differences between T1, T2 and the control group, with OLS estimates and standard errors (in parentheses). *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 13: Treatment effects: Beliefs about Turkish Couples

	(1)	(2)
	Beliefs: 0 children	
T1	-4.536***	-4.714***
	(1.464)	(1.306)
T2	-7.071***	-5.667***
	(1.464)	(1.309)
Controls	No	Yes
p-value: T1 = T2	0.084	0.465
N	1600	1600
Control mean	29.39	29.39

Notes: This table reports OLS estimates of the effects of the treatments on beliefs about Turkish couples' children intentions. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 14: Treatment effects: Beliefs about Syrians Couples

	(1)	(2)	(3)	(4)	(5)	(6)
	Beliefs: 0 children		Beliefs: n. children		Beliefs: ideal children	
T1	-5.648***	-5.165***	-0.0252	-0.0428	-0.522***	-0.599***
	(1.282)	(1.242)	(0.0919)	(0.0842)	(0.161)	(0.139)
T2	-9.501***	-8.195***	-0.365***	-0.327***	-0.768***	-0.748***
	(1.282)	(1.245)	(0.0919)	(0.0844)	(0.161)	(0.140)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1 = T2	0.003	0.014	0.000	0.001	0.127	0.283
N	1600	1600	1600	1600	1600	1600
Control mean	18.87	18.87	4.57	4.57	5.89	5.89

Notes: In the first two columns, the outcome is the belief about what percentage of Syrian couples don't have children, in the second two columns, the outcome is the belief about the average number of children Syrian couples have, in the last two columns, the outcome is the belief about the ideal number of children Syrian couples have if they could choose. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 15: Total Fertility Rate (TFR) by province

Province	2018	2019	2020	2021	2022	2023
Adana	2.13	2.02	1.88	1.83	1.83	1.68
Ankara	1.65	1.53	1.42	1.34	1.29	1.20
Bursa	1.87	1.75	1.65	1.57	1.48	1.41
Istanbul	1.73	1.61	1.49	1.39	1.30	1.20
Izmir	1.60	1.49	1.40	1.36	1.32	1.22
Kocaeli	1.97	1.86	1.70	1.66	1.58	1.49
Konya	2.08	1.95	1.85	1.81	1.76	1.65
Sanliurfa	4.16	3.91	3.72	3.82	3.61	3.27
Türkiye	2.00	1.89	1.77	1.71	1.63	1.51

The table includes only the provinces in which this study was conducted.
Source: "Total fertility rate by provinces, 2009-2023" by General Directorate of Civil Registration and Citizenship Affairs.

Table 16: Age Restricted Treatment effects: Intention to have a child

	(1)	(2)	(3)	(4)	(5)	(6)
	Child within 2 years		Child within 5 years		Child at some point	
T1	-0.0191	-0.0146	-0.0296	-0.0259	0.0329	0.0331
	(0.0229)	(0.0228)	(0.0283)	(0.0270)	(0.0331)	(0.0308)
T2	-0.0483**	-0.0438*	-0.0465	-0.0560**	-0.00932	-0.00927
	(0.0230)	(0.0231)	(0.0284)	(0.0272)	(0.0332)	(0.0310)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1 = T2	0.204	0.203	0.552	0.265	0.205	0.170
N	1361	1361	1361	1361	1361	1361
Control mean	0.16	0.16	0.26	0.26	0.48	0.48

Notes: This table reports OLS estimates of the effects of the treatments on the intention to have children variables, but for female participants under 45 and for male participants whose partners are under 45. In the first two columns, the outcome is intention to have child in two 2 years, in the second two, it is intention to have child in 5 years; and in the third two, it is intention to have child at some point. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 17: Age Restricted Treatment effects: Ideal number of children

	(1)	(2)
	Ideal Number of Children	
T1	-0.471***	-0.478***
	(0.102)	(0.0904)
T2	-0.876***	-0.931***
	(0.102)	(0.0912)
Controls	No	Yes
p-value: T1 = T2	0.000	0.000
N	1361	1361
Control mean	4.45	4.45

Notes: This table reports OLS estimates of the effects of the treatments on the ideal number of children participants would choose, but for female participants under 45 and for male participants whose partners are under 45. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 18: Age Restricted Treatment effects: Stigma

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	-0.00249	-0.00199	0.0578**	0.0441*
	(0.0327)	(0.0329)	(0.0268)	(0.0259)
T2	-0.0457	-0.0497	0.121***	0.0943***
	(0.0328)	(0.0332)	(0.0269)	(0.0261)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.188	0.148	0.020	0.053
N	1361	1361	1361	1361
Control mean	0.43	0.43	0.15	0.15

Notes: This table reports OLS estimates of the effects of the treatments on the stigmatization variables, but for female participants under 45 and for male participants whose partners are under 45. In the first two columns, the outcome is perceived higher stigmatization about having children, and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 19: Age Restricted Treatment effects: Beliefs about Turkish Couples

