

Assessment of Mothers' Knowledge, Attitudes, and Practices towards Teething in Uselu Community, an Urban Area of Benin City

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ABSTRACT

Background: Teething is an important developmental milestone in young children. It typically begins around the age of six months. However, mothers have erroneously associated systemic symptoms with teething.

Objective: To assess mothers' knowledge, attitudes, and practices towards teething in Uselu community, an urban area of Benin City

Materials and Methods: A descriptive cross-sectional study was conducted among 347 mothers in the Uselu Community. A convenience sampling technique was used to recruit the study participants. The tool for data collection was a researcher-administered structured questionnaire. Data was analyzed using SPSS Version 23.0 Software with a level of significance set at 0.05.

Results: A total of 347 mothers participated in the study. A majority, 298(85.8%), were aware of teething, with 31.7% reporting the source of information as being from neighbours who are mothers. The maternal beliefs about symptoms associated with teething were fever 304(87.5%), diarrhoea 237(68.3%), and irritability/crying 136(39.2%). About half of the respondents, 191(55.0%) had a fair knowledge of teething. The attitude of the respondents in this study revealed that just over half (59.2%) of the respondents believe that teething is physiological, and 145 (41.7%) disagree that dentists are the best professionals to visit. Overall, 252(73%) of all respondents had a negative attitude towards teething. An assessment of the mothers' practices during teething showed that 334(96%) self-medicated, over half; 204(61.1%) of which always use teething syrup, with a composite safe practice score of fair, 208 (60.0%). Bivariate analysis on teething practices and the sociodemographics of the respondents revealed that the proportion of respondents with good practices increased with increasing levels of education, and this was statistically significant ($p=0.001$). **Conclusion:** The common symptoms of teething reported by mothers in the study were fever, diarrhoea, and irritability. Overall, the participants had fair knowledge but a negative attitude towards teething. Mothers with tertiary level of education had good practices, and the composite safety practice score for this study was fair.

Key word: Teething, maternal knowledge, attitude and practice

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INTRODUCTION

Teething is described as a harmless, normal physiological phenomenon and is a term used to describe the emergence/eruption of primary teeth.¹ Tooth eruption is the process by which a tooth moves from its pre-eruptive position in the alveolar bone through the mucosa into its functional position in the oral cavity. The eruption of a tooth is divided basically into three phases: pre-eruptive, eruptive, and post-eruptive tooth movement. The pre-eruptive teeth movement is the preparation of the dental follicle to erupt into the oral cavity. The various movements that take place include bodily movement and eccentric growth. At the same time, the jaws are also growing; hence, this movement of dental follicles helps to maintain the position of the growing jaw.² Before tooth eruption, the crown of the tooth is covered by reduced enamel epithelium, and as the tooth migrates from its position in the jaw into the oral cavity, the enamel epithelium and oral epithelium fuses over the advancing tooth, the fused epithelium subsequently breaks down, and the tooth erupts into the mouth. The physiological process of tooth eruption is regulated by an array of genes, hormones, and factors such as interleukin 1 and thyroid hormones.³

The appearance of the first tooth in the oral cavity of an infant is regarded as an important developmental milestone in the child's life and is associated with a lot of emotions from parents. However, sometimes this period in infants can be difficult and distressing both for the child and their parents. Tooth eruption has, however, been held responsible for a variety of unrelated symptomatic manifestations.⁴ Studies have shown that parents' or caregivers' understanding of and belief about teething can have a profound impact on the clinical care of the child.⁵ This could impede preventive efforts, be an obstacle to medical care and in turn result in the use of ineffective or harmful remedies. Their traditional health beliefs permeate their attitudes towards seeking professional health care services, which could lead to morbidity or mortality.

