

		Ca	Mg	Se	Zn Bioavailability			Fe Bioavailability (i)				Iodine	
		(c)			High	Mod.	Low	15%	12%	10%	5%	(o)	
		mg/d	mg/d	µg/d	mg/d			mg/d				µg/d	
Infants	Premature											30 µg/kg(p) 15 µg/kg	
	0-6 mo	300 (a)	26 (a)	6	1.1 (e)	2.8 (f)	6.6 (g)	(k)	(k)	(k)	(k)		
	7-11 mo	400 (b)	36 (b)	10	0.8 (e)			6 (l)	8 (l)	9 (l)	19 (l)	135	
					2.5 (h)	4.1 (h)	8.3 (h)						
Children	1-3 y	500	60	17	2.4	4.1	8.4	4	5	6	13	75	
	4-6 y	600	73	21	3.1	5.1	10.3	4	5	6	13	110	
	7-9 y	700	100	21	3.3	5.6	11.3	6	7	9	18	100	
Adolescents													
	Males 10-18 y	1300 (d)	250	34	5.7	9.7	19.2	10	12	15	29	135	
									(10-14 y)			(10-11 y)	
									12	16	19	38	110
										(15-18 y)			(12 + y)
	Females 10-18 y	1300 (d)	230	26	4.6	7.8	15.5	9	12	14	28	140	
									(10-14 y) (m)			(10-11 y)	
									22	28	33	65	100
										(10-14 y)			(12 + y)
									21	26	31	62	
										(15-18 y)			
Adults													
	Males 19-65 y	1000	260	34	4.2	7.0	14.0	9	11	14	27	130	
	Females												
	19-50 y (pre-meno.)	1000	220	26	3.0	4.9	9.8	20	24	29	59	110	
	51-65 y (meno.)	1300	220	26	3.0	4.9	9.8	8	9	11	23	110	
	Males (65+ y)	1300	230	34	4.2	7.0	14.0	9	11	14	27	130	
	Females (65+ y)	1300	190	26	3.0	4.9	9.8	8	9	11	23	110	
Pregnancy	1st trim.		220		3.4	5.5	11.0	(n)	(n)	(n)	(n)	200	
	2nd trim.		220	28	4.2	7.0	14.0	(n)	(n)	(n)	(n)	200	
	3rd trim.	1200	220	30	6.0	10.0	20.0	(n)	(n)	(n)	(n)	200	
Lactation	0-3 mo	1000	270	35	5.8	9.5	19.0	32	40	48	95	200	
	4-6 mo	1000	270	35	5.3	8.8	17.5	32	40	48	95	200	
	7-12 mo	1000	270	42	4.3	7.2	14.4	32	40	48	95	200	

Appendix 8a.7 FAO/WHO Recommended nutrient intakes — minerals (a) Human breast milk. (b) Infant formula. (c) The data used in developing calcium RNIs originate from developed countries, and there is controversy as to their appropriateness for developing countries. This notion also holds true for most nutrients, but based on current knowledge, the impact appears to be most marked for calcium. (d) Particularly during the growth spurt. (e) Human-milk fed infants only. (f) Formula-fed infants, moderate zinc bio-availability. (g) Formula-fed infants, low zinc bio-availability due to infant consumption of phytate rich cereals and vegetable protein based formula. (h) Not applicable to infants consuming human milk only. (i) There is evidence that iron absorption can be significantly enhanced when each meal contains a minimum of 25 mg of Vitamin C, assuming three meals per day. This is especially true if there are iron absorption inhibitors in the diet such as phytate or tannins. (k) Neonatal iron stores are sufficient to meet the iron requirement for the first 6 mo in full-term infants. Premature infants and low birth weight infants require additional iron. (l) Bio-availability of dietary iron during this period varies greatly. (m) Non-menstruating adolescents. (n) It is recommended that iron supplements in tablet form be given to all pregnant women because of the difficulties in correctly evaluating iron status in pregnancy. In the non-anaemic pregnant woman, daily supplements of 100mg of iron (e.g., as ferrous sulphate) given during the second half of pregnancy are adequate. In anaemic women higher doses are usually required. (o) Data expressed on a per kg body weight basis is sometimes preferred, and this data is as follows: children 1-6 y = 6 µg/kg/day, children 7-11 y = 4 µg/kg/day, adolescents and adults 12+ y = 2 µg/kg/day, pregnancy and lactation = 3.5 µg/kg/day. (p) In view of the high variability in body weights at these ages the RNIs are expressed as g/kg body weight/day.