	(1)	(2)	(3)	(4)
	Beliefs: n. children		Beliefs: ideal children	
T1	-0.00506	-0.00579	-0.447***	-0.525***
	(0.0694)	(0.0671)	(0.0811)	(0.0802)
T2	-0.114	-0.109	-0.697***	-0.695***
	(0.0697)	(0.0677)	(0.0814)	(0.0810)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.118	0.124	0.002	0.035
N	1361	1361	1361	1361
Control mean	2.35	2.35	3.36	3.36

Notes: This table reports OLS estimates of the effects of the treatments on the beliefs about Turkish couples' number of children variables, but for female participants under 45 and for male participants whose partners are under 45. In the first two columns, the outcome is the belief about the average number of children Turkish couples have, in the second two columns, the outcome is the belief about the ideal number of children Turkish couples have if they could choose. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 20: Attrition and Controls

	Attrition
Female	-0.0344*
	(0.0179)
Religious	0.0245
	(0.0178)
Conformity	-0.0325*
	(0.0177)
N	1600

Notes: This table reports OLS estimates of the effects of the gender, religiosity and conformity on attrition. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 21: Stigma: Religiosity heterogeneity

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	0.0290	0.0318	0.0568*	0.0474
	(0.0410)	(0.0408)	(0.0337)	(0.0324)
T2	0.0647	0.0776*	0.0697**	0.0542
	(0.0424)	(0.0423)	(0.0349)	(0.0336)
Religious	0.137***	0.149***	0.0601*	0.0673**
	(0.0420)	(0.0418)	(0.0346)	(0.0332)
T1×Religious	-0.0574	-0.0637	0.0275	-0.00487
	(0.0596)	(0.0589)	(0.0490)	(0.0468)
T2×Religious	-0.192***	-0.224***	0.0772	0.0528
	(0.0595)	(0.0591)	(0.0490)	(0.0469)
Controls	No	Yes	No	Yes
p-value: T1+ T1xReligious = 0	0.511	0.458	0.018	0.213
p-value: T2+ T2xReligious = 0	0.002	0.000	0.000	0.001
N	1600	1600	1600	1600
Control mean	0.40	0.40	0.15	0.15

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with religiosity on the stigmatizaton variables. In the first two columns, the outcome is perceived higher stigmatization about having children, and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 22: Stigma: gender heterogeneity

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	0.0207	0.0238	0.111***	0.0811**
	(0.0463)	(0.0460)	(0.0382)	(0.0364)
T2	-0.0317	-0.0474	0.165***	0.131***
	(0.0444)	(0.0441)	(0.0366)	(0.0349)
Female	0.0638	0.0315	0.0417	0.0989**
	(0.0426)	(0.0506)	(0.0352)	(0.0400)
T1×Female	-0.0394	-0.0392	-0.0747	-0.0616
	(0.0606)	(0.0597)	(0.0500)	(0.0472)
T2×Female	0.00694	0.0192	-0.0961*	-0.0900*
	(0.0600)	(0.0593)	(0.0495)	(0.0469)
Controls	No	Yes	No	Yes
p-value: T1+ T1xFemale = 0	0.632	0.690	0.255	0.523
p-value: T2+ T2xFemale = 0	0.539	0.485	0.038	0.199
N	1600	1600	1600	1600
Control mean	0.40	0.40	0.15	0.15

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with gender on the stigmatization variables. In the first two columns, the outcome is perceived higher stigmatization about having children, and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 23: Intention to have child: conformity heterogeneity

	(1)	(2)	(3)	(4)	(5)	(6)
	Within 2 years		Within 5 years		At some point	
T1	-0.00443	-0.00100	-0.00165	0.000386	0.0440	0.0424
	(0.0271)	(0.0268)	(0.0337)	(0.0320)	(0.0405)	(0.0366)
T2	-0.0361	-0.0516*	-0.0391	-0.0829**	0.0339	-0.0113
	(0.0282)	(0.0280)	(0.0351)	(0.0334)	(0.0421)	(0.0382)
Conformistic	-0.0423	-0.0223	0.0137	0.0185	0.00786	0.0388
	(0.0300)	(0.0297)	(0.0374)	(0.0354)	(0.0449)	(0.0406)
T1×Conformistic	-0.0313	-0.0304	-0.0713	-0.0422	-0.0665	-0.0278
	(0.0416)	(0.0411)	(0.0518)	(0.0490)	(0.0622)	(0.0561)
T2×Conformistic	-0.0133	0.00640	-0.0282	0.0357	-0.0985	-0.0132
	(0.0417)	(0.0417)	(0.0520)	(0.0497)	(0.0624)	(0.0569)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1+ T1xConformistic = 0	0.258	0.315	0.064	0.261	0.635	0.732
p-value: T2+ T2xConformistic = 0	0.109	0.139	0.080	0.193	0.161	0.557
N	1600	1600	1600	1600	1600	1600
Control mean	0.15	0.15	0.25	0.25	0.45	0.45