In addition, at approximately 6 months of life, when the primary tooth erupts, protective maternal antibodies wane, exposing infants to the risk of infections. Furthermore, at this age, these children are known to put objects in their mouths to soothe their itchy gums, a phenomenon known as "mouthing". Mouthing can complicate the already

susceptible immunity, especially in a setting characterized by poor parental and environmental hygiene, further increasing the risk of infection, which an unsuspecting mother may wrongly attribute to teething. These erroneously associated symptoms include high fever, diarrhoea and the attendant susceptibility to infection.⁴ Unlike these symptoms, which may lead to dehydration and death, the classical symptoms of teething are usually milder and include symptoms like redness and/or swelling of the gingiva, a slight increase in temperature, irritability, drooling, mouthing and sleep disturbances

To manage these symptoms, parents and health professionals use teething remedies whose efficacy is unsupported or unsubstantiated by scientific evidence. In many situations, parents use these remedies without the advice of a dental professional, but based on input from community nurses, friends, other mothers, self-help books, medical doctors and pharmacists. These remedies include but not limited to, pharmacological and non-pharmacological strategies, such as analgesics (paracetamol and ibuprofen) and non-pharmacological means like local massage.⁶

In a hospital-based study assessing the knowledge, attitude and perception of teething myths among medical doctors in Nigerian hospitals,⁷ authors found that a substantial number of doctors knew at least one associated symptom of teething. Their sources of information were mainly from school, personal experiences, parents and grandparents. In another Nigerian study among mothers, fever was the predominant complaint, and most mothers believed and attributed symptoms such as diarrhoea, vomiting, and increased salivation to teething.⁸ Moreover, most mothers agreed to seek medical help for teething symptoms and this attitude was found to be associated with their level of education. The authors thus concluded that the level of education had an impact on the attitude and health-seeking behaviour of mothers.

Despite the existence of ample evidence of varied racial and cultural beliefs in the efficacy of home remedies and their influence on health-seeking behaviour among adults, there is a dearth of research that examines the extent to which parents or guardians' knowledge about, response to, and their practices measures due to teething. Hence, this study assessed the knowledge, attitude and practice

of mothers concerning teething in Uselu, an urban area in Benin City, Nigeria. The outcome of this study would serve as a useful tool for the design of targeted healthcare programmes to educate and enlighten the group.

MATERIAL AND METHODS

This was a descriptive cross-sectional study carried out among mothers in the Uselu Community, located in Egor Local Government Area, Benin City, Edo State. All mothers who were available at the time of the study and willing to participate were included in the 3-month study period.

The minimum sample size for mothers was calculated using Cochran's formula for minimum sample size determination in a cross-sectional study⁹:

$$n = \frac{z^2 pq}{d^2}$$

Where N = Minimum sample size when the population is >10,000

Z = Standard normal deviate set at 1.96, corresponding to 95% confidence Interval

d = Degree of accuracy or error margin = 5% = 0.05

p = Prevalence in the target population estimated to have a particular characteristic

q = 1.0 – p

Therefore, using p = 71.7% proportions of mothers who believed that infant teething is associated with various symptoms in a study in Benin City, Nigeria¹⁰

p = 0.717

q = 1 - 0.717 = 0.283

N = $\frac{1.96^2 \times 0.283 \times 0.717}{0.05^2} = 311.8$

N = 311.8 = 312

Adjusted sample size for 10% non-response = N/1-0.10 = 346.67 = 347.

An interviewer-administered structured questionnaire (anonymous and with no identifiers) was used to elicit information from five broad areas, i.e. socio-demographic characteristics, knowledge, beliefs, attitudes and practices of nursing mothers towards teething.

Knowledge score: A scoring system was developed to assess the respondents' knowledge of teething. Five questions were used to assess knowledge. Appropriate responses to related questions were given a score of 5, and wrong answers were given a

score of 0. Cumulative scores were obtained from the addition of the appropriate and incorrect responses. A cumulative of 6 was obtained. The scores will be converted to percentages and classified as

- Poor knowledge is a score of 0-1, 0 to 39.9%
- Fair knowledge is a score of 2-3, 40.0 to 59.9%
- Good knowledge is a score of 4-5, 60.0 to 100%

Attitude score: Questions on the attitude of mothers towards teething were assessed using the 5-item Likert scale of strongly agree, agree, indifferent, disagree, and strongly disagree. There were ten questions assessing attitude. The "strongly agree" response to a question was given a score of '5' while the "strongly disagree" response to a question had a score of 1. The maximum score is 50, and the total score is converted to a percentage and classified thus:

- A negative attitude is a score of less than 50%
- A positive attitude is a score greater than or equal to 50%

Practice score: Ten questions assessed respondents' practice towards teething. For each question, a score of 3 was given for always, a score of 2 for sometimes, a score of 1 for rarely, while never was given a score of '0'; the maximum possible score was 30. The total score was converted to a percentage and classified thus:

- Poor practice is a score of 5-10, 0-49.9%
- Fair practice is a score of 11-20, 50 to 69.9%
- Good practice is a score of 21-30, 70% and above

The protocol for this study was reviewed by the College Ethics and Research Committee of the University of Benin, Benin City, Nigeria. Written informed consent and assent were obtained from all participants after explaining the objective of the study and assuring them of the confidentiality of the data.

Data analysis:

The questionnaires were screened for completeness, coded and entered into the IBM-SPSS Statistics 21.0 software. Results were presented using frequency tables and charts. Variables were compared using Fisher's exact test, the T-test for quantitative variables, and the chi-squared test for qualitative variables. The level of significance was set at $p \leq 0.05$.

RESULTS

A total of 347 mothers participated and responded in the study, giving a response rate of 100%. All the

respondents, 347 (100%), were females, 309 (89.2%), were married, and 263 (75.8%) had a secondary level of education. Two hundred and twenty-five (65.0%) respondents were from Benin, 327 (94.2%) were Christians, 145(41.7%) of the respondents had children aged 19-36 months, and 207(59.7%) of their children were males [Table 1].

Regarding the source of information, three-quarters of all respondents, 298(85.8%) were aware of teething, and 94 (31.7%) of them reported that they obtained their knowledge from their neighbours who are mothers, 85(28.6%), health practitioners (nurse), and 47(15.6%) from parents [Table 2]

With regards to maternal belief about symptoms associated with teething, over four-fifths 304(87.5%) of the respondents believed fever, 237(68.3%) diarrhoea, and irritability/crying 136, 39.2%) were symptoms associated with teething. [Table 3]

On the knowledge of the respondents, results from this study revealed that over half, 191(55.0%) of the respondents had a fair knowledge of teething, with only one sixth of the mothers, 58(16.7%) having a good knowledge of teething. [Figure 1]

Bivariate analysis of teething knowledge and the socio-demographics of the respondents revealed that knowledge of teething increased as the level of education increased, with 60% of mothers who had a tertiary level of education having good knowledge of teething. However, this association was not statistically significant ($p=0.770$). [Table 4]

An assessment of the attitude of the respondents revealed that just over half (59.2%) of the respondents believe that teething is physiological, 145 (41.7%) disagree that dentists are the best professionals to visit, and 202 (58.3%) disagree that

the use of an herbal mixture is not advisable.[Table 5] Overall, nearly three-fourths, 252(73%) of all respondents had a negative attitude towards teething [Figure 2] Bivariate analysis on teething attitude and the sociodemographics of the respondents revealed that mothers with no formal education have a negative attitude towards symptoms of teething, but this finding was not statistically significant ($p=0.195$) [Table 6]

Analysis of maternal practices during the teething revealed that over two-thirds of all respondents 263(75.8%) always offer self-treatment for symptoms of teething, 311(89.6%) of respondents never visit the dentist, 232 (66.7%) of all respondents never visit well baby clinic, 252(72.5%) of all respondents never visit medical doctor, and about 249(71.7%) of all respondents sometimes visit the pharmacists [Table 7]. Out of the 344(96 %) mothers who practice self-medication, more than half, 204(61.1%), always use teething syrup, 177(53.1%) sometimes use antibiotics, 123 (36.9%) sometimes use analgesics, 150 (44.9%) sometimes use the herbal mixture and 215(64.7%) never use teething toy. [Table 8] As regards composite score for practice among mothers, over half, 208 (60.0%) of all respondents had fair practice of safety measures, while 21.7% of all respondents had good practice, and 18.3% had poor practice. [Table 9]

Bivariate analysis on teething practices and the socio-demographics of the respondents revealed that with increasing levels of education, the proportion of respondents with good practices increased, and this was statistically significant ($p=0.001$) [Table 10]