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with conformity on the intention to have a child. In the first two columns, the outcome is intention to have a child in two 2 years, in the second two, it is intention to have a child in 5 years; and in the third two, it is intention to have a child at some point. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 24: Stigma: conformity heterogeneity

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	0.0940**	0.107***	-0.0529*	-0.0369
	(0.0395)	(0.0393)	(0.0318)	(0.0311)
T2	0.0447	0.0476	-0.0228	0.0166
	(0.0411)	(0.0410)	(0.0330)	(0.0324)
Conformistic	0.190***	0.194***	0.0102	0.0145
	(0.0438)	(0.0435)	(0.0352)	(0.0344)
T1×Conformistic	-0.245***	-0.259***	0.240***	0.200***
	(0.0607)	(0.0602)	(0.0488)	(0.0476)
T2×Conformistic	-0.205***	-0.208***	0.238***	0.159***
	(0.0609)	(0.0610)	(0.0490)	(0.0483)
Controls	No	Yes	No	Yes
p-value: T1+ T1xConformistic = 0	0.001	0.001	0.000	0.000
p-value: T2+ T2xConformistic = 0	0.000	0.000	0.000	0.000
N	1600	1600	1600	1600
Control mean	0.40	0.40	0.15	0.15

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with conformity on the stigmatization variables. In the first two columns, the outcomes is perceived higher stigmatization about having children and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 25: Intention to have child: Turkish environment heterogeneity

	(1)	(2)	(3)	(4)	(5)	(6)
	Within 2 years		Within 5 years		At some point	
T1	-0.0243	-0.0130	-0.0295	-0.0166	0.0335	0.0478*
	(0.0214)	(0.0213)	(0.0265)	(0.0254)	(0.0318)	(0.0290)
T2	-0.0420*	-0.0362*	-0.0429	-0.0579**	-0.0155	-0.0120
	(0.0215)	(0.0215)	(0.0267)	(0.0257)	(0.0320)	(0.0293)
Turkish majority	0.0292	-0.0361	0.0341	-0.0620	0.190***	0.0517
	(0.0495)	(0.0495)	(0.0615)	(0.0591)	(0.0737)	(0.0675)
T1×TR_majority	-0.0162	-0.0129	-0.0644	-0.0402	-0.235**	-0.200**
	(0.0725)	(0.0714)	(0.0902)	(0.0852)	(0.108)	(0.0974)
T2×TR_majority	-0.102	-0.0965	-0.0916	-0.0429	-0.0590	-0.0367
	(0.0686)	(0.0677)	(0.0852)	(0.0808)	(0.102)	(0.0923)
Controls	No	Yes	No	Yes	No	Yes
p-value: T1+ T1xTR majority = 0	0.559	0.704	0.276	0.484	0.051	0.102
p-value: T2+ T2xTR majority = 0	0.028	0.038	0.097	0.186	0.442	0.576
N	1600	1600	1600	1600	1600	1600
Control mean	0.15	0.15	0.25	0.25	0.45	0.45

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with majority of Turkish in the environment on the intentions to have a child. In the first two columns, the outcome is intention to have a child in two 2 years, in the second two, it is intention to have a child in 5 years; and in the third two, it is intention to have a child at some point. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 26: Stigma: Turkish environment heterogeneity

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	0.0156	0.0153	0.0654**	0.0407
	(0.0312)	(0.0313)	(0.0257)	(0.0248)
T2	-0.0118	-0.0162	0.119***	0.0808***
	(0.0314)	(0.0317)	(0.0259)	(0.0251)
Turkish Majority	0.0895	0.0972	-0.0950	-0.0786
	(0.0724)	(0.0729)	(0.0596)	(0.0577)
T1×TR_majority	-0.193*	-0.152	0.0141	0.0553
	(0.106)	(0.105)	(0.0873)	(0.0832)
T2×TR_majority	-0.195*	-0.202**	-0.0518	0.00640
	(0.100)	(0.0996)	(0.0826)	(0.0789)
Controls	No	Yes	No	Yes
p-value: T1+ T1xTR majority = 0	0.080	0.172	0.341	0.227
p-value: T2+ T2xTR majority = 0	0.030	0.020	0.391	0.242
N	1600	1600	1600	1600
Control mean	0.40	0.40	0.15	0.15

Notes: This table reports OLS estimates of the effects of the treatments and their interaction with majority of Turkish in the environment on the stigmatization variables. In the first two columns, the outcome is perceived higher stigmatization about having children and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 27: Treatment effects on pregnancy 2nd wave