Table 1: Sociodemographic characteristics of respondents

Variables	Frequency (N= 347)	Percent (%)
Marital status		
Single	14	4.1
Married	309	89.2
Separated	9	2.5
Widowed	6	1.7
Cohabiting	9	2.5
Religion		
Christianity	327	94.2
Islam	14	4.2
African Traditional Religion	6	1.7
Level of education		

No formal education	6	1.7
Primary	29	8.3
Secondary	263	75.8
Tertiary	49	14.2
Ethnic group		
Benin	225	65.0
Esan	37	10.8
Igbo	27	7.8
Urhobo	15	4.2
Etsako	14	4.0
Yoruba	12	3.3
Ijaw	11	3.2
Owan	6	1.7
Sex of child		
Male	207	59.7
Female	140	40.3
Age of child (months)		
0 – 18	121	35.0
19 – 36	145	41.7
37 and above	81	23.3

TABLE 2: Mother's awareness of teething and source of information

Variable	Frequency (N=347)	Percent (%)
Awareness of teething		
Yes	298	85.8
No	49	14.2
Source of information*		
	n = 298	
Radio/TV	32	10.8
Parents	47	15.6
Doctor	29	9.6
Nurse	85	28.6
Dentist	11	3.7
Neighbour	94	31.7

*multiple response

Figure 1: Knowledge Score of Mothers about Teething

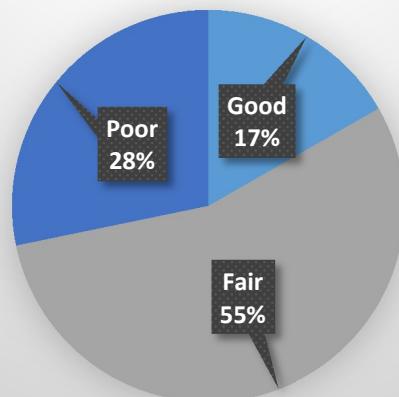


TABLE 3: Maternal symptoms and beliefs associated with teething

Perceived teething symptom*	Frequency(multiple)	Percent (%)
Diarrhea	237	68.3
Fever	304	87.5
Irritability/Crying	136	39.2
Conjunctivitis	11	3.2
Drooling of saliva	16	4.5
Rashes	46	13.3
Convulsion	3	0.8
Sleep disturbance	69	20.0
Headache	61	17.5
Vomiting	49	14.2

*Multiple response

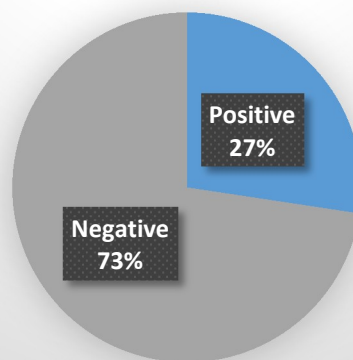
Table 4: Sociodemographics and knowledge of teething of mothers

Level of education	Knowledge of teething Frequency (%)			
	Good	Fair	Poor	Total
No formal education	0 (0.0%)	6 (100.0%)	0 (0.0%)	6 (100.0%)
Primary	9 (30.0%)	20 (70.0%)	0 (0.0%)	29 (100.0%)
Secondary	20 (7.6%)	145 (55.1%)	98 (37.3%)	263 (100.0%)
Tertiary	29 (60.0%)	20 (40.0%)	0 (0.0%)	49 (100.0%)

p= 0.770 Fischer exact= 4.998

Table 5: Attitudes of mothers towards teething

	Attitude towards Teething Frequency (%) N=347				
	Strongly agree	Agree	Indifferent	Disagree	Strongly disagree
Teething is physiological	205 (59.2)	52 (15.0)	78 (22.5)	11 (3.3)	0(0.0)
Doctors have a role to play in management of teething symptoms	145 (41.7)	23 (6.7)	49 (14.2)	43 (12.5)	87 (25.0)
Mothers have a role to play in management of teething symptoms	301 (86.7)	11 (3.3)	29 (8.3)	3 (0.8)	3 (0.8)
Use of herbal mixture is not advisable	58 (16.7)	61 (17.5)	20 (5.8)	202 (58.3)	6 (1.7)
Dentist are the best professionals to visit during teething	75 (21.7)	58 (16.7)	11 (3.3)	145 (41.7)	35 (10.0)
Self-medication is not always advisable	64 (18.3)	52 (15.0)	9 (2.5)	145 (41.7)	20 (5.8)
Teething syrup is not good for teething symptoms	87 (25.0)	115 (33.3)	6 (1.7)	115 (33.3)	23 (6.7)

Figure 2: Maternal attitude towards teething

TABLE 6: Sociodemographics and Attitude towards teething

Sociodemographics	Frequency (%)		Total
	Positive	Negative	
Level of education			
No formal education	1 (16.7%)	5 (83.3%)	6 (100.0)
Primary	6 (20.2%)	23 (79.8%)	29 (100.0)
Secondary	82 (31.2%)	181 (68.8%)	263 (100.0)
Tertiary	6 (17.5%)	43 (82.5%)	49 (100.0)
p= 0.195 $\chi^2=3.388$			

Table 7: Maternal Practices during Teething

	Frequency (%) N= 347			
Safety practices	Always N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)
Self-treatment	263(75.8)	71 (20.4)	10(2.9)	3(0.9)
Visit to the Dentist	9 (2.6)	11 (3.2)	16(4.6)	311(89.6)
Visit to the Well Baby Clinic	20(5.8)	37 (10.8)	58(16.7)	232(66.7)
Visit to a medical doctor	5 (1.4)	23 (6.6)	67 (19.3)	252(72.6)
Visit to a pharmacist	64 (18.4)	249 (71.8)	5 (1.4)	29 (8.4)

Table 8: Self-treatment undertaken by mothers during teething

	Frequency (%) N=333			
Practices of Self-Treatment	Always N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)
Use of teething syrup	204 (61.1)	78 (23.5)	43 (12.9)	8 (2.5)
Antibiotics	33 (10.0)	177(53.1)	78 (23.3)	45 (13.6)
Analgesics	93 (27.9)	123 (36.9)	52 (15.6)	65 (19.5)
Herbal mixtures	26 (7.8)	150 (45.0)	97 (29.1)	60 (18.0)
Teething toys	3 (0.9)	17 (5.1)	97 (29.1)	216(64.9)

Table 9: Composite Score for Practice among Mothers

Safety practice score	Frequency N= 347	Percent (%)
Good	75	21.7
Fair	208	60.0
Poor	64	18.3

Table 10: Sociodemographics and Maternal Practices during Teething

Level of Education	Maternal Practices Frequency (%)			
	Good	Fair	Poor	Total
No formal education	0(0.0%)	6(100.0%)	0(0.0%)	6(100.0%)
Primary	9(30.0%)	20(70.0%)	0(0.0%)	29(100.0%)
Secondary	37(14.1%)	162(61.6%)	64(24.3%)	263(100.0%)
Tertiary	29(60.0%)	20(40.0%)	0(0.0%)	49(100.0%)

p= 0.001 Fischer exact= 28.244

DISCUSSION

Teething is a natural process that creates little discomfort owing to the fusion of the tooth's reduced enamel epithelium with the oral epithelium, forming the junctional epithelium and allowing a relatively non-traumatic emergence of the tooth through the gingiva.¹¹ This fusion eliminates the need for the tooth to "cut" through the mucosa, potentially

minimizing inflammation and discomfort. Teething typically starts around 6 months old and can continue until the child is 2-3 years old, by which time all the primary teeth should have erupted.

In this study, the Benin tribe was the predominant tribe, and most respondents were Christians. This may be attributed to the fact that the study was

carried out in the city of Benin, where Christianity is the main religion of the people.

This study revealed that a high proportion of the respondents have heard about teething from their mother, neighbours and nurses. This finding is in agreement with another Nigerian study by Aliyu et al.⁸ Neighbours were a source of such information because they are the closest contacts to nursing mothers outside family members in any given community, and nursing mothers' interaction with nurses during antenatal, postnatal, and immunization clinics may have contributed. The rationale behind the fact that parents, especially mothers and grandmothers, are a source of information on teething could be due to the common practice of "**Omugwo**." This is a postpartum cultural practice among several Nigerian ethnic groups where the mother or mother-in-law of the new mother comes to **support, guide, and care** for both the mother and the newborn during the early weeks following childbirth.