	(1)	(2)
	Pregnancy at follow up	
T1	0.0200	0.0184
	(0.0157)	(0.0159)
T2	0.0128	0.0135
	(0.0158)	(0.0160)
Controls	No	Yes
p-value: T1 = T2	0.649	0.754
N	1366	1366
Control mean	0.05	0.05

Notes: This table reports OLS estimates of the treatment effects on being pregnant or having a pregnant partner for the second wave. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 28: Pregnancy: 2nd Wave gender heterogeneity

	(1)	(2)
	Pregnancy at follow up	
T1	0.0360	0.0328
	(0.0247)	(0.0247)
T2	0.0218	0.0193
	(0.0238)	(0.0238)
Female	0.0314	0.00485
	(0.0227)	(0.0275)
T1×Female	-0.0283	-0.0243
	(0.0321)	(0.0318)
T2×Female	-0.0149	-0.0105
	(0.0319)	(0.0317)
Controls	No	Yes
p-value: T1+ T1xFemale = 0	0.708	0.678
p-value: T2+ T2xFemale = 0	0.746	0.678
N	1366	1366
Control mean	0.05	0.05

Notes: This table reports OLS estimates of the treatment effects and their interaction with gender on being pregnant or having a pregnant partner for the second wave. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 29: Pregnancy: 2nd Wave religiosity heterogeneity

	(1)	(2)
	Pregnancy at follow up	
T1	0.0635***	0.0530**
	(0.0214)	(0.0216)
T2	0.0492**	0.0435*
	(0.0224)	(0.0226)
Religious	0.0399*	0.0346
	(0.0224)	(0.0225)
T1×Religious	-0.0946***	-0.0744**
	(0.0315)	(0.0316)
T2×Religious	-0.0727**	-0.0612*
	(0.0316)	(0.0317)
Controls	No	Yes
p-value: T1+ T1xReligious = 0	0.178	0.357
p-value: T2+ T2xReligious = 0	0.291	0.430
N	1366	1366
Control mean	0.05	0.05

Notes: This table reports OLS estimates of the treatment effects and their interaction with religiosity on being pregnant or having a pregnant partner for the second wave. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 30: Treatment effects: Stigma on having children 2nd wave

	(1)	(2)	(3)	(4)
	People think I should have more children		People think I should have fewer children	
T1	-0.0665**	-0.0622**	0.0438	0.0354
	(0.0314)	(0.0303)	(0.0293)	(0.0267)
T2	-0.0763**	-0.0625**	0.0243	0.000947
	(0.0315)	(0.0306)	(0.0295)	(0.0269)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.754	0.993	0.506	0.194
N	1366	1366	1366	1366
Control mean	0.39	0.39	0.24	0.24

Notes: This table reports OLS estimates of the effects of the treatments on the stigmatization variables. In the first two columns, the outcome is perceived higher stigmatization about having children, and in the second two columns, the outcome is perceived lower stigmatization about having children. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 31: Treatment effects: Beliefs about Turkish Couples Second Wave

	(1)	(2)	(3)	(4)
	Beliefs: n. children		Beliefs: ideal children	
T1	0.311***	0.268***	-0.0309	-0.112
	(0.0664)	(0.0650)	(0.0759)	(0.0731)
T2	0.223***	0.153**	-0.0910	-0.128*
	(0.0668)	(0.0655)	(0.0763)	(0.0736)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.182	0.074	0.427	0.817
N	1366	1366	1366	1366
Control mean	2.50	2.50	2.55	2.55

Notes: This table reports OLS estimates of the effects of the treatments on the beliefs about Turkish couples' number of children variables. In the first two columns, the outcome is the belief about the average number of children Turkish couples have, in the second two columns, the outcome is the belief about the ideal number of children Turkish couples have if they could choose. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.

Table 32: Treatment effects: Beliefs about Syrian Couples Second Wave

	(1)	(2)	(3)	(4)
	Beliefs: n. children		Beliefs: ideal children	
T1	0.226***	0.158**	0.0261	-0.107
	(0.0825)	(0.0747)	(0.134)	(0.121)
T2	0.282***	0.228***	0.157	0.0786
	(0.0830)	(0.0753)	(0.134)	(0.122)
Controls	No	Yes	No	Yes
p-value: T1 = T2	0.496	0.342	0.328	0.123
N	1366	1366	1366	1366
Control mean	3.81	3.81	4.53	4.53

Notes: This table reports OLS estimates of the effects of the treatments on the beliefs about Syrian couples' number of children variables. In the first two columns, the outcome is the belief about the average number of children Syrian couples have, in the second two columns, the outcome is the belief about the ideal number of children Syrian couples have if they could choose. Odd columns report the estimates obtained without controls in the regression and even columns report the estimates obtained using controls. Standard errors are reported in parentheses. *, **, and *** denote significance at 10, 5 and 1 percent level, respectively.