In this study, most of the study participants erroneously chose fever as the most common symptom of teething. This finding is like some Nigerian and Indian studies¹³⁻¹⁵ The reported fever by the participants in this study may be due to other causes, which could be viral or bacterial infections. Diarrhoea was also reported by a majority as a symptom, yet again erroneously ascribed to teething. A finding similar to studies by Opeodu and Popoola,¹⁴ More et al,¹⁵ Owias et al,¹⁶ and Getaneh et al.¹⁷ However, the diarrhoea reported may be due to other causes, which may be related to the mouthing action by the child during this period and the attendant increase in the risk of infection. There is also a possibility of a gastrointestinal reaction from the introduction of food supplements during this period. Irritability was the third ascribed symptom, which coincidentally was a correct response according to the literature. Irritability associated with teething may be associated with the pain and discomfort the child experiences from the gum before the tooth emerges. However, in this study, irritability was reported by a minority, which is contrary to previous studies, where it was a majority response.¹⁵⁻¹⁷ This difference may be due to a lack of appropriate knowledge by the majority in this study. The misconceptions that teething causes high-grade fever and diarrhoea would often lead to inappropriate health-seeking behaviour or neglect of

potentially serious conditions and eventually the death of the child. Hence, parents are advised to seek prompt medical evaluation for any significant symptoms such as high-grade fever, persistent diarrhoea, vomiting, rash, or lethargy, rather than attributing these signs solely to teething

Overall, as regards knowledge of teething, we found a fair level of knowledge among the study participants. The term "fair knowledge" in this context typically refers to a partial understanding of teething symptoms and onset, often coexisting with misconceptions and culturally influenced beliefs. Thus, we can conclude that knowledge of our participants is neither completely accurate nor lacking, and is similar to the findings of a previous study by Jauro TS et al.¹³ Mothers with tertiary educational levels had better knowledge in our study, although this finding was not statistically significant. This is like reports from previous studies,^{13,14} and may be associated with the fact that mothers with tertiary education are less likely to attribute systemic symptoms to teething. These mothers are also more likely to identify true symptoms such as local gum inflammation, irritability, and a mild increase in temperature, and thus would avoid harmful traditional practices.

This study revealed that over half of the participants disagreed that the use of an herbal mixture is not advisable. Overall, most of the respondents have a negative attitude towards teething, which is similar to a finding in a previous Nigerian study.¹⁸ Due to the negative attitude towards teething, serious symptoms are viewed as normal, and thus medical attention is not sought. Instead, these mothers rely on over-the-counter medications which could jeopardize the health of their wards.

Therefore, the practice of mothers concerning teething is a subject of considerable importance, particularly in paediatric health and public health in general. In this study, the majority never visited a dentist or a medical doctor but rather over half self-medicated their children with teething syrups and antibiotics. This finding is like that by Jauro et al,¹³ and Osadiaye and Ogbeide.¹⁹ The rationale behind such practice could be due to the training from their mothers or grandmothers during the **Omugwo**, coupled with the ease with which such mothers have access to over-the-counter drugs, which greatly encourages self-medication.

The overall composite safety practice in this study was fair. A finding in agreement with a similar study by Osadiaye and Ogbeide,¹⁹ but at variance with a study by Olatunya et al,²⁰ that reported poor practice. The difference in their study and ours could be because they reported several harmful traditional practices, which reflects such practices in their study locality. In our study, mothers with tertiary educational levels had good practice of teething, a finding that was statistically significant and like a previous study.²¹ However, the unnecessary use of medications will no doubt worsen the already increasing problem of antimicrobial resistance. This study further underscores the importance of education for women.

CONCLUSION

The common symptoms of teething reported by mothers in the study were fever, diarrhoea, and irritability. Overall, the participants had fair knowledge and a negative attitude. Whereas mothers with a tertiary level of education had good practices, the composite safety practice score for this study was fair.

RECOMMENDATIONS

Public health programmes that will prioritize teething education and the integration of teething education into antenatal and immunization clinics, especially in rural or underserved areas or less educated populations, to bridge knowledge gaps and reduce harmful practices.

Source of Support

Nil

Conflict of interest

None declared